General Practitioners, Dr B and Dr C

A Report by the

Health and Disability Commissioner

(Case 03HDC10134)

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

Parties involved

Ms A	Consumer
Dr B	Provider, General Practitioner
Dr C	Provider, General Practitioner
Dr D	Consultant Physician, Public Hospital
Ms E	Client Support Manager, medical software company

Complaint

On 7 July 2003 the Commissioner received a complaint from Ms A about the general practice services she received. The complaint was summarised as follows:

Dr B did not provide services of an appropriate standard to Ms A on 11 April 2003. In particular:

- *He prescribed penicillin, which Ms A was allergic to, without checking her medical record where the allergy had been previously noted.*

Dr C did not provide services of an appropriate standard to Ms A on 22 April 2003. In particular:

- *When Ms A presented with a headache, stiff neck, vomiting, diarrhoea, fever and photophobia he did not admit her to hospital, or otherwise conduct or arrange further investigation of her symptoms.*

An investigation was commenced on 6 August 2003.

Information reviewed

- Letters of complaint from Ms A, dated 24 June 2003 and 21 October 2003
- Letters of response and accompanying documentation from Dr B, the first undated and received 8 September, the second dated 26 November 2003
- Information from a medical practice, in a town, dated 4 September 2003
- Ms A's clinical records from a Public Hospital
- Information received from ACC
- Independent expert advice from Dr Ian St George, general practitioner

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

Information gathered during investigation

Drug reaction

On 11 April 2003 Ms A consulted Dr B of a medical practice as she had been feeling progressively unwell. According to the clinical record, Ms A complained of left-sided pleuritic chest pain but had no cold symptoms, no systemic symptoms and some coughing. Dr B examined Ms A and diagnosed pleuritis. Dr B prescribed an antibiotic, Augmentin 500mgs with potassium clavulanate 125mgs one tablet orally three times a day. Ms A said that she felt Dr B should have diagnosed meningitis at this consultation.

Dr B informed me that it is his usual practice to ask patients, at the time of consultation, about any allergies they have. Dr B could not remember whether he had asked Ms A at the time.

On Sunday 13 April Ms A said she could "hardly move" and that her "whole body ached" and her hands and feet were swollen and inflamed. Ms A returned to the medical centre and was seen by another doctor, Dr C, who noted that she had been given penicillin by his colleague, Dr B. Ms A said that Dr C informed her she had been prescribed a type of penicillin, which she was allergic to. Dr C diagnosed acute respiratory infection and prescribed Ms A a corticosteroid, a bronchodilator and Rulide, another type of antibiotic. Ms A said that she felt Dr C should have considered meningitis at this consultation.

Dr B informed me that the computerised patient management system contained a warning of Ms A's drug allergy both in her record and on the warning system. Dr B accepted that he obviously failed to see the warnings on both Ms A's notes and the computer warning system.

In his initial response Dr B said that he noted Ms A had been prescribed penicillin intramuscularly on 27 March and had not suffered side effects, whereas Augmentin prescribed previously had elicited swelling of Ms A's fingers and toes after a day. Dr B said that this information suggested Ms A had a hypersensitivity to Augmentin and not an allergy to penicillin. Dr B said that while this did not excuse his prescribing error it put the incident in context.

Non-diagnosis of meningitis

On Monday 14 April Ms A rang the medical centre again as she was not feeling any better and had a migraine-like pain, which was not improving. Ms A said she was advised that there would be a transition between the medications and not to expect immediate improvement. This call is not recorded in Ms A's clinical record. Ms A took the week off work and had a family gathering over the weekend (Easter).

