General Practitioner, Dr C

A Rest Home

A Report by the

Health and Disability Commissioner

(Case 03HDC07253)

Parties involved

Mrs A	Consumer
Mr B	Complainant / Mrs A's son
Dr C	Provider / General Practitioner
Ms D	Provider / Manager at the rest home
Dr E	Provider / General Practitioner

Complaint

On 16 May 2003 the Commissioner received a complaint from Mr B about the care provided to his mother, Mrs A, by Dr C and a rest home. On 24 June 2003 an investigation was commenced. The following issues relating to Dr C were investigated:

In April 2003 general practitioner Dr C did not provide services of an appropriate standard to Mrs A. In particular Dr C:

- *did not arrange blood tests following Mrs A 's discharge from a public hospital on 7 April 2003*
- *did not perform an assessment of Mrs A 's medical condition to an appropriate standard on 19 April 2003*
- *between 20 and 22 April 2003 did not respond appropriately to the signs of Mrs A 's recovery following her significant deterioration in health*
- *did not admit Mrs A to a public hospital prior to 22 April 2003.*

The issues relating to the care provided to Mrs A by the rest home are addressed in a separate report.

Information reviewed

- Information received from:
  - Dr C
  - Mr B
  - Ms D
  - A social service organisation
- Mrs A 's clinical records from the public hospital
- Independent expert advice from Dr Philip Jacobs, a general practitioner, and Andrea Avent, a nurse consultant.

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

HDC

Information gathered during investigation

Background

In January 2001 Mrs A, aged 78 years, was admitted to the public hospital when she was found at her home in a conscious but incapacitated state. Her medical problems were hypertension, congestive heart failure, constipation, and mild chronic obstructive airways disease, plus memory loss and a high alcohol intake. On 27 January 2001 Mrs A was discharged to the rest home having been assessed as Support Needs Level 3 (SNL 3). She was able to perform her daily needs independently with supervision, and could walk to the local shopping centre.

Shortly after her admission, the rest home staff became aware that Mrs A was alcohol dependent and self medicating with aspirin and laxatives. As a result Mrs A had problems with bleeding from the bowel, electrolyte imbalance from diarrhoea and increased mental confusion.

On 3 March 2003 the rest home nursing team leader together with Mrs A completed an 'Admission Agreement – Informed Consent Serious Illness & Resuscitation' form. In the section for 'Serious Illness' Mrs A gave the following instructions in the event of serious illness: "I give consent for my medical officers to use their professional discretion at the time." There was a footnote to this section of the form, which specified that the person holding a Welfare Enduring Power of Attorney or the person completing the form could change the above instructions at any time. (The 'Resident Information' form noted that Mrs A's solicitor held such a power of attorney for Mrs A.)

Family meeting March 2002 – concerns about care
On 15 March 2002 a meeting was arranged between Dr C, Mrs A's general practitioner, and rest home staff to discuss with Mrs A and her family, the family's perceptions of deficiencies in the care of Mrs A at the rest home. Mrs A and her family expressed their concern that Dr C had no interest in the decline in her health. It was agreed at the meeting that Dr C would be more of an advocate for Mrs A in relation to her health.

Health concerns – 2003
Between March 2002 and April 2003 there were no apparent concerns about Mrs A's health, except for her persistent self medication with laxatives and aspirin, and high alcohol intake.

On 1 April 2003 Dr E (a general practitioner contracted to visit patients at the rest home, in partnership with Dr C), admitted Mrs A to the public hospital for assessment when she became acutely unwell with incontinence, was confused and disorientated. In the public hospital Mrs A suffered a number of epileptic type seizures and a heart attack. She was found to have hyponatraemia (abnormally low sodium levels in the blood), possibly caused by the diuretic medication she was prescribed. Mrs A was also bleeding from her stomach. The bleeding was thought to be due to her persistent use of aspirin. Her fitting was treated and sodium imbalance corrected.

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

HDC

Mrs A was discharged back to the rest home on 7 April 2003. The discharge instructions were for her to have her sodium levels rechecked in one month, and her haemoglobin levels checked and stool specimens tested for occult blood, with consideration of a referral for gastroscopy if there was any abnormality. She was to have her hydration levels reviewed, diuretics withheld and, if after two weeks her blood sodium was stable, consideration was to be given to commencing an ACE inhibitor (used to treat high blood pressure and/or heart failure).

Mrs A was seen by Dr E on 8 April. He noted that she was feeling reasonably well, but seemed to be vague about her admission to the public hospital. Dr E arranged for Mrs A to have repeat blood tests on 14 April to check her sodium levels. However, there is no record of the test results being received at the rest home or followed up.

On 9 April the nursing notes state that Mrs A was seen by Dr C because her left hand was very swollen. The notes record his opinion that the swelling could be mechanical, caused by her lying on her arm. The notes over the following two days record that faecal specimens were collected.

On 13 April the nursing notes record:

> "[Mrs A] still very confused. Went down to road to buy Aspirin apparently, as brought back by [a rest home staff member who] lives near there and recognised her. Staff did not see [Mrs A] go off the premises. Handbag checked – 2 pkts of Aspirin found. Requested it for headache. Remainder confiscated and locked in drawer in Dining room. Incident form completed."

The following evening at about 6.30pm Mrs A was found outside the rest home by staff. It was getting dark and raining. Mrs A stated that she wanted to telephone her son.

18 April – deterioration in condition

The afternoon nursing staff on 18 April noted that Mrs A had been unwell all day, but "nothing specific observed". At 6pm she was noted to be very rigid and frightened. Her blood pressure was elevated at 240/110 and her pulse was 100 beats per minute. Dr C and Mr B were notified of the change in her condition. Dr C saw Mrs A at 6.45pm and ordered Halcion 0.25mg (sedative) and MST 10mg (morphine) to give her a restful sleep. Dr C ordered two-hourly assessments of her blood pressure and pulse, and that her fluid intake/output be documented, and noted that he would review her the following day. Dr C informed me:

> "I phoned and spoke with [Mr B] ([Mrs A's] son) and his wife about [Mrs A's] condition, I said that she was not well and that it may be serious and that she may have some surgical disorder. I thought we could care for her overnight and review the situation the following morning. **I also specifically asked him if he wanted me to admit his mother to hospital that evening**, I told him that I would give his mother a sedative that night and review her the following morning."

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

HDC

The nursing staff provided Mrs A with fluids throughout the evening, but noted that when they offered her fluid at 9.30pm she choked and "spluttered". Her limbs remained stiff throughout the night and her blood pressure was described as "still quite high and irregular".

At 7.20am on 19 April Mrs A was noted to be unconscious and not responding, but her observations (blood pressure pulse and temperature) were stable and her colour satisfactory. Dr C and the family were notified. Dr C considered that Mrs A had developed a deepening CVA (stroke), a cardiac episode, or that the metabolic disorder she had suffered in March had exacerbated. He requested urgent laboratory testing of Mrs A's blood.

