General Practitioner

A Report by the

Health and Disability Commissioner

(Case 01HDC11911)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Consumer
Dr B	Provider, General Practitioner
Mr C	Complainant, Consumer's Husband
Dr D	General Practitioner, Dr B's Practice Partner

Independent expert advice was obtained from Dr Keith Carey-Smith, general practitioner.

Complaint

On 15 October 2001 the Commissioner received a complaint from Mrs A's solicitor, Mr E about Dr B. The complaint is summarised as follows:

Dr B did not provide services of an appropriate standard to Mrs A on 9 and 10 April 2001. In particular:

- *During two consultations on 9 April 2001 he did not adequately assess Mrs A or take appropriate action to manage her condition.*
- *On 10 April 2001 he did not visit Mrs A or follow up on her condition after advising that he would visit.*

An investigation was commenced on 24 January 2002.

Information reviewed

- Letter of complaint from Mr E, Mrs A's solicitor
- Notes of discussions between Mr C and Investigation Officer
- Letter of response from Dr B, including Mrs A's medical records
- Note of discussion between Dr B and Investigation Officer
- Copy of Mrs A's medical records and associated correspondence from a public hospital
- Letter of response from Dr B to investigation questions.

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

Information gathered during investigation

On the evening of Sunday 8 April 2001, whilst hanging curtains Mrs A fell off a set of kitchen steps and struck her head on an old sewing machine. Mr C was at the other end of the house and did not witness the fall. He was unsure whether Mrs A had been knocked unconscious. Mr C stated that Mrs A came through to where he was quite soon after the fall with a "mighty big bump on the back of her head". As a consequence of the fall, Mrs A suffered a severe headache.

On the morning of 9 April Mr C contacted her usual general practitioner, Dr B, as Mrs A had a severe headache and started vomiting early that morning. Dr B visited Mrs A at 8.30am. Dr B stated that he was told Mrs A had not been knocked unconscious and had a mild frontal headache and had vomited twice. According to Dr B's clinical notes Mrs A suffered concussion on 8 April 2001, vomited twice and was given Digesic. Dr B further stated that on examination he found Mrs A to be "not particularly unwell", with normal eye signs and symmetrical strength. Dr B undertook routine post head injury questioning to determine Mrs A's state of consciousness including questions about her memory of the fall and whether there were any witnesses to the fall. Dr B advised Mrs A to rest and said that he would review her that evening.

Mr C stated that he did not recall Dr B asking questions about Mrs A's level of consciousness; Dr B seemed preoccupied with filling out the ACC form and Mr C left the room at that stage. Mr C stated that Mrs A had continued to vomit throughout the day on Monday, was not eating and was having trouble sleeping because of the severity of the pain. He stated that the vomiting became retching saliva and that after the doctor left in the morning Mrs A was "in bed with a little bowl and a towel all day". Mr C stayed with Mrs A and the vomiting continued throughout the day.

At 7.30pm Dr B visited Mrs A again. Dr B stated that Mrs A was no worse and had not vomited again, but she was still nauseous and flushed. Dr B gave Mrs A an intra-muscular injection of Stemetil and prescribed a course of Augmentin, as he thought Mrs A might have a sinus infection. Dr B said that he discussed hospital admission. He told Mr C and Mrs A that he would call again and reassess Mrs A in the morning.

Dr B did not keep his morning appointment on 10 April. In response to my provisional opinion Dr B said that his workload was a factor influencing his case management. Mr C was so concerned about Mrs A's condition that he phoned the medical centre. Dr D, another doctor at the medical centre, saw Mrs A, suspected bleeding in the brain, and arranged for her to be admitted immediately to a public hospital. According to Dr D's hospital referral form, Mrs A had had a severe headache and vomiting since her fall on Sunday evening, and had taken Digesic and Stemetil to no avail. According to the the Ambulance Patient Report form, Mrs A described her pain as between 6 and 8 out of 10 (a subjective scale where 0 = no pain and 10 = excruciating unbearable pain) throughout the period from the fall until admission to hospital.