On Tuesday 22 April Ms A awoke with a "thunderous headache, vomiting, diarrhoea and fever and could not stand light". Ms A recalled that she could not lift her head and had a stiff neck, so her husband took her to the medical centre at 12.15pm where she saw Dr C again. Ms A stated that she explained her symptoms and was put in a darkened cubicle and given an injection for her headache. Dr C did not wish to respond to Ms A's complaint (to

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

the Health and Disability Commissioner) but had recorded in the clinical record that Ms A had a headache which had started that day, had vomited two hours ago, had photophobia and a sore right ear. He also noted that Ms A's lungs were clear. Dr C recorded his diagnosis as a migraine and ordered an intramuscular injection of Tilcotil (a nonsteroidal anti-inflammatory analgesic). Dr C ordered a urine test and blood pressure monitoring for 45 minutes after the injection and recorded that Ms A was to return in the afternoon for review. Ms A said that the symptoms of her illness had been present for longer than Dr C recorded.

Ms A said that her husband and aunt were worried about her during the afternoon of 22 April and her husband rang the medical centre again. Ms A stated that although her husband was advised to take her back to the medical centre, he decided to take her straight to the hospital. Dr C faxed a referral letter to the hospital at 5.19pm stating the Ms A had "migraine?" and included his clinical record of her visit earlier in the day. Ms A informed me that Dr C must have sent the referral letter following her husband's phone call to the medical centre.

At 5.30pm Ms A arrived at the Emergency Department at the Public Hospital. According to the admission record Ms A complained of a headache of "a few days" duration which was relieved by paracetamol. However, that morning (22 April) Ms A had awoken with severe frontal headache and vomiting. After examination, the casualty doctor made a provisional diagnosis of "?subarachnoid (brain haemorrhage) ?viral" and ordered a lumbar puncture.

Ms A was further examined by Dr D, consultant physician, who noted that Ms A had a three-day history of severe frontal headache, that she had never had such severe pain before, and that she was not a migraine sufferer. Dr D ordered urgent tests to rule out meningitis with a differential diagnosis of subarachnoid haemorrhage. A presumptive diagnosis of viral meningitis was made following a lumbar puncture.

Medical software general practitioner electronic record system

Dr B said that Ms A had been prescribed penicillin intramuscularly on 27 March and had not suffered side effects.

However, the computerised patient records supplied by Dr B differed from those submitted by the medical practice. This printout showed an entry in the records for 4 April 2002 identifying that Ms A did have an allergic reaction to the penicillin prescribed on 27 March. In explaining the difference, Dr B forwarded a printout of the screen view he used to compose his initial response, which did not show the 4 April entry (relating to the allergic reaction). Ms E, the medical software company's client support manager, informed me that it is possible for doctors to produce three different printouts from a patient record. In addition to a standard preset report, other printouts (known as screen dumps) can be generated depending on the information the doctor selects. Medical warnings such as drug allergies must be selected in order to appear on a screen dump. The document sent by the medical practice was a preset report. The screen view used by Dr B to compile his response

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

and the consequent patient record insert in Dr B's response was a selected screen dump without the medical warning selected.

Ms E informed me that once a medical warning (drug allergy is one such) has been entered on the record it will show up on the front page. Further, once a medical warning has been entered it will show in the interactions box when the doctor prescribes medication for that patient. The warnings are colour coded and the patient records and front page have a medical warning tab, which turns red when a warning is added.

ACC
ACC accepted that Ms A suffered a personal injury as a result of medical error when Dr B prescribed a drug she was allergic to. ACC did not accept that Ms A suffered personal injury as a result of Dr C's missed diagnosis.

Independent advice

Advice to ACC
The following expert advice was provided to ACC by Dr Ian St George, general practitioner:

"1. I respond to your letters of 28 August 2003 seeking advice about Ms [A's] claims for medial misadventure in relation to prescription of penicillin when she was allergic to it, and delayed diagnosis of viral meningitis. The specific advice sought was whether the claimant has suffered physical injuries, and if so whether

- registered medical professionals were involved in the treatment, and if so
- the injuries were caused by medical error on the part of the registered health professionals; or if not
- error could be attributable to an organisation; and if not
- the claims meet the criteria for medical mishap.

You asked further whether

- there are competence issues that should be referred to the relevant professional body or the Health and Disability Commissioner, or
- it raises issues that in the public interest ACC should report to the appropriate authority.

