Medical Officer, Dr B

An Accident and Medical Clinic

A Report by the

Health and Disability Commissioner

(Case 07HDC16428)

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

Complaint and investigation

On 14 September 2007 the Commissioner received a complaint from Ms A and Mr A about the services provided by Dr B to their mother, Mrs A. The following issues were identified for investigation:

- *The appropriateness of the care provided to Mrs A by Dr B on 29 August 2007.*
- *The appropriateness of the care provided to Mrs A by an accident and medical clinic on 29 August 2007.*

An investigation was commenced on 23 October 2007. Independent expert advice was obtained from general practitioner and Accident and Medical specialist Dr Simon Brokenshire, and general practitioner Dr Stuart Tiller.

Parties Involved

Mrs A	Consumer
Ms A	Complainant/Mrs A's daughter
Mr A	Complainant/Mrs A's son
Dr B	Provider/Medical officer
Mrs C	Registered general and obstetrics nurse
The Accident and Medical Clinic	An Accident and Medical Clinic

Information gathered during investigation

Background

At 5pm on 29 August 2007, Mrs A, a previously fit and well 79-year-old who lived alone, was "overcome with severe pain in her neck and head" while talking on the telephone. The pain was so severe she could no longer continue her conversation.

Mrs A telephoned her daughter, Ms A, at 5.15pm, when she felt able to. She told her daughter that she thought she was "seriously ill". Ms A immediately collected her mother and took her to an Accident and Medical Clinic (the Clinic), arriving at 6.03pm. Ms A described her mother as "shaky on her feet, confused, and still in pain".

The Accident and Medical Clinic

On the evening of 29 August 2007, Dr B was the only rostered doctor on duty. Dr B is a registered with the Medical Council of New Zealand within a general scope of practice. He is employed as a salaried medical officer at the Clinic. Also working at

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the Clinic that evening was the receptionist and registered general and obstetrics nurse Mrs C.

The Clinic was busy on the evening of 29 August. The clinic records indicate that, between the start of Dr B's shift at 3pm and the time of Mrs A's arrival at 6.03pm, Dr B saw 11 patients. At the time of Mrs A's arrival there were three patients waiting, and another arrived a short time later.

Because of the workload, Mrs C decided that the back-up doctor should be called. This was in accordance with the policy that the decision to call a back-up doctor is a nursing decision and is based on "the numbers through the door and triage load". Mrs C recalls that Dr B was "not very pleased" when the receptionist told him that a back-up doctor had been called; he said they did not need to worry about him and that he would cope.

In contrast, Dr B recalls that he was more surprised than displeased when the receptionist told him a back-up doctor had been called. Dr B explained that this was primarily because on previous nights, which had been just as busy, no back-up had been called and he was simply told to "work faster". The Clinic confirmed that there had been nights when a back-up doctor had not been called, when one was perhaps indicated.

The back-up doctor was called at 6.20pm and arrived at 6.40pm.

Triage

As the nurse on duty, Mrs C was responsible for triaging[1] patients prior to being seen by the doctor. Mrs C called Mrs A through for triage at 6.20pm. Mrs C recalls that Mrs A walked from the waiting room to the triage room unaided. However, Ms A commented that Mrs C may not have seen her helping her mother go to the triage room.

Mrs C greeted Mrs A and her daughter, introduced herself and invited them to sit down — which they did. Before she was able to begin her assessment Dr B entered the room and stated that he would see Mrs A now. Dr B then led Mrs A and her daughter through to his consultation room.

In the clinical records, under "Triage" Mrs C recorded "1820hrs Straight to Dr". She categorised Mrs A as triage category 5 (low priority) because Mrs A was able to walk into the clinic and to the triage room and responded appropriately to her greeting.

Consultation

According to Ms A, the consultation with Dr B began with her mother outlining her concerns. However, before Mrs A could finish, Dr B interrupted stating that "he had limited time and would not listen to a long saga re her health". Ms A then took over

[1] The system of prioritising patients based on the severity of their condition.

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describing her mother's symptoms. Ms A recalls telling Dr B that her mother was generally fit and well, and that morning she had even driven herself to, and participated in, her weekly mah jong game. However, a few hours after returning home she had been "overcome with head pain". Ms A also explained to Dr B that since her mother had been started on a new medication a couple of weeks earlier, she had been feeling a bit "fuzzy headed [and] unsteady". Ms A gave Dr B her mother's medications, as she thought that this might be helpful to him in reaching a diagnosis. However, Ms A explained that Dr B pushed the medications aside and said that "they had nothing to do with it".

Dr B denies that he said that he did not want to "listen to a long saga re [Mrs A's] health". He considers that such a statement would have been "insulting, and it is not the approach [he] takes to the critical task of history taking". Dr B said that he was shown Mrs A's medications, and concern was expressed as to whether the medications could have caused her headache and unwellness. He said that he would come back to the medications, but first he asked that Mrs A, with her daughter's help, explain what her current symptoms were. This was "in order to build a picture of the symptoms, and create a context for her immediate concerns".

Following their discussion, Dr B understood that Mrs A had been unwell for at least two weeks. He recalls that the symptoms were vague but involved her feeling unsteady on her feet. He said that Ms A then explained that her mother had developed a right frontal headache over the course of the afternoon. Mrs A described a feeling of pressure in her head and face. When asked to locate the position of her headache, Mrs A indicated the right frontal aspect of her head. Dr B also noted that Mrs A had a past medical history of sinusitis, hypercholesterolaemia[2] and mild hypertension.[3]

Dr B recorded:

> "Unsteady on her feet at times last couple of weeks.
> Onset [right] frontal headache this afternoon — severe, head/face under pressure.
> Nil change vision, power, sensation or other on enquiry.
> [Past medical history] sinusitis in the past, hypercholesterolaemia, mild hypertension.
> Nil allergies."

