General Practitioner

Report on Opinion - Case 97HDC6919

Complaint

In mid-May 1997 the complainant wrote to the New Zealand Medical Council with a complaint about the services provided to his wife, ("the consumer") by the provider, a general practitioner. The New Zealand Medical Council forwarded the complaint to the Commissioner in accordance with the Medical Practitioners Act 1995. The complainant's complaint is that*:*

- *The complainant's wife, the consumer, was 24 weeks pregnant when she developed lower abdominal pains in April 1997.*
- *The following day the consumer and her husband attended a medical centre, where they saw the provider GP.*
- *The provider incorrectly diagnosed the consumer as suffering from gastroenteritis, sent her for blood and urine tests and told the consumer and her husband to come back in the late afternoon if the pains did not go away. The provider did not do a vaginal examination or refer the consumer to hospital.*
- *After the consultation, the consumer's waters broke and a baby boy was born 1 or 2 minutes later in the toilet. The baby was rushed to hospital but later died.*

Investigation

The complaint was received by the Commissioner on 27 June 1997 and an investigation was undertaken. Information was obtained from:

The Complainant
The Consumer
The Provider/General practitioner

The consumer's medical records were obtained from her general practitioner and the hospital and were reviewed. The Commissioner also obtained medical advice from a General Practitioner.

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Outcome of Investigation

One evening in early March 1997 the consumer developed lower abdominal pains. The pains were severe at times and kept her awake. Towards the early hours of the morning she suffered three bouts of diarrhoea. The pains became quite regular, occurring approximately every twenty minutes.

Between 7.00am and 8.00am the next morning the complainant took the consumer to a medical centre where she was seen by the provider. The consumer recounted her symptoms and told the provider she was pregnant. By this time the pains were occurring about every five minutes. This was the consumer's first pregnancy.

The provider examined the consumer's abdomen and recorded her blood pressure and pulse rate. He noted her abdomen was soft, and there was no vaginal discharge or bleeding. He did not perform a vaginal examination.

The provider advised the Commissioner he had treated several cases of gastroenteritis that week and believed the consumer had similar symptoms. The provider diagnosed gastroenteritis, ordered urgent blood and urine tests and prescribed an electrolyte replacement. The request was made to the laboratory and the consumer went from the clinic to the laboratory. The provider placed a "fax" instruction on the request but did not mark the request "urgent". All the provider's laboratory requests are faxed so there was nothing on this request which instructed the laboratory to complete the test and send the results urgently. The provider made a note to contact the consumer later that day when the results were to hand.

The provider told the consumer to go home. The provider noted that the consumer usually saw another general practitioner and was attending the local public hospital for ante-natal care.

After returning home the consumer was unable to settle, making repeated visits to the toilet. The complainant left the house. The consumer's pains continued, becoming more painful and frequent. After about two hours the consumer felt an urgent need to push. Within minutes her waters broke and her baby boy was born in the toilet.

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Outcome of Investigation, *continued*

The consumer rang the medical centre. Another doctor and a nurse arrived immediately. When the doctor arrived the baby took one or two voluntary breaths. The doctor immediately ordered an ambulance, delivered the afterbirth and recorded the consumer's observations as satisfactory. The doctor inserted an IV therapy line and transferred both the consumer and her baby to hospital.

The consumer was admitted to hospital that day at 11.45am. The records show that the consumer's condition was satisfactory but her baby had died. The histological report of the placenta and umbilical cord shows chorioamnionitis.

The provider advised the Commissioner that he did not believe the consumer was in premature labour because:

- There was no PV loss or bleeding or show
- The location of the pain
- The presence of loose motions over the previous 12 hours
- There were no contractions or bearing down.

The provider added that subsequent laboratory investigations revealed a considerably raised white cell count consistent with sepsis, possibly gastroenteritis. The bacteriuria was confirmed as a urinary tract infection.

Records from the consumer's usual general practitioner show she had an uneventful ante-natal period until that time. She was booked to have ante-natal care and delivery at the obstetric unit at the hospital.