2. I have assessed whether Ms [A's] conditions could be defined as personal injuries from medical misadventure according to the definition given in S32 of the 2001 Act, as medical errors according to the definition given in S33 of the Act, or as medical mishaps according to the definition given in S34 of the Act. I state here I have no personal, financial or professional connection with any party that could bias my assessment.

3. With respect to claim [1] penicillin) I have read

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

- your letter
- the ACC45
- the Treatment Details report
- Ms [A's] letters
- [Medical director's] letter with the full computer printout of contemporaneous clinical records from [the medical practice], 27 Feb 02 to 22 April 03
- the [Public] Hospital discharge summary
- Dr [C's] admission note of 22 April; I am confused as to the meaning of this letter, as Ms [A] says she self-admitted to the hospital
- Dr [B's] letter, with selected excerpts from the contemporaneous clinical record dated 11 and 13 April.

4. The relevant facts are traversed in Ms [A's] letter. There does not appear to be any dispute by any of the parties.

5. There is no previous condition that might predispose to this.

6. In my opinion

- The clinical records from [the medical practice] but provided by [the medical director] clearly show that she was given Penicillin G intramuscularly on 27 March 2002, and that on 4 April 2002 she was suffering swelling of her fingers and feet and pruritus (itch). The notes read 'Wrn (warning) – penicillin', and the front page entry made on that day reads (under Medical Warnings) 'penicillin – fingers and feet swollen, pruritus'.
- Dr [B] did not send these entries to ACC, and in fact in his last paragraph he stated, 'I note that she was given Penicillin intramuscularly, as prescribed by another colleague, on the 27th of March 2002, without suffering any side effects'. This is not what the records show.
- Dr [B] gave her Augmentin on 11 April, and on 13 April the clinical record reads 'Fingers and little joints respectively swollen' and the Augmentin was stopped and Rulide substituted, with Dr [C] telling Ms [A] that Dr [B] should not have given her penicillin.
- Ms [A] has suffered a personal injury in the form of a penicillin reaction, after having been prescribed Augmentin by Dr [B], who had before him her clinical record clearly showing a previous allergic reaction to penicillin.
- This was a medical error on Dr [B's] part.
- She has been the subject of medical misadventure.
- I have concerns about Dr [B's] competence, and on the fact of it wonder if he has consciously misrepresented what was in the medical records.

7. With respect to claim [2] (missed viral meningitis) I have read (in addition to the above)

- Your letter
- [Letter from Public Hospital], with Dr [D's] report, and the inpatient hospital records.

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

8. The relevant facts are traversed in Dr [D's] report and Ms [A's] letter (little light is cast on how the hospital received Dr [C's] referral letter, but Dr [D] wrote that it 'was sent', though the admission notes say she was admitted via A&E). Otherwise there does not appear to be any dispute by any of the parties. I note there is no response from Dr [C], and wonder why that is so.

9. There is no previous condition that might predispose to this.

10. In my opinion

- Ms [A] did not have the symptoms of viral meningitis when she consulted Dr [B] on 11 April. Her worsening condition the following day can be ascribed to the viral infection of her body and the penicillin reaction.
- I do not think Dr [B] missed the diagnosis of viral meningitis on 11 April.
- On 14 April Ms [A] complained of headache: she called the practice but was not seen. She deteriorated with the developing symptoms of meningeal irritation: photophobia, headaches and stiff neck. By 22 April she was much worse and saw Dr [C] again. His record notes 'Headache. Just started with today. Vomited last 2 hours ago. Photophobia. RT ear sore. Lungs clear.' He then goes on to describe the management.
- That afternoon, by her account she self-referred to the hospital when the diagnosis of viral meningitis was obvious.
- Dr [C] clearly missed the diagnosis; his records do not include any indication that he even thought of meningitis, and certainly his recording of his physical examination is quite deficient: there is no mention of temperature or examination for meningism, for instance. His referral letter to the hospital was sketchy, simply reiterating his clinical record; how and when it got to the hospital is unclear in the absence of any response from Dr [C].
- The question is, did Ms [A] suffer personal injury as a result of the missed diagnosis? I think not – the natural history of the disease could not have been altered by earlier diagnosis, though perhaps the worst of her symptoms might have been controlled, and her anxieties allayed earlier.
- Thus despite Dr [C's] error, there has been no personal injury, and therefore no medical misadventure.
- I do have concerns about Dr [C's] competence, and think he should be referred for consideration of a competence review."

