General Practitioner/Locum General Practitioner

Report on Opinion - Case 98HDC15681

Complaint

The Commissioner received a complaint about the treatment the complainant's grandson received from a general practitioner and a locum general practitioner. The complaint was that:

- *Between late May 1998 and early June 1998 the consumer was being treated by a general practitioner and his locum for diarrhoea and vomiting and had been prescribed Flagyl, Augmentin and Chloromycetin eye ointment.*
- *In early June 1998 the locum general practitioner again prescribed Flagyl for the consumer who was still suffering from diarrhoea. His condition got neither worse nor better but he was not taking his bottle.*
- *The consumer's grandmother was concerned that the providers were not communicating with each other over her grandson's condition and the locum general practitioner did not look at his medical file. The nurse at the Medical Centre commented that the consumer's breathing was "funny".*
- *Two days later the consumer was cold, his lips were purple, he was a little lethargic, irritable and was still not taking his bottle. Before 10.00pm his grandmother rang the clinic and was told that the the general practitioner was on duty. The general practitioner was telephoned at home and said "It's just a 24 hour bug. Give him heaps of water". The general practitioner was contacted two or three times that evening.*
- *At approximately 2.00-2.30am the following morning the consumer woke up very distressed and spots were noticed on his shoulder. He was taken to the general practitioner's house at around 3.00am. The consumer was examined by the general practitioner, who then telephoned to arrange his admission to hospital. Staff discussed whether to take the consumer to a hospital by ambulance or helicopter and he was given antibiotics.*
- *A decision was made to take the consumer to the hospital by ambulance. The ambulance only travelled a short distance and returned. The consumer's heart had stopped beating and ambulance staff spent approximately one hour trying unsuccessfully to resuscitate him.*
- *A paediatrician arrived by helicopter from the hospital and asked "How long has he been like this?" At this point, apart from the ambulance driver and clinic assistant, all medical staff had disappeared and the consumer's body was taken home by his family.*

General Practitioner/Locum General Practitioner

Report on Opinion – Case 98HDC15681, continued

Complaint *continued*

- *Later that day police and health workers arrived at the family's residence and family who had been in contact with the consumer were given preventative medication.*
- *The family was well informed about meningitis through the media and are concerned that the consumer's life was taken prematurely by a failure to correctly diagnose his condition by medical providers.*

Investigation Process

The complaint was received on 23 June 1998 and an investigation was commenced on 29 October 1998. Information was obtained from:

Complainants / consumer's grandparents
Provider / general practitioner
Provider / locum general practitioner
Medical Officer of Health from one city
Medical Officer of Health from a second city
Public Health Group, Ministry of Health

Relevant clinical records were obtained and viewed along with a copy of the post mortem report. The Commissioner obtained advice from an independent general practitioner.

Expert advice was submitted from the Director of Public Health at the Ministry of Health.

Information Gathered During Investigation

The consumer was born in late January 1997.

In early June 1998 the consumer's grandmother took him to a medical clinic. The consumer saw a locum general practitioner ("the locum") who had been contracted to provide services for a general practitioner ("the GP") from late May 1998. The locum advised the Commissioner that this was the first time she had seen the consumer. He presented with diarrhoea, vomiting and a slight fever of two days' duration. The locum was aware, from reading the GP's notes, that he had seen the consumer the day before she had started, in late May 1998, and had prescribed Chloramphenicol and Augmentin for an eye infection. She did not believe the problem the consumer presented with to the GP had any bearing on the present consultation.

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General Practitioner/Locum General Practitioner

Report on Opinion – Case 98HDC15681, continued

Information Gathered During Investigation *continued*

The locum advised the Commissioner:

> "*During my two weeks of working at the* […] *surgery I had seen many children with a gastroenteric illness that was going around the town. The symptoms were diarrhoea and vomiting lasting for several days, stool samples grew nothing, and it seemed to be helped with a course of metronidazole* [Flagyl]. *I assumed from* [the grandmother's] *history that this was what was causing* [the consumer's] *symptoms. I can recall examining* [the consumer], *assuring myself that he wasn't dehydrated. I talked to* [the consumer's grandmother] *about the importance of fluids and offered to give her some gastrolyte but we decided that he was keeping enough fluids down and his urine output at that stage was fine. I am sure that I would have also stressed to her, as I had to all the mothers of children with this particular illness, the importance of not letting him get dehydrated and that if he was getting worse or not taking fluids then he needed to be seen straight away. I prescribed some metronidazole* [Flagyl] *as it had helped other children who had a similar illness*."

