Report on Opinion - Case 98HDC11212

Complaint

The Commissioner received a complaint from a woman on behalf of her deceased husband, the consumer. The complaint was that in mid-August 1996 the provider, a general practitioner, failed to accurately diagnose and treat the consumer.

Investigation

The complaint was received on 19 January 1998 from the complainant and an investigation was commenced. Information was obtained from:

The Complainant/Consumer's widow
The Provider/General Practitioner

A general practitioner gave advice to the Commissioner.

Outcome of Investigation

The complainant reported that on a Friday in mid-August 1996, the consumer woke feeling unwell. The consumer took 7.5mg of Renitec, his hypertensive medication, instead of the usual 5mg that morning because he thought the symptoms might have been related to high blood pressure. The consumer went to work but returned home later that day feeling dizzy and sleepy, and coughing up phlegm. As his usual GP was unavailable, the family contacted the provider, the nearest available GP for a consultation.

The provider reported that the consumer presented with vague symptoms of feeling unwell with dizziness and shortness of breath on exertion. The consumer was a non-smoker with no history of asthma or cardiac disease besides having hypertension. On examination the provider noted the consumer's blood pressure and pulse were within the normal range. The provider reported the consumer had a slight cough bringing up some whitish-yellow sputum. He had no symptoms of hot and cold or chest pain. The provider then made a diagnosis of bronchitis with a differential diagnosis of exercise-induced asthma and commenced the consumer on Respolin autohaler. The provider reported that he advised the family to contact him again if his sputum turned yellow so that he could prescribe antibiotics.

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Outcome of Investigation *continued*

The general practitioner advising the Commissioner reported that:

> *The presenting symptoms gave no indication of cardiac pathology. So an ECG was not warranted. It did not seem at that time that significant follow-up or close monitoring was indicated. It was the progress and deterioration in [the consumer's] condition that indicated the need for more/increased medical attention.*

The complainant reported that at the time of the consultation the provider diagnosed the consumer with asthma, not bronchitis, and gave him an inhaler. Furthermore, her husband was complaining of feeling cold and this was not reported accurately by the provider.

Later that evening, the complainant reported that the consumer began to cough up blood-tinged sputum and the family telephoned the provider once more. The provider prescribed an antibiotic (Augmentin) and arranged for the family to pick up the medication without seeing the consumer.

The provider stated he does not believe that he was told that the consumer was coughing up traces of blood or that the consumer's condition had deteriorated, when the consumer's brother-in-law picked up the prescription for antibiotics. The provider stated that if he had known there was blood in the consumer's sputum, he would have insisted on a further consultation. Instead he considered the later telephone call as a continuation of the original consultation.

The consumer's cough continued to trouble him overnight and he was unable to lie down for any period of time because of the persistent cough. The cough improved somewhat towards the morning. The family tried to telephone the provider the next morning. However the provider was not on call over the weekend. The family did not make any further attempt to call for medical assistance. During the morning, the consumer was given some cough medicine, and his cough had improved substantially.

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Outcome of Investigation *continued*

However the consumer's symptoms began to worsen later that day and an ambulance was called. The consumer collapsed at 7.30pm and on arrival the paramedics were unable to resuscitate the consumer. A postmortem examination reported the cause of death as myocardial infarction with congestive cardiac failure.

In the notes written by the provider there is no distinction made between the consultation and the subsequent telephone conversation with the family. From the notes it appears that the diagnosis of bronchitis and asthma was made at the same time with an inhaler and antibiotics prescribed. In his response to the Commissioner on 20 February 1998, the provider did not refer to this telephone conversation. However the provider has stated in a letter of 8 May 1998 to ACC as part of their investigation into the matter, that he did have this later telephone conversation with the consumer's family. The provider advised he thought the bronchitis to be of viral origin and therefore did not immediately prescribe antibiotics. The provider understood that the conversation related solely to the prescription of antibiotics, and their administration.

The 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.

Opinion: No Breach

Right 4(2)

In my opinion the provider has not breached the Code of Health and Disability Services Consumers' Rights.

The provider saw the consumer for the first time in August 1996. At this consultation the consumer had no clinical signs or symptoms that were suggestive of myocardial infarction. The provider made a diagnosis which was reasonable given the presenting clinical features of the consumer at this time.

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Opinion: No Breach, *continued*

The consumer's family and the provider give conflicting accounts on what information was given to the provider by telephone on the day of the initial consultation. The complainant and her father both stated they informed the provider that the consumer was coughing up blood-tinged sputum while the provider stated he was told that the consumer's sputum was a whitish-yellow colour. There is insufficient evidence to know which account is correct. However the provider's intervention of prescribing antibiotics is consistent with his belief that the consumer was suffering from an asthma-induced chest infection.

In my opinion, the provider's treatment of the consumer did not amount to a breach of the Code in respect of the original consultation. Furthermore, the accounts of the follow-up telephone call some hours later with the family member and the picking up of the prescription by the brother-in-law provide insufficient evidence that the treatment amounted to a breach of the Code. As the provider was not available the following day and no further medical advice was sought, it is my opinion that the provider did not breach the Code of Rights.