General Practitioner, Dr D / Midwife, Ms E

Opinion - Case 98HDC18102

Complaint

The Commissioner received a complaint from complainant/consumer's sister, Ms B, and complainant/consumer's mother, Mrs C, concerning the care and treatment that consumer, Ms A, received from general practitioner, Dr D, of the medical centre, and from Ms E, midwife, at the Maternity Centre. The complaint is that:

- *Between February and April 1998 general practitioner, Dr D, did not provide appropriate treatment to consumer, Ms A, when she presented with severe pain and vomiting at 32-36 weeks pregnant stating "... it is not life threatening".*
- *Between February and April 1998, appropriate treatment was not given to Ms A at the the maternity centre, the public hospital, Crown Health Enterprises, by midwife, Ms E, when she presented with severe pain, vomiting and weight loss between 30-36 weeks of pregnancy.*

Complaint Process

The Commissioner received the complaint on 28 September 1998 and an investigation commenced on 9 February 1999. Information was obtained from the following:

Ms A	Consumer
Ms B	Complainant / Consumer's sister
Mrs C	Complainant / Consumer's mother
Dr D	Provider / General Practitioner
Ms E	Provider / Midwife
Ms F	Corporate Staff Solicitor / Crown Health Enterprises

Ms A's general practitioner's medical notes were obtained and reviewed. Relevant clinical records and documents were obtained from Crown Health Enterprises and were reviewed by the Commissioner. The Commissioner sought advice from an independent general practitioner.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

General Practitioner, Dr D / Midwife, Ms E

Opinion - Case 98HDC18102, continued

Information Gathered During Investigation

On 6 September 1997, consumer, Ms A, found out that she was seven weeks pregnant. Later the same day Ms A was admitted via ambulance to the public hospital due to an exacerbation of her asthma. During her admission she complained of having lower abdominal cramps which were documented as easing quickly during the admission.

On 8 September 1997 Dr D, general practitioner, first saw Ms A following her discharge from the public hospital. At this appointment, Dr D noted that Ms A's last menstrual period was 15 July 1997 and her expected date of delivery was 22 April 1998. She was noted to be 71kg. Dr D became Ms A's lead maternity carer (LMC). He organised for Ms E, midwife, to provide Ms A with maternity care. Crown Health Enterprises advised the Commissioner that Ms E was expecting to have two antenatal appointments with Ms A prior to Ms A's labour commencing. All other antenatal care was to be provided by Dr D.

Dr D advised the Commissioner that when Ms A came to him, she wished to be placed on a sickness benefit, as she was anxious about her pregnancy. Ms A advised Dr D that her partner had wanted her to get an abortion and she was worried about seeing him and did not wish to go back to work. Dr D advised that he had been reluctant to place Ms A on the sickness benefit but did so to avoid her having an anxious reaction to her pregnancy.

On 11 September 1997 Ms A was referred acutely to the public hospital by a general practitioner at the Community Health Services because she had sudden low right iliac fossa (RIF) pain associated with approximately 20mls of fresh vaginal bleeding. "[T]*he pain has persisted … an ectopic* [pregnancy] *must be a high possibility*" was documented in the hospital notes. After admission, Ms A had no further pain or blood loss. Her notes record probable threatened abortion. On discharge an ultrasound was arranged with instructions for the following Monday and a medical certificate given.

On 15 September 1997 Ms A had an ultrasound of her pelvic area. Both ovaries were seen to have a normal appearance with no abnormality in the rest of the pelvis; in particular there was no focal abnormality seen in the area of pain in the RIF. Ms A was documented as having a live eight-week intra-uterine pregnancy.

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General Practitioner, Dr D / Midwife, Ms E

Opinion - Case 98HDC18102, continued

Information Gathered During Investigation *continued*

After seeing Ms A at the outpatients clinic on 30 September 1997, a doctor wrote a further letter to Dr D, saying "[Ms A]*, with the principal diagnosis of bronchial asthma, was reviewed in my OP* [outpatient] *clinic this morning where she felt very well in herself and had no symptoms referable to any system*".

On 16 October 1997 Dr D documented Ms A's weight as 69.3kg. Her antenatal records of 15 November 1997 note her weight as 67.1kg. Foetal heart and foetal movement were checked and recorded as evident on the same date.