The locum did not see the consumer again. She is currently working in another country.

The consumer's grandparents advised the Commissioner that three days later their grandson was a little lethargic, irritable and was not taking his bottle or eating. He was in bed with his grandfather at approximately 7.30–8.00pm.

The GP was on call that evening.

When the consumer's grandmother telephoned the GP at 10.00pm that evening, she told him that the consumer had a fever and asked for general advice. The GP advised that "*no rash was evident from specific enquiry*". He suggested the consumer be given Pamol. The GP advised the Commissioner that there was no specific symptoms described, and the consumer's grandmother described the consumer as being "*generally unwell*". The GP said that he has a "*low threshold for detecting concern in relation to patient's illnesses*" and that, in this case, he did not detect a *"high level of concern*" from the consumer's grandmother. He indicated that, in a rural area, and in keeping with the time of year, there were many children with gastroenteric and flu-like illnesses.

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General Practitioner/Locum General Practitioner

Report on Opinion – Case 98HDC15681, continued

Information Gathered During Investigation *continued*

The GP advised the Commissioner he was not involved in treating the consumer's vomiting and diarrhoea prior to this time and had no knowledge of his visit to the locum.

The consumer's grandmother telephoned again at 10.30pm and told the GP that the consumer was vomiting. The GP advised the Commissioner that the consumer's fever was "*less evident*" and his impression was of "*a child with non specific febrile illness, probably viral*". He said fluids were discussed as treatment. He told the consumer's grandmother to call again if she was worried.

The consumer's grandmother telephoned the GP at 3.00am the following morning. She told him that the consumer had a rash and purple lips. The GP asked her to bring the consumer in straight away. He diagnosed meningococael meningitis rash and possible septisaemia and/or meningitis.

The GP contacted a paediatrician at a hospital. He asked what dosage of Penicillin should be given at a local health centre prior to the consumer's transfer to the hospital.

The GP went to the health centre to supervise the consumer's treatment. Penicillin was administered and the consumer was given oxygen.

Clinical records indicate:

> "*Baby presented with family members, cyanosed (central), respirations rapid, oxygen 6 litres via Hudson mask initiated, Penicillin 700,000 units prepared and given at 0340 hours as per Dr's orders.*"

Transfer to the hospital by ambulance was arranged and departed at 3.52am.

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General Practitioner/Locum General Practitioner

Report on Opinion – Case 98HDC15681, continued

Information Gathered During Investigation *continued*

The ambulance returned to the health centre two minutes later. Clinical records indicate:

> "*Chief Complaint: Meningococal Meningitis ∏ cardiac arrest 14/6/98 2200hrs Grandmother rang Dr. Patient unwell, no rash Diarrhoea/vomiting. Advised fluids. 2230 Further call to GP. Patient still vomiting. Advised fluids. 0300 rang GP again, 'purple lips', rash, fever. Sent to* [the] *Health Centre for antibiotics and transfer via ambulance to* [the hospital]. *O/A Patient conscious, respiration rapid, slight cyanosis around mouth and ears. Oxygen being administered at 6 litres per minute – cyanosis improved slightly. Patient loaded oxygen 6 litres per minute cardiac monitored. Initially heart rate 126 ∏ ↓ 35. Baby non-breathing – leads checked IPPV, returned to health centre (time period of two minutes). CPR commenced.*"

The GP commenced resuscitation with the assistance of hospital and ambulance staff. The paediatrician from the hospital arrived by helicopter at approximately 5.00am. Resuscitation was discontinued. The paediatrician pronounced the consumer dead at 5.05am.

The consumer's grandfather advised the Commissioner that the paediatrician left with the GP and the nurse. The ambulance driver and nurse remained. The consumer's grandfather advised the Commissioner:

> "*My daughter carried* [the consumer] *out of the ambulance wrapped in a blanket and wearing the clothes he died in. Wrapped up in his clothes was a half used syringe with the cap on. All medical staff disappeared, with the only comfort from the ambulance driver, who is a teacher at my daughter's school.*"

The consumer's grandmother asked what would happen now and the consumer was taken into the family room at the health centre. He was taken home, washed, dressed and laid out on a mattress in the lounge.

