General Practitioner

Report on Opinion - Case 97HDC8774

Complaint

The Commissioner received a complaint from a father about the services that were provided to his daughter, ("the consumer") by the provider, a general practitioner. The complaint is that:

- *In late July 1997 during a home visit, the GP did not conduct an adequate examination of the consumer.*
- *The GP did not respond appropriately to the consumer's presenting symptoms and the medical history provided by her friends who were present during the examination.*

Investigation

The Commissioner received the complaint on 17 September 1997 and an investigation was undertaken. Information was obtained from:

The Complainant / Consumer's father
The Provider / General Practitioner
Two of the consumer's friends

The consumer's medical records were obtained and the Commissioner sought advice from an independent general practitioner.

Background

The consumer has a history of cardiac problems and a previous stroke. She had a significant history of congenital heart abnormality, which included a reversal of the great arteries to the heart and one ventricle instead of two. This had been surgically corrected many years before. The consumer also suffered a left cerebra vascular accident in 1994 when she was 22 years old.

This history is well documented in the consumer's medical records that were held by her general practitioner. She was on medication for both of these problems and in addition was taking epilepsy medication. The consumer received follow-up care at a Hospital from both the cardiology and neurology departments.

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Outcome of Investigation

The consumer was staying with friends. One day in late July 1997 she began to feel unwell, suffering from a headache and she was vomiting. The next day the consumer felt better and was able to eat a small amount of food. The day after that she was again unwell with frequent vomiting.

Three days after the initial onset of illness the consumer was showing no signs of improvement and her friends were becoming concerned. One of the consumer's friends advised the Commissioner that the consumer had spent most of the day in bed and when she got up in the early evening she *"wasn't with it"*. During the day the consumer had been vomiting and was suffering from a severe headache. In the evening the friend called a Medical Centre where the consumer's usual general practitioner practised, and asked for a home visit, as she was concerned about the consumer's health. The consumer's general practitioner was not available but the provider/GP under investigation was the duty doctor on call and he agreed to visit after he had completed the evening surgery.

The GP arrived at the friends' home at about 10pm. He was shown to the bedroom where the consumer was lying down. The friend advised that she informed the GP of the consumer's history including her heart condition, previous stroke and epilepsy. She also showed the GP the consumer's current medication. The GP examined the consumer's stomach and concluded that she did not have appendicitis. The GP said that he would give the consumer something to stop the vomiting and in about an hour's time she should have something to eat.

The GP advised the Commissioner that:

> "*The consumer is a patient of* [another GP] *and I reviewed his notes of her previous history before leaving for the house call. I was accordingly informed about the medication she was on, and her medical history, particularly in relation to her cardiac history and epilepsy.*

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Outcome of Investigation, *continued*

I arrived at approximately 9.30am. I spent approximately half an hour on the attendance. The history that I obtained from [the consumer's friend] *indicated that she had been intermittently vomiting over the past two days, that vomiting had not been frequent. The history was obtained from* [the friend], *although* [the consumer] *was conscious and could answer some questions. After obtaining the history of intermittent vomiting and headache, I examined* [the consumer]. *I tested her neck for rigidity, which was not present. I was checking for any cerebral irritation or meningitis. I took her pulse and examined her abdomen. There was no abdominal pathology present, nor was she dehydrated.*

The history that had been presented was consistent with gastroenteritis, and I prescribed Maxolon to stop the vomiting. I asked [the consumer's friend] *to contact me if there were any further difficulties, and specifically to telephone me in the morning and let me know how she was feeling.*"

The GP's medical records indicate that:

"*House call requested by friend. Vomiting and not with it. Can't walk.*

Intermittent vomiting with headache 2/7 duration. Afebrile. No neck rigidity, no dehydration, abdomen ✓ Migraine.

Maxolon."

The consumer continued to vomit during this consultation. The GP also prescribed Mylanta.

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Outcome of Investigation, *continued*

The consumer's two friends were present through most of the consultation. One left for a short period after the consumer vomited. Both advised the Commissioner that the consumer was barely able to speak. They also advised that while the GP examined the consumer's abdominal area, they could not recall him examining her eyes, ears, heart, or taking her blood pressure.

The following morning, the friend rang the GP and informed him that the consumer had taken her Mylanta and had a little bit of soup that morning. He advised that the consumer continue with the food and liquid and he would ring at the end of surgery.

Between 12.00 and 12.30pm the GP rang to ask about the consumer. She had had a little bit more to eat and had not vomited anymore. She had not been up and had been asleep most of the time. The GP indicated that he would ring the chemist and prescribe Paramax for her headache. The friend advised the GP that she was not to have anything stronger than panadol because of her seizures.

The complainant advised the Commissioner that he arrived during the afternoon of that day to find his daughter disoriented with a fever, stiff neck, violent headache, photophobia and incontinence. She responded to commands and had no weakness, although she was unable to stand or walk.

The complainant attempted to contact his daughter's general practitioner but it was the doctor's day off. He then telephoned the Hospital Accident and Emergency Department and spoke to the casualty officer. The complainant was advised to bring his daughter to Hospital as soon as possible. She travelled to Hospital in an ambulance and on arrival was seen by the medical consultant and a CT scan was arranged. The CT scan confirmed that the consumer had a cerebral haemorrhage. She was transferred to the neuro-surgical ward at a second Hospital and two days later, was transferred to the intensive care unit with breathing and heart problems.

