Dr A

A Public Hospital

A Report by the

Health and Disability Commissioner

(Case 01/11439)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Dr A	Senior House Officer, Provider
Ms B	Complainant
Dr C	Clinical Director, Emergency Service, A District Health Board
Dr D	General Practitioner
Dr E	Dr A's Registrar

Complaint

On 5 October 2001 the Commissioner received a complaint from Ms B concerning the services provided to her by Dr A and staff at a District Health Board. The complaint is summarised as follows:

> *On 29 July 2001 and 26 August 2001, staff at* [the public hospital's] *Accident and Emergency Department failed to provide services to* [Ms B] *with reasonable care and skill. In particular:*
>
> - *They failed to diagnose her subdural haematoma*
> - *On 26 August 2001* [Ms B] *was treated with Largactil, a treatment for migraine, which was inappropriate given her brain injury.*

An investigation was commenced on 9 January 2002.

Information reviewed

- Complaint letter from Ms B, dated 25 September 2001
- Response from Dr A, dated 12 February 2002
- Response from the District Health Board, dated 15 February 2002, and attached medical records
- Medical records from Dr D, dated 1 March 2002

Independent expert advice was obtained from Dr Peter Freeman, an emergency medicine specialist.

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Information gathered during investigation

On 29 July 2001 Ms B was involved in a serious car accident in which she suffered a very sore neck, collar bone, shoulder and ankle, and a severe headache. Ms B presented to the public hospital Emergency Department that same evening. X-rays of Ms B's shoulder, neck and collar bone were taken and Ms B was discharged with a prescription of pain-killers.

Ms B advised me that she suffered severe headaches throughout the month of August 2001 and these got progressively worse. On 26 August 2001 Ms B again attended the Emergency Department of the public hospital. Ms B was seen by Dr A, Senior House Officer, who recorded in his notes:

> "Involved in MVA [motor vehicle accident] one month ago, no head injury but pain left side chest and neck which had improved – c-spine films normal alignment and no break seen.
>
> Family history of SAH [sub arachnoid haemorrhage] – brother and uncle.
>
> History of migraine – left side of head.
>
> Thursday night – 9pm gradually developed headache – mainly left sided and behind left eye but also in a band around the head.
>
> Had eaten chocolate one hour previously.
>
> Throbbing character and aggravated by movement in any direction, especially bending over and coughing. Also return of pain left side of neck radiating up to behind left ear and feels a little dizzy.
>
> Pain became more severe over the course of the next 12 to 24 hours – especially whilst in town shopping.
>
> No photophobia/no nausea/no vomiting/no neck stiffness.
>
> Has used Paracetamol and Codeine with no relief – has not been pain free since Thursday.
>
> Usually uses Paradex for migraine.
>
> Under a lot of stress recently – mother died recently.
>
> Also c/o [complains of] brief episodes of pins and needles in left hand since accident (1-2/week, duration 3 minutes) – improving.
>
> No fever/no rash.

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> Patient feels that this pain is similar to her migraine but is concerned it could be SAH or related to her IHD [ischaemic heart disease]."

Ms B advised me that some of the information recorded by Dr A was not correct. She stated that the pain had not developed over the previous few days, but had been "relentless" for almost a month and had become "volcanic" over the past few days. She also advised that she took Paradex for hip pain and not migraine, and that she had not suffered a migraine for years.

Dr A advised me that he performed a full neurological examination and found no abnormality. Dr A made a preliminary diagnosis of migraine. After discussion with his registrar, Dr E, during which he was advised that a CT scan was not indicated, Dr A prescribed chlorpromazine (also called Largactil) and Ms B was discharged. Before leaving, Dr A advised Ms B to return if she felt the headache was worse or if she felt limb numbness, weakness or visual problems.

Ms B advised me that Dr A did not check her before she was discharged and that the Largactil did nothing but increase her pain. She stated that over the following two days she felt even worse, and on 28 August she visited her general practitioner, Dr D. Dr D requested an urgent CT scan and Ms B was admitted to a ward of the public hospital where she was diagnosed with a subdural haematoma.