Dr B then carried out an examination, noting that Mrs A did not have a temperature, had no neck stiffness and a regular pulse. He observed that she had a slight cough, and some nasal congestion, noting that she was breathing through her mouth and had a "significant post nasal drip". He also observed visible redness and heat over the right medial aspect of her forehead. On investigation, he found that her headache became worse with percussion over the right frontal sinus. He noted that her pupils were equal

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[2] High cholesterol level.

[3] Raised blood pressure.

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and reactive to light, and she had normal power, tone and sensation in her limbs. Dr B advised that he noted that Mrs A was not exhibiting any upper motor neurone signs. He recorded:

> "[afebrile]
> pulse 80/min Reg
> neck supple
> heat, tenderness, erythema — over frontal sinuses — [Right]>>[Left]. Percussion over [Right] frontal sinus exacerbates headache.
> PERLA[4]
> Limbs — tone, power, sensation, reflexes normal
> Nil else of note on exam."

Dr B recalls that he carried out a cranial nerve examination which was normal. However, he did not document his observations.

Following his examination, Dr B diagnosed frontal sinusitis.[5] He stated:

> "My assessment — based on the chronicity of this illness, the history of sinusitis, and the clearly visible red, hot, tender area over the right frontal sinus — was that [Mrs A] had right frontal sinusitis."

Ms A denies that her mother had any nasal congestion and was breathing through her mouth. Ms A recalls that when Dr B told her mother that she had sinusitis, she replied that she had had sinusitis 30 years ago and did not feel this was the same problem. Mrs A then reached for her medications again to ask Dr B some more questions about them, but he took them and "swiped them with force with his arm, resulting in them being scattered across the floor" and told her, in an "inpatient manner", to forget about them as they were not the issue.

Dr B does not recall Mrs A stating that she did not feel that day how she felt when she previously had sinusitis. However, he does not deny that this may have occurred. In his view, Mrs A's concern for her medications was distracting from the consultation and increasing her anxiety. He "dropped" the medications on the floor "in a small piece of theatre … in [an] attempt to try and help refocus the consult". Dr B elaborated that he "gently dropped them on the ground right next to his left foot … from approximately the height of his midcalf (whilst sitting)". His actions were intended "to try and move [Mrs A's] focus away from the medications". Dr B stated: "I certainly did not throw the medications across the room. In fact, I recall [Ms A] smiling at the time and I felt she had understood the reason for my action."

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[4] Pupils equal and reactive to light and accommodation.

[5] Mucosal inflammation of the paranasal sinuses.

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Dr B does not believe that any offence was taken at the time. However, he "accepts unreservedly that in hindsight it would have been preferable to not drop [Mrs A's] medications on the floor".

In contrast, Ms A denies indicating that she in any way approved of Dr B's actions. She was "privately appalled but kept quiet to see where he was going with this". She stated that any expression on her face would have more likely been a "grimace of anxiety". She recalls smiling only to reassure her mother.

Ms A specifically recalls Dr B telling her mother that she was not having a stroke. He also stated that he had been practising medicine for over 20 years and while GPs did sometimes make mistakes, this was not very common, and he provided them with reassurance that he was confident in his diagnosis. However, he said that they should go to hospital if they were concerned. Dr B said this in a "if you don't believe me kind of way". Ms A stated that the way he said this was "crucial because later on that evening when I was unsure about leaving Mum this particular conversation ran through my head [and] served to assure me I was ok to leave her".

Ms A recalls that after Dr B had provided this reassurance, she said, "If you are absolutely sure it is sinusitis then that is good news," and agreed to take the prescription for the antibiotics, antihistamines and nasal spray. Dr B then said to Mrs A that "you are not having a stroke … you will be surprised how quickly you will feel better once the antibiotics take effect".

Dr B advised that, while he specifically considered the possibility of stroke, given Mrs A's history and age, he considered that the most common signs and symptoms of stroke had been eliminated, including "one, or a combination of altered power and/or sensation (usually unilateral), speech, and/or visual disturbances". Dr B stated:

> "The headache was unilateral, frontal, and exacerbated by gentle percussion over the area of heat and tenderness. I was reassured that there was no neck stiffness or story of severe occipital headache with rapid onset — which would have been more consistent with subarachnoid haemorrhage."

Dr B confirmed that when he was asked, he "reiterated that he could find no evidence, on examination, that [Mrs A] was having a stroke". He followed this up by saying that if they had any ongoing concerns they could go to hospital for review. He also emphasised the need to see her GP the following morning.

Dr B did not take Mrs A's blood pressure. He states that this was probably because he assumed that the triage nurse had already taken it. (Ms A says he "knew full well that nothing had been checked or recorded" because he interrupted the nurse in the triage room within the first minute.) Dr B accepts that he should have checked Mrs A's blood pressure. However, he does not believe that Mrs A's headache was typical of malignant hypertension, so even if her blood pressure had been measured, the results may not have changed his opinion.

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Ms A recalls that Dr B then spoke about how the government was not looking after the health system, saying that "the medical profession is grossly underpaid, young guys in IT are earning more than doctors". She also recalls him talking about her mother's previous general practitioner. Ms A stated that she "presumed he was chatting like this to help [her mother] take her mind off worrying about her health and to relax her".