Dr C informed me:

> "The level of consciousness may have lightened. She still had equivocal abdominal signs, there was a past history of bowel bleeding and she may have had further bleeding. I was hopeful that the blood might help in the diagnosis of the cause of her unconsciousness.
>
> About this time I saw both [Mr and Mrs B] with their mother. This was in a new room that was in a better location for the nursing staff to attend [Mrs A's] greatly increased nursing requirements. …
>
> I said that her level of unconsciousness was not fully explained, that she may have some form of metabolic disorder such as hyponatraemia. If the bloods that I requested earlier in the day showed this, she would be admitted to hospital, as this was an extremely correctable medical disorder. [Mrs B] was worried about the need for hydration. I said that at this stage her hydration was satisfactory because she was overhydrated in her body tissues, and if systemic hydration was needed this would be provided at a public hospital. **We agreed that hydration would not be given**.
>
> I felt that her level of hydration was adequate at this stage and if she had low sodium when the blood results returned, then she would be admitted to hospital anyway. We all agreed to care for her at [the rest home] if her condition remained grave, as the home provided excellent facilities in the care of the terminally ill."

At 3pm, a registered nurse contacted Dr C as the blood sodium test results were "abnormal but results indicate a very little raise". Dr C advised the nurse to continue with all nursing cares and to give Panadol suppositories if Mrs A's temperature rose.

Dr C saw Mrs A at 6pm. He noted the results of her blood tests, and that her blood sodium was 130 which was "low, but not so low as to induce coma". The haemoglobin was normal and there was no indication of major bowel bleeding. There was also no indication of cardiac damage or major sepsis in the test results. Dr C made no change to his earlier orders and informed the nursing staff that he would review her again the following morning. The nursing notes record that although Mrs A remained "slightly sweaty and clammy", and her breathing was irregular, her blood pressure, temperature and pulse chart was discontinued. The notes at 9.17pm state:

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

HDC

> "[Dr C] has notified Mrs [A's] son [Mr B], about her condition (2000hrs). Family want to be contacted immediately when [Mrs A] passes away."

Dr C informed me:

> "The results did not indicate the need for hospital resuscitation in particular, in spite of my feelings that very low sodium may be implicated in her clinical condition. The results did not support this. I decided that the cause of her condition was a major cerebral vascular accident.
>
> I tried a number of telephone numbers to contact [Mr B] and finally left an answer phone message on his son's cell phone. His son did ring later that evening. He was a fourth year trainee doctor. I explained to him that the bloods had returned, I'm not sure how much detail I gave him, but that I thought that they did not give an alternative explanation other than a cerebro-vascular accident for [Mrs A's] medical condition.
>
> [Mr B] phoned me at my home sometime later that night. I also explained that the bloods did not show any other cause of her condition than a stroke, and that I thought she was in a terminal state."

In my response to my provisional opinion Dr C reiterated that Mrs A's blood tests did not indicate that she had a major infection "that would be required to provide the degree of unconsciousness that was present at the time".

Mr B informed me that the family had agreed to "No resuscitation". Mr B stated that their understanding of this term was:

> "An instruction we assumed to mean 'no heroics', an expression we used and understood to mean no defibrillation or artificial ventilation in the event of a major cardiac or similar event. We did not anticipate that this would mean withholding of all fluids and sustenance, despite whatever the circumstances were."

Dr C saw Mrs A at 8am, 11.30am and 6pm on 19 April. He recorded his impression that her condition was deteriorating. At 6pm he advised the staff to provide "terminal care". Ms D advised me that staff at the rest home would equate terminal care with palliative care.

Dr C informed me that he never gave the nursing staff instructions to withhold fluids or food to Mrs A. There is no evidence in the clinical records that Dr C gave these instructions to the nursing staff.

Mrs A's condition continued to deteriorate. The night shift nursing staff of 19/20 April noted that Mrs A was "unresponsive, peripherally shut-down, extremities ice-cold".

At about 9am on 20 April Mrs A suffered a seizure that lasted about a minute. She was seen by Dr C at 9.30am. Dr C gave no further orders regarding Mrs A's treatment. Her family visited at 11.30am.

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

HDC

Mr B informed me:

> "I visited [Mrs A] again on Saturday [20 April] morning and there did not appear to be much change in her condition. I returned to [the country] about midday and after we received further calls from [the rest home] later in the day we returned to [the city] around midnight on the Saturday and visited [Mrs A]. Her condition had apparently further deteriorated; her complexion had become yellow and waxy and her breathing was even more irregular. The end did not seem very far away. The rest home staff continued to maintain what appeared to be a good level of monitoring of her status, with regular look-ins and turning etc, but still no attempt to provide her with water or food."

Ms D, Nurse Manager, at the rest home, informed me:

> "[Dr C's] failure to make a diagnosis and set the pace for curative treatment by the team, in consultation with the resident's family, let the registered staff down enormously. He prescribed terminal care, which set up a mind set for the team."

The nursing notes record that Mrs A was provided with comfort cares, including pain relief and regular turns.

Mr B informed me:

> "We visited [Mrs A] in the morning [of 21 April] and noticed her complexion colour had become more flushed with none of the yellow waxiness of the previous day. Her breathing had steadied and was less erratic and her eyes were open, but she was not easily roused. We thought we had some responsiveness from her by asking her to blink if she understood what we were saying to her. She blinked, apparently on cue on three separate occasions, giving us the impression that she had heard and understood. We commented on this apparent change of appearance and expressed the opinion that maybe [she] was not going to die just yet, to the [rest home] staff on duty [who] were non-committal on this change. … [T]he [rest home] staff remained unmoving on the issue raised by us of possibly admitting that the type of care they were providing to [Mrs A] was totally wrong. Staff reiterated the policy for managing [Mrs A] as requested by [Dr C], of no fluids or food, but to be made comfortable by turning every two hours and mouth washes to prevent dryness."

Dr C recorded on 21 April:

> "This lady is in terminal stage. Staff report fitting last night when turning her. For sedation – MST 10mg BD."

On 22 April the morning nursing staff recorded that Mrs A "woke up" and recognised her son. She was unable to speak or swallow but was able to nod to questions.

There is a discrepancy in the information about the timing of Mrs A's recovery. Mr B informed me that he visited "first thing" on the morning on his way to work and was assured that his mother would be seen that morning as a priority. Mr B stated that he

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

HDC

thought that his mother was "fighting for her life against the odds" and expressed his opinion to the staff about the change in his mother's condition, but the staff reiterated Dr C's management plan. Mr B recalled that he specifically asked that she be reviewed by a doctor as a high priority, but was told that she would be seen by a doctor the following morning for comfort care only. Mr B stated that he noted his mother's recovery but, despite his requests for intervention, she was not admitted until 24 April.

