General Practitioner

Report on Opinion - Case 97HDC8479

Complaint

An Investigation was undertaken on the Commissioner's initiative about the services provided to the consumer by the general practitioner. The investigation centred around:

- *Whether steps taken during the general practitioner's "two house visits" to the consumer (deceased) in mid-February 1997 were reasonable in all the circumstances.*

Investigation

In July 1997 the Medical Council of New Zealand advised the Commissioner of this case and an investigation was undertaken. Information was obtained from the following:

The Consumer's Husband
The General Practitioner
The Ambulance Officer
The Paramedic

The consumer's medical records were obtained from the general practitioner. The ambulance case notes were also obtained. The Commissioner received advice from an independent general practitioner.

Information Gathered During Investigation

Background

The consumer was admitted to a public hospital in December 1996 and was diagnosed as suffering from angina. The hospital discharge summary dated early December 1996 sets out the consumer's condition in detail. This included "*very poorly controlled NIDDM* [non-insulin-dependent diabetes mellitus]" for which the consumer had recently been started on daily *insulin* in addition to her oral hypoglycaemic medication. She also had ishaemic heart disease in the form of angina and was on long acting nitrate medication and an ACE inhibitor. After reviewing the consumer's case history, the Commissioner's advisor noted that the consumer's age and disease put her at a high risk of further ischaemic heart problems, including angina, myocardial infarction (heart attack) and cardiac arrest.

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Information Gathered During Investigation, *continued*

First Visit

On a day in mid-February 1997 the general practitioner was the doctor on-call in a town. He was contacted by the consumer's husband who advised him that the consumer was experiencing chest pain. The general practitioner recalled receiving this call at approximately 8pm and arrived at the family's house within three minutes. When the general practitioner arrived the consumer was sitting on the side of her bed clutching her chest. The general practitioner recalled the consumer describing her pain as constant and "*crushing"* in character. The general practitioner's assessment on examining the consumer was that she was suffering from anginal pain, which he recorded in his clinical notes as having been present for half an hour prior to his arrival. The general practitioner administered *sub-lingual nitrate* spray. He told the Commissioner that the pain then diminished slowly over the next ten minutes.

Conflicting advice was given to the Commissioner as to whether or not the general practitioner suggested that the consumer be hospitalised. In his response to the Commissioner, the general practitioner stated that he was aware that the consumer had been admitted to hospital recently with a cardiac problem. He recalled suggesting that she should be referred to the hospital for observation. The general practitioner stated that the consumer "*was adamant she did not want this option",* that she *"refused"* transfer to the hospital and was "*quite distressed"* when hospital was mentioned. The general practitioner recorded in his notes "*Advised to transfer to hospital but refused*". Conversely, the consumer's husband advised the Commissioner that the general practitioner never mentioned possible hospitalisation. The general practitioner told the Commissioner that he then "*suggested they call me immediately if there was a recurrence of symptoms."*

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Information Gathered During Investigation, *continued*

The Second Visit

Conflicting evidence was also given to the Commissioner as to the amount of time that lapsed before the consumer's husband telephoned the general practitioner again. The general practitioner stated that he received a phone call from the consumer's husband approximately one hour after his departure to advise that the consumer was continuing to experience severe pain. The general practitioner told the Commissioner that he suggested during this conversation that the consumer's husband request ambulance assistance. The general practitioner then attended the consumer for the second time that evening. He advised the Commissioner that on arrival he found the consumer semi-conscious and that she lost consciousness soon after his arrival. He then gave the consumer a further dose of *sub-lingual nitrate* spray.

The general practitioner recalled diagnosing cardiac arrest at about the time the ambulance arrived. He stated that he was pulling the consumer off the bed and onto the floor to perform cardiopulmonary resuscitation ("CPR") when the ambulance officers entered the house at approximately 10.11pm. The ambulance officer told the Commissioner that on her arrival, the general practitioner came rushing out of the house and said something to the effect of *"quick, quick, hurry"* and *"panicked and was in a state".* An ECG monitor was attached and intravenous access gained. Monitoring indicated profound bradycardia (very slow heart rate) which responded to intravenous *atropine* so that the consumer restarted spontaneous respiration with a reasonable cardiac output denoted by blood pressure of 90/60. The general practitioner also recalled *lignocaine* being administered through the intravenous line. This was then followed by sudden asystole (complete stopping of heart rhythm) and cardiopulmonary resuscitation was continued with intravenous *adrenaline*, but without any response.