Dr B agrees that they did have a brief discussion at the end of the consultation about the shortage of doctors in New Zealand. He believes it was "precipitated by the observation from [Ms A] that [Mrs A's] long-standing GP had left and gone overseas and that he had been such a good GP and a loss to [New Zealand]". Dr B knew Mrs A's former GP from medical school. Dr B stated that his comments were made empathetically in response to Ms A and that he did not initiate the conversation.

Dr B stated that he told Mrs A to see her new GP the following morning, because frontal sinusitis is not a common condition and he felt it was important for her progress to be monitored. Dr B said he also felt that it was important for Mrs A to establish a relationship with her new GP. The clinical records state "GP review mane".

In contrast, Ms A vehemently denies that Dr B told her mother to see her GP the following day — "this conversation did not happen … never was a GP visit discussed and it is totally contradictory to his assurances that [my mother] would be surprised how quickly she felt better once the antibiotics took effect". Furthermore, Ms A stated:

> "I could not have missed this and was not the type of daughter to ignore such advice and Mum was clearly very concerned over how she felt [and] dubious of the sinusitis diagnosis hence referring back to her pills all the time that in turn got discarded … Neither she or I would have ignored advice for further enquiry."

According to the clinic records, the consultation lasted 30 minutes, ending at 6.50pm. Mrs A paid $70 for the consultation, at 6.52pm.

Return home

Ms A recalls that when her mother stood up following the consultation, she "could not put one foot in front of the other" without assistance. In contrast, Dr B recalls that although Mrs A walked slowly, "she did walk unaided both into and out of the consulting room".

Ms A advised that they left the Clinic and went "very slowly" across the road to the pharmacy to collect the prescription. Ms A then took her mother back to her house. Ms A stayed and had dinner with her mother as she still did not feel confident that her mother was all right. After Ms A had helped her mother get ready for bed, she left.

Ms A returned the following morning to check on her mother. When she didn't answer the door, Ms A let herself in. She found her mother on her bed semi-

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conscious, covered in vomit, and lying in her own urine and faeces. Ms A immediately called an ambulance and her mother was taken to North Shore Hospital.

North Shore Hospital
Mrs A was admitted to North Shore Hospital on 30 August 2007 at 11.42am. At the time of admission she presented with a decreased level of consciousness, was agitated, and could not speak.

A CT scan was subsequently performed (the hospital records refer to the history of a "thunderclap headache") and Mrs A was diagnosed as having had a haemorrhagic stroke — "large right fronto-parietal-temporal haemorrhage".

Mrs A was initially treated conservatively with strict blood pressure control. On 7 September 2007, while still on the ward, Mrs A deteriorated. A repeat CT scan showed a further bleed. A decision was subsequently made to treat Mrs A with palliative care only. She was discharged to private hospital care on 15 September 2007 and died a few days later.

The Clinic policy
The Clinic policy on "Neurology: Sudden Onset Headache" in place in August 2007 stated that "any patient presenting with a history of *sudden onset headache*, must have the possibility of *intracranial bleed* included in the differential diagnosis and be *discussed with the on call Medical Registrar*".

However, Dr B stated that because this policy had been introduced only the month before his consultation with Mrs A, "it had not been internally debated or brought to his attention in any way".

Changes made by Dr B
Dr B says that he is now vigilant about checking whether a patient has been triaged and about ensuring all observations, such as blood pressure monitoring, are carried out and recorded. He is also now more "conservative" in his approach and has a lower threshold for referring a patient to hospital in case of complexity or diagnostic rarity (such as frontal sinusitis).

Dr B is sorry his actions during the consultation were seen as disrespectful and discriminatory, since it was not his intention to be disrespectful. He has now adjusted the way he manages patient anxiety.

Dr B also now ensures that he has regular breaks and has slowed down to ensure that he is not rushing through patients. He had previously expressed concern about the workload pressures at the Clinic and the unavailability of back-up doctors, which leads to "a feeling of lack of safe clinical practice".

Response from the family
Ms A commented on Dr B's response to her mother's case as follows:

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> "Unfortunately, any changes [Dr B] claims to have made now are of no comfort to us as a family and the knowledge that my mother's final hours of consciousness were spent alone, scared and more likely in great pain, instead of in hospital with family around and as comfortable as possible with the aid of proper medical care. We are passionate about trying to prevent anybody else going through this trauma."

Independent advice to Commissioner

Accident and medical advice
The following expert advice was obtained from an Accident and Medical specialist, Dr Simon Brokenshire:

"*Statement of objectives*
I have been asked to provide an opinion to the Commissioner on case number 07/16428

I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

Declaration of possible conflict of interest
I am unaware of any conflict of interest that I may have in commenting on this case.

Qualifications:
MB.ChB (Otago, 1984), Dip Obs (Akld,); Dip Com A&E (Akld, 1995), FRNZCGP; FAMPA

Experience
I graduated in 1984, went into General Practice in 1990 where I have worked in city, rural and provincial settings. With the increasing trend for General Practice after hours care to be conducted out of an A&M setting I chose to do further training in this area of medicine obtaining my diploma in community accident and medical practice, followed by my fellowship of AMPA.

Over the last 6 years I have devoted my time solely to Accident and Medical care, working as a Senior Medical Officer in a busy A&M centre which also acts as the General Practice after hour's service. It sees some 60,000 patients/ year.

…

Further reading/ references
1. M. Ramzan; M. Fisher. Headache, migraine, and stroke. Up-to-date 15.2 Dec2007.
2. T. Schwedt; D. Dodick. Thunderclap headache. Uptodate15.2 Dec 2007.

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3. F. Cutrer. Evaluation of headache in the emergency department. Uptodate15.2 Dec 2007.
4. A. Holgate. Lecture: Headache. Emergency Medicine Symposium on Neurology. Nov 30, 2007. Christchurch, NZ.