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General Practitioner/Locum General Practitioner

Report on Opinion – Case 98HDC15681, continued

Information Gathered During Investigation *continued*

The GP advised the Commissioner that after he informed the whanau of the consumer's death he went home because there was nothing else he could do. As he did not know the cause of the consumer's death he could not sign a death certificate. He did not attempt to contact the Medical Officer of Health as it was outside normal working hours. The GP advised the Commissioner that neither he nor the paediatrician discussed the possibility of a post-mortem with the consumer's whanau. The GP acknowledged that he would do so if such a situation occurred again.

The GP contacted the Medical Officer of Health as soon as the office opened at 8am because he suspected that the consumer died of meningitis which is a notifiable infectious disease. Police and health workers went to the consumer's grandparents' home and the consumer's whanau were given antibiotics, as were those people who had had contact with him in the previous five days. The consumer's whanau were told the consumer needed to be taken to another city for a post mortem.

The Medical Officer of Health advised the Commissioner that it was necessary to perform the post mortem in the different city as the facilities at closer cities were not considered suitable from an infection control perspective.

The consumer's grandfather advised the Commissioner that his grandson's coffin was closed at 7.20pm that evening. The consumer's grandmother and her sister drove him to the other city that evening. The consumer's body was returned to his grandmother and the whanau at 6.20pm the next day.

A post mortem was carried out earlier that day. The report noted:

> "*This child appears to have been well cared for prior to the terminal illness. The diarrhoea reported by the grandmother was due to a rotavirus infection and the severity of the fluid loss associated with the diarrhoea led to dehydration which was apparent at autopsy.*
> *The cause of death was meningococcal septicaemia and although Nisseria meningitidis was grown from the cerebral fluid, no histologic evidence of meningitis was yet apparent. Death was due to natural causes.*"

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General Practitioner/Locum General Practitioner

Report on Opinion – Case 98HDC15681, continued

Information Gathered During Investigation *continued*

The final diagnosis was meningococcal septicaemia and rotavirus infection leading to dehydration.

The consumer's grandfather complained that the whanau were allowed to bring the consumer home and that a lot of people could have been put at risk because of this. He said the consumer went to a kohanga reo and was visited and kissed by a lot of children and adults.

Independent Advice to Commissioner

A Medical Officer of Health advised the Commissioner that meningococcal organisms colonise in the nose and throat and are spread by coughs and sneezes. People who have had contact with the deceased are at far greater risk of disease by associating with each other than they are with the person who has died because some of those people may have been colonised by the bug. That is why antibiotics are prescribed. There is little or no risk of infection to people having contact with the dead person.

The Commissioner sought independent advice from a general practitioner who, in response to a question about the indicators of meningococcal septicaemia, stated:

> "*The indicators for meningococcal septicaemia can be widespread and varied. The signs and symptoms can vary as the disease progresses from being non specifically unwell, to the classical headaches, vomiting, photophobia, neck stiffness and skin rash.*
>
> ***Treatment***
> *Menigococcal septicaemia requires intravenous antibiotics.*
>
> ***Was* [the locum's] *treatment reasonable in the circumstances?***
> *Given the symptoms and signs were primarily those of diarrhoea, vomiting and fever, and in the local disease context for that area at that time,* [the locum's] *management with Metronidazole, fluids and general advice was appropriate.*

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General Practitioner/Locum General Practitioner

Report on Opinion – Case 98HDC15681, continued

Independent Advice to Commissioner *continued*

Was the advice and treatment by* [the GP] *reasonable?
a. 2200 – with the given symptoms of fever, the advice of Pamol was appropriate. There is however no record of questioning or the information of any other type discussed.
b. 2230 – with the symptoms of vomiting now, and improved fever, advice regarding fluids was appropriate.
c. 0300 – with symptoms of a rash, immediate and correct assessment of the child was made, specialist advice sought and management started.
Overall this was reasonable management of these signs and symptoms.