Independent advice to Commissioner

The following expert advice was obtained from Dr Peter Freeman, an independent emergency medicine specialist:

> "*Claim*
> On 26 August, staff at [the public hospital's] Accident and Emergency Department failed to provide services to [Ms B] with reasonable care and skill. In particular:
>
> - They failed to diagnose her subdural haematoma.
> - [Ms B] was treated with Largactil, a treatment for migraine, which was inappropriate given her brain injury
>
> *Response from Dr Peter Freeman*
> In your opinion, was the examination of [Ms B] on 29th July 2001 sufficient?
>
> > *On the night of the 29th July and the morning of the 30th July* [Ms B] *was seen in the ED at the public hospital …In my view, given the history, the examination of* [Ms B] *was thorough and appropriate.*

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Was the examination of 26th August, conducted by [Dr A], sufficient?

> *On the 26th August* [Ms B] *was seen in the ED at the public hospital by* [Dr A]. *In my view, given the history, the examination of* [*Ms* B] *was thorough and appropriate.*

Should any further tests or examinations (for example, a CT scan) have been ordered?

> *Given the history of recent trauma the possibility of subdural haematoma should have been in the differential diagnosis and CT should have been considered and discussed with a senior Doctor.*

Was [Dr A's] provisional diagnosis reasonable and his prescription and anti-migraine medication appropriate?

> [Dr A] *has been thorough in his documentation of the history and examination. However he has narrowed his diagnosis down to Migraine without any documented evidence that he took the previous recent trauma into consideration. This is more a matter of experience rather than neglect. It was reasonable for Migraine to be in the differential diagnosis. However, as the presenting symptom was headache, post-traumatic subdural haematoma should have been in the differential diagnosis as well despite the absence of history of head injury. In defence of* [Dr A] *subdural haematoma is less likely following neck injury versus head injury. The prescription of anti-migraine medication was not unreasonable in the light of the diagnosis of migraine and will not have had any clinically significant effect of the eventual outcome. Chlorpromazine causes hypotension rather than hypertension.*

Full hospital notes have been submitted for your review. The actions of individual public hospital staff, apart from [Dr A], have not at this stage been investigated. In your opinion, is there sufficient information from the medical notes, to form an opinion on whether the service [Ms B] received was provided with reasonable care and skill?

> *The medical notes would indicate that the service to* [Ms B] *was provided with reasonable care and skill.* [Dr A] *went to the trouble of asking advice from the ED Reg* [Dr E] *and it is arguable that this doctor should have confirmed the history from the patient before advising anti-migraine medication. This however is a counsel of perfection and in a busy Emergency Department it is often not possible for an individual doctor to confirm history and re-examine every patient discussed by more junior staff.*

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Are there any aspects of any of the hospital staff which you consider warrant either:
Further exploration by the investigation officer?
Additional comment?

No."

Response to provisional opinion

In response to my provisional opinion, Dr A stated:

"I would like to make two comments. These are with respect to Dr Freeman's comment 'Given the history of recent trauma the possibility of subdural haematoma should have been in the differential diagnosis and CT should have been considered and discussed with a senior doctor.'

The first related to [Ms B's] neck injury. I was aware that [Ms B] had been involved in a motor vehicle accident one month previously and I had inquired as to the nature of the accident and the injuries sustained. In particular, I asked if she had received a head injury as a result of this accident, the nature of the impact and reviewed the notes from her previous attendance and also the report of the cervical spine x-rays. My reasoning behind this was to try and elucidate whether the headache was related to trauma, which would include the possibility of a post-traumatic subdural haematoma. Due to the combination of there being no history of head injury, the one month time lapse between the trauma and the onset of this headache and the apparent similarity between this headache and previous migraines, I felt that the probability of a subdural haematoma (or other intra-cranial bleed – [Ms B] had been concerned about having a sub-arachnoid haemorrhage) was low. This in retrospect was incorrect. I would like to submit however that I did consider it, and that my conclusion as to diagnosis was not unreasonable in these circumstances.

My second comment relates to [Dr E] and his supervisory relationship. A senior colleague was available at all times in the [public hospital] Emergency Department during the period I worked there. The registrars were all very approachable and we were encouraged to ask for assistance at any time. I trusted and valued the opinions of all the registrars and [Dr E] was no exception. Often the registrars would review the patient in person however, as Dr Freeman points out, this was not always possible.