Summary of events
This has been adequately outlined by the investigator and will not be repeated here.

Opinion regarding specific questions and advice sought

1. Please comment generally on the standard of care provided to [Mrs A] by [Dr B].

I believe the crux of this case hinges on whether the doctor adequately obtained the history, and then directed his examination to substantiate or discount postulated diagnoses, to a standard deemed acceptable by his peers.

The pertinent points in this case are an elderly woman presenting with a severe sudden onset of headache on the afternoon of presentation. This history alone gives 3 important red flags which may make a doctor consider discussing such a patient with a Colleague in secondary care. It certainly behoves a doctor to carefully tease out the history. Examination should be directed to give any weight to a possible secondary cause of the headache and attempt to formulate a likely differential diagnosis.

From my review of all the supplied documentation I believe that this history of a severe sudden onset of headache ***was*** *available to the doctor.*

I do not however believe this history was straightforward or necessarily easy to elicit. It appears the consultation was complex, had overlay of anxiety and concern, the patient may have been in pain and possibly had an element of confusion or slowed mentation, the doctor had outside pressures of a high workload, and to some degree the consultation appeared to break down providing a further barrier to eliciting such a history.

Added to this is the setting of an incident based environment where the patient's general appearance and functioning is unknown to the doctor, and that we are often seeing disease in an early stage of its evolution and when symptoms or signs can be subtle.

I base my opinion, that this *history* ***was*** *available to [Dr B],* on the facts that:

a. [Dr B's] notes reflect a history of a severe headache that afternoon.
b. That the patient presented with her daughter who would be able to give her account of her mother's history and of her normal functioning status.
c. In a letter some [two weeks] following this incident the daughter gave a history of her mother's presentation being that of a headache with neck pain

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whilst on the phone which was of a severity such that she was unable to carry on with the call.

d. This history also appears to have been conveyed to the hospital on the day following her review at the A&M clinic as there is documentation that one of the indications for CT scan was that of a 'thunderclap headache'.

Expansion/ explanation of opinion and audit of the medical notes
[Dr B's] notes are legible, time-lined, and concise. His notes document a history of a severe headache on the afternoon of presentation. No such documentation exists as to the nature of the onset. I believe it important to have attempted to clarify the nature and onset of the headache and clearly document such by pertinent positives and negatives. Headache is a common presentation to primary care. Primary headache is by far the more common headache than secondary headache. Even if a history of acute onset headache was not obtained a history of a severe headache was gained (along with some possible gait disturbance). Whilst one is aware of the statistically more likely diagnosis of a primary headache (which may be tension, cluster or migraine), in a setting of incident based acute care, one should be attempting to exclude any possibility of an important secondary cause. A differential of such may be meningitis, temporal arteritis, subarachnoid bleed, hypertensive crisis, space occupying lesion (e.g. abscess or tumour possibly with an acute change e.g. bleed), glaucoma, venous thrombosis, cervical artery dissection, ischaemic or haemorrhagic stroke.

Sinusitis is also a common diagnosis. Such a headache is however usually subacute in presentation. If it is of an acute nature and is due to sinusitis then it is often acute due to related intracranial complications having occurred. Also there is often some prodrome or history of conditions leading to sinusitis e.g. an upper respiratory tract infection, congestion, hayfever or a history of recurrent sinus problems. Although a history of past sinusitis is noted the daughter's account is one episode some years prior and that the mother stated that headache was dissimilar to that event.

[Dr B's] notes appear to enquire of other neurological symptoms which are negative. A past history is noted, along with sinusitis, of that of treated hypertension and hypercholesterolemia. No mention of the specific medications is made. Note is made of no allergies being known.

Documented examination observations include that of a normal pulse rate and no fever. No blood pressure is recorded and was an omission noted by the doctor. This is an important observation in an elderly woman with headache as one needs to rule out a hypertensive crisis.

Tenderness, warmth and erythema are noted over the frontal sinus with exacerbation of headache on percussion. No comment re congestion or signs of predisposing conditions to sinusitis are made. (The significance of these signs are debatable but did appear to lead the doctor along a certain diagnostic path.) There is comment on the neck being supple on examination. No specific comment re

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Kernig's sign (although often a late sign or subtle in a subarachnoid haemorrhage or meningitis).

There is limited documentation of a neurological examination with comment on pupils signs, examination of the limbs for tone, power and sensation with normal reflexes. It is unsure if this includes plantar reflexes which would be important.

There is comment that there was 'nil else on examination'. There is no documentation of a full cranial nerve examination including eye movements, fields and fundi. (The presence of fundi changes especially papillodema would be an important positive sign.) There is no comment on palpation of the temporal arteries. A diagnosis of sinusitis has been entered with treatment given but not specifically outlined in the bulk of the notes.

Follow-up is suggested by her GP in the morning with other review 'as required'. This is not unreasonable to suggest review as the doctor recognised some perceived anxiety around the consultation and review by someone who knew her is appropriate to ensure things are improving. More urgent review is also important and this instruction would typically involve expansion of what symptoms would warrant review. Such detail would not be expected to be documented.

It is my opinion that there were no overt neurological signs. The patient walked into the clinic and the daughter in her account talks of her Mother eating and drinking that evening following her departure from the clinic. However I believe a thorough neurological exam should have been conducted and documented as any subtle neurological deficit may have raised some concern in the doctor's mind. Such an exam may well have been normal. In this case there were some focal signs of tenderness and warmth over the frontal sinus. However in an elderly woman with a severe headache of relative sudden onset I feel on balance this history alone warranted a more cautionary approach.