Summary
It is my opinion that [the providers'] *management of this case was reasonable. The signs and symptoms as they were given were not specific for meningococcal septicaemia, and the alternative diagnoses reached were indeed probably more likely. When the signs and the symptoms were more obviously suggestive of meningococcal septicaemia, correct assessment and management was started. Unfortunately the more specific indicators for meningoccal septicaemia appeared too late for the diagnosis and ideal management to commence. This is a recognised feature of this disease.*"

The Commissioner received the following response to his opinion dated late April 2000 from the Director of Public Health at the Ministry of Health:

"*As you are aware, New Zealand is still in the grip of a meningococcal meningitis epidemic with approximately 20 fatal cases each year. Ensuring public awareness of issues, and promoting vigilance by the medical profession to ensure prompt diagnosis and appropriate management have been key components of our strategy to reduce the impact of this disease generally, but in particular is important in maintaining a low case fatality rate. As such the Ministry has provided the public and the medical profession with a great deal of information on this matter and has stressed the importance of getting your doctor to check for signs of this illness if you have any other symptoms.*

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General Practitioner/Locum General Practitioner

Report on Opinion – Case 98HDC15681, continued

Independent Advice to Commissioner *continued*

Based on the information in your report, the telephone consultation appears to be totally deficient and resulted in an incorrect diagnosis. The doctor assumed the child had a 24 hour viral gastroenteritis. He did not take a full history of the illness to determine that this was indeed the case. In addition, he did not ask to examine the child to confirm his initial conclusion. He could not possibly rule out the presence of a more serious illness with confidence, as was feared by the child's whanau. I consider this failure to correctly diagnose the seriousness of the child's illness as a significant breach of the Code.

The illness was clearly not a 24 hour illness and the doctor should have determined this fact during the telephone conversation. Had the GP taken an accurate history of the illness, he would have known that the child had already been seen by another doctor on two occasions for the same illness. Diarrhoea and vomiting over several days leading to dehydration in a young child is in itself a serious and potentially fatal illness. He did not, therefore adequately assess the extent to which the child was at risk from this problem, aside from any other illness.

In addition, any child presenting with a febrile illness, diarrhoea and vomiting needs to be examined to rule out a number of other diagnoses that may require antibiotic treatment, including meningococcal meningitis. If the child is reported by the family to have these symptoms, and to be 'very unwell' they should be seen immediately and examined for signs of meningococcal meningitis. These diagnoses cannot be ruled out over the telephone. ..."

General Practitioner/Locum General Practitioner

Report on Opinion – Case 98HDC15681, continued

Response to Commissioner's Provisional Opinion

The GP responded to the Commissioner's provisional opinion dated early March 2000 as follows:

> "*Thank you for the opportunity to respond regarding* [the consumer].
>
> *My comments are as follows:*
>
> *1.) The family chose to take* [the consumer] *home on their request.*
>
> *2.) Those at risk were already so – due to their contact with the child while he was ill.*
>
> *3.) Antibiotics would not be available for some time as prescribing them were the Medical Officer of Health's decision, and the appropriate drugs were not in the* […] *region.*
>
> *4.) The Medical Officer of Health would not probably be contactable till normal working hours.*"

The GP, through his solicitor, responded to the Commissioner's opinion dated late April 2000 as follows:

> "*I note that in your final opinion your recommendations were that* [the GP] *apologised in writing, and familiarised himself with his obligation under the Coroners Act and under the Health Act to ensure that he passes relevant information on to the family/whanau in the future. I understand that* [the GP] *has complied will be complying with these requirements.*
>
> *Your letter of* [early] *May then refers to a further step that you wish to take, and gives* [the GP] *the opportunity to respond to that, presumably in accordance with concepts of natural justice.*

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General Practitioner/Locum General Practitioner

Report on Opinion – Case 98HDC15681, continued

Response to Commissioner's Opinion *continued*

The Ministry of Health appears to have your opinion, and disagrees with it. With respect, this is not an unusual situation between medical practitioners, particularly when a specialist in a certain area of medicine is consulted or forms an opinion regarding a general practice matter. It is submitted that in such a situation, the opinion of the doctor who has had all of the original material prior to giving an opinion is to be preferred. In order to make findings against a practitioner of a particular specialty, it is usual practice to require the opinion to be from a practitioner of that specialty, in a similar situation to the doctor concerned. It would not be usual to ask a specialist to comment on a general practice requirement.

Again, with respect to [the] opinion [of the Director of Public Health], she is concentrating on a particular type of illness, as is required by public medicine specialists. In contrast, general practitioners see a vast number of patients who may only have diarrhoea and vomiting as symptoms which may or may not lead to meningitis. It is submitted that it is accepted that meningitis is one of the most difficult diagnoses for a general practitioner to make. As your opinion states 'it is a recognised feature of meningococcal septicaemia that the more specific signs do not arise until it is too late for effective treatment to be initiated'.