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Outcome of Investigation, *continued*

The GP advised the Commissioner that:

> "*At the time of the examination there were no clinical signs or symptoms suggestive of cerebral haemorrhage. As you will see, I followed up the patient's condition the following day. I advised her friend to contact me if there was any change in her condition. Unfortunately the symptoms that* [the consumer] *presented with were consistent with gastro-enteritis, and this was the working diagnosis that I made at the time of attendance.*"

Advice to Commissioner

The Commissioner's independent general practitioner advised:

> "*Examination details indicate that* [the consumer] *had no temperature with no neck stiffness, a normal abdominal examination and no dehydration. The GP records in his notes "?Migraine", although in his letter dated* [mid] *March 1998 he states the history was consistent with gastro-enteritis. In the notes there is no comment on the patient's state of consciousness, although his letter notes that she was conscious and could answer some questions. There is no record of the papillary reactions or other neurological examination. I would admit that high on the list of priorities of illnesses presenting with these symptoms would be gastro-enteritis. Cerebral haemorrhages are rarely seen in general practice and clinical diagnosis would be difficult without significant alteration in consciousness, neck stiffness or focal neurological signs, such as altered speech or weakness.*"

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Advice to Commissioner, *continued*

On whether the GP responded appropriately to the consumer's presenting symptoms and her medical history the advisor stated:

> *"[The GP] states that he did review notes of [the consumer's] previous history before leaving for the home visit and was informed particularly of her cardiac history and epilepsy. There is no comment on the fact that she had previously had a cerebral bleed, the cause of which was uncertain, and for which it appears she was not adequately investigated. The letters from the hospital indicate that there were some suspicion that [the consumer] did have a vascular abnormality in the left anterior portion of the brain.*
>
> *If indeed [the GP] did have this information then it should possibly have increased his index of suspicion, but once again I note the extreme difficulty of diagnosing a cerebral haemorrhage in someone this age with these symptoms at home. It is difficult to know whether early admission to hospital would have made a significant difference to the eventual outcome.*
>
> *[The GP] did appear to instigate appropriate follow-up arrangements.*
>
> *In summary, I would note that [the GP's] examination and assessment of the overall situation was probably not thorough.*"

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Response to Commissioner's Provisional Opinion

The GP responded to the Commissioner's provisional opinion as follows:

> *"Your advisor's opinion is written looking back on the events. I was conscious of [the consumer's] history cerebral haemorrhage*. [sic] *That had happened 3-4 years prior to my consultation with [the consumer]. There was no comprehensive cause for the intracerebral haemorrhage. It was not investigated any further at the time. However, it seemed from the notes, that cerebro vascular accident was most probably from the heart, or vascular deformity in the brain. [The consumer] was therefore not likely to have a significantly increased risk of cerebro vascular accident.*
>
> *In any event, I checked [the consumer] for neck stiffness. Here* [sic] *neck was not stiff. This precludes blood bleeding into the spinal cord. [She] did not have a significant alternation in consciousness, and was able to answer some questions. It is clear from your provisional opinion that [she] deteriorated considerably between the time that I saw her and the time of her father's arrival about 15 hours later.*
>
> *Your general practitioner advised that cerebral haemorrhages would be rarely seen in general practice and the clinical diagnoses would be difficult. In his or her assessment that my examination and assessment of the overall situation was probably "not thorough", does not seem to be based on any particular matters* [sic]. *I looked for alteration in consciousness, neck stiffness and altered speech. [The consumer] did not present to me with any of these symptoms. I clearly turned my mind to the fact that [she] could have suffered further cerebral accident because I checked neck stiffness, I was aware of level of consciousness, and I spoke with [her] and she was able to answer some questions."*

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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.

3) Every consumer has the right to have services provided in a manner consistent with his or her needs.

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Opinion: Breach

In my opinion the GP breached Right 4(2) and 4(3) of the Code of Health and Disability Services Consumers' Rights as follows:

The consumer had a significant medical history which was documented on her records. The GP advised me that he knew of the consumer's medical history. However there is no indication that he turned his mind to the possibility that she could have suffered a further cerebral accident. There is no documentation that at the time of the consultation he assessed the consumer's level of consciousness, pupil reaction, whether or not she could move her limbs, her state of speech or her reaction to light.

I accept my medical advisor's comments that cerebral haemorrhages are rarely seen in general practice and clinical diagnosis would be difficult without significant alteration in consciousness, neck stiffness or local neurological signs such as altered speech or limb weakness. While this may be so with most patients the consumer had a significant medical history which included cerebrovascular haemorrhage. Given that the GP said he read the consumer's history prior to the consultation he should have conducted a more extensive examination than he did. The GP's failure to conduct a more extensive examination is a breach of Right 4(2) and Right 4(3).

Record Keeping
The GP's recollection of the consultation extended to matters he did not record. In my opinion the GP's records did not represent a full record of the consultation. All health professionals have a duty to record full details of their consultations. This is particularly important when the consultation is a "one-off" and it is reasonable to conclude that other doctors may need to refer to these notes.

In my opinion the GP's failure to keep a full record of the consultation is also a breach of Right 4(2).

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Actions

I recommend that the GP take the following actions:

- Provide a written apology to the consumer for his breach of the Code. This letter is to be forwarded to my office and I will send it to the consumer.

- Review his method of record keeping to meet the current standards expected of a practitioner.

Other Actions

A copy of this opinion will be sent to the Medical Council of New Zealand.

A copy with names removed will also be sent to the Royal New Zealand College of General Practitioners to be published for educational purposes.