[Dr B] despite being under some considerable work pressure does not appear to have been casual in his approach in that he spent upward of 30 minutes with this patient. His notes despite the omissions mentioned covered many aspects I would regard as important in record keeping and is more than I have observed when auditing some of my Colleagues' notes.

However for the reasons outlined I think on this occasion [Dr B's] performance is below the standard that is expected by his peers. …

I would regard [Dr B's] deviation from such a standard as being more to the mild end of the spectrum and I have considerable understanding and empathy for him in what appeared to be a difficult presentation and unfortunate outcome, the outcome of which may very well have been unlikely to have been greatly different even if an earlier admission to hospital had been achieved. This patient suffered from the outset a major medical event."

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Dr Brokenshire subsequently confirmed that the standards he applied are relevant for a medical practitioner working in an accident and medical setting, even though [Dr B] was not vocationally trained. In his view the history of sudden onset headache was available to [Dr B] and he did not provide an acceptable standard of care.

General practice advice
The following expert advice was obtained from general practitioner Dr Stuart Tiller:

> "[Dr B] has acknowledged that cerebrovascular accident (CVA) was on his list of differential diagnoses for [Mrs A]. He considered the physical findings 'more consistent with sinusits'. I agree that he did consider CVA. He specifically mentioned the absence of neck stiffness on two occasions and normal neurological findings in the limbs. He did not document examination of the cranial nerves or of balance and coordination.
>
> Medical students are taught that 60% or more of the information required to make a correct diagnosis is found within the history of the illness. The importance of history taking is emphasised to students. Studies in general practice have also shown that the majority of patients if left to talk uninterrupted at the outset of a GP consultation will complete what they wish to immediately convey to the doctor in two minutes. It is good practice not to interrupt a patient in that first two minutes. Until a patient feels 'heard' by the doctor they will not have confidence that the doctor understands the presenting problem. Once this initial information is shared it is then appropriate for the general practitioner or Accident and Medical doctor to focus further enquiry upon the main differential diagnostic possibilities.
>
> The presenting complaint of [Mrs A] required further 'teasing out' to clarify the significance of the headache.
>
> Was [Mrs A] prone to headache? Has she been a migraineur? Has she ever had a headache of this nature before? How did the headache start and how has it progressed? Of what intensity (out of a score of ten) is the headache?
>
> It is my understanding from the complaint letter of [Ms A] that the headache was of instant onset, while 'she had been on the phone' and was of a 'severe' intensity and started 'in her neck and head'. [Mrs A] immediately felt unwell, 'shaky on her feet', 'confused' and 'still in pain'. Something about this event convinced [Mrs A] and her daughter that they should seek immediate medical attention.
>
> [Mrs A] had experienced sinusitis once, thirty years ago, 'and it felt nothing like this'. Acute sinusitis usually arises in the context of a recent upper respiratory tract infection and is usually associated with nasal discharge and /or obstruction. The headache associated with sinusitis can be severe but usually would be gradual in onset over a period of a day.

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It would be most unusual for an isolated acute episode of sinusitis to present with a headache of acute onset 'like a thunderclap' and in the absence of prodromal respiratory symptoms.

Cerebral haemorrhage, conversely, almost invariably is acute in onset, may commence with neck pain proceeding to severe headache, and arises with no warning symptoms. A past history of hypertension or vascular disease may be identified. It is my view, in this regard, that the attempt of [Mrs A] to draw the attention of [Dr B] to her medication for hypertension and hyperlipidaemia was pertinent.

[Dr B] thought he could allay [Mrs A's] anxiety regarding 'stroke' by light hearted dismissal of her medications. It is my view that while humour may be appropriate with a well known patient where there is previous mutual understanding of some duration, a patient presenting for the first time who is clearly anxious requires careful explanation and discussion of the clinical reasoning in order to be reassured and not feel trivialised or treated dismissively.

[Dr B] has mentioned how busy he was that night. The blood pressure recording was mandatory but was omitted. [Dr B] documented advice that [Mrs A] should seek 'GP review mane'. There would have been no need for mandatory GP review the next morning for an appropriately treated acute sinusitis. It is my view that this documentation might suggest that he held some measure of residual concern regarding the possibility of a cerebral haemorrhagic event and thus suggested 'GP review mane'.

Cerebral haemorrhage is a medical emergency and where there is a mild to moderate degree of possibility of such a diagnosis, discussion with a hospital medical registrar or consultant should be undertaken. A doctor should take greater care when a potential diagnosis could have serious, if not fatal, consequences. Failure to correctly diagnose sinusitis could wait until 'GP review mane' but a diagnosis of possible cerebral haemorrhage cannot wait until 'GP review mane'.

It is my view that the communication of [Dr B] with [Mrs A] was inappropriate in the circumstances.

It is my view that [Dr B] did not provide diagnostic care of an acceptable standard for an A&M doctor making a diagnosis related to acute onset of severe headache."

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Response to first provisional opinion

Dr B

In response to my first provisional opinion, Dr B advised that he accepts Dr Brokenshire's criticisms and has made changes to his practice to ensure a similar event does not occur again. This includes either ensuring that triage has been performed or checking that all relevant information is gathered, before making a clinical decision.

Dr B advised that he is also more mindful at the way he "presents and interacts" in consultations. He believes that "long term heavy workloads had contributed to his sense of chronic time pressure, which may have led to giving the impression of hastiness or abruptness". He now ensures that he takes regular breaks.

In relation to the neurological examination, Dr B submitted that his clinical records indicate that upper motor neurone signs had been assessed and that they were normal. Dr B accepts that he did not document a full cranial nerve examination. However, he does recall testing Mrs A's eye movements, facial sensation, and gag reflex (while examining her throat) which were all normal. Dr B also advised that he observed no tongue deviation, and that Mrs A's hearing appeared normal.