Ms A had an ultrasound performed over two visits on 1 December and 4 December 1997 as there was some difficulty in obtaining adequate views of the foetus due to the position on the initial examination. The report stated:

> "*A single live foetus was visualised. The liquor volume appears normal … there is good visualisation of foetal anatomy. No abnormality could be seen. Impression a normal eighteen and a half week gestation.*"

On 10 January 1998 Dr D saw Ms A and her weight was noted as 67.2kg. During this appointment, Ms A complained of heartburn, which Dr D treated with Mylanta medication.

Ms A had a check-up with Dr D on 13 January 1998, when she was 26 weeks pregnant. Her weight was recorded as 67.8kg. On 20 January 1997 Ms A consulted Dr D as she had dysuria (difficult or painful urination), frequency and an uncomfortable bladder sensation. A mid stream urine (MSU) specimen was taken and Dr D prescribed Bactrim (an antibiotic).

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General Practitioner, Dr D / Midwife, Ms E

Opinion - Case 98HDC18102, continued

Information Gathered During Investigation ***continued***

On 18 January 1998, a nurse at the maternity centre documented that Ms A's mother rang to say that Ms A appeared to be in labour. The on-call midwife was contacted to advise that Ms A was coming into the maternity centre for a CTG (cardiotocography: electronic monitoring of the foetal heart rate). When Ms A arrived at the Centre with her mother, she was documented as explaining that the pain was 'coming and going', had started about three hours previously and was located in the pelvic area shooting up into the abdominal area. Dr D was documented as being away. A CTG was carried out, Ms A was reviewed by a doctor, diagnosed as not being in premature labour, and discharged home.

On 24 February 1998 at 32 weeks, Dr D documented Ms A's weight as 64.2kg.

On 1 March 1998 the afternoon nurse at the maternity centre documented that at 10.55pm Ms A's sister, Ms B, telephoned the the maternity centre to advise that Ms A was having abdominal pain, had a rash and was in distress. She advised that the pain had been occurring every 10 minutes since 8.00pm that evening. Ms A was advised to come into the hospital. At 11.05pm Ms A arrived at the the maternity centre, a CTG tracing was commenced and Dr D was notified.

Dr D assessed Ms A and documented that she had right upper quadrant pain with no contractions and erythemia (redness) on her right upper quadrant. Dr D questioned the cause of this. Dr D stated that Ms A was admitted overnight because she did not wish to go home.

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General Practitioner, Dr D / Midwife, Ms E

Opinion - Case 98HDC18102, continued

Information Gathered During Investigation *continued*

Ms B, Ms A's sister, advised the Commissioner that when Ms A was between 32 to 34 weeks pregnant she saw Dr D. Ms B stated that:

> "[Ms A] *was treated as 'having a urine infection and also a (sic) infection in the kidneys. Then she went back a couple of days later about the same problem,* [Dr D] *then decided to send her for blood tests. The blood tests came back showing 160 white cells in her urine, which meant she and her baby or even both weren't getting any protein. Then on a Sunday night we went again to the hospital this time when she was 35-36 weeks pregnant, she was in severe pain and vomiting continuously. The nurse on duty called* [Dr D] *in. He then turned up, not very happy about being pulled out of bed and said rudely, 'what's your problem this time?'. I had explained to him about her vomiting and pains and he just asked 'well what do you want me to do about it?'. He tried telling her that she had food poisoning. I asked him if he was going to keep* [Ms A] *in over night as she is a very severe asthmatic as well. He just said 'It's not life threatening?' then I said that was not the question I had asked him and asked him again. He then decided to keep her in.*"

Dr D advised the Commissioner he could not understand how the comment "*It is not life threatening ...*" was misconstrued as rude. He advised that Ms A was not acutely distressed but that Ms B, who had accompanied her, was anxious about her sister's condition. Dr D explained that despite Ms A having asthma, it was not relevant to the issue whether she should be admitted to hospital that night (of 1 March 1998) or not:

