General Practitioner, Dr B

A Report by the

Health and Disability Commissioner

(Case 00HDC07631)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Complainant / Consumer's wife
Mr A	Consumer
Dr B	Provider / General Practitioner

Independent expert advice was obtained from general practitioner Dr Steve Searle.

Complaint

On 31 July 2000 the Commissioner received a complaint from Mrs A about the care provided to her husband, Mr A, by general practitioner Dr B. The complaint is summarised as follows:

- *On 17 July 2000, Dr B visited Mr A following a fall Mr A had taken on the previous day. Dr B did not adequately examine Mr A on this visit.*
- *During the week 17 July to 21 July 2000, Dr B would not arrange for Mr A to be transported by ambulance to an Accident & Emergency clinic for x-rays, even though Mr A was in too much pain to move.*
- *Dr B did not diagnose the injuries that Mr A sustained in his fall, which included fractured ribs and a collapsed lung.*

An investigation was commenced on 21 September 2000.

Information reviewed

- Information supplied by Mr A and Mrs A
- Information and medical notes supplied by Dr B
- Medical notes from the public hospital

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Information gathered during investigation

Sunday 16 July 2000
Mr A (aged 69 years) fell backwards off his stepladder, hitting his back, head and elbow on a concrete wall. Mr A was in considerable pain. He went to bed to see if rest would help.

Monday 17 July 2000
The following morning, Mr A could not move. At 9.30am his wife, Mrs A, telephoned his regular general practitioner, Dr B. Dr B was unavailable but returned Mrs A's call at 10am. Mrs A explained that her husband was unable to move and was confined to bed following a fall the day before. He was unable to come to the surgery so Dr B agreed to a home visit. As Mr A and Mrs A lived in the country and Dr B was unsure how to get there, Mrs A arranged to pick up Dr B, and drive him to her home.

Mr A and Mrs A recall that Dr B's examination was brief, lasting around 10 to 15 minutes. Neither Mr nor Mrs A can recall Dr B physically examining Mr A. Mr A advised me that Dr B "just talked to him". Mr A was lying flat and could not move. Mr A did not think that Dr B listened to his chest, although Dr B did place his hands on Mr A's ribs. He could not recall whether Dr B had looked at his eyes/pupils. Mrs A advised me that Dr B gave her husband an injection of Tilcotil (anti-inflammatory painkiller) and a prescription for Tramal tablets (anti-inflammatory painkillers) and Norflex tablets (skeletal muscle relaxant). Mrs A claimed that Dr B stated: "See you at the surgery on Tuesday or Wednesday. It is no good going to hospital as they will just say bed rest and valium." Mrs A drove Dr B back to his surgery.

Dr B recalls the examination of Mr A differently. He advised that the round trip, including travel, took between an hour and 75 minutes. The travel time was no more than 10 to 15 minutes each way, with the remainder of the time spent on examining Mr A. Dr B's receptionist provided me with the following written statement:

> "I confirm that on the 17th July 2000, that [Dr B] was out of the surgery for about an hour. [Mrs A] drove him out to her house at about 11.00am as [Dr B] was unsure where they lived and dropped him back at the surgery afterwards. As far as I can remember he had an appointment at 11.45am but he was late back for that appointment as the patient was waiting in the waiting room."

Dr B advised me that he undertook a full head to toe examination of Mr A, as he was concerned that Mr A might have sustained a head injury. Dr B claimed that he told Mrs A the neurological symptoms to be alert for and that could necessitate an immediate trip to the public hospital. Dr B documented his examination of Mr A as follows:

> "Fell backwards off stepladder yesterday.
> Remembers fall, then being on ground.
> KOD ?? (fall wasn't witnessed)
> Mild abrasions crown of scalp
> PERL Rest of skull no evident bony tenderness
> No hyphaema No diplopia Chest clear
>
> Norflex for muscle spasm.
> Tramal 20(mg tablets)

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> No scaphoid or upper tenderness
> either hand
> C/o (complaining of) paravertebral lumbar m(uscle) spasm
> Offset to the R(ight side). No pelvic/hip bony tenderness
> No parasthesiae in buttocks or legs. Fully mentioned neuro obs(ervations) that any change LOC (level of consciousness) to go to [the public hospital].
> No external rotation of feet
> Bowels and bladder – no change since fall
> Alert. Orientated PERL (pupils equal and reactive to light)
> N(ormal) level of consciousness. Tilcotil 15mg IM stat
> Wife says no evidence of (reduced) cognition nor clouding (of) consciousness since fall.
> Norflex q6h and Tramal cover for pain.
> Step de(formity)."

Dr B advised me that the phrase "chest clear" proves that he listened to Mr A's chest and that there was no evidence of a burst lung. The main area of Mr A's pain was offset away from the area of his lumbar spine. The phrase "bowels and bladder no change" indicate that there was no evidence of a bowel obstruction since the fall. The two words "step def" indicate that Dr B was aware of the step deformity in the right side of Mr A's chest wall.

Dr B explained that he did not arrange for an x-ray that day, as Mr A was in a lot of pain. He did not consider that there was an injury that justified or required an emergency referral to hospital, and it would have been too painful to transfer Mr A to the A&E Centre for an x-ray. Dr B recalls explaining to Mr and Mrs A that it was better to treat the pain first and that he told Mrs A to phone him the following day if there were any problems.

Tuesday 18 July 2000

The next morning, 18 July 2000, Mrs A telephoned Dr B and advised him that her husband's pain level was no better. Mrs A was also concerned that her husband now had a red rash on his waistline. Dr B visited Mr A at lunchtime and recorded the following about his examination:

> "No headaches
> No LOC (no decreased level of consciousness)
> Not confused
> Orientated fully
> Pain below R costal margin posteriorly
> No urinary discoloration
> No liver tenderness. No abdo tenderness.
> No rebound. Appears to be muscle spasm, palpitation of ribs not particularly painful but step deformity R chest wall.
> Appearance of heat rash on abdo front and back (unable to turn around in bed due to pain)
> Tramal at Tq4h (1 tablet every 4 hours)
> And Tilcotil injection
> ineffective for pain

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> hips not tender
>
> Try morphi(ne) 2mg/1ml
> 3 to 8ml (with) Maxolon and Codalax
>
> add Brufen 600mg PRN (if needed)
>
> X-ray tomorrow when mobile."

Dr B advised me that when he examined Mr A there was no evidence of