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On admission to a public hospital at 10.30am on 10 April, Mrs A was examined by the admitting doctor, who noted Mrs A had pain over the frontal and occipital areas of 6-7/10 severity, the nature of which was a "constant ache" with no improvement over the two days since the fall. An additional diagnosis of dehydration was made. A CT scan showed acute subdural haematoma and Mrs A was admitted to the ward for observation. Mrs A suffered further rapid deterioration in her level of consciousness, and an urgent right temperoparietal craniotomy and evacuation of an acute subdural haematoma was carried out at 11pm on 10 April 2001.

Currently Mrs A has left hemiplegia and is at a rest home, and requires full hospital care. In response to my provisional opinion, Mr C said that Mrs A still has a confused memory and no use of her left hand, arm or leg.

Independent advice to Commissioner

The following independent expert advice was provided by Dr Keith A Carey-Smith:

"**Purpose**
To obtain independent general practitioner advice which will enable the Commissioner to form an opinion on whether the standard of care provided by [Dr B], general practitioner, was provided with reasonable care and skill.

Consumer's Complaint
The complaint was that:

[Dr B] did not provide services of an appropriate standard to [Mrs A] on 9 and 10 April 2001. In particular:

- *During two consultations on 9 April 2001 he did not adequately assess [Mrs A] or take appropriate action to manage her condition*
- *On 10 April 2001 he did not visit [Mrs A] or follow up on her condition after advising that he would.*

Documents and records reviewed

- HDC Medical/Professional Expert Advice outline document
- Letter of complaint from [Mr C's] lawyer (A)
- Action notes of discussions between [Mr C] and Investigation Officer (A1)
- Investigation letter (B)
- Letter of response from [Dr B], including his clinical records (C)
- Action note of discussion between [Dr B] and Investigation Officer (C1)
- Copy of [Mrs A's] medical records and associated correspondence from [a public hospital] (D)
- Letter of response from [Dr B] to investigation questions (E)

Introductory comments
In commenting on this case, an opinion will only be given in relation to the care provided by [Dr B]. Hospital management will be mentioned only where it relates to or clarifies the care provided by [Dr B].

It should be noted also that:

- [Dr B's] clinical records are brief with poor legibility. However omissions from the records may not always reflect omissions in standard of care. The evidence for the standard of care provided is therefore inadequate to make a clear decision about several of the questions.

- There are several factual discrepancies
  a. Records and other evidence do not indicate that [Mrs A] **lost consciousness**, despite a note to this effect in the hospital inpatient summary. She was not observed at the time of the fall, but walked from the room soon afterwards. The presumption is that she was not knocked out.

  b. The exact nature, severity, and extent of **vomiting** is not clear. [Dr B's] notes (C) seem to suggest that [Mrs A] had vomited twice before his first visit, and only nausea was recorded at the second visit (though the notes are not clear as to which entries related to which visit). The complaint letter (A) mentions no vomiting before the initial visit, but vomiting during the day prior to the second visit. The fact that intramuscular stemetil was given at the second visit suggests that either vomiting was continuing, or nausea was severe. This discrepancy makes it impossible to make a clear decision regarding whether [Mrs A] was stable or deteriorating with regard to the vomiting at each visit (see below under Question 2).

  c. Similarly the severity of **headache** is not clearly established. [Dr B] in his letter describes a mild frontal headache, but there is no mention of this in the records (apart from a mention of analgesia 'Digesic'). However in the ambulance officer record a pain score of 6-8 (/10) is noted, and the GP admission form and the admission notes record 'severe headache' – '15 min (after fall) … constant, no improvement over 2 days'. The evidence suggests that headache was continuous and of moderate or severe intensity.

  d. [Mr C] states that [Dr B] completed ACC documentation at the SECOND visit. It is more likely that this would be done at the first visit since the incident was clearly an accident. A copy of the ACC certificate is not available, but would be useful to help clarify [Dr B's] diagnostic thoughts.

  e. The alleged comment by [Dr B] that he had noticed **bleeding** the previous evening is in my opinion a misunderstanding (as stated by [Dr B]). No bleeding was mentioned in [Dr B's] or the hospital records, and if present, would have resulted in different management.

f. [Dr B] states that he discussed hospital admission with [Mrs A] at the second visit (C), with a joint decision being made to 'reassess in the morning'; whereas [Mr C] in the action note (A1) denied this conversation.

I will comment on each of the points requiring my decision separately, giving the standard appropriate to general practice where relevant.