In response to the change in Mrs A's condition, Dr E, who was visiting the rest home on the morning of 22 April, was asked to see Mrs A. He was informed that Mr B wanted his mother admitted to hospital. Dr E noted that admission was appropriate as, although she was dehydrated, there was a possibility that Mrs A would survive.

In his referral letter to the public hospital, dated 22 April, Dr E noted:

> "You will have records of this lady, admitted [a public hospital] 4.4.03 and discharged 7.4.03 – status epilepticus + melaena, CHF [congestive heart failure] & hyponatraemia.
>
> She deteriorated greatly on 18.4.03, unconscious and ?further CVA [stroke]. Over last 3//7 [three days] she has been seen by my partner, [Dr C[. She became more deeply unconscious and she was thought to be terminal. However, overnight she has recovered and is now awake. BP 140/80. Dehydration ++ and smell of acetone on breath.
>
> Responds to talk + nods, but can't speak. No febrile fitting this time. Has taken no fluid and food for the last 3/7 [three days]. She looks as if she could survive, so urgently needs IV fluid and a diagnosis."

A Public Hospital

On admission to a public hospital Mrs A was found to have a urinary tract infection, which had caused her to develop septicaemia, and was in renal failure. The medical team judged her prognosis to be poor, and warned the family that she was unlikely to survive.

Mrs A was treated with intravenous fluids and antibiotics and made good progress until 27 April when she deteriorated. Although her condition improved over the next few days, she did not return to her pre-illness level of functioning. She was assessed as requiring hospital level care and was discharged to a private hospital on 5 May 2003.

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

HDC

Additional information

Dr C's response to the investigation
Dr C informed me:

> "The symptoms of [Mrs A's] lightening consciousness that [Mr B] reports were not made available to me. It would appear that his visits on his mother and my medical visits were out of phase during the days of the 20th to the 22nd 2003. His concerns were not conveyed to me, either by himself, or through the nursing staff.
>
> I felt that she would continue to deteriorate and was in a terminal state. To maintain constant hydration generally prolongs the stages of decline, so I did not expect to provide this. However if there was a lightening in level of consciousness she may well have needed admission. Dr E saw her on the Tuesday morning about 1100hrs and admitted her to hospital. … I fully agree that [Mrs A] needed admission to hospital. I was very surprised I had not been informed of this situation, either during the night, or first thing Tuesday morning. I have left instructions with the staff of [the rest home] to contact me early in the morning of normal workdays at (0730hrs) so that I am able to make visits to the home before attending my private practice. Information concerning [Mr B's] worries about his mother's perceived condition would have helped me in my decisions to consider admission to the [public hospital]."

Independent advice to the Commissioner

Initial advice
The following independent advice was obtained from Dr Philip Jacobs, general practitioner:

> "Medical/Professional Expert Advice-03/07253
>
> My name is Philip Jacobs and I have been asked by the Health and Disability Commissioner to provide independent advice about whether [Mrs A] received an appropriate standard of care from General Practitioner [Dr C].
>
> I have read and agree to follow the Commissioner's Guidelines for Independent Advisors. I have been supplied with and read the following supporting information:
>
> - [Mr B's] letter of complaint marked 'A' (1-10)
> - Response from [the rest home], relevant policies and nursing records marked 'B' (11-188)
> - Response from [Dr C] with relevant medical records marked 'C' (189-224)
> - [Mrs A's] medical records for her admissions to [the public hospital] on 2 April and 22 April marked 'D' (225-432).

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

HDC

I am currently in General Practice but also hold the position of Palliative Care Liaison GP for the Pegasus Independent Practice Association. I have an interest in Palliative Care, having been the Medical Director of a Hospice for six years and having attained a Diploma in Palliative Care from the University of Wales. My current role involves working part time in a Hospice, advising other General Practitioners in the care of their palliative care patients, and educating the membership in this area of medicine. I am also a facilitator in the GP Education Programme and am an accredited teacher, hosting a GP Registrar within my Practice. I hold a Diploma in Obstetrics and am a Fellow of the Royal New Zealand College of General Practitioners. I have served on the Executive of the Royal New Zealand College of General Practitioners and was the founding Council Member on the Consumer Liaison Committee. I hold a Distinguished Service Medal from the College.

Background

[Mrs A] was admitted to [the rest home] on the 27th January 2001 directly from hospital. She was admitted to hospital from home after being discovered in a 'conscious but incapacitated state'. There seems to have been concerns about memory loss and a high alcohol intake. She suffered from other medical problems including hypertension and congestive heart failure, treated hypothyroidism, chronic urinary retention, mild chronic obstructive airways disease, chronic constipation, previous duodenal ulcer, previous pulmonary embolism and dyslipidaemia.

At a family meeting on 15/3/2002 there appears to have been concerns voiced by [Mr B] (son). These appear to be related to a perceived lack of care and an impression that [Dr C] had no interest in [Mrs A's] decline. There were a number of outcomes of this meeting but one in particular was that the Doctor would be more of an advocate for [Mrs A's] health.

Over the next 8 months there appear to be no major problems but there seems to have been repeated reports of laxative, aspirin and alcohol self medication.

On the 1/4/03 [Mrs A] became acutely unwell, was confused, disorientated and incontinent. She was admitted acutely to [the public hospital] by [Dr E] a fellow medical officer at the Rest Home. In hospital she suffered a number of epileptiform seizures and had evidence of a gastric bleed. She was found to be severely low in serum sodium and this was thought to be the cause of her fits. The low sodium was thought to be due to the diuretic medications that she was on. As a consequence of her illness, she also suffered a myocardial infarction (heart attack). Her fits were treated and her low sodium corrected. The bleed was thought to be due to aspirin ingestion.

At discharge, she had improved and was returned to the Rest Home on 7/4/03 with instructions to have her sodium rechecked in one month (a form was given to her by the Hospital staff), consideration for gastroscopy if her haemoglobin dropped or if she had positive faecal occult bloods in 6 weeks. She was to have her fluid status reviewed and

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

HDC

diuretics withheld. Consideration to use an ACE inhibitor in 2 weeks if her [sodium] was stable.

On 8/4/03 she was readmitted to the Rest Home by Dr E. He said she described feeling OK but she appeared very vague about her recent admission. He arranged for the blood test to be done on 14/4/03.

On 18/4/03 [Mrs A] became unwell and spastic with her movements. She was seen by [Dr C] who examined her. Her vital observations were normal but she did seem to have some abdominal discomfort. He wondered whether she had had some epileptic event or whether she had a bowel disorder. He spoke to her son and daughter in law, and decided to observe her overnight, keep her comfortable and review the next day.

On 19/4/03 at 0800 she was unconscious, sweating slightly, flaccid. Her pulse was irregular but BP satisfactory at 160/80. The cause of her collapse was not readily apparent to [Dr C] but he considered her condition critical. He requested some blood tests to help understand what was happening.