It is also important, to take into account the context of the telephone discussion. With the benefit of hindsight, it is very easy to suggest that a different course should have been pursued.

In that regard [the GP's] *instructions are as follows:*

1. *He was on call the evening* [the consumer's grandmother called]. *The initial telephone call from* [the consumer's grandmother] *was one of seeking general advice.* [The GP] *was advised that* [the consumer] *had a fever and was generally unwell. There were no specific symptoms described. And the telephone call was one requesting advice;* [the consumer's grandmother] *did not exhibit a high level of concern. It is clear that in this rural vicinity, and in keeping with the time of year, there were many children with gastroenteric and flu like illnesses.*

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General Practitioner/Locum General Practitioner

Report on Opinion – Case 98HDC15681, continued

Response to Commissioner's Opinion *continued*

2. *The development recorded in the second telephone call with* [the consumer's grandmother] *was vomiting. Again advice was given regarding fluids and to call back if there are any concerns.*

3. *In relation to the later events, it is clear that* [the GP] *and* [the paediatrician] *both saw the patient, and his family. Unfortunately neither* [the GP] *nor* [the paediatrician] *discussed the possibility of a post-mortem with* [the consumer's] *whanau, and* [the GP] *acknowledges that he would do so today.*

4. *In relation to contacting the principal medical officer of health,* [the GP] *did this as soon as the office was open, at 8am in the morning. He acknowledges that he should have advised the family that the Ministry of Health would be contacting them regarding any prophylactic measures. He also states however that antibiotics would not have been available for some time, as prescribing them was the Ministry of Health's decision, not his, and the appropriate drugs were not in the* […] *region.*

5. *As a result of this case,* [the GP] *has instructed me that he has changed his practice, with regard to young children showing flu like or diarrhoea and vomiting symptoms. He now sees any child whose parents ring up for advice regarding flu like and/or diarrhoea and vomiting symptoms. As you can imagine, being a rural general practitioner in an isolated area, this imposes an increased and extremely heavy workload on* [the GP] *during the winter months, when such illnesses are prevalent, and very few if any will be caused by meningococcal disease. This practice is, no doubt, more than most of* [the GP's] *colleagues would do. The change of practice is, however, a direct result of* [the consumer's] *death.*

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General Practitioner/Locum General Practitioner

Report on Opinion – Case 98HDC15681, continued

Response to Commissioner's Opinion *continued*

It is submitted however, that regardless of this change in practice, [the GP] *met an acceptable standard of care in relation to the telephone conversations at 10pm and 10.30pm that he had with* [the consumer's grandmother].

It follows therefore, that my instructions are that it is not accepted that there was a deficit of care as argued in [the] letter [from the Director of Public Health]. In such circumstances, it is submitted that there is no justification for a referral for competence. ..."

Response to Commissioner's Further Provisional Opinion

The GP, through his solicitor, responded to the Commissioner's further provisional opinion dated mid-June 2000 as follows:

"[The GP] *would ask you to take into account the reality of being a sole rural general practitioner covering patients in a large area. This is very different from being a public medicine specialist, or a city general practitioner, where after hours services cover the majority of problems that arise outside of the working day.*

In this context, [the GP] *is very experienced at taking telephone calls out of hours about illness. In this context also, the reality is that* [the GP] *has a low threshold for detecting concern in relation to patients' illnesses. In this case he did not detect a high level of concern from the grandparents during their calls to him. They were seeking advice.*

While [the GP] *did not take a lengthy history from the caller, he did have a clinical picture available from the description the grandmother gave, of the patient and his level of unwellness.* [The GP] *instructs me that if he had thought it was necessary to take a lengthy clinical history, he would have got the patient in, rather than dealt with them on the telephone.*

In these circumstances it is submitted that there is no need for a competence review of [the GP's] *performance, and that much of this matter is being looked at with the benefit of hindsight, and not taking into account, it is submitted, the realities of rural general practice.*"

General Practitioner/Locum General Practitioner

Report on Opinion – Case 98HDC15681, continued

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

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

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 –

e) Any other information required by legal, professional, ethical, and other relevant standards; …

General Practitioner/Locum General Practitioner

Report on Opinion – Case 98HDC15681, continued

Other Relevant Legislation

Coroners Act 1988

4. Deaths that must be reported-

(a) Every death that appears to have been-

(i) Without known cause; or
(ii) Suicide; or
(iii) Unnatural or violent.