Response to second provisional opinion

Dr B

On behalf of Dr B, his lawyer stated that "the practice of medicine is as much 'art' as 'science'" and reiterated Dr B's belief that, based on the evidence available, Ms A most likely had frontal sinusitis.

The lawyer contested a number of the facts and conclusions in the report, submitting that Ms A's recollection of events may have been influenced by the subsequent tragic outcome. She stated:

> "Where there is a tragic death, as in this case, it is urged that the Commissioner takes into account that the outcome must inevitably colour the recollections and perceptions of the consultation. It is important to assess the likelihood of certain events occurring and statement being made during the consultation against this background. Further, in hindsight, matters which were of no significance to [Mrs A] and [Ms A] during the consultation, and which were done for a specific reason, which was understood and not considered inappropriate at the time, have taken on a more unacceptable hue with the elapse of time and in light of [Mrs A's] death."

As an example, the lawyer stated that while Ms A "vehemently denies" Dr B recommended Mrs A see her GP the following morning, the contemporaneous clinical records support Dr B's assertion that he did.

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The lawyer reiterated that, while Dr B agrees that in hindsight he should not have dropped Mrs A's medications on the ground, he believes that it needs to be considered in the context of him trying to refocus the consultation. The lawyer stated that Dr B only dropped the medications on the ground "absolutely **only** after [Dr B] had examined the medication and discussed it with both [Mrs A] and [Ms A]". Furthermore, Dr B was confident that Mrs A's symptoms were indicative of frontal sinusitis, and not related to her medications.

The lawyer submitted that "[Dr B] was not inappropriately 'moaning' during the course of the consultation" and that Ms A initiated the conversation about why so many GPs are leaving to work overseas. Dr B used this "controversial opening to again stress the importance to Ms A of seeing her GP next morning as well as the importance of developing a relationship with her new GP" in accordance with Clinic policy. The lawyer stated that "it seems that the discussion about the general state of the health system … has also taken on a complexion and significance which is not justifiable or warranted".

The lawyer requested that the "'science' of inaccurate patient recall following consultations" be taken into account in reaching a final decision.

The lawyer reiterated Dr B's belief that the history he was provided by Mrs A was of a gradual onset headache, which had come on over the course of the afternoon. The information elicited during the course of the consultation supported the diagnosis of frontal sinusitis. The lawyer stated:

> "[Dr B] had previously, and subsequently, successfully determined very minor and subtle neurological signs consistent with stroke in many patients. He was, however, unable to elicit any such neurological signs on examining [Mrs A] on 29th August 2006. He discussed with them that whilst he could not find evidence of stroke, frontal sinusitis was a condition which would explain [Mrs A] feeling very unwell, but that follow-up with her regular GP in the morning was necessary. His plan was based on the understanding that for frontal sinusitis, in the absence of neurological signs, a 24-hour trial of oral antibiotics is appropriate, followed up by further assessment, and intravenous antibiotics if progress remains unsatisfactory. He genuinely believed that [Mrs A] would improve rapidly, but even then he still clearly advised, and documented, the importance of GP follow-up the next morning."

The lawyer submitted that the comments made by Dr Tiller were influenced by "hindsight bias" and reiterated that Dr B was never advised that Mrs A's headache had a sudden onset. This was the reason why Dr B did not engage in a discussion at the time with the hospital registrar or consultant. In the circumstances, taking into account the information he was presented with, "[Dr B's] working diagnosis was reasonable".

In summary, the lawyer commented:

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"[Dr B] acknowledges the imperfections of the consultation, and that he let the [family], the clinic and himself down; he has higher standards and knows that he did not meet them on this occasion. He repeats his sincere apologies to [Mrs A's] family, and sympathises deeply with their loss.

…

The Commissioner is therefore urged to follow the expert advice it received, and to conclude similarly that referral to the Medical Council for a competence review only is appropriate and sufficient. If there are deficiencies in [Dr B's] practice identified, they will be addressed and remedied, and patients will be safeguarded and protected.

While in no way comparing the grief suffered by [Mrs A's] family, it is a factor that [Dr B] has also suffered substantially as a result of this unimaginable outcome. It is hoped that he may also be extended some compassion and understanding in reaching a determination in the final opinion. "

Ms A

Ms A advised that she and her brother have never blamed Dr B for their mother's death. She stated, "We fully understand the extent of the type of stroke she suffered and that death was inevitable," highlighting the fact that her first letters of complaint were written prior to her mother's death.

Ms A explained that their main concerns have always related to the misdiagnosis and the disrespect shown by Dr B during the consultation. Ms A stated:

"… the night we visited [Dr B] she shouldn't have been left alone to go to bed scared and to be covered in vomit and faeces during the night, to be found by me the next morning, she was still conscious at this point (although not able to communicate properly) and suffering how much? We will never know. The point is she could have been in hospital, comfortable and monitored from the previous night.

…

They are inferring that in channelling my grief I am embarking on a witch-hunt of [Dr B] and I fiercely resent this. I do blame [Dr B] that she suffered alone that night and the unnecessary indignity of her demise. I also take personal responsibility for not following my gut instincts that night that something was more seriously wrong. But as stated in earlier correspondence, [Dr B's] assurances that he was confident in his diagnosis of sinusitis, the manner in which he said 'you could go to hospital' in a 'if you don't believe me' kind of way and his statement that she was not having a stroke, were all crucial factors in my leaving her that night."