The general practitioner told the Commissioner that at about this time the paramedic from a larger town arrived and took over supervision of the resuscitation attempt while the general practitioner attempted to offer the consumer's husband some comfort. The ambulance notes indicate that after fifty minutes of resuscitation the consumer remained in asystole, and resuscitation attempts were abandoned at 11.15pm. The general practitioner told the Commissioner that he stayed with the consumer's husband assisting him to contact family members and waited with him until the undertaker arrived.

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Information Gathered During Investigation, *continued*

The Commissioner's advisor noted the following about the drugs that were administered:

> "*I would not describe it as "normal practice" for lignocaine to be given at the same time as atropine. Lignocaine is really only intended for the treatment of arrhythmias namely ventricular ectopic beats, ventricular tachycardia and ventricular fibrillation. Nowhere in the written evidence is there any record of these arrythmias being noted on the monitor. If this was the case then the administration of lignocaine would be inappropriate in this situation in view of developing lignocaine toxicity, as the toxic to therapeutic balance of lignocaine is very narrow*".

The Commissioner was provided with conflicting evidence in the respect of the administration of *morphine* by the general practitioner. The general practitioner told the Commissioner that he carried 15mg ampoules of *morphine* in his on-call bag. The consumer's husband recalled that *morphine* was given on the second visit, by injection on two separate occasions into the top of the consumer's shoulders alternately. Both injection sites were reported by the consumer's husband to be "*bleeding profusely"* and he recalled the consumer stating to the general practitioner "*you've killed me this time".* The general practitioner stated that if *morphine* was given at all, this had to have occurred on the first visit as the consumer was semi-conscious when he arrived the second time.

The ambulance case notes recorded that the general practitioner had given *morphine sulphate* intra-muscular, indicating that this information had probably been given to the ambulance officers by the general practitioner, although the general practitioner does not recall whether or not he gave *morphine*. The general practitioner stated that it is his usual practice to inject *prochloroperazine* (*stemetil*) at the same time as *morphine* to prevent opiate induced vomiting, which may explain the consumer's husband's recollection of two injections. The general practitioner did not record the administration of the *morphine.*

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Information Gathered During Investigation, *continued*

In relation to the intra-muscular administration of *morphine*, the Commissioner's advisor stated:

> *"Intra-muscular administration of morphine would have been inappropriate in this situation, especially if given in the dosage of 15mgs each at two different sites".*

The paramedic advised the Commissioner that she took control of the resuscitation when she arrived and that she intubated the consumer. The ambulance case notes indicate the consumer was intubated at 10.45pm, which is thirty-four minutes after the ambulance arrived at the scene. The consumer was in asystole when the paramedic arrived. The ambulance case notes record large doses of *adrenaline* and *atropine* were given by the paramedic, but to no avail.

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.
3) Every consumer has the right to have services provided in a manner consistent with his or her needs.
4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.

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Opinion: Breach The General Practitioner

In my opinion the general practitioner breached Rights 4(1), 4(2), 4(3) and 4(4) of the Code of Health and Disability Consumers' Rights as follows:

The general practitioner's actions in running out to meet the ambulance were inappropriate. I am advised that the first three to four minutes of cardiac arrest are vital moments and that it would certainly be totally inappropriate to leave an unconscious arrested patient and run out of a house to hurry the ambulance officers along. Once an arrest is diagnosed CPR should be undertaken immediately and not interrupted.

While the general practitioner does not recall administering *morphine* to the consumer, the consumer's husband is adamant that *morphine* was given to his wife. As this is also recorded in the ambulance officer's case notes, it seems likely that *morphine* was administered at some stage. Further, the ambulance case notes recorded that the general practitioner administered *morphine* intra-muscularly. I am advised that the intra-muscular route is not always recommended as patients in the consumer's situation are often shocked. Absorption from muscle may be variable and onset of action delayed.

It is poor practice not to keep a register of *morphine* in stock and a record of administration. As a result of this lack of recording of the administration of *morphine*, the general practitioner is unable to account for his actions.

Finally the administration of *lignocaine* in this situation was inappropriate.

In summary, in my opinion the general practitioner did not provide medical care to the consumer which met appropriate standards as required by the Code.

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Actions

I recommend the general practitioner takes the following actions:

- Provides a written apology to the consumer's husband for breaching the Code of Rights. This letter is to be sent to my office and I will forward it to the consumer's husband.
- Keeps a record of his consultations and also completes a *morphine* register.
- Participates in an advanced cardiac life support course.

Other Actions

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