General Practitioner

Report on Opinion - Case 97HDC8283

Complaint

The Commissioner received a complaint from parents regarding the treatment their daughter ("the consumer") received from a general practitioner. The complaint was that:

- *The GP's examination of the consumer was inadequate, in that it was very short and lacked professional depth.*
- *The GP's failure to diagnose dehydration resulted in the consumer's death.*

Investigation

The complaint was received by the Commissioner on 29 August 1997 and an investigation was undertaken. Information was obtained from:

The Complainants
The Provider/General Practitioner

Relevant clinical records were obtained and viewed. The Commissioner obtained independent advice from a general practitioner.

Outcome of Investigation

The consumer's father advised that his 12-month-old daughter became ill with vomiting and diarrhoea one day in late May 1997. As a result, his wife took their daughter to a Medical Centre that evening. The consumer was seen by a doctor who diagnosed gastro-enteritis and prescribed an electrolyte liquid.

The consumer's father said that after three days his daughter's vomiting and diarrhoea had not improved and her condition deteriorated in the evening of the third day. Around 9.00a.m. the next morning, another doctor (the family GP), examined the consumer and also diagnosed gastro-enteritis. This doctor prescribed maxolon and advised the consumer's mother about the management of the child's diet and fluids.

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Outcome of Investigation, *continued*

The consumer's father said that that evening his daughter's condition worsened and she was seen by the provider, a general practitioner, at a different Medical Clinic at approximately 11.00pm. The consumer's father advised this GP that the consumer had had diarrhoea and had been vomiting for three days, but had stopped vomiting since seeing her GP that morning, although the diarrhoea was still occurring. He further advised that the consumer's hands and feet were very cold and they had been unable to warm them, her lips were blue, her skin was pale, her eyes were sunken and that she was very weak and poorly. The consumer's parents expressed their concerns to the GP and suggested he check the consumer's temperature. The GP felt the consumer's head and neck and reassured them that she was not hot. The consumer's father then asked the GP if his daughter could have a low temperature. The GP explained that a low temperature was very unusual and would mean the baby was very sick. The father then asked the GP where he could buy a thermometer. He said the GP made it obvious he considered it a waste of time and money. The GP said he was not sure where they could have bought a thermometer at that time of night, as the pharmacy was closed, and he had tried to reassure the parents again.

The GP observed the consumer's fontanel and observed "that it was flat". The father said the only other examination was a "quick feel of her stomach". The GP said it may have appeared cursory but he was palpating for tenderness or guarding and that, during his examination, the consumer tried to push his hand away, and that her hands were warm. He said her skin turgor felt normal and that, although pale and grumpy, she was quite strong in her resistance. The GP did not observe the consumer to have blue lips, although a lot of the time she was drinking from her bottle.

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Outcome of Investigation, *continued*

The GP's consultation notes recorded:

SUBJECTIVE/HIST
Diarrhoea and vomiting 3/7. Seen at [first Medical centre] *and by GP today. Given Maxolon. No vomiting today but has diarrhoea ++.*

OBJECTIVE/O/E
"Pale, grumpy. Not hot. Fontanelle 3Abd NAD."

ASSESSMENT / DIAGNOSIS
GASTROENTERITIS

PLAN
Advised

The consumer's father said they discussed with the GP the possibility of taking the consumer to Hospital but that the GP said the consumer would be sent straight home if she were seen drinking. The GP said that as the consumer was drinking from her bottle and seemed to be recovering, he again reassured the parents.

The GP advised that as the consumer had been recently seen by other doctors, including her own GP, he "preferred to concentrate on the salient points" rather than conduct a full examination. He concluded that with a current diagnosis of gastro-enteritis, he had a child who had stopped vomiting, was taking oral fluids, was showing little or no sign of dehydration and was beginning a recovery phase. The GP asserted that his examination and assessment together with his differential diagnosis was not cursory.

The father believed the consultation to be very short, lacking professional depth, and that while they were no wiser afterwards, they were reassured that all was in order.

The consumer died in her bed in the early hours of the morning five days after the vomiting and diarrhoea began. The post mortem indicated that death was due to dehydration secondary to acute gastro-enteritis.

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Outcome of Investigation, *continued*

The GP advised the Commissioner that his distress at the consumer's death prompted him to bring forward his decision to leave active medical practice. He no longer engages in medical practice and does not envisage ever returning to it. The GP has an annual practicing certificate which is paid up until March 1999. The Medical Council of New Zealand is unaware of his decision to cease active medical practice.

Code of Health and Disability Services Consumers' Rights

RIGHT 4
Right to Services of an Appropriate Standard

2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

Opinion: Breach

In my opinion, the GP breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights by not performing a thorough examination of the consumer.

Despite other doctors performing thorough examinations previously, the GP should have performed an equally thorough examination when he saw the consumer. By not conducting a thorough examination, and concentrating only on the more "salient points", the GP failed to provide services which met required professional standards.

By way of example, this requirement for examination is recognised in the New Zealand Medical Association's Code of Ethics which states that it is a physician's duty to *"ensure that every patient receives a complete and thorough examination into their complaint or condition"*.

Further, during his clinical assessment of the consumer, the GP did not give sufficient weight to the concerns expressed by the consumer's parents regarding her condition. These concerns included the fact that the GP was the third doctor consulted in four days and the second doctor consulted in a 12 hour period, their specific comment about the consumer's cold hands and feet, and her blue lips, together with their enquiries about hospitalisation.

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Opinion: Breach, *continued*

In my opinion, the GP's failure to take the mother's concerns into account in the clinical assessment, and the failure to investigate the matter further or to refer the consumer to Hospital, meant that the GP failed to provide services that met a relevant standard.

Additionally, I have been advised that effective management of gastro-enteritis includes ensuring an adequate fluid intake with specifically formulated rehydration fluids and monitoring the child closely for signs of dehydration. My advisor commented that vomiting and diarrhoea, persisting for more than two or three days, is particularly significant in children and that this *"would certainly require more detailed clinical evaluation".*

As a result of his failure to carry out a more detailed clinical evaluation, the GP failed to provide services of an appropriate standard.

Finally, in my opinion the GP failed to meet record-keeping standards as he did not adequately document his plan in his consultation notes. The notation "*advised"* is inadequate for future reference.

Future Actions

I recommend that the GP apologise in writing to the parents for his breach of the Code of Rights. This apology should be sent to the Commissioner who will forward it to Mr & The consumer's mother.

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

The matter will be referred to the Director of Proceedings for the purposes of deciding whether to take any action under section 45(f) of the Health and Disability Commissioner Act 1994.