> "*In stating that* [Ms A's] *condition was not life threatening, I was attempting to focus* [Ms B's] *attention on what was important for somebody with stomach pain late at night. I felt that it was safe for* [Ms A] *to go home, as she did not appear acutely distressed by the time I saw her, but when* [Ms B] *did not seem happy with this plan, I did indeed ask her what she wanted me to do, not because I wished to be rude or insulting, but I wished to ascertain what I could do to help relieve her anxiety and effectively deal with the difficult situation she and her sister found herself to be in.*"

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General Practitioner, Dr D / Midwife, Ms E

Opinion - Case 98HDC18102, continued

Information Gathered During Investigation *continued*

During the night Ms A was documented as feeling nauseated and having tightenings intermittently. At 3am she vomited a large amount and thereafter she was documented as feeling better and her tightenings lessened. She took Panadol (pain relief) and Temazepam (sleeping pills) as prescribed and her pain was noted to decrease. She was documented as sleeping until Dr D saw her at 8.15am. A MSU specimen was taken and Ms A was discharged home.

In the obstetric record at the maternity centre it is documented that on 12 March 1998 Ms A telephoned Ms E to report that she had had pain for eight hours and uterine contractions, which were one in every five minutes. Ms E documented that she visited Ms A at home and reported that she had right-sided pain in the kidney region, was urinating frequently and was feeling full and bloated. Ms E then contacted Dr D who arranged for Ms A to be seen that afternoon at his surgery and he ordered an MSU specimen to be taken.

On assessing Ms A, Dr D documented in his notes that Ms A weighed 64.8kg, and noted her as having a left kidney infection for which he prescribed Amoxyl 500mg TDS (antibiotic medication to be taken three times per day).

At 9.30pm that day, Ms B rang the maternity centre and advised that Ms A was in terrible pain and had a tight hard abdomen. She was advised to bring Ms A to the maternity centre. Ms A was met there by Ms E and examined immediately by Dr G, the evening duty doctor.

Dr G reported that Ms A was quite distressed, tender over the right kidney and RIF. He documented that her uterus was otherwise fine but she was probably having a few mild contractions. Dr G advised Ms A to continue with the antibiotic course commenced earlier that day by Dr D. While Ms A was at the maternity centre, the foetal heartbeat was checked and Ms E took a CTG. Following this Ms A was discharged home.

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General Practitioner, Dr D / Midwife, Ms E

Opinion - Case 98HDC18102, continued

Information Gathered During Investigation *continued*

On 24 March 1998, Ms A self referred to the maternity centre as she was distressed by contractions and had had a show (light vaginal bleeding which can often occur in early labour). Dr H, the on-duty doctor assessed Ms A, as Dr D was unavailable, and documented that Ms A had acute loin pain. An MSU specimen, blood tests and a CTG tracing were taken and documented as being normal. The CTG showed three to four contractions in ten minutes and her baby was palpated. Ms A was documented as being malnourished and Dr H documented that he queried whether she was abusing substances. Dr H made arrangements for Ms A to be transferred to the public women's hospital.

While waiting to be transferred, Ms A was noted at 12.10pm as having mild backache and dehydration, and was encouraged to drink fluids. At 6.30pm Dr H reassessed her and a repeat scan was organised. An appointment was made for her to see Dr D on 26 March 1998 and she was discharged home.

On 26 March 1998 Dr D saw Ms A and wrote a referral letter to Crown Health Enterprises:

> "*She has been complaining of abdo pain for last 1-2 months – frequent presentations at maternity – N.A.D (no abnormalities detected). She was admitted at 7/40 …. She had a scan yesterday showing a breech presentation, small for a gestation of 34/40. Today at view she looks unwell (previous MSU's have shown no growth) and I wonder if something such as an appendix abscess could be behind it all. Thanks for assessing her and treating her, and arranging delivery of the breech.*"

Ms A was admitted to the public women's hospital on 26 March 1998. On 27 March 1998 Ms A was noted to have abnormal liver function tests. An ultrasound of her liver was performed and showed multiple small mobile calculi in her gall bladder. She was diagnosed with oligohydramnios (an abnormally small amount or absence of amniotic fluid), intrauterine growth retardation (IUGR – abnormal process in which the development and maturation of the foetus is impeded or delayed by genetic factors, maternal disease, or foetal malnutrition caused by placental insufficiency), and cholecystitis (acute or chronic inflammation of the gall bladder).