(b) Every death in respect of which no doctor has given a doctor's certificate (within the meaning of section 2 of the Birth, Deaths, and Marriages Registration Act 1995):

Health Act 1956

74. Medical practitioners to give notice of cases of notifiable disease-

(1) Every medical practitioner who has reason to believe that any person professionally attended by him is suffering from a notifiable disease or from any sickness of which the symptoms create a reasonable suspicion that it is a notifiable disease shall -

(a) In the case of a notifiable disease, forthwith inform the occupier of the premises and every person nursing or in immediate attendance on the patient of the infectious nature of the disease and the precautions to be taken, and forthwith give notices in the prescribed form to the Medical Officer of Health, and, except where the disease is specified in Section B of Part I of the First Schedule to this Act, to the local authority of the district:

General Practitioner/Locum General Practitioner

Report on Opinion – Case 98HDC15681, continued

Opinion: No Breach Locum General Practitioner

In my opinion the locum did not breach Right 4(2) of the Code of Health and Disability Services Consumers' Rights by her failure to diagnose the consumer's meningitis.

My advisor informs me that the indicators of meningococcal septicaemia can be widespread and varied. Signs and symptoms can vary as the disease progresses, from being non-specifically unwell to classic symptoms such as headache, vomiting, light sensitivity, neck stiffness and skin rash. It is treated with large doses of intravenous antibiotics.

When the consumer was seen by the locum in early June 1998 the signs and symptoms were primarily those of diarrhoea, vomiting and fever. The locum had recently treated other children with the same symptoms in the district who had a gastroenteric illness and she based her diagnosis on the local context. In my opinion the locum's treatment was appropriate in the circumstances and complied with professional standards.

Opinion: Breach General Practitioner

In my opinion the GP breached Rights 4(2) and 6(1)(e) of the Code.

Right 4(2)

Telephone consultation

The Director of Public Health advised me that any child reported by the family to have a febrile illness, diarrhoea and vomiting, and to be "*very unwell*", needs to be examined to rule out other diagnoses that may require antibiotic treatment, including meningococcal meningitis. The GP advised me that general practitioners see many patients who may have only diarrhoea and vomiting as symptoms that may or may not lead to meningitis. He stated that, during the first telephone consultation with the consumer's grandmother three days later, he was advised that the consumer had a fever and was "*generally unwell*". The GP was subsequently advised that the consumer's fever was "*less evident*" and that he was vomiting.

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General Practitioner/Locum General Practitioner

Report on Opinion – Case 98HDC15681, continued

Opinion: Breach General Practitioner *continued*

My independent advisor informed me that, prior to 3.00am, the consumer's symptoms were not specific for meningococcal septicaemia and the diagnosis of non specific febrile illness was probably more likely. My advisor stated that, in these circumstances, the GP's advice regarding Pamol, at 10.00pm, and regarding fluids, at 10.30pm, was appropriate. When the consumer's grandmother telephoned at 3.00am the signs and symptoms more obviously suggested meningococcal septicaemia. My advisor commented that, at this time, the GP made an immediate and correct assessment, sought specialist advice in relation to treatment and appropriate management was commenced.

The issues raised by the Director of Public Health related to deficiencies in the GP's telephone consultation, not his failure to make a correct diagnosis in the first instance. The GP stated that there were no specific symptoms described in the initial telephone discussion with the consumer's grandmother, that he did not detect a high level of concern from her and that she was seeking advice. The GP, through his solicitor, indicated that he has a "*low threshold for detecting concern in relation to patient's illnesses*" and that "*he did not detect a high level of concern from the grandparents during their calls to him*". This statement implies that the level of concern exhibited by the consumer's grandmother was a critical aspect in the GP's assessment. The consumer's grandmother is not a medical practitioner. However, she was sufficiently concerned to contact the GP on two occasions, late on a Sunday evening, prior to the consumer developing a rash.

I accept the advice of the Director of Public Health that it was incumbent on the GP to take a full medical history to assist him in deciding whether or not the consumer was experiencing a 24 hour gastroenteric or flu-like illness, or whether the symptoms were suggestive of more serious illness. The Director commented that "*diarrhoea and vomiting over several days leading to dehydration in a young child is in itself a serious and potentially fatal illness*". The GP was unaware that the consumer had been seen by the locum three days earlier and that he had presented with diarrhoea, vomiting and a slight fever of two days' duration. Without the benefit of a full medical history, the GP was not in a position to determine whether even a gastroenteric illness should have been treated with a greater degree of concern.