<u>Question 1</u>: When [Dr B] was called to see [Mrs A] on the morning of 9 April 2001, [Mrs A] had had a fall. The fall resulted in her having a large lump on the back of her head and suffering from severe headache. What examination and assessment should [Dr B] have undertaken at this time? Were the actions [Dr B] took appropriate?

For any case of actual or suspected head injury the following aspects of history and examination should be included, particularly if after initial assessment the patient is considered to be at moderate or high risk of complications[(i)]. [Mrs A's] case falls into the 'moderate risk' group according to current ACC guidelines[(i)], because of severe headache accompanied by vomiting, unreliable history of injury (not observed by another person), aspirin therapy, and possibly the patient's age. (Essential items considered by me to be of particular importance in this case are marked with an asterisk *.)

History:
- *Mechanism of fall**
- *Clinical state since injury and currently**
- *Loss of consciousness**
- *Patient's recollection of events–amnesia**
- *Associated injuries*
- *Medication/ alcohol use; comorbidities*
- *Associated symptoms and duration: lightheadedness, vertigo, loss of balance, tinnitus, blurred vision, headache*, nausea/vomiting*, photophobia*

Examination:
- *ABC: airway, breathing, circulation (pulse*, blood pressure*)*
- *Neurological state: level of consciousness* (eg Glasgow coma score), pupils*, focal neurological signs* (limb movement/power/reflex asymmetry), cranial nerves (brief check), cerebellar function (eg balance), speech, vision, coordination*
- *Head and neck examination: fluid/blood from nose or ears*, neck, skull* examination*

[(i)] ACC Treatment Profiles 2001.

- *Mental status: orientation*, memory*, concentration*
- *Exclude other injuries*

From [Dr B's] letter and records we can only confirm examination for eye signs and symmetry of strength. There is a record of pulse but probably at the second visit. It is likely that, as an experienced general practitioner, [Dr B] rapidly obtained a history of the injury (he states that this is his normal practice (document E)), as well as assessing the level of consciousness, limb movement ([Mrs A] had been walking around), mental status, speech, cerebellar function and coordination during his history taking. We presume he confirmed the scalp bruising and would have noted any abnormal blood or fluid from nose or ears. The deficiencies in assessment appear to be confined to blood pressure (and possibly pulse) measurement, and specific limb reflex, power and cranial nerve examination. There is no note that he checked for other injuries, but presumably thought these unlikely as no symptoms in other regions were complained of. It is not known what specific eye examination was performed. Overall I consider that the assessment was adequate.

The actions taken by [Dr B] were to advise rest and review (and apparently recommend panadol or digesic). However in such a case the patient should be observed carefully for deterioration, and the carers given advice on what observations are appropriate, and when to seek further assessment (ACC provides a handout for this purpose. [Dr B] mentions that he hands out such a sheet but is unlikely to have brought a copy with him). There is no record that specific instructions of this sort were given; however [Dr B] presumably was happy that [Mrs A] was in good hands and would not be left alone. He states that the family knew how to contact the surgery if there was a problem. He took the step of returning later that same day himself to reassess [Mrs A], indicating that he had some concern for the patient (in most situations it is appropriate for a competent GP to give the patient or carer the responsibility for telephoning or initiating further review if there was a concern or deterioration).

A recent head-injury management update[(ii)] lists the following admission criteria:
- GCS 13 or less (or 14-15 if no carers at home)
- Abnormal CT scan
- Persisting nausea or vomiting
- Alcohol or drug ingestion
- Age over 60 or under 5 years

Two of these criteria (nausea/vomiting and age) existed in this case to justify admission.

[(ii)] Head Injury Management, Arnold Bok (neurosurgeon, Auckland Hospital): in NZ GP 20/3/02, p 32.

In addition, ideally (according to ACC guidelines) in a case of moderate risk like this a CT scan should be considered, or at least an Xray to check for skull fracture.

However, admission would have involved moving [Mrs A] some distance to hospital, and [Dr B] made a decision (later to be shown to be incorrect) not to take this step. This situation is an example of the many difficult decisions made daily by general practitioners, particularly in rural areas, where the ideal management may not be adhered to because of other factors. In addition it should be noted that subdural haemorrhage is a notoriously difficult condition to diagnose (eg loss of consciousness is not always a feature), and largely relies on an informed decision based on assessing degree of risk in every head injury case.