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General Practitioner, Dr D / Midwife, Ms E

Opinion - Case 98HDC18102, continued

Information Gathered During Investigation *continued*

Foetal movement was noted throughout her stay in the hospital. On 30 March 1998 Ms A was seen by a dietician who suggested Ms A have dietary supplements. On review by the medical team on 30 March 1998, it was documented that Ms A's baby was in a breech presentation (intrauterine position of the foetus in which the buttocks or feet present) and the baby's head was sitting under Ms A's gall bladder. A plan was made for Ms A to stay in hospital and that she would be induced in two weeks. On 1 April 1998 a decision was made to discharge Ms A, with follow-up from Dr D for management of her problems.

On 8 April 1998 Ms A arrived at the maternity centre complaining that there was a history of no foetal movement for the last 12 hours. Ms E commenced a CTG, which showed good reaction tracing. Ms A was sent home with advice to ring the maternity centre midwife with details of the foetal movement. Ms E contacted Ms A at 7.00pm who advised her there was now plenty of movement.

On 9 April 1998 Ms A was seen by Dr D who weighed her at 68.6kg. That evening Ms A rang the maternity centre, as she had not had any foetal movement. Ms A had contacted the public women's hospital and had been advised to attend the maternity centre if she was worried. Ms A attended the maternity centre for a CTG. The nurse documented that the CTG showed a:

> "*... reactive trace, beat to beat variation 10 +/-. Movements present. Uterine activity – tightening only – irregular but frequent.* [Ms A] *reassured and happy to go home.*"

Ms A was re-admitted to the public women's hospital as planned on 14 April 1998. She presented with a breech presentation at 39 weeks, intrauterine growth retardation, oligohydramios, having abnormal monitoring of the foetal heart, and a probable mid water leak. A plan was documented for her to be admitted and to have a caesarean section. At 9.15am on 15 April 1998, Ms A had a live female infant in "*good condition*" via caesarean section. The placenta was manually removed. The placenta was noted to be very small and slightly gritty. Ms A was transferred to the maternity centre on 18 April 1998 for postnatal care.

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General Practitioner, Dr D / Midwife, Ms E

Opinion - Case 98HDC18102, continued

Information Gathered During Investigation ***continued***

Ms A advised the Commissioner that her pain during her pregnancy was treated by Dr D as a urine infection and he had told her that her baby was sitting against her liver. She stated that she had had a scan at seven months at the public hospital to find out what was going on and Dr D had got a second opinion from the public women's hospital. Ms A stated that the pain was on her left side. She advised that she had the pain from the time she was three months pregnant until she had the baby, that this pain occurred every three days and that she had had contractions from seven and a half months.

Ms A advised that Dr D had told her that the pain was due to the pregnancy, as everything was stretching. Dr D additionally told her that these high contractions were normal. She stated that Dr D did not listen to her concerns during her pregnancy and on one occasion when her waters broke slightly, Dr D told her she had wet herself.

Dr D advised the Commissioner that during Ms A's pregnancy she had seen about six doctors at the maternity centre complaining of cramps. He explained that this was why her pain was not investigated between 32 and 34 weeks of pregnancy. He stated that Ms A had pain in her right and left quadrants and in her loins and her pain was generally in every direction. He advised that the visits to the maternity centre occurred at Ms B's instigation and he felt that Ms B was anxious about matters concerning Ms A. Dr D advised that he was usually able to have a discussion with Ms A, but with Ms B present, the situation was different and Ms A's level of anxiety rose no matter what was discussed.

Dr D stated the first time that he had seen Ms A in hospital with right quadrant pain he had taken an MSU specimen. This had come back with a 160 white cell count and from this he had presumed Ms A had a urine infection. He advised that the gallstone discovery was an incidental find later on in Ms A's pregnancy.