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In conclusion, Ms A stated:

> "We find comfort that both Dr Brokenshire and Dr Tiller in their summaries found [Dr B's] performance to be below that standard expected by his peers, he did not provide an acceptable standard of care (Dr Brokenshire).
>
> And from Dr Tiller — greater care should have been taken when a potential diagnosis could have serious or fatal consequences, communication was inappropriate and diagnostic care was not of an acceptable standard for a diagnosis related to acute onset of severe headache."

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 1

Right to be Treated with Respect

(1) Every consumer has the right to be treated with respect.

RIGHT 4

Right to Services of an Appropriate Standard

(1) Every consumer has the right to have services provided with reasonable care and skill.

Other relevant standards

"Good Medical Practice — A Guide for Doctors" (Medical Council of New Zealand, 2004):

> "Domains of competence:
>
> …
>
> 2. Good clinical care must include:

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- an adequate assessment of the patient's condition, based on the history and clinical signs and, if necessary, an appropriate examination
- providing or arranging investigations or treatment when necessary
- taking suitable and prompt action when necessary."

Key findings

1. Mrs A, a previously fit and well 79-year-old, experienced a severe, sudden onset headache at 5pm on 29 August 2007. Around 6pm, she attended an Accident and Medical clinic accompanied by her daughter. She took all her regular medications with her.

2. Dr B, a doctor registered within a general scope of practice, working in Accident and Medical practice, saw Mrs A and her daughter. The clinic was fairly busy (Dr B saw 11 patients from 3pm to 6pm) but Dr B was coping.

3. Dr B interrupted the nurse's assessment of Mrs A in the triage room. He took Mrs A and her daughter straight through to his consultation room. The consultation commenced at 6.20pm and ended at 6.50pm.

4. Mrs A was understandably anxious. It appears that it was not easy for Dr B to elicit her relevant history.

5. Dr B interrupted Mrs A's account of her symptoms, listened to Ms A's explanation of her mother's history and symptoms, and documented a history of sinusitis, hypercholesterolaemia and mild hypertension. He also recorded the onset of a severe frontal headache that afternoon.

6. Dr B undertook and documented a thorough physical examination (checking temperature, pulse and neck suppleness — all normal). He noted tenderness and warmth over the frontal sinuses and found that the headache was exacerbated by percussion over the right frontal sinus. Her pupils were equal and reactive to light and her limb reflexes were normal.

7. Dr B detected no signs of a stroke such as altered power, sensation, speech, or visual disturbances. However, he failed to document a cranial nerve examination.

8. Dr B did not take Mrs A's blood pressure and did not check that the nurse had done so.

9. Dr B did not elicit that Mrs A's headache had come on suddenly.

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10. Dr B diagnosed "right front sinusitis", explained this to Mrs A, and reassured her that she was not having a stroke. However, he said that she should go to the hospital if she was concerned.

11. Dr B threw[6] Mrs A's medications on the floor and engaged in a conversation with her and her daughter in which he bemoaned the state of the health system and the fact that doctors are "grossly underpaid".

12. Although Ms A does not recall him doing so, it appears that Dr B told Mrs A to see her regular GP the next morning. I note that straight after the consultation he documented this advice — "GP review mane".

13. Mrs A deteriorated overnight and was diagnosed by a CT scan at North Shore Hospital the next day as having suffered a "large right fronto-parietal-temporal haemorrhage" (a stroke). Hospital staff elicited and documented a finding that the headache had an acute onset "like a thunderclap".

14. Mrs A's condition deteriorated and she died shortly afterwards.

15. Dr B is sorry for his misdiagnosis and has explained his mistake as due to work pressure and (in relation to throwing the medications on the floor) a misguided attempt to refocus the consultation. He has made changes to his practice (greater vigilance in checking blood pressure, lower threshold for referral to hospital, scheduling regular breaks).

Opinion

16. Dr B undertook a careful examination of Mrs A and kept a good record of his findings. The fact that a doctor in a busy Accident and Medical clinic, seeing a new patient for the first time, misdiagnoses a stroke (in the absence of signs of visual or speech disturbance or altered power) as sinusitis is not in itself evidence of a lack of care and skill.

17. Dr B failed to exercise reasonable care and skill in taking Mrs A's history. There were important clues to her stroke, including the sudden onset of her severe headache, her lack of history of severe headache, her age (79) and her medication for high blood pressure. The lack of any recent history of sinusitis was also not elicited. Even if Mrs A was confused, her daughter was well informed and capable of providing a full history for Dr B. As noted by my accident and medical expert, Dr Brokenshire, "it certainly behoves a doctor to carefully tease out the history". Dr B failed in this basic medical skill.

[6] I find Dr D's description of having "gently dropped" the medications on the floor from midcalf entirely unconvincing. Such a mild action would not have refocused the consultation, and is unlikely to have been recalled so vividly by Ms A.

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18. In failing to record Mrs A's blood pressure, Dr B overlooked "an important observation in an elderly woman with headaches" (in the words of Dr Brokenshire). As noted by Dr Tiller, "the blood pressure recording was mandatory but was omitted".

19. Dr B failed to document his cranial nerve examination. I note Dr Brokenshire's advice:

> "[A] thorough neurological examination should have been conducted and documented as any subtle neurological deficit may have raised some concern in the doctor's mind."

20. Because he failed to elicit the history of sudden onset headache, Dr B failed to take reasonable steps to eliminate the possibility of intracranial bleed from the differential diagnosis.