On balance, with the history of a fall without loss of consciousness, headache and several vomits, but no neurological deficit, I consider it reasonable though risky to initially observe this patient at home for a short period, but with a low tolerance for admission for any deterioration or continued headache or vomiting (see also comments under Question 2).

Question 2: When [Dr B] returned to see [Mrs A] in the evening of 9 April 2001, [Mrs A] had been vomiting, continued to have a severe headache, and was unable to sleep. Given this history, what examination and assessment should [Dr B] have undertaken at this time? Were the actions [Dr B] took appropriate?

Similar standards apply at the first visit: ie the history and examination listed above should ideally be repeated, in particular checking for any deterioration in consciousness, worsening of symptoms, or the development of neurological abnormalities, such as might indicate increasing intracranial pressure.

[Dr B] states that [Mrs A] had not deteriorated, and had not vomited again (only nausea was mentioned in the notes) (see also comments above on page 2, para (b)). Parts of the notes are not legible, but one comment appears to read 'no better', perhaps referring to the headache. No record of any neurological or mental state examination, or blood pressure recording is present.

[Dr B] says he suspected sinusitis from the 'tender sinuses' and prescribed accordingly. However the nausea was sufficient to justify a stemetil (antiemetic) injection. He is likely to have noticed any significant deterioration in consciousness or neurological status. If it is true that no further vomiting was present (and headache not severe), it was reasonable to continue to observe the patient. If however the complaint letter was correct in stating the vomiting had 'started during the day', and severe headache persisted, this would indicate deterioration and justify admission.

It is important to note that when [Dr B's] colleague assessed [Mrs A] the following morning he noted 'severe' headache and vomiting since the injury, and diagnosed raised intracranial pressure (?subdural haemorrhage) on his admission form. [Dr B] states

(document C) that [Dr D] found the patient's condition deteriorated overnight. There is no additional evidence (eg from the ambulance record or hospital notes) that [Mrs A's] symptoms and signs had materially changed from the night before.

On balance, I consider that [Dr B] did not carry out an adequate neurological assessment at this visit. However, if [Dr B] had carried out a full assessment, no further information likely to have altered management would have been found. The fact that even after admission the next day (and discovery of the subdural haemorrhage) no action was taken (apart from observation) for the first 10 hours, tends to support this opinion.

However [Dr B's] decision to continue monitoring at home in my opinion constitutes an error of judgement, despite the lack of deterioration in history and neurological findings. The ongoing headache (and probable vomiting) should have raised suspicion of raised intracranial pressure at both visits.

Question 3: Was it appropriate for [Dr B] to arrange to visit [Mrs A] the following morning (10 April 2001)?

Further review, at least by telephone, was indicated every few hours, at least until the symptoms of headache and vomiting had resolved.

Question 4: Are there any other matters in the information reviewed that warrant comment?

Standard of records: The brevity and lack of legibility of [Dr B's] records make it impossible to determine the extent of his assessment of [Mrs A] at both visits.

In my opinion [Dr B's] clinical records are below the normal RNZCGP standards, particularly in respect of legibility, clear recording of history, assessment and management plan.

Arrangements for cover and contact It is clear that [Dr B] is operating under a heavy clinical and administrative workload, and appears to be thinking about addressing this issue (although as with many rural doctors, relief is not easy to find). It should be noted, however, that [Dr B], despite the pressures of rural practice, made sure the patient had his home phone number in case of problems overnight. In addition it is clear that there is a satisfactory practice cover arrangement so that even though [Dr B] forgot to attend the third time the next morning, a colleague was readily available.

Hospital Management The delay in intervention after admission is surprising in the presence of diagnosed intracranial bleeding with symptoms of raised intracranial pressure.

CONCLUSION
I conclude that [Dr B's] assessment at both visits was likely to be adequate, but that his management constitutes an error of judgement. His decision against serious pathology (because of absence of loss of consciousness and abnormal neurological *signs*) appeared to inappropriately outweigh in his mind the significant *symptoms* of raised intracranial pressure (headache and vomiting). In this respect [Dr B's] standard of care was below that normally expected of an independently practising general practitioner.
References:

i. ACC Treatment Profiles 2001
ii. Head Injury Management. Arnold Bok (neurosurgeon, Auckland Hospital) NZGP 20/3/02, p 32."