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General Practitioner/Locum General Practitioner

Report on Opinion – Case 98HDC15681, continued

Opinion: Breach General Practitioner *continued*

In my opinion the GP did not query the consumer's grandmother sufficiently during their initial telephone conversation. A basic question should have been to ask how long the consumer had been ill. While the GP did not have access to the clinic's records, questioning would have led to his being informed of the extended duration of the illness and lack of progress. This would have informed him of the need to access the clinical records. It is a fundamental rule of diagnosis to obtain a medical history. This lack of inquiry was a breach of Right 4(2).

Right 6(1)(e)

Post mortem
The GP informed the consumer's whanau of the consumer' death and then left the medical centre's grounds. The consumer's grandfather described how his daughter exited the ambulance with the consumer's body in her arms and the consumer's grandmother questioned what would happen next. While the GP left the scene because he believed there was nothing else he could do, the consumer's whanau did not know what more, if anything, was required of them. In my opinion the GP was responsible for informing the whanau of the reasons for the necessary next steps and that, by failing to do so, he breached Right 6(1)(e).

Right 4(2)

The GP did not discuss the possibility of a post mortem with the consumer's whanau. Under section 4 of the Coroners Act 1988, unless the cause of death can confidently be established, and a death certificate signed, a doctor has an obligation to notify the Police of the death. The Police must then inform the Coroner. A Medical Officer of Health advised me that, in accordance with the Coroners Act, the body must either stay where it is or, more usually, be moved to the hospital mortuary until the Coroner gives directions. The Coroner may decide not to perform a post mortem and in that case the body may be taken home or be released to a funeral director.

As the GP was unable to sign the consumer's death certificate he had a legal obligation to notify the Police and he should have explained this to the whanau, and told the whanau they could not take the consumer home until the Coroner had decided whether a post mortem was required. His failure to do so was in breach of a legal duty imposed by section 4 of the Coroners Act and accordingly a breach of Right 4(2) of the Code.

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General Practitioner/Locum General Practitioner

Report on Opinion – Case 98HDC15681, continued

Opinion: Breach General Practitioner *continued*

Infection Control

I recognise that the consumer's sudden death was difficult for all present. However, it was incumbent on the GP, as a medical practitioner, to take the lead and inform the whanau about the procedures that must be followed since he suspected that meningitis, a notifiable infectious disease, caused the consumer's death. Under section 74 of the Health Act 1956 it was necessary for him to inform the Medical Officer of Health and to explain to the consumer's whanau the need to take immediate precautions against them developing the disease. In terms of infection control, people who have had contact with the person prior to death should take antibiotics to stop a potential spread of infection. The GP was aware of this obligation and contacted the Medical Officer of Health that morning.

The GP advised the Commissioner that he did not tell the consumer's whanau of the risk of infection as they would already have been exposed to meningitis during the course of the consumer's illness. He did not attempt to prescribe antibiotics as he considered that decision would be more appropriately made by the Medical Officer of Health.

Although the GP acted in good faith and may have wished to spare the consumer's whanau any additional grief, I do not accept that it was reasonable for him to return home without informing the consumer's whanau of the need to take precautions against their developing the disease. In my opinion the GP's failure to do so was a breach of a legal duty imposed by section 74 of the Health Act and accordingly a breach of Right 4(2) of the Code.

General Practitioner/Locum General Practitioner

Report on Opinion – Case 98HDC15681, continued

Actions

I recommend that the GP takes the following actions:

- Apologises in writing to the consumer's whanau for his breaches of the Code. This apology is to be sent to the Commissioner who will forward it to the consumer's grandparents.

- Familiarises himself with his obligations under the Coroners Act and the Health Act and ensures he passes relevant information on to family/whanau in the future.

Other Actions

A copy of my report will be sent to the Medical Council of New Zealand, with a recommendation that a review of the GP's competence be undertaken, and the Royal New Zealand College of General Practitioners. A copy of my report with parties' details removed will also be sent to the College for education purposes and to the Director of Public Health for distribution to Medical Officers of Health.

Actions Taken

The GP advised that as a result of the consumer's death, he has changed his practice and has undertaken to see any child showing flu-like or diarrhoea and vomiting symptoms whose parents call him for advice.