My discussion with [Dr E] involved me relating my history and examination findings and discussing the possible differential diagnoses and treatment options. As I noted in my original submission, the need for a CT head scan was raised and at that time we decided it was not indicated. [Ms B] informed me that her headache had improved after the chlorpromazine infusion. If it had not I would certainly have discussed the

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case again with my registrar and would have obtained either a CT head scan or referral to the medical registrar for admission.

In summary I believe that I did consider the possibility of a subdural haematoma and did discuss it with a senior colleague.

Finally I would like to again express my regret at diagnosing [Ms B] with migrainous headache. I hope that she has made a full recovery and, regardless of your final opinion, I am willing to express my regrets in writing to [Ms B]. This episode has been a valuable lesson in the difficulty of the diagnosis of headache."

Code of Health and Disability Services Consumers' Rights

The following Right in the Code of Health and Disability Services Consumers' Rights is applicable to this complaint:

RIGHT 4

Right to Services of an Appropriate Standard

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

Opinion: No Breach – The Public Hospital

Examination on 29 and 30 July 2001

Following a car accident on 29 July 2001, Ms B was transported to the Emergency Department at a public hospital where she was examined and prescribed pain relief. Ms B was diagnosed with a bruise on her chest wall, a sprained ankle and neck pain. The possibility of head injury was considered, but on examination none was found. My emergency medicine advisor stated that the examination and history taking begun on 29 July 2001 and continued into the early hours of 30 July, was thorough and appropriate. I accept the advice of Dr Freeman. In my opinion, staff at the public hospital provided services with appropriate care and skill and did not breach Right 4(1) of the Code with respect to the examination and treatment of Ms B on 29 and 30 July 2001.

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Opinion: No Breach – Dr A

Examination on 26 August 2001
Dr A saw Ms B on 26 August 2001, ascertained her history and conducted an examination including a full neurological examination. Dr Freeman advised me that Dr A's examination was appropriate, but noted that given Ms B's history of recent trauma the option of a CT scan should have been considered and discussed with a senior doctor. I note that it is clear that Dr A did discuss the possibility of a CT scan with his registrar, Dr E, and that together they decided this step was unnecessary. In my opinion, Dr A provided services with appropriate care and skill and did not breach Right 4(1) of the Code with respect to his examination of Ms B.

Diagnosis
Having examined Ms B and taken a history from her, Dr A made a diagnosis of migraine. Dr Freeman advised me that a differential diagnosis of migraine was reasonable, and I accept that Dr A acted appropriately in identifying migraine as a possible cause of her symptoms. Dr Freeman also advised me that Dr A should have included Ms B's neck injury as a possible source of the symptoms and should have investigated this possibility before making a final diagnosis.

In response to my provisional opinion, Dr A advised me that he did consider the possibility of subdural haematoma (along with other types of intra-cranial bleeding raised as a concern by Ms B). Dr A stated that he inquired into the nature of Ms B's car accident and injury, reviewed the notes of her previous attendance and discussed the case with Dr E before discounting subdural haematoma as a diagnosis. With the benefit of hindsight, it is clear that the diagnosis of migraine was incorrect. However, in my opinion Dr A did consider the possibility of subdural haematoma, and took reasonable steps to eliminate this from his differential diagnosis. While Dr A's decision was incorrect, I accept the advice of Dr Freeman that it was not unreasonable. In my opinion, by taking steps to eliminate Ms B's recent trauma as a source of her symptoms, Dr A provided services with reasonable care and skill and did not breach Right 4(1) of the Code.

Prescription of Largactil
My emergency medicine advisor stated that Dr A's prescription of anti-migraine medication was not unreasonable and would not have had any clinically significant effect given that Ms B was actually suffering from a subdural haematoma. I accept Dr Freeman's advice that with respect to the prescription of Largactil, Dr A exercised reasonable care and skill. In these circumstances, Dr A did not breach Right 4(1) of the Code.

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Opinion: No Breach – The District Health Board

Vicarious liability
Employers are vicariously liable under section 72(2) of the Health and Disability Commissioner Act 1994 for ensuring that employees comply with the Code of Health and Disability Services Consumers' Rights. Since, in my opinion, Dr A did not breach the Code, no question arises of vicarious liability of his employer, the district health board.

Actions

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

- A copy of this opinion, with identifying features removed, will be sent to the Australasian College for Emergency Medicine and placed on the Health and Disability Commissioner's website, www.hdc.org.nz, for educational purposes.

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