General Practitioner, Dr C

A Report by the

Health and Disability Commissioner

(Case 99HDC10975)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Complainant / Consumer's Wife
Mr B	Consumer (deceased)
Dr C	Provider / General Practitioner

Independent expert advice was obtained from a general practitioner.

Complaint

On 6 October 1999 the Commissioner received a complaint forwarded by the Medical Council of New Zealand from Mrs A about the services her late husband, Mr B, received from Dr C. The complaint is that:

- *On the morning of 6 September 1999, Mr B had a consultation with Dr C because he was experiencing chest pains. Dr C referred Mr B to a public hospital but left Mr B to find his own way to the hospital. Mr B collapsed at about 11:30am on 6 September 1999. Mrs A later learnt after her husband's death that the reason for his collapse was a heart attack.*
- *On the afternoon of 6 September 1999 Mrs A asked Dr C why her husband had not been sent to hospital by way of ambulance. Dr C told Mrs A that he had told Mr B not to walk and to get a ride to hospital.*
- *On 7 September 1999 Mrs A again asked Dr C why her husband was not sent to hospital by ambulance. Dr C told Mrs A that Mr B was not too bad.*
- *Mrs A is extremely concerned that someone in Dr C's position could send what was obviously a critical case to the hospital by their own means. Mrs A believes her husband's death might have been avoided had he been sent to hospital by ambulance.*

An investigation was commenced on 12 November 1999.

Information reviewed

- Mr B's medical records were obtained and viewed.

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

Mr B was 39 years old. On the morning of 6 September 1999, Mr B had a consultation with Dr C, general practitioner, because he was experiencing chest pains. Dr C saw Mr B between 10.00-10.30am. Mr B drove himself to Dr C's surgery.

Dr C advised the Commissioner that Mr B's presenting complaint was that he had pain over the right sternum, right mammary area, right axilla or armpit and right side of the neck. Dr C advised the Commissioner that Mr B told him at the consultation that the pain had come on while he was jogging.

Dr C advised the Commissioner that Mr B had been able to get himself to the surgery without difficulty and was able to climb up the stairway to his surgery waiting room. Dr C stated that he observed that Mr B was able to move freely without any aggravation or apparent discomfort or pain. Dr C stated that "certainly the pain was not bad enough to require analgesia".

Dr C advised the Commissioner that, in his view, there were no apparent symptoms such as nausea, sweating, dizziness or palpitations to indicate that the pain was of a cardiac nature. Dr C observed that Mr B appeared comfortable. Dr C recorded in the notes that Mr B's blood pressure was 160/104 sitting. The first number in the blood pressure reading, 160, is called the systolic reading and an acceptable reading would be within a number range of 100 plus the age of a patient at the time the reading is taken. The second number, 104, is the diastolic reading and an acceptable range is 70 to 90.

Dr C recorded in the notes that Mr B's heart rate was 84 beats per minute, which is within a normal range. The notes state that Mr B's heart rhythm was regular on examination and a chest auscultation was reported as normal. Chest auscultation is where a doctor listens to a patient's heartbeat using a stethoscope.

Dr C advised the Commissioner that when he examined Mr B it was not possible to determine clearly whether the pain he was suffering from was of cardiac or non-cardiac origin. Dr C stated that he advised Mr B it was necessary for him to be assessed at the hospital to determine whether it was cardiac or not. Dr C stated that Mr B agreed with his recommendation. Dr C gave Mr B a referral letter to the public hospital.

Dr C did not consider Mr B sufficiently unwell to require transportation by ambulance to hospital. Dr C advised that "if I had considered [Mr B] was this sick then I would not have hesitated to arrange for an ambulance to take him to hospital".

Dr C advised the Commissioner that he checked with colleagues and he understood it was quite common practice in cases like this to recommend that the patient get to the hospital under their own means. Dr C advised that he thought it entirely appropriate for Mr B to get a ride with somebody else to hospital and he told Mr B not to walk to hospital. Dr C advised the Commissioner that he wanted Mr B to get someone else to drive him to hospital in case his condition worsened and he required assistance. Dr C does not

remember what Mr B said in response to this recommendation that he get a ride with somebody else.

Dr C advised the Commissioner that he observed Mr B moving around the surgery while the receptionist typed up the referral letter and he did not appear to be sick at all. Dr C advised that Mr B did not appear to be significantly unwell although he thought it was important for Mr B to have a prompt assessment at hospital.

Dr C advised that had Mr B been plainly unwell on presentation then he would not have hesitated to have called an ambulance right then and there. Dr C stated, "I have done this in the past for other patients."