21. If Dr B did harbour a suspicion of a stroke, he needed to take a more precautionary approach. As noted by Dr Tiller:

> "Cerebral haemorrhage is a medical emergency and where there is a mild to moderate degree of possibility of such a diagnosis, discussion with a hospital medical registrar or consultant should be undertaken. A doctor should take greater care when a potential diagnosis could have serious, if not fatal, consequences. Failure to correctly diagnose sinusitis could wait until 'GP review mane' but a diagnosis of possible cerebral haemorrhage cannot wait until 'GP review mane'."

22. Dr B did not exercise reasonable care and skill in diagnosing sinusitis. As noted by Dr Tiller, "it would be most unusual for an isolated episode of sinusitis to present with a headache of acute onset 'like a thunderclap' and in the absence of prodromal respiratory symptoms".

23. Dr B was rude and disrespectful in throwing Mrs A's medication on the floor. This was highly unprofessional behaviour and cannot be excused as banter and an attempt at "a small piece of theatre". It was also insensitive for Dr B to spend time during a consultation with an anxious, unwell elderly woman and her daughter, bemoaning the state of the health system and the level of doctors' incomes. The Medical Practitioners Disciplinary Tribunal has recognised that failing to treat a patient with sensitivity and respect is unacceptable behaviour that may warrant disciplinary sanction: *Re Frizelle* (MPDT 219/02/94D, 3 December 2002), paras 68, 71.

24. Dr B's conduct during the consultation cannot be excused by work pressure at the clinic. Although the clinic was busy, he had been working for only three hours and had seen a steady flow of 11 patients. I also note that Dr B was able to spend 30 minutes in the consultation with Mrs A. Whatever concerns Dr B had expressed to management about work pressure in the past, there is no evidence

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that it was a significant factor on the evening of 29 August 2007. In any event, I do not accept that work pressure would ever justify rude and disrespectful behaviour during a consultation with a patient.

25. I conclude that Dr B breached Rights 4(1) and 1(1) of the Code, by his lack of care and his rude behaviour. He did not meet the standard of care and communication expected of a doctor working in an Accident and Medical clinic.

26. I conclude that the Clinic is not liable for the breaches of the Code by its employee, Dr B. The Clinic had appropriate policies in place to manage presentation of sudden onset headache, and a back-up doctor had appropriately been called when the clinic became busy after 6pm. Dr B's failings were his own and cannot be attributed to the system in which he was working.

27. I note Dr Brokenshire's empathy for Dr B's handling of "a difficult presentation" with an "unfortunate outcome". I accept that an earlier admission to hospital may not have prevented Mrs A's ultimate death. However, in my view Dr B must be held accountable for his inadequate care and his unprofessional behaviour. I also consider that his competence (clinical and communication skills) needs to be reviewed.

Non-referral to Director of Proceedings

This case is borderline for a referral to the Director of Proceedings. As noted by Venning J in *McKenzie v Medical Practitioners Disciplinary Tribunal* [2004] NZAR 47, an objective test must be applied in assessing conduct in a disciplinary context:[7]

> "The purpose of the disciplinary procedure is the protection of the public by the maintenance of professional standards. That object could not be met if in every case the Tribunal and the Court was required to take into account subjective considerations relating to the practitioner."

I endorse the following comment of Judge Doogue in *Perera v Medical Practitioners Disciplinary Tribunal*:[8]

[7] At para 71. This test has also been applied by the Health and Disability Commissioner in determining whether a doctor's conduct amounted to a breach of the Code of Consumers' Rights: see Opinion 02HDC01833, 30 September 2003 — poor care by doctor in accident and medical clinic not excused by doctor's personal circumstances. In a recent appeal to the High Court (*Dr E v Director of Proceedings*, HC WN CIV-2007-485-2735, 11 June 2008), Ronald Young J commented obiter that there may be personal circumstances that affect the seriousness of the conduct (paras 25–27).

[8] District Court, Whangarei, MA94/02, para 57.

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> "There can be no doubt that the test is harsh on medical practitioners who are working under-resourced and under-staffed and often extreme hours. The expected standard in relation to medical practitioners must be high, because unlike with lawyers and psychologists, errors can be life threatening or fatal. …"

Dr B did not meet the high standard expected of a medical practitioner. Although his lack of care (especially in history taking) may not meet the threshold for disciplinary action, in my view his rude behaviour is an example of conduct "likely to bring discredit to the profession".[9]

Relevant features in determining whether to refer Dr B to the Director of Proceedings include:

1. The complainant's support for referral.
2. Dr B is willing to undergo a performance assessment by the Medical Council, but submits that referral to the Director of Proceedings would be an excessive step, and not consistent with the independent advisor's assessment of Dr B's omissions.
3. Dr B has acknowledged that he did not meet expected standards, and has apologised to the family.
4. There is a public interest in denunciation (via professional disciplinary proceedings) of unprofessional behaviour, including disrespectful conduct towards patients, and in highlighting appropriate professional standards.
5. No broader public safety concerns arise in this case.

On balance, I have decided not to refer Dr B to the Director of Proceedings. In making this decision, I have taken account of Dr B's acknowledgment of his failures during the consultation on 29 August 2007, his assurance that he has learnt from this investigation, and his willingness to undergo a performance assessment by the Medical Council. In my view the public interest in denunciating his conduct and highlighting appropriate professional standards will be sufficiently achieved by holding Dr B accountable for breaching the Code of Rights, and publishing an anonymised version of this report on the HDC website. Little more would be achieved by the additional step of disciplinary proceedings.

[9] See the Health Practitioners Competence Assurance Act 2003, s 100(1)(b).

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Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand with a recommendation that it review Dr B's competence.
- A copy of this report, with details identifying the parties removed, except North Shore Hospital, will be sent to the Royal New Zealand College of General Practitioners and the Accident and Medical Practitioners Association, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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