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General Practitioner, Dr D / Midwife, Ms E

Opinion - Case 98HDC18102, continued

Independent Advice to Commissioner

The Commissioner received advice from an independent general practitioner as follows:

"*1. Was the treatment that* [Dr D] *provided to* [Ms A] *reasonable and provided in a timely manner?*

With the advantage of the diagnoses that we now have, you could say that perhaps a more reasonable diagnosis could have been obtained earlier but, given the information [Dr D] *had each time that* [Ms A] *presented, then I think we could say the treatment was reasonable. Obviously it could be said that with the advantage of knowing a definitive diagnosis now, an earlier scan might have been useful. Nevertheless, with the presentation made at the time, I think that the management of* [Ms A] *was reasonable and timely.*

2. Should [Dr D] *have sent* [Ms A] *for a second opinion earlier? If not, why not? And if so, when should this have occurred?*

Again, with the advantage of hindsight, perhaps an earlier second opinion could have been useful. But this is not at all clear cut. The problem was that [Dr D] *was quite certain that the symptoms that* [Ms A] *presented with were of a urinary nature and the fact that she complained that the pain was on the left side as well as the right was clearly a factor in reaching the diagnosis of urinary tract infection.*

As well [Ms A] *did complain of uncomfortable bladder sensation on a number of occasions and thus the diagnosis of a urinary tract infection, as well as the fact that the urine did show raised white cell count, lead to a presumption of a urinary tract infection. This was later proved to be not so but I feel it was reasonable for* [Dr D] *to reach that conclusion through the pregnancy.*

For this reason it is hard to say that a second opinion should have been sought earlier. What might well have been useful would have been for an ultrasound scan of her kidneys and gallbladder to be done earlier for a diagnosis to be reached.

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General Practitioner, Dr D / Midwife, Ms E

Opinion - Case 98HDC18102, continued

Independent Advice to Commissioner *continued*

3. *Was* [Ms A's] *care, treatment and diagnosis appropriate by* [Dr D]*?*

Given the diagnosis that [Dr D] *thought he had, namely, urinary tract infection, then* [Ms A's] *care and treatment was reasonable. If a diagnosis of gallbladder disease (cholecystitis) had been made earlier all that would have happened was that* [Ms A] *might have been advised of a low fat diet; basically the treatment would simply have been one of pain relief and rest at the time of the attack. Thus the treatment would not necessarily have been substantially different had the more correct diagnosis been reached earlier. Likewise the care would not necessarily have been any different either.*

4. *Was there enough done to prevent this outcome? If not, why not?*

In fact the outcome of this pregnancy was quite satisfactory, namely, a healthy baby was born though somewhat growth retarded and had the correct diagnosis of gallbladder disease been made, this situation would not have changed. It is not the practice of any surgeon to perform a cholecystectomy (removal of gallbladder) during pregnancy and all of us would much prefer to wait until a pregnancy is over before a gallbladder is removed. Thus it is hard to see what else could have been done for [Ms A].

5. *Did* [Dr D] *give enough information to* [Ms A] *throughout her pregnancy?*

I believe [Dr D] *gave as much information as he knew to* [Ms A]. *The fact that he did not know of the gallbladder disease meant that he could not inform her of this.*

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General Practitioner, Dr D / Midwife, Ms E

Opinion - Case 98HDC18102, continued

Independent Advice to Commissioner *continued*

6. *Should* [Dr D] *have investigated* [Ms A's] *decreasing weight and was her decreasing weight suggestive of any diagnosis?*

A decreasing weight is always a worry in pregnancy. There are some women who do nevertheless have a decreasing weight, predominantly due to vomiting, and we certainly know that women who have recurrent urinary tract infections all have weight fluctuations that are unsatisfactory in pregnancy. Clearly this is what [Dr D] *thought was the cause of* [Ms A's] *weight loss. In retrospect we now know that it was due to her gallbladder disease but again, if the correct diagnosis had been reached earlier, there would not necessarily have been any significant change in this.*

As I mentioned before, removal of a gallbladder was not a viable option. The only investigation that [Dr D] *might perhaps have had carried out was a repeat of a scan of* [Ms A's] *kidneys and gallbladder.*

7. *Could* [Dr D] *have found out about the cholecystitis problem earlier?*

He could have found out certainly. To do this he would have had to have a scan of [Ms A's] *gallbladder performed but it needs to be remembered that there are times when a scan does not show gallstones and more invasive tests need to be done. Again, it needs to be said that even had the diagnosis been made earlier it would not have materially affected the management of* [Ms A's] *pregnancy, although* [Ms A] *could have been informed why she was losing weight and why she was having abdominal pain and vomiting from time to time.*