Mr B went home after leaving Dr C's surgery and asked his daughter to drive him to hospital. Mr B's daughter did not have a licence to drive and refused out of fear of being caught driving without a licence. Mr B's daughter then saw her father standing by the table, holding onto a chair and clutching his chest. Mr B moved approximately one metre away from the table and chair and collapsed in the hallway. Mr B's daughter telephoned St John's Ambulance. An ambulance was despatched at 11.20am and arrived at Mr B's home at 11.32am. The ambulance officers found Mr B dead on arrival.

Dr C advised that on the afternoon of 6 September 1999, Mrs A came to his surgery and informed him of the news of her husband's sudden death. Mrs A had found a referral letter from Dr C, in an envelope marked "emergency", on the dashboard of her husband's car. Dr C said he took Mrs A into his consulting room and tried to reassure and comfort her in her grief. Dr C told Mrs A he was surprised to hear of Mr B's death and that he thought it was quite unexpected. Dr C also expressed his sadness and sorrow to Mrs A.

On 7 September 1999 Mrs A went to Dr C's clinic and asked him again why her husband was not sent to hospital by ambulance. Dr C said that is was because Mr B was not too bad.

On 29 September 1999 Dr C received a letter from Mrs A. In the letter Mrs A stated:

> "I am extremely concerned that someone in your position could send what was obviously a critical case to the hospital by their own means. Not only am I now having to deal with my husband's death but also with the fact it might have been avoided."

Dr C advised that when he received the letter he telephoned Mrs A and asked her to visit him so that they could discuss the matter. Dr C advised that Mrs A told him she would come in the afternoon but she did not arrive.

Dr C provided a copy of the referral letter he gave to Mr B to take to the hospital. The referral letter states:

> "Sudden persistent moderately severe chest pain after a jog. Bit discomfort in right axilla & neck. BP 160/104 [blood pressure reading]. Heart 90/mt [heartbeats per minute] regular."

Dr C provided the Commissioner with a copy of his notes for Mr B. The notes for Mr B's visit on 6 September 1999 state:

> "160/104, 84/mt, → chest pain ADU [Acute Discharge Unit] collapsed at home & died."

In the notes, Dr C reported Mr B's heart rate or pulse as 84 beats per minute but in the referral letter to the hospital it is reported as 90 beats per minute.

Independent advice to Commissioner

The Commissioner referred the complaint to an independent general practitioner to review whether the treatment provided by Dr C was appropriate for the symptoms with which Mr B presented. The advisor stated:

> "In this case reasonable clinical judgement would be required rather than any specific standard – each case must be evaluated on the symptoms presented. It is easier to see in retrospect that [Mr B's] pain was cardiac. This can be rather more difficult 'on the spot'."

It was the advisor's opinion that in this case, Dr C's clinical judgement was adequate.

The advisor stated that "the central issue in this case is the transfer of care".

The advisor considered whether Mr B was "reasonably clinically at risk of catastrophe" (ie, at risk of dying). It was the advisor's opinion that if a cardiac cause of Mr B's chest pain was strongly suspected then yes, Mr B was at risk of catastrophe. The advisor commented that neither the clinical notes nor the hospital letter indicated what Dr C suspected to be the cause of Mr B's chest pain, and that it was "very difficult to judge" whether the potential catastrophe was indicated by his condition at the time of the consultation. The Commissioner's advisor stated:

> "I think it would have been prudent to make better transport arrangements – at least to establish that safe transport was easily accessed. [Dr C] … [did not] make it his business to enquire about specific transport arrangements. …

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

[Dr C] correctly determined that [Mr B] needed to be further assessed in hospital and a cardiac cause for the pain ruled out or treated.

However, there were some clinical indicators that the pain was cardiac:

The blood pressure was significantly elevated at 160/104 – high for a 39 yr old.
The pain occurred during strenuous exercise.
The pain was over a classic cardiac distribution.
A casual pulse of 90/min in someone who jogged regularly is probably a bit high.

[Dr C] did not enquire exactly what transport was available to take [Mr B] to hospital and did not make arrangements for him to be collected. He did not find out who was available to transport him.

To counter that:

[Mr B] was not shocked
He was moving about without apparent distress
Had climbed stairs without distress
He did not seem unhappy about the prospect of making his own way to hospital
He did not tell [Dr C] that getting a ride to hospital would be difficult/dangerous/illegal.

[Dr C] apparently did not have access to an ECG machine / and or the facility for reading ECG tracings. This is still acceptable for solo practitioners.