The Commissioner obtained advice from a General Practitioner. The General Practitioner advised that while it was appropriate to examine the consumer abdominally and take her blood pressure, pulse and temperature:

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Outcome of Investigation, *continued*

"he [the provider] *failed to consider the implications of the fact that she was 23 - 24 weeks pregnant. In particular he failed to recognise the fact that the consumer was 23 - 24 weeks pregnant considerably affected the potential diagnosis. Even if he felt that gastroenteritis was the likely diagnosis he should have recognised that gastroenteritis is a potentially very dangerous problem in pregnancy because the release of prostaglandins from the smooth bowel can precipitate labour. To this end any pregnant woman who may be considered to have gastroenteritis needs to be assessed very carefully. Both [the consumer] and [the provider] acknowledged that the pains were occurring every 5 minutes or so and that she had had 3 loose bowel motions."*

The General Practitioner further advised the Commissioner that in this case it would appear that the consumer was in premature labour and that the colicky abdominal pains that she had been describing as occurring every few minutes were labour pains. The general practitioner said that the provider could have observed from his examination that she was having tightening of the uterus consistent with contractions.

"I feel that what [the provider] should have done was admit [the consumer] forthwith to [the hospital] for assessment. While it is reasonable to think that a vaginal examination to elicit the state of the cervix and whether or not any change was taking place might be appropriate the really important thing he should have done was to admit her to [hospital] for further monitoring and investigation. That I feel is the most serious deficit here. While an interim diagnosis of gastroenteritis may well be understandable it was not good medical practice to have allowed [the consumer] to simply go home again. If [the consumer] had been admitted forthwith to [hospital] for further investigation and observation the baby would have been born in more favourable circumstances."

Furthermore:

"...with the advantage of hindsight we can now see from the pathology report of the placenta that in fact she had an infection of the membranes called chorioamnionitis and in fact it was this that precipitated her labour."

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Code of Health and Disability Services Consumers' Rights

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

Opinion - Breach

In my opinion the provider breached Right 4(2) and Rights 6(1)(a) and 6(1)(b) of the Code of Health and Disability Services Consumers' Rights as follows:

Right 4(2)
The consumer was 23 - 24 weeks pregnant and suffering abdominal pain, which had persisted for over ten hours. The pain was regular and increasing in frequency and severity. The provider's records indicate he did not turn his mind to whether the consumer could be in premature labour. Given the consumer's history and symptoms the provider's failure to consider that she could have been in premature labour was a breach of Right 4(2) of the Code of Health and Disability Services Consumers' Rights.

The provider considered that the consumer had gastroenteritis. This is potentially critical in pregnancy, therefore the provider should have referred her to hospital. Given the effects of gastroenteritis on pregnancy, the provider's failure to refer the consumer to hospital where she could have been more appropriately monitored and investigated was a breach of Right 4(2) of the Code of Health and Disability Services Consumers' Rights.

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Opinion - Breach, *continued*

Right 6(1)(a), 6(1)(b)

The provider diagnosed that the consumer had gastroenteritis. Given that the consumer was 24 weeks pregnant, the provider should have informed her of the possibility of diarrhoea triggering the onset of labour. In my opinion the failure to do so was a breach of Rights 6(1)(a) and 6(1)(b) of the Code of Rights. Had the consumer been aware of the risk of labour starting both the consumer and her husband would have been capable of making their own decision about whether or not the consumer should proceed to the hospital.

The provider did not advise the consumer to ring him if symptoms persisted or advise her of his concerns. While in his response the provider advised he requested an urgent response from the laboratory, the request to the laboratory was not marked urgent, the provider did not document the urgency in his notes, nor was any urgency or concern expressed to the consumer and her husband.

Actions

I recommend that the provider take the following actions:

- Apologise in writing to the consumer and her husband for his breach of the Code in relation to the consumer's and the baby's care. This apology is to be sent to the Commissioner's office and it will be forwarded to the consumer and her husband. A copy of the apology will be retained on the Commissioner's file.
- Familiarise himself with the Code of Health and Disability Services Consumers' Rights, and confirm in writing to my office that he has done so.

I will refer this matter to the Director of Proceedings under section 45(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any actions should be taken.

A copy of this opinion will be sent to the New Zealand Medical Council with a request that the provider's competency to practice as a general practitioner be assessed.

A copy of this opinion with all identifying features removed will be sent to the Royal New Zealand College of General Practitioners and Royal Australasian College of Surgeons for their information.