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General Practitioner, Dr D / Midwife, Ms E

Opinion - Case 98HDC18102, continued

Independent Advice to Commissioner *continued*

8. Any other issues that arise from the supporting information?

What appears to be clear to me from reading [Ms A's] *complaint and* [Dr D's] *reply is that there was a substantial communication problem between the two of them. One gets the feeling that* [Dr D] *was irritated by the number of times he was called to see* [Ms A] *and perhaps this irritation did show through at the time of the consultations. It is also clear that he had a very poor relationship with* [Ms A's] *relatives and this shows through on a number of occasions.*

A good example of the problem regarding communication that [Dr D] *had with* [Ms A] *and her relatives is when he made the statement 'It is not life threatening'. I believe that patients have a fundamental right to know whether a condition they have is life threatening or not, but how this information is imparted is of enormous importance. If it is imparted in a way which the patient might find belittling then they will often take offence at it, as obviously the relatives of* [Ms A] *did. On the other hand, if it is imparted in a reasonable way, then the patient feels better informed about his or her condition. I think the way this comment is interpreted speaks volumes for the type of communication and rapport that* [Dr D] *had with* [Ms A].

It is clear that even after referral to [the public hospital] *and the specialists at the Obstetric Unit there, it was felt that it was perfectly safe for* [Ms A] *to return back to* […] *in spite of the fact that there appeared to be a decreased fluid around the baby and the baby seemed to be growth retarded. Thus* [Dr D] *can justifiably say that his management of rest and watchful expectancy was entirely reasonable for* [Ms A]. *The fact that the baby was growth retarded and that there was decreased liquor around the baby thus cannot be blamed upon* [Dr D]. *He was aware of this as were the obstetric consultants at* [the public hospital] *but the management did not change.*

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General Practitioner, Dr D / Midwife, Ms E

Opinion - Case 98HDC18102, continued

Independent Advice to Commissioner ***continued***

Thus the crucial issues around this complaint are, firstly, one of communication which I think was poor between [Dr D] *and* [Ms A] *and her family, and secondly, that of the non-diagnosis of the cholecystitis that was present.*

I think the non-diagnosis of the cholecystitis in pregnancy occurs very commonly and a lot of practitioners have been surprised to make such a diagnosis after the pregnancy had ended. I do not believe that a practitioner can be blamed unduly for missing such a diagnosis. This is especially so where the complainant gave not a very characteristic history of cholecystitis and the number of times it is mentioned that her pain seems to be on the left and right of her abdomen. In any event, as already stated, this condition would not have been managed any differently had the cholecystitis been detected earlier.

Overall, it is apparent to me that [Dr D] *did provide* [Ms A] *with care the complied with professional standards during the time that he looked after her.*"

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General Practitioner, Dr D / Midwife, Ms E

Opinion - Case 98HDC18102, continued

Code of Health and Disability Services Consumers' Rights

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

RIGHT 1
Right to be Treated with Respect

1) *Every consumer has the right to be treated with respect.*

RIGHT 4
Right to Services of an Appropriate Standard

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

…

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

RIGHT 5
Right to Effective Communication

1) *Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter.*

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General Practitioner, Dr D / Midwife, Ms E

Opinion - Case 98HDC18102, continued

Opinion: No Breach Midwife, Ms E

Right 4(3)

In my opinion midwife, Ms E, did not breach Right 4(3) of the Code of Health and Disability Services Consumers' Rights.

Ms E provided the consumer, Ms A, with midwifery support during Ms A's pregnancy. Between February and April 1998 it appears from the notes that Ms E saw Ms A on two occasions. In my opinion Ms E provided Ms A with midwifery services in a manner consistent with her needs by assessing her, referring her on to the general practitioner, Dr D, and following up to see if her baby was moving satisfactorily. Accordingly, Ms E did not breach Right 4(3) of the Code.

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General Practitioner, Dr D / Midwife, Ms E

Opinion - Case 98HDC18102, continued

Opinion: No Breach General Practitioner, Dr D

Right 4(1)

In my opinion, the general practitioner, Dr D, did not breach Right 4(1) of the Code of Health and Disability Services Consumers' Rights.