In this circumstance though, I personally would feel that it would be prudent (the term used advisedly) to make very definite and clear arrangements for transport to cover the possibility of a catastrophic event occurring.

Sending [Mr B] to hospital in the ambulance would not necessarily have prevented his death. It would only have allowed access to the best possible potential for resuscitation. But rapid access to emergency care, particularly defibrillation, definitely increases the possibility of survival from a coronary."

The advisor commented about Dr C's notes and stated that:

"The notes are consistently inadequate. The letter of referral could be said to be inadequate."

Response to Commissioner's Provisional Opinion

Dr C responded to the Commissioner's provisional opinion on 13 June 2000. His response is set out below in its entirety:

> "I thank you for your Provisional Opinion and inviting me to comment on them. I found it interesting to read. I accept and respect all the opinions and comments in your report. I am merely expressing my personal feelings, beliefs and comments as under.
>
> 1. Regarding blood pressure reading of 160/104. Please compare this reading with that of 120/70 on 19-04-79, 150/90 on 02-08-93 and 110/70 on 10-07-98. Anxiety related to chest pain on that day could have raised his blood pressure as a normal physiological response. If on the other hand it had been low around 96/80 or so I would have sent for an ambulance there and then. The fact that [his] heart was coping well with a blood pressure of 160/104 was a good sign.
>
> 2. Regarding discrepancy of heart rates on my record and on the referral letter. To speed up his despatch to hospital one person with the record was on the telephone while the other was preparing the referral letter and it contained the rate from the memory of it being somewhere between 80 to 90.
>
> 3. Regarding my case notes: The notes are primarily meant for my personal use to help me care for my patients. Over the years notes build up to a thick file if unrestricted and then it becomes more and more difficult to screen or to look back to the record at subsequent consultations. Hence over thirty years in this practice I have kept to minimum notes necessary to serve my patients by me. In so doing I have put their interest first and exposed myself to the criticism.
>
> 4. Regarding notes on referral letter: I mentioned the presenting problem and then quoted the blood pressure reading along with the heart rate. This indicated his condition when seen by me and provided a baseline reading for subsequent observation, I had already spoken to the admitting doctor at the hospital and answered all the queries. It was quite obvious that the reason for referral was for urgent assessment of chest pain of undetermined aetiology and cardiac cause needed to be excluded or confirmed. By writing more I did not wish to delay the admission to the hospital.
>
>   Guidelines from Medical Council, Medical Association and The College are set at a National level. To make the best use of resources, I think they should be flexible to accommodate variations for each region, each practice, each patient and even each consultation.
>
> 5. Regarding the ambulance: [The hospital] is about twenty minutes drive from my practice. The most crucial point for survival in a patient with chest pain which may be of cardiac origin is to get him into the hospital as soon as possible. Vehicle wise ambulance transfer is best. Since [Mr B's] death I have

sent about seven patients to hospital with chest pain. In four of them the relations opted to take the patient in their own car. Three went by ambulance. It took anything from ten minutes to one hour for ambulance to arrive at my practice. I expected [Mr B] in the hospital within thirty minutes if he had followed my instructions. He turned out to be too shy to tell me about his difficulty to comply with my instructions. Once again I exposed myself for criticism when I acted in good faith to do the best for a patient. To call an ambulance all I have to do is to ask the receptionist to arrange for it. Time wise private transport is quicker from my practice to hospital.

Lesson: When sending patients with chest pains or any other serious illness to hospital insist on ambulance transfer.

Action plan: After receiving Final Opinion Report from the Commissioner to comply with it.

…

Please note that in 1995 I had a practice visit from the Director of the Quality Assurance Unit from the […] Royal New Zealand College of General Practitioners. It was at my own initiative to help me with the recreditation. Would you like to read it?

My expressions may not be very neat and tidy. Please excuse me for it. Please do ring me if any of the points is not clear."

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.*

Other Relevant Standards

The New Zealand Medical Association 'Code of Ethics'

Standards of Care

…

4. Ensure that accurate records of fact are kept.

In the 1999 edition of the Medical Council of New Zealand's ("the Council") publication entitled *Coles Medical Practice in New Zealand*, the Council advises that:

"A doctor is expected as part of quality service to maintain adequate records."

Opinion: No Breach

Right 4(1)

On 6 September 1999 Mr B consulted Dr C because he was experiencing chest pains. Mr B presented with pain over the right sternum, right mammary area, right axilla or armpit and right side of the neck. The pain had come on while Mr B was jogging.