Advice to HDC
Dr St George provided advice to the Commissioner on 10 December 2003 as follows:

"1. I respond to your correspondence of 5 December 2003 seeking advice in relation to Ms [A's] complaints against Drs [B] and [C]. I am asked to advise the Commissioner whether the doctors provided services to Ms [A] that complied with appropriate standards.

2. I have read the following supporting information

- Ms [A's] letter of complaint, dated 24 June 2003 (pages 1-3).

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

- Further correspondence from Ms [A], dated 21 October 2003 (pages 4-14).
- Dr [B's] letter of response and accompanying clinical notes, received 8 September 2003 (pages 15-17).
- Dr [B's] letter and accompanying clinical notes, dated 26 November 2003 (pages 18-23).
- Full copy of Ms [A's] clinical record from [the medical practice, in a town] (pages 24-26).
- My expert advice to ACC, dated 3 September 2003 (pages 27-29).
- [Public Hospital] records (pages 30-48).

3. You note that in my expert advice to ACC I stated that I had concerns about Dr [B's] representation of what was in Ms [A's] medical records.

And you ask

'After reading Dr [B's] letter of 26 November 2003 and attached computer screen print-out please answer the following questions:

Is Dr [B's] explanation for the difference between the records he submitted and those submitted by [the medical director] plausible? Please comment.

If you do accept Dr [B's] explanation how does this change your expert advice?

Should Dr [C] have diagnosed meningitis in Ms [A] when he saw her on 13 April 2003?'

4. I have assessed whether the doctors' actions were reasonable in the circumstances by the standards of the profession, as far as they have been stated or previously judged, at the time of the incidents. I state here I have no personal, financial or professional connection with any party that could bias my assessment.

5. In my opinion

- Dr [B's] letter claims a fault in the computerised records where inexplicably an entry ('Warning: penicillin – fingers and feet swollen, pruritus') appears at the end of a 27 March 2002 entry in one printout, and in a 4 April 2002 entry in another printout.
- Dr [B] claims the computer screen showed a different sequence from that in the printout, and this led him to believe Ms [A's] reaction may have been to an ingredient of Augmentin, rather than to penicillin.
- I cannot comment on Dr [B's] credibility, but even if his claim is true it does not explain his failure to note the record of penicillin (or Augmentin) reaction when he prescribed Augmentin.
- Thus I have no reason to revise my advice in paragraph 7 of my report to the ACC dated 3 September 2003.
- Whether his explanation is 'plausible' would require comment from one sophisticated in the structure of the software – and I am not that.

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

6. I noted in my advice to ACC,

‘• On 14 April Ms [A] complained of headache: she called the practice but was not seen. She deteriorated with the developing symptoms of meningeal irritation: photophobia, headaches and stiff neck. By 22 April she was much worse and saw Dr [C] again. His record notes “Headache. Just started with today. Vomited last 2 hours ago. Photophobia. RT ear sore. Lungs clear.” He then goes on to describe the management.
- That afternoon, by her account she self-referred to the hospital when the diagnosis of viral meningitis was obvious.
- Dr [C] clearly missed the diagnosis; his records do not include any indication that he even thought of meningitis, and certainly his recording of his physical examination is quite deficient: there is no mention of temperature or examination for meningism, for instance. His referral letter to the hospital was sketchy, simply reiterating his clinical record; how and when it got to the hospital is unclear in the absence of any response from Dr [C].’