On 19/4/03 at 11.30 she was again reviewed by [Dr C] where he felt her level of consciousness had improved slightly. Once again he wondered about some abdominal problem as she appeared to have a painful response when he felt her abdomen. He was still awaiting the blood test results. [Dr C] states that around this time he spoke to family members. This is not recorded in the notes but a nurse's note said that he did indeed speak with the family at 2000hrs.

On 19/4/03 at 1800 she was reviewed by [Dr C] and he found her to again be deeply unconscious with a low BP and pulmonary congestion. He reviewed the blood tests which showed that although the Sodium was low, he did not feel it was low enough to be the sole cause of her decline. Her kidney function was within normal limits. Her haemoglobin was normal and her white cell count mildly elevated at 13.47, with an increase in the total number of neutrophils. Her Troponin T which is a measure of whether she had suffered heart damage (eg if she had a heart attack), was normal.

It is apparent that [Dr C] did not feel that there was going to be any simple remedy to [Mrs A's] illness and that she was in a terminal care situation with a poor short term outlook.

On 20/4/03 Dr C reviewed Mrs A, found her still to be unconscious, have a low BP and requiring palliative care. Dr C stated that he did not notice any lightening of her conscious level when he visited.

On 21/4/03 [Dr C] visited [Mrs A] and described her as being in the terminal stages. The nurses had noted her to be fitting on turning. [Dr C] requested that she be given slow release morphine rectally for sedation. From the nursing notes it appears that [Mrs A] remained unconscious all day except that she appeared to be in discomfort when being turned by the staff.

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

HDC

On 22/4/03 the nursing notes state that [Mrs A] woke up and recognized her son. She was unable to speak or swallow but able to nod to questions. Dr E who was visiting that morning assessed [Mrs A] and felt that she was dehydrated. He stated that her son wanted her admitted to hospital. Dr E noted that because there was a possibility of survival, admission to hospital was appropriate.

On admission [Mrs A] was found to have an E Coli septicaemia (bacteria in the blood) from a urinary tract infection and to be in renal failure. Her prognosis was thought to be poor and the expectation by the medical team was that she would be unlikely to survive.

She was treated with intravenous fluids and antibiotics. It appears [Mrs A] made good progress until 27/4/03 when her level of consciousness deteriorated, her BP dropped and she again appeared seriously ill. She became very restless and agitated but eventually improved again. There persisted a degree of disorientation and confusion and her general level of function did not return to pre-illness levels. She was reassessed as requiring hospital level care and arrangements were made for her to be admitted to [a private hospital] although there appeared to have been some delay whilst the funding was being sorted out. Transfer proceeded on 5/5/03.

Definitions and relevant literature review

1. The new WHO definition of Palliative Care (1) states that 'Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative Care:

   a. provides relief from pain and other distressing symptoms
   b. affirms life and regards dying as a normal process
   c. intends neither to hasten or postpone death
   d. integrates the psychological and spiritual aspects of patient care
   e. offers a support system to help patients live as actively as possible until death
   f. offers a support system to help the family cope during the patient's illness and in their own bereavement
   g. uses a team approach to address the needs of patients and their families, including bereavement counseling, if indicated
   h. will enhance quality of life, and may also positively influence the course of the illness
   i. is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

2. The Bedford Geriatric Research and Education Clinical Centre (2) developed an approach that tracks where Alzheimer's patients are in the disease process and helps

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

HDC

to identify which patients are nearing the end of life. Clinical criteria that indicate a poor prognosis are

a. Inability to dress independently
b. Inability to bathe properly
c. Inability to walk
d. Consistent weight loss
e. Lean body mass less than 70% of ideal body weight
f. Ability to say about six words or less
g. Faecal and urinary incontinence
h. Other serious medical problems.

At a family meeting participants discuss advance care planning issues, such as the patient's more immediate prognosis, or the decisions the surrogate will need to make. Family members may have high expectations for the outcomes of medically aggressive treatment and may need more information about actual programmes before making a decision. The levels of treatment used are

a. Level One: Diagnostic workups, treatment of other medical conditions, transfer to acute care when necessary, CPR in the event of heart attack, and tube feeding

b. Level Two: Less aggressive care, Do Not Resuscitate status established; otherwise same as level one

c. Level Three: Do Not Resuscitate and no acute transfer for medical management

d. Level Four: Previous restrictions, as well as no workup or antibiotic treatment for life threatening infections; antipyretics and analgesics for comfort

e. Level Five: Supportive care, eliminating tube feeding.

3. The need to treat dehydration in terminally ill patients has become a very controversial topic (3). The arguments against rehydration have been
   a. Comatose patients do not experience symptom distress
   b. Parenteral fluids may prolong dying
   c. Less urine results in less need to void or use catheters
   d. Less gastrointestinal fluid, nausea and vomiting
   e. Less respiratory tract problems such as cough and pulmonary oedema
   f. Decreased oedema and ascites
   g. Dehydration may act as a natural anaesthetic for the Central Nervous System
   h. Parenteral hydration is uncomfortable and limits patient mobility.

There are also arguments for rehydration. 'We have concluded that the data reported to date is insufficient to reach a final conclusion on the benefit or harm of dehydration in terminally ill patients.'

4. The New Zealand Medical Association Code of Ethics (4) states 'Standard treatises on medical ethics cite four moral principles: autonomy, beneficence, non-

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

HDC

maleficence, and justice. Autonomy recognizes the rights of patients to make decisions for themselves. Beneficence requires a doctor to achieve the best possible outcome for an individual patient, while recognizing resource constraints. Non-maleficence implies a duty to do no harm. (This principle involves consideration of risks versus benefits from particular procedures.) Justice incorporates notions of equity and of the fair distribution of resources.'

Recommendation Number 20 states 'Doctors should bear in mind always the obligation of preserving life wherever possible and justifiable, while allowing death to occur with dignity and comfort when it appears to be inevitable. Doctors should be prepared to discuss and contribute to the content of advance directives and give effect to them. In the case of conflicts concerning management, doctors should consult widely within the profession and, if indicated, with ethicists and legal authorities.'