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 4

Right to Services of an Appropriate Standard

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

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(1)

Initial Assessment
Mrs A was 76 years of age at the time of her unobserved fall. My independent expert advised that "severe headache accompanied by vomiting, unreliable history of injury (not observed by another person), aspirin therapy, and possibly the patient's age" put Mrs A in the 'moderate risk' group according to ACC guidelines. The brevity of Dr B's records make it impossible to determine what assessment was made but Dr B stated that he was advised Mrs A was not knocked out, had a mild frontal headache, and had vomited twice, and that on examination she had normal eye signs and symmetrical strength.

My independent expert advised that as an experienced general practitioner, Dr B would have obtained a history of the injury. This is confirmed by Dr B, who advised me that he

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undertakes routine post head injury questioning in such cases. My expert noted that Dr B would also have carried out an assessment including level of consciousness and mental function. Dr B told Mrs A to rest and said that he would review her that evening. My expert advised me that he considered the initial assessment was adequate overall.

Dr B was required to provide medical services to Mrs A with reasonable care and skill in his initial assessment of her condition. I am guided by my expert's advice. Accordingly, in my opinion Dr B did not breach Right 4(1) of the Code.

Opinion: Breach

Rights 4(1) and 4(2)

Second assessment and management plan
Dr B returned as promised to see Mrs A at 7.30pm on 9 April 2001. Again, it is not possible to tell from Dr B's notes what assessment occurred. Mr C said that Mrs A had continued to vomit throughout the day on Monday, was not eating and was having trouble sleeping because of the severity of the pain. Dr B said that when he visited, Mrs A was no worse and had not vomited again.

My expert advised that history taking and neurological or mental status assessment should have been the same for the second visit as for the initial visit. There is no record that any examination was carried out. Dr B's notes record that the headache was no better. It appears that he considered a sinus infection for which he prescribed Augmentin (an antibiotic). The only other entry in the clinical record was that Mrs A was still nauseous and that intramuscular Stemetil was administered. Dr B decided to reassess Mrs A in the morning. Although Dr B omitted to see Mrs A on the morning of 10 April 2001, practice cover arrangements meant that Dr D was readily available and visited.

According to Dr D's referral form, Mrs A had had a severe headache and vomiting since her fall on Sunday evening and according to the ambulance report Mrs A described her pain as 6-8 /10 throughout. Dr D diagnosed "raised intracranial pressure (?subdural haemorrhage)" on the admission form. There was no evidence that Mrs A's signs and symptoms had changed from the night before when she also required an antiemetic injection for nausea. I accept my expert's advice that the evidence suggests Mrs A's headache was continuous and of moderate to severe intensity.

My expert noted that if no further vomiting occurred and the headache was not severe it was reasonable to continue to observe Mrs A. If, however, Mrs A had started vomiting during the day and continued to have a severe headache, hospital admission was indicated. On the balance of the evidence I agree with my expert that Dr B made an error in judgement in not suspecting raised intracranial pressure in the presence of significant symptoms (headache and vomiting), and in continuing to monitor Mrs A at home. In my opinion, Dr

B failed to exercise reasonable care and skill in treating Mrs A and accordingly breached Right 4(1) of the Code.

Record keeping
In keeping with professional standards, Dr B was required to "keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed."[1]

My independent expert advised me that Dr B's clinical records were below the normal RNZCGP standards and that the legibility, history record, assessment and management plan make it impossible to determine the extent of his actual physical assessment of Mrs A.

In my opinion, Dr B failed to comply with professional standards of record keeping in relation to Mrs A and accordingly breached Right 4(2) of the Code.

Actions taken

In response to my provisional opinion, Dr B provided an apology for Mr C and Mrs A and confirmed that he has reviewed his practice in light of this report. The apology has been forwarded to Mr and Mrs A.

Further actions

- A copy of this report has been sent to the Medical Council of New Zealand with a recommendation that it consider whether a review of Dr B's competence is indicated.
- A copy of this report, with all identifying details removed, will be sent to the Royal New Zealand College of General Practitioners, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

[1] Good Medical Practice: A Guide for Doctors (Medical Council of New Zealand, 2000).

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