My advisor stated that in this case reasonable clinical judgement would be required rather than any specific standard, the reason being that each case must be evaluated on the symptoms presented. The advisor noted that it is easier to see in retrospect that Mr B's pain was cardiac, but this can be rather more difficult "on the spot".

The advisor stated that Dr C correctly determined that Mr B needed to be further assessed in hospital and a cardiac cause for the pain ruled out or treated.

Based on the independent advice received, in my opinion Dr C's clinical judgement was adequate and he exercised reasonable care and skill. In these circumstances, in my opinion, Dr C did not breach Right 4(1) of the Code.

Opinion: Breach

Right 4(1)

Transfer of care
The advisor stated that the central issue in this case is the transfer of care.

The advisor considered whether Mr B was clinically at risk of catastrophe. It was the advisor's opinion that if a cardiac cause of Mr B's chest pain was strongly suspected then yes, Mr B was at risk of catastrophe. The advisor stated that it would have been prudent or sensible for Dr C to have made better transport arrangements or at least to have established that safe transport was easily accessed. The advisor commented that Dr C did not make it his business to enquire about specific transport arrangements.

The advisor noted that there were some clinical indicators that the pain was cardiac:

> "The blood pressure was significantly elevated at 160/104 – high for a 39 year old.
> The pain occurred during strenuous exercise.
> The pain was over a classic cardiac distribution.
> A casual pulse of 90/min in someone who jogged regularly is probably a bit high."

It was the advisor's opinion that in the circumstances, which included Dr C's inability to access an ECG machine, it would have been more prudent for Dr C to have made very definite and clear arrangements for transport to cover the possibility of a catastrophic event occurring.

The advisor noted that sending Mr B to hospital in an ambulance would not necessarily have prevented his death, but it would have allowed access to the best possible potential for resuscitation.

In relation to matters of diagnosis and treatment, I accept that professional opinion will usually be decisive as to whether a medical practitioner has exercised reasonable care and skill. But in relation to a matter such as the need to ensure immediate transport, professional opinion of standard practice will ultimately be only a guide to my opinion. In such a case, I think it appropriate to ask what a reasonable consumer, in the particular consumer's circumstances, would expect of his or her practitioner. Viewed in that light, I have no doubt that a reasonable consumer, whose doctor had reason to suspect a clinical risk of dying, would expect that doctor to ensure that he had immediate transport to hospital. Dr C did have reason to suspect that Mr B's pain was cardiac, and was concerned enough to refer him to the Emergency Department at the hospital. In my opinion it was not merely prudent but necessary for Dr C to ensure that Mr B had immediate transport from the surgery to hospital. Dr C's omission amounted to a failure to exercise reasonable care and skill. Dr C therefore breached Right 4(1) of the Code.

Opinion: Breach

Right 4(2)

In my opinion Dr C breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights relative to the following matter.

Inadequate notes
Dr C reported in the notes that Mr B had a pulse or heart rate of 84 beats per minute but in the referral letter Mr B's pulse or heart rate was reported as 90 beats per minute.

The advisor commented that neither the clinical notes nor the hospital letter indicated what Dr C suspected to be the cause of Mr B's chest pain.

Good record keeping is an essential requirement for good professional practice. Rule 4 of the New Zealand Medical Association (NZMA) Code of Ethics states that accurate records of fact must be kept. Additionally, the Medical Council of New Zealand, in *Cole's Medical Practice in New Zealand* (1999) advises: "A doctor is expected as part of quality service to maintain adequate records." The advisor commented that Dr C's notes are consistently inadequate and that the letter of referral could be said to be inadequate.

In my opinion, Dr C's notes were both inaccurate and inadequate and did not comply with Rule 4 of the NZMA Code of Ethics and the Council's guidelines. In this respect Dr C breached Right 4(2) of the Code.

Actions

I recommend that Dr C take the following actions:

- Apologise in writing to Mrs A for not arranging ambulance transfer for Mr B. This letter is to be forwarded to the Commissioner and will be sent to Mrs A.

- Review his standard of record keeping and referral letters.

- Arrange for the Royal New Zealand College of General Practitioners (the College) to undertake a practice visit at Dr C's expense, similar to the practice visit undertaken in the College's accreditation programme.

  The purpose of the practice review is to ensure a thorough assessment of Dr C's practice management including standard of record keeping and referral letters. The results of that practice visit, and any recommendations following the visit, are to be forwarded to the Commissioner.

Further actions

- A copy of this opinion will be sent to the Medical Council of New Zealand.
- A copy of this opinion will be sent to the Royal New Zealand College of General Practitioners with a recommendation that a practice visit be undertaken to assess Dr C's practice management.