In answer to your second question, I do not think Dr [C] should have diagnosed meningitis on 13 April. The illness was at an early stage then, and the symptoms were those of a non-specific viral infection coupled with penicillin reaction. On 22 April 2003 Dr [C] should clearly have considered meningitis.”

Response to provisional opinion

In response to my provisional opinion Dr B confirmed that he prescribed penicillin in error and did not note the warning that Ms A’s medical records contained at that time.

The administrator for the medical centre provided both a “screen dump” printout and a report/patient/medical history printout of Ms A’s file on the medical software computer system, for the period relating to the complaint. The screen dump view clearly shows the patient visits as Dr B described them and the report/patient/medical history view shows a different chronology. Dr B said that it is clear that a discrepancy exists between the on-screen material and the actual chronology of events.

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

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.

Opinion: Breach – Dr B

Inappropriate prescription of penicillin
It is accepted by the parties that Dr B prescribed Augmentin for Ms A on 11 April 2003 when she had a known allergy to penicillin. Warnings of Ms A's allergy to penicillin were recorded in her computerised clinical records and the computer warning system. Dr B acknowledged that he failed to note the warnings when prescribing the penicillin.

When Ms A returned to the medical centre and saw Dr B's colleague, Dr C, two days later on 13 April, she was noted to be suffering from a reaction to penicillin. My expert noted that Dr B prescribed Augmentin while "[having] before him [Ms A's] clinical record clearly showing a previous allergic reaction to penicillin".

In my opinion, Dr B failed to take reasonable care and skill when prescribing antibiotics for Ms A and therefore breached Right 4(1) of the Code.

Opinion: Breach – Dr C

Non-diagnosis of meningitis
Ms A returned to see Dr C on 22 April with a severe headache, vomiting, and photophobia. Dr C diagnosed a migraine and prescribed an intramuscular injection of Tilcotil. While Dr C arranged for Ms A to return in the afternoon for review, Ms A self-referred to hospital that afternoon and was diagnosed with viral meningitis.

My expert advised:

> "Dr [C] clearly missed the diagnosis; his records do not include any indication that he even thought of meningitis, and certainly his recording of his physical examination is quite deficient: there is no mention of temperature or examination for meningism, for

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

instance. His referral letter to the hospital was sketchy, simply reiterating his clinical record."

In my opinion, in not considering a diagnosis of meningitis, Dr C did not provide Ms A with services with reasonable care and skill and therefore breached Right 4(1) of the Code.

Comment

Non-diagnosis of meningitis prior to 22 April
Ms A said that Dr B should have considered meningitis as a diagnosis when she first consulted him on 11 April and that Dr C should have diagnosed meningitis when she consulted him on 13 April suffering from a penicillin allergy. I note my expert's advice that Dr B did not "miss" the diagnosis of viral meningitis on 11 April. Further, my expert advised that he did not think Dr C should have diagnosed meningitis on 13 April as Ms A's illness was at an early stage and the symptoms were consistent with a non-specific viral infection and with penicillin reaction.

Presentation of information
Dr St George, in his advice to ACC, questioned the computerised record that Dr B included with his response to Ms A's complaint, as this record differed from that submitted with the medical centre's response. Further investigation of the medical software patient record system revealed that different printouts with differing chronology may be produced depending on what information is needed.

I accept Dr B's submission that he prepared his response to Ms A's complaint using the abbreviated screen dump printout of the episode of care involved. Dr B did not seek to mislead with his use of this printout. I also note that Dr B did not seek to excuse his error by proposing that Ms A's reaction may have been to an ingredient of Augmentin, rather than to penicillin. Dr B fully accepted his prescribing error.

I am satisfied that the medical software patient record system has sufficient checks to alert the doctor of drug allergies and accept that Dr B failed to note the red alert warning on the front screen and the warning in the interaction box on the prescription screen.

Action taken

I note that Dr B has apologised in writing to Ms A for breaching the Code. This apology has been forwarded to Ms 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.

Further actions

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

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