Questions

1. **Were [Dr C's] actions in relation to arranging and following up [Mrs A's] blood tests after her discharge from [a public hospital] on 7/4/03, appropriate and timely?**
   The discharge letter from [the public hospital] gives instructions to the GP regarding follow up. The instructions are contradictory and open to interpretation. They state that a Sodium level and haemoglobin level be performed in one month and that a form was given (I assume to accompany the patient back to the Rest Home). However, a further comment states that the GP should consider introducing an ACE inhibitor (drug used for treating high blood pressure and/or heart failure) in two weeks if the sodium was stable. This implies that a sodium level should be done in two weeks. [Dr E] readmitted [Mrs A] to the Rest Home on 8/4/03 and decided to repeat the blood tests on 14/4/03. Dr C in his response to the complaint stated that Dr E remembered asking for a copy of the blood test result to come to the home. This did not happen and the result went only to the hospital. I assume that the results were reviewed at the hospital and as these did not show signs of any major change or deterioration in sodium levels, no action was taken. However, no recognition was made at the Rest Home level that the blood tests had failed to arrive. There is a note in the Integrated Communication that the Doctor reviewed [Mrs A] on the morning of 9/4/03 because of a swollen hand. No mention is made in the notes of blood tests. This was a systems fault that included the failure of the Medical Laboratory to forward a copy to the Rest Home, a failure of the Hospital to contact or forward the result, contradictory instructions from the Hospital, lack of communication from [Dr E] to [Dr C] that a blood test had been ordered 3 weeks prior to that requested by the hospital, and a failure of the nursing staff to follow up the results. Therefore, whilst [Dr C] undertook overall responsibility for [Mrs A's] care, I do not believe that he can be held solely culpable. I believe his actions were acceptable under these circumstances.

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

HDC

2. **Was [Dr C's] assessment of [Mrs A's] condition on 18/4/03 reasonable under the circumstances?**
   Since [Mrs A's] discharge from hospital on the 7/4/03, it is recorded in the nursing notes that she had been confused, wandering down to the shops to buy aspirin and getting lost, saying that she was going home. [Dr C] did attend [Mrs A] and examined her. It appears that there were no specific pointers as to why she was unwell, her observations were stable and her temperature normal. However he did not check her urine to rule out urinary infection nor consider faecal impaction as possible causes of non specific deterioration. In light of [Mrs A's] deterioration since her return from hospital I believe that [Dr C's] assessment and management plan overnight was acceptable but not perfect. It may have been that her deterioration was a short lived fluctuation in her mental state and that by the morning she would have improved. He also spoke to the family that night to keep them informed.

3. **Was [Dr C's] decision to not admit [Mrs A] on 18/4/03 appropriate? Did she need admission?**
   I believe that [Dr C's] decision not to admit [Mrs A] to hospital on the evening of 18/4/03 was appropriate. The decision to admit a patient with Alzheimer's disease to an acute care hospital is not one that is made lightly. There is a high risk of increasing confusion and exposing the patient to the consequences that may ensue (eg falling, getting lost), just by change of environment. Furthermore admission may result in a number of medical interventions that may be inappropriate. The question about needing admission is one that mustn't be answered with the benefit of hindsight. Based on the information that [Dr C] had to hand, his judgement was that she did not need admission at that time.

4. **Was [Mrs A's] condition terminal at any stage between 18th and 22nd April?**
   By the morning of the 19/4/03 [Mrs A] had deteriorated considerably. She was unconscious and clearly very unwell. [Dr C] considered that she had suffered an acute event, such as heart failure or a cerebrovascular event. He described her condition as critical. She remained in a similar very ill state through to the 22/4/03. There is no doubt that she suffered an acute illness that in retrospect proved to be a Gram negative septicaemia from a urinary tract infection with secondary renal failure. The decision to treat her with palliative care was based on [Dr C's] assessment that she was indeed seriously ill and highly likely to die from this illness. The nursing staff have recorded in their notes that [Mrs A] was very unwell and not responding. This decision to treat in a palliative way is a very complex one and may have been based upon his knowledge of her premorbid health status (already mentioned), her degree of Alzheimer's disease, including her confusion, and her self medicating behaviour. The natural history of Alzheimer's disease is for a gradual and steady decline in function with often marked deterioration with intercurrent illness and [Dr C] would have seen [Mrs A] over a period of time to gauge this progression. I believe that [Mrs A] was very unwell and had a very high probability of not surviving. She was closely monitored, and as such, when it appeared that despite the odds she may survive, referral to hospital was made.

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

HDC

5. **Were [Dr C's] actions and interventions appropriate and timely at all times between 18/4/02 to 22/4/03?**
   [Dr C] appears to have considered [Mrs A's] status overnight on the 18/4/03 and awaited the results of blood tests to see if there was any treatable cause. After seeing the blood tests, he had reached the conclusion that there was no simple remedial cause to enable her to survive this illness and [that she] was appropriate for palliative care. He visited her three times on the 19/4/03 and spoke to the family at least once. He saw her again on [19/4/03 and 21/4/03]. He did not check her urine for infection and he did not consider the possibility of her having a septicaemia. The blood tests did show that [Mrs A] had a mildly raised white cell count and the possibility of infection should have been considered. Nevertheless, given the apparent overwhelming nature of this illness and the appearance that survival was unlikely, I do not think this knowledge would necessarily have altered the course of action taken.

6. **Was it appropriate to not give [Mrs A] fluids? Whose decision is this to make and at what point?**
   As stated in the attached literature, the issue of hydration versus non hydration is a controversial one with proponents emphatic on both sides. Given that [Dr C] thought that [Mrs A] would die from her illness, it would seem inappropriate that parenteral fluids be given. If there had been a possibility that some treatment could be administered that could reverse the disease process, then clearly fluids would have been appropriate. It is also important to remember that it was [Mrs A's] illness, not [Dr C] that rendered her incapable of drinking – indeed her unconscious state made it dangerous to try. Secondly, it was the septicaemia not the dehydration that initially made her unwell and unconscious (her kidney function was initially normal on the blood tests). The decision to hydrate or not hydrate is a clinical decision based on issues already mentioned. Parenteral rehydration is an invasive medical procedure and needs to be undertaken only if there is a perceived medical benefit.

7. **Was communication between [Dr C] and the nursing staff regarding [Mrs A's] condition between the 18/4/03 and 22/4/03 adequate and timely?**
   The only information I have regarding this aspect is from the clinical notes and the nursing notes. It would appear that from this source, communication between these parties was adequate and timely. However the complaint made by [Mr B] denies this and states that [Mrs A] was showing signs of increasing consciousness all day on the 22/4/03. He seems to have become confused about the dates as [Mrs A] was actually admitted on the morning of the 22/4/03, not the 23/4/03. Assuming that he meant the 21/4/03, there is no mention in the nursing notes that [Mrs A] was becoming more conscious, only that she appeared distressed on being moved by staff. He also believed that [Mrs A] was denied food and fluids by the staff at the request of [Dr C]. There is no mention in the medical or nursing notes supporting this claim and [Dr C], in his reply actively denies that this was the case.

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

HDC

8. **Did [Mrs A] exhibit signs of recovery that [Dr C] should have been alert to?**
   There is no mention in the notes that [Mrs A] made any sign of recovery until the morning of the 22/4/03. It appears that as it was [Dr E] who was doing a round, he was made aware of this change in status and arranged for her to be admitted to hospital. [Dr C] was advised of her admission after it had been arranged.