The consumer, Ms A, presented to Dr D and other doctors at the maternity centre with differing symptoms, pain on her left and right sides, and an uncomfortable bladder sensation. Her MSU sample showed a high white cell count the first time Ms A presented with these symptoms. Dr D concluded that Ms A had a bladder infection and treated this with antibiotics. My independent advisor stated that based on the clinical symptoms and the raised white cell count, it was reasonable for Dr D to reach the conclusion that Ms A was suffering from a urinary tract infection.

When the problem persisted Dr D referred Ms A to Crown Health Enterprises for a second opinion. It later transpired that Ms A had cholecystitis. While Dr D failed to diagnose cholecystitis at the time, my independent advisor noted that the non-diagnosis of the cholecystitis in pregnancy occurs very commonly. This is especially so when the complainant gave "*not a very characteristic history of cholecystitis*".

In my opinion Dr D provided antenatal services to Ms A with reasonable care and skill and did not breach Right 4(1) of the Code.

Rights 1(1) and 5(1)

Consumers have the right to be treated with respect and to effective communication in a manner that enables them to understand the information provided. From the outset of her pregnancy Ms A told Dr D that she was anxious about it. Throughout her pregnancy Ms A had a number of visits to Dr D for pain, weight loss, heartburn, dysuria, uncomfortable bladder sensation and vomiting. Ms A's mother and sister were concerned about her and accompanied her on some of her several visits to the maternity centre, including when Ms A was experiencing intermittent pain in the latter part of her pregnancy.

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General Practitioner, Dr D / Midwife, Ms E

Opinion - Case 98HDC18102, continued

Opinion: No Breach General Practitioner, Dr D *continued*

Ms A and her sister complained that Dr D was rude to them. In relation to one episode of pain when Ms A was 35-36 weeks pregnant and sought help from Dr D during the night, he said that her condition was "*not life threatening*". Ms A's sister says this was said rudely and in the context of having already made it clear that he was unhappy at having been called out at night to attend Ms A.

Dr D has said that he did not mean his comment rudely and that he was attempting to explain that it was safe for Ms A to go home and that she did not need to be admitted to hospital.

After further conversation with Ms A's sister, Dr D agreed to admit her to hospital overnight to help relieve Ms A and her sister's anxiety, rather than because he considered there were clinical indications for admission. She was discharged home the following morning.

My independent advisor commented:

> "*What appears to be clear to me from reading* [Ms A's] *complaint and* [Dr D's] *reply is that there was a substantial communication problem between the two of them. One gets the feeling that* [Dr D] *was irritated by the number of times he was called to see* [Ms A] *and perhaps this irritation did show through at the time of the consultations. It is also clear that he had a very poor relationship with* [Ms A's] *relatives and this shows through on a number of occasions.*
>
> *A good example of the problem regarding communication that* [Dr D] *had with* [Ms A] *and her relatives is when he made the statement 'It is not life threatening'. I believe that patients have a fundamental right to know whether a condition they have is life threatening or not, but how this information is imparted is of enormous importance. If it is imparted in a way which the patient might find belittling then they will often take offence at it, as obviously the relatives of* [Ms A] *did. On the other hand, if it is imparted in a reasonable way, then the patient feels better informed about his or her condition. I think the way this comment is interpreted speaks volumes for the type of communication and rapport that* [Dr D] *had with* [Ms A]."

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Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

General Practitioner, Dr D / Midwife, Ms E

Opinion - Case 98HDC18102, continued

Opinion: No Breach General Practitioner, Dr D *continued*

I agree that patients have a fundamental right to know whether a condition they have is life threatening, and that how this information is explained is very important. It is not difficult to see how a woman in Ms A's circumstances could be offended by the comment that her condition was "*not life threatening*". However, this one comment needs to be seen in the context of the ongoing antenatal care that Dr D provided to Ms A. In all the circumstances, I am satisfied that Dr D did not fail to treat Ms A with respect or to communicate with her effectively. Accordingly, in my opinion Dr D did not breach Right 1(1) or Right 5(1) of the Code.

Actions

A copy of this opinion will be sent to the Medical Council of New Zealand. A copy of this opinion with identifying details removed will be sent to the Royal New Zealand College of General Practitioners for educational purposes.

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