Death by cardiac arrest following transfer of care

(99HDC10975, 27 June 2000)

General practitioner ~ Standard of care ~ Transfer of care ~ Record-keeping ~ Cardiac arrest ~ Rights 4(1), 4(2)

A woman complained about the services her late husband received from a GP. Although the GP had referred her husband to hospital to assess whether his chest pains were cardiac in origin, he was not sent by ambulance, and she felt that his death from a heart attack could have been avoided.

It was held that, based on the presenting symptoms, the GP showed reasonable clinical judgement insofar as he correctly determined that his patient required further assessment in hospital to rule out or treat a cardiac cause for the chest pain. However, the GP breached Right 4(1) in that the transfer of care was seriously lacking. Having considered the advisor's opinion that it would have been prudent for the GP to have made very definite and clear transport arrangements, the Commissioner stated:

> "In relation to matters of diagnosis and treatment, I accept that professional opinion will usually be decisive as to whether a medical practitioner has exercised reasonable care and skill. But in relation to a matter such as the need to ensure immediate transport, professional opinion of standard practice will ultimately be only a guide to my opinion. In such a case, I think it appropriate to ask what a reasonable consumer, in the particular consumer's circumstances, would expect of his or her practitioner. Viewed in that light, I have no doubt that a reasonable consumer, whose doctor had reason to suspect a clinical risk of dying, would expect that doctor to ensure that he had immediate transport to hospital. [The GP] did have reason to suspect that [the patient's] pain was cardiac, and was concerned enough to refer him to the Emergency Department at the hospital. In my opinion it was not merely prudent but necessary for [the GP] to ensure that [the patient] had immediate transport from the surgery to hospital. [The GP's] omission amounted to a failure to exercise reasonable care and skill. [The GP] therefore breached Right 4(1) of the Code."

The GP also breached Right 4(2), as his clinical notes were inaccurate and inadequate, and the referral letter was inconsistent with his notes. Neither the notes nor the letter indicated the GP's suspicions regarding the cause of his patient's chest pain.

The Commissioner recommended that the GP review his standard of referral letters and record-keeping, and arrange a practice review by the Royal New Zealand College of General Practitioners.