9. **Should [Mrs A] have been admitted to hospital at any stage between 18/4/03 and 22/4/03? Please explain why and whose responsibility it was to arrange this?**
   It was appropriate that [Mrs A] be admitted to hospital on the morning of 22/4/03 and it should have been done by either of the medical officers involved in her care. [Mrs A], despite the odds, did clinically improve from her life threatening episode. The decision to admit a patient is a clinical decision and should take into account all information available – that includes information from the Doctor, the Nursing staff, the patient (where able) and the family/whanau. The person taking overall clinical responsibility for care, in this case [Dr C], and in his absence [Dr E], are responsible for arranging admission. Where there is a dispute about this, either between nurses and doctors, nurses and family or doctors and family, a second opinion should be sought.

10. **Are there any matters of relevance that you would like to bring to the Commissioner's attention?**
    a. The relationship between [Dr C] and the family of [Mrs A] seem to have been strained for some time preceding the events beginning 1/4/03. This is reflected in comments made in the family meeting on 15/3/02. This 'lack of faith' appears to have continued on and raised the expectation that [Dr C] would not and could not act in [Mrs A's] best interests. The relationship was put under extreme pressure when some difficult decisions were made. It is unfortunate that this breakdown in doctor/family relationship was not recognized earlier thereby allowing a new relationship to be formed with another Doctor.

    b. [Mrs A] was suffering from Alzheimer's disease. She does not possess all the clinical criteria that would mean she was terminally ill as a result of the disease. However, I believe that her self destructive behavioural patterns (alcohol, aspirin and laxative usage) in combination with her other comorbid illnesses, meant a much poorer prognostic outcome compared with someone with just that degree of Alzheimer's and nothing else. It is noted in the hospital notes on both her admissions that restricted resuscitation orders reflect other medical teams' opinion regarding her prognosis.

    c. This is a complex case with many ethical issues about care of the elderly at the end of life. A paper (5) titled 'The attitudes of carers and old age psychiatrists towards the treatment of potentially fatal events in end stage dementia', showed clinicians were less active than students and carers in their attitude to treatment of potentially fatal events in end-stage dementia. Carers chose more aggressive treatment for family members than they would want for themselves. The authors

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

HDC

conclude that carers and doctors have significantly different attitudes. Attempts to unify them will require better communication between the two parties.

References

1. WHO Definition of Palliative Care ANZSPM Newsletter Vol 12 Issue 2 December 2003
2. Improving Care for the End of Life: A Sourcebook for Health Care Managers and Clinicians, Oxford University Press or www.abcd-caring.org
3. When to Treat Dehydration in the Terminally Ill Patient? Robin L Fainsinger, Department of Oncology, University of Alberta or http://www.palliative.org
4. New Zealand Medical Association Code of Ethics, PO Box 156 Wellington
5. The attitudes of carers and old age psychiatrists towards the treatment of potentially fatal events in end-stage dementia, Coetzee RH, Leask SJ, Jones RG, Int J Geriatr Psychiatry 2003; 18(2): 169-173."

Additional advice
The following additional advice was obtained from Dr Jacobs:

"I have received the opinion of Andrea Avent, Nurse Consultant, have read and considered her opinion concerning this case.

1. **Do you wish to revise any aspect of your advice in light of the nurse advisor's report?**
   The comments made are around two separate issues, firstly the behaviour of [Dr C] and secondly the actions of the Nursing staff and the processes around care plans and policies. [Dr C's] actions need to be taken into account given the unfolding of events at the time. It is neither appropriate nor fair to retrospectively judge his actions with the information that only subsequently became available. Looking from [Dr C's] perspective at the time, this was a lady with significant major co-morbidities, including moderate dementia, who quite rapidly became unwell to the point where she was seriously ill. The severity of the illness was to the degree that she was unconscious, and it appeared to both [Dr C] and the nursing staff that her short term prognosis was poor. It is true that the diagnosis was in doubt and the possibilities that were entertained included a surgical problem in her abdomen and a CVA. Given the assessment that [Mrs A's] general condition was very poor, a decision was made that vigorously pursuing a diagnosis was unlikely to alter the course of events. Indeed the decision that was made was probably designed to protect [Mrs A] from a hospital admission that might include invasive tests, movement and handling and allow her to stay in her own bed and die peacefully and with dignity.

   In my opinion the policies in place for the nursing home were extensive and proscriptive. The decision to keep [Mrs A] at the home was a clinical one – this clinical decision was made by the Medical Officer in charge based upon his knowledge of the patient's pre existing status and his previous experience. It is very

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

HDC

appropriate that if there appears to be a major discordance in opinion between staff members about the course of action, individual members should make their concerns known and act independently. In this case there is no suggestion in the notes that the staff disagreed with [Dr C's] clinical assessment. I do not believe the staff acted inappropriately. I do not believe that had the written policies or processes been different this would have altered the course of events.

There is a lot of discussion about fluids, pain and suffering. As in my first submission to you, there is little evidence that dehydration in a terminally ill patient causes either of these. I suspect that her apparent distress was a result of lightening of her level of consciousness with fluctuating awareness. Her condition was assessed as being terminal, therefore not using fluids was appropriate.

2. **How significant a departure from standards was [Dr C's] failure to exclude urine infection/faecal impaction as a possible cause of [Mrs A's] condition?**
[Dr C] did not request a urine test, nor did he consider a urinary tract infection initially, nor septicaemia as a result of urinary tract infection in his differential diagnosis. Although faecal impaction may cause confusion it would be unlikely to cause loss of consciousness. It would have been appropriate for Dr C to check [Mrs A's] urine on the evening when she was beginning to feel unwell. He did not and this was a significant departure from accepted standards. The following day when [Mrs A] was unconscious and it appeared her demise was imminent, to collect a urine would have required the insertion of a catheter. This is invasive and if it can be avoided in a dying patient, should be.

3. **Was [Dr C']s decision to not admit [Mrs A] reasonable given the lack of diagnosis and her previous history of responding to treatment?**
The decision to admit or not admit a patient in this situation to an acute hospital is a complex one. To make an appropriate decision there are a number of factors that need to be taken into account viz

- The patient's premorbid level of functioning
- The patient's quality of life
- Co-morbid illness that is likely to impair the ability to recover to pre-morbid levels
- The nature of the acute illness. Is there a likelihood that a specific treatment could effect resolution of the illness?
- The severity of the illness. Is the severity of the illness such that acute care is unlikely to alter the course of the illness ie is it overwhelming?
- The ability of caregivers (staff) to care for this patient's basic needs. The opinion of family members who may not only have their own opinion, but who through their knowledge of that individual may be able to extrapolate what their family member 'may have wanted' in this circumstance
- The opinion of staff who may or may not feel comfortable providing this level of care.

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

HDC

The decision in this instance was made by [Dr C]. He knew [Mrs A], knew about her previous illnesses, had an idea of her level of functioning and her quality of life. He did not know what the nature of the acute illness was but did know that it was severe and that there was a high likelihood that [Mrs A] would die as a result. He clearly had confidence in the staff to care for [Mrs A] and the staff appeared comfortable performing this task until the time where [Mrs A] regained consciousness. [Dr C] did communicate with family members, and it appeared to me from the notes that they were aware that [Mrs A] might die.

The decision made subsequently to admit her to hospital was based on the change in her condition (especially that the severity of the illness was lessening), the family were no longer comfortable and it appeared that administration of IV fluids may improve her status. It became apparent that [Mrs A], contrary to early clinical signs, would recover.

I believe that [Dr A's] decision not to admit [Mrs A] to hospital when she became severely unwell a reasonable one under the circumstances at the time. I also believe that the decision to admit her when she showed signs of recovery was also reasonable. There is debate about firstly when the recovery was noticeable and secondly, what clinical factors constituted signs of recovery.

Notwithstanding my opinion about [Dr C's] decision to not admit, it is clear that had [Dr C] considered a urinary infection on the evening prior to [Mrs A] becoming acutely well and prescribed an appropriate antibiotic, the episode of severe acute illness may have been avoided. In this respect he was clinically deficient."

Response to Provisional Opinion

Dr C responded to the Commissioner's provisional opinion as follows:

"There are a number of issues that I would like to comment on, but the most important one is, the one that you find that I have breached the Code … by failing to do a urine test and not consider the possibility of a urine infection and septicaemia. I feel that I had considered the possibility of sepsis. I am at a disadvantage here in that the basis of [Mrs A] having a bacterial infection and septicaemia are in the clinical notes from [the public hospital]. I would like to view the public hospital clinical notes and all investigations conducted while she was in hospital, together with the discharge letter from the houseman and registrar. This will give me a better understanding of the findings of Dr Jacobs."

This information was provided to Dr C, who provided the following additional response:

"I wish to reply to your [provisional] finding that I was in breach of the Code in that I did not provide reasonable care and skill in my management of [Mrs A's] condition in

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

HDC

that I did not order a urine test or consider the possibility of a urine infection as a cause of her poor health.

It is true that I did not order a urine test on the night or the following day. I did not find any general signs of infection in that her BP, pulse and temperature were normal. The bloods did not indicate that she had a major infection that would be required to provide the degree of unconsciousness that was present at the time.

I would like to point out that if [Mrs A] had a urinary tract infection when I saw her on 19-4-03 of such severity that it produced the profound loss of consciousness that she had, why had her condition improved on the fourth day? She had not received any antibiotics.

I feel that the presence of urosepsis and septicaemia that she had on admission to hospital was a secondary disorder that occurred while she was unconscious. My working diagnosis of a central cerebrovascular accident was still the most likely explanation for her medical condition. This would be a more likely explanation of her unexpected improvement in her medical condition.

Dr Jacobs' comments that I had not considered faecal impaction needs to be refuted. I examined her abdomen for signs of obstruction and that includes faecal overload, a common disorder in the elderly. I have a tendency to record mainly abnormal signs and overlook normal findings when making notes.

I would like you to take this view into consideration before your final report is completed."

Code of Health and Disability Services Consumers' Rights

The following Rights 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.

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

Professional Standards

New Zealand Medical Association *'Code of Ethics'* (1989)

"Standard of Care

…

3. Ensure that every patient receives a complete and thorough examination into their complaint or condition."

Opinion: No Breach – Dr C

Assessment of condition on 18/19 April 2003
Right 4(1) of the Health and Disability Services Consumers' Rights (the Code) states that every consumer has the right to have services provided with reasonable care and skill.

Mr B complained that when his mother's condition deteriorated on 19 April 2003, Dr C did not conduct an adequate assessment into the causes of her condition.

In March 2003 Mrs A had a sudden deterioration in her health with a worsening of her cognitive function, which required an admission to the public hospital. She was found to be suffering from low sodium levels in her blood which was thought to have contributed, in part, to her condition. She was discharged back to the rest home, but 11 days later suffered a further acute deterioration. The nursing records noted Mrs A to be unwell, rigid and frightened but there did not appear to be anything specifically amiss. Dr C and Mrs A's son were notified of the nursing observations. Dr C saw Mrs A at 6.45pm and ordered sedatives and two-hourly assessments of her blood pressure and pulse, and that her fluid intake/output be documented, and noted that he would review her the following day. However, at 7.20am on 19 April Mrs A was found to be unconscious and unresponsive. Dr C saw Mrs A and was unable to determine the cause of her condition, and ordered urgent blood tests to check for any signs of an exacerbation of her previous metabolic disorder, or a gastric bleed. The blood tests were returned at 3pm that afternoon and gave no indication of the cause of her deterioration. Dr C considered that the cause was a cardiac or neurological condition, and that Mrs A was terminally ill. He gave the nursing staff instructions to provide her with palliative care.

My expert noted that when Dr C attended Mrs A and examined her on 18 April he found no specific pointers to explain her illness. Her observations were stable and her temperature normal. However, he did not check her urine to rule out the possibility of a urinary tract infection, or consider faecal impaction as possible causes of her deterioration. My expert advised that in light of Mrs A 's deterioration since her return from hospital, Dr C's assessment and management plan for the evening and night of 18/19 April, based on the

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

HDC

possibility that her deterioration might be a short-lived fluctuation in her mental state, was "acceptable but not perfect".

However, my expert was critical of Dr C's failure to request a urine test:

> "[Dr C] did not request a urine test, nor did he consider a urinary tract infection initially, nor septicaemia as a result of urinary tract infection in his differential diagnosis. Although faecal impaction may cause confusion it would be unlikely to cause loss of consciousness. It would have been appropriate for [Dr C] to check [Mrs A's] urine on the evening when she was beginning to feel unwell. He did not and this was a significant departure from accepted standards."

In response to my provisional opinion, Dr C stated that he did not order a urine test on Mrs A on 18/19 April as she was not presenting any signs of infection and her vital signs were normal. He stated that he did examine Mrs A 's abdomen for signs of faecal overload, but as it is his practice to record only abnormal findings his conclusion that there was no evidence that she had faecal impaction was not recorded. Dr C stated:

> "My working diagnosis of a central cerebrovascular accident was still the most likely explanation for her medical condition. This would be a more likely explanation of her unexpected improvement in her medical condition."

I accept Dr C's statement that he examined Mrs A for signs of faecal impaction, and that his working diagnosis of stroke was reasonable, based on the presenting clinical picture. However, urinary tract infection is known to cause serious illness in the elderly and Dr C should have considered this as a possible cause for Mrs A's condition and ordered a urine test. Nonetheless, I am satisfied that Dr C's overall assessment of Mrs A, when her condition began to deteriorate on the evening of 18 April 2003, was satisfactory, and he therefore did not breach Right 4(1) of the Code.

Follow-up of blood test results
Mr B stated that following his mother's discharge from the public hospital in April 2003, instructions were given for blood tests to follow up on her hyponatraemia. Mr B alleged that Dr C failed to do this.

On 1 April 2003 Mrs A became acutely unwell and was admitted to the public hospital from the rest home by Dr E. She was confused, disorientated and incontinent. At the hospital she suffered a number of seizures and appeared to have a gastric bleed. The gastric bleed was thought to be a result of her habit of taking aspirin. She was found to be suffering from hyponatraemia – very low levels of sodium in the blood – which was possibly the cause of the seizures. She also suffered a heart attack. Mrs A's various conditions were treated and when she improved she was discharged back to the rest home on 7 April. The discharge instructions were for her sodium levels to be checked in one month, haemoglobin levels and faecal occult bloods to be assessed in six weeks and, if abnormal, consideration to be given for an investigative gastroscopy. She was to have her fluid status reviewed, diuretics withheld and, if after two weeks her sodium levels remained stable, Dr C was advised to consider commencing her on an ACE inhibitor.

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

HDC

My medical advisor noted that the public hospital discharge letter to Mrs A's general practitioner regarding follow-up was contradictory and open to interpretation. The instructions state that sodium and haemoglobin levels should be performed in one month. However, the letter recommended that the doctor consider introducing an ACE inhibitor in two weeks if the blood sodium was stable. The latter instruction implied that a sodium level should be done in two weeks. Dr E readmitted Mrs A to the rest home on 8 April and decided to repeat the blood tests on 14 April. Dr E remembered asking for a copy of the blood test result to come to the home. This did not happen and the result went only to the hospital, where it was noted that there was no abnormality in the levels and therefore no action was taken. The rest home did not recognise that the blood tests had failed to arrive, and although the records show that Mrs A was reviewed for a swollen hand on 9 April, there is no mention of the blood tests.

My advisor stated:

> "This was a systems fault that included the failure of the medical laboratory to forward a copy to the rest home, a failure of the hospital to contact or forward the result, contradictory instructions from the hospital, lack of communication from [Dr E] to [Dr C] that a blood test had been ordered 3 weeks prior to that requested by the hospital, and a failure of the nursing staff to follow up the results. Therefore, whilst Dr C undertook overall responsibility for [Mrs A's] care, I do not believe that he can be held solely culpable. I believe his actions were acceptable under these circumstances."

In these circumstances Dr C cannot be held accountable for the failure to follow up Mrs A's blood test results in April 2003, and therefore did not breach Right 4(1) of the Code.

Response to signs of recovery and decision to admit to hospital
Mr B complained that Dr C did not respond appropriately to the signs of Mrs A's recovery. He stated:

> "[I]t was only through, we believe, our advocacy, intervention and insistence, that [Mrs A's] type of care was changed from that for terminal illness to proactive hospitalisation, and that she survived."

At 7.20am on 19 April Mrs A was reported in the nursing notes to be unconscious and unresponsive although her colour was normal and her vital signs stable. Dr C and Mrs A's family were notified. Dr C saw her that morning and considered that she had had a deepening stroke or exacerbation of the metabolic disorder she had in March, and ordered urgent blood tests. The blood test results were reported at 3pm that afternoon and Dr C was notified of the results, which did not indicate a cause for Mrs A's condition. The following morning Mrs A suffered a seizure, and she appeared to be deteriorating. On Dr C's instruction, Mrs A was provided only with comfort cares.

There is a discrepancy in the information supplied about the timing of Mrs A's deterioration and of her referral. The family state that they noted a slight improvement in Mrs A 's condition on 21 April which they reported to the staff, and the following day they noted a

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

HDC

further improvement in their mother's condition and requested an urgent review by a doctor. Mr B recalled that he visited early in the morning (of 22 April) and found that his mother had not been seen by a doctor as he had requested, and insisted that she be seen that morning as a priority. The family alleged that despite their requests for medical review, Mrs A was not seen by a doctor until 24 April.

The clinical records show that Dr C reviewed Mrs A on 21 April when he noted that the nursing staff reported that she was fitting when moved. He recorded his impression that Mrs A was in a terminal state and ordered morphine to be given to keep her comfortable.

The nursing records on the morning of 22 April note that Mrs A "woke up" and recognised her son. Dr E was visiting the rest home that morning and was asked to review Mrs A . He noted that she had been deeply unconscious and had taken no food or fluids for three days, but "looks as if she could survive". He wrote a referral letter outlining her history and requesting admission to the public hospital for assessment and treatment. Mrs A was admitted to the public hospital at about 9am.

My medical advisor noted that the decision to admit a patient with dementia to an acute care hospital is not made lightly as there is a high risk of increasing confusion and the consequences of a change of environment, such as falling. My advisor considered that Dr C's decision not to admit Mrs A on 18 April, given the information he had to hand, was appropriate.

Dr Jacobs noted that Mrs A had deteriorated considerably by the morning of 19 April, and that Dr C's decision to treat her with palliative care was based on his assessment of her blood test results and his conclusion that there was no simple remedial cause to enable her to survive the illness.

I accept my expert's advice that whether to treat dehydration in terminally ill patients is controversial. The arguments against hydration in this situation include that parental fluids may prolong dying, there is less risk of respiratory tract problems, and dehydration may act as a natural anaesthetic. My expert acknowledged that there are also arguments for hydration, since the data against hydration is insufficient to reach a final conclusion on the benefit or the harm of dehydration in the terminally ill. My expert quoted from the New Zealand Medical Association *Code of Ethics* which states that doctors should, wherever possible, allow "death to occur with dignity and comfort when it appears to be inevitable".

Dr Jacobs advised:

> "It is also important to remember that it was [Mrs A's] illness, not [Dr C] that rendered her incapable of drinking – indeed her unconscious state made it dangerous to try. …. The decision to hydrate or not hydrate is a clinical decision based on issues already mentioned. Parental rehydration is an invasive medical procedure and needs to be undertaken only if there is a perceived medical benefit."

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

HDC

There is no mention in the clinical records that [Mrs A] made any signs of recovery until the morning of 22 April, which was when Dr E (who was on duty that day) was asked to see her. Dr E was notified of her change in status and arranged for her admission to hospital.

Dr C's earlier assessment of Mrs A's condition and instructions were appropriate, and there is no evidence that Dr C was aware of the change in Mrs A's condition and that his treatment orders needed to be revised. In these circumstances, Dr C acted appropriately and did not breach Right 4(1) of the Code.

Opinion: No breach – the rest home

Vicarious liability

Employers are responsible 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 (the Code). Under section 72(5) of the Health and Disability Commissioner Act 1994 it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the employee's breach of the Code.

In any event, Dr C has not been found in breach of the Code, no question of vicariously liability arises.

Recommendations

I recommend that Dr C review his practice in light of this report.

Follow-up actions

- A copy of this opinion will be sent to the Medical Council of New Zealand and the Royal New Zealand College of General Practitioners.
- A copy of this opinion, with identifying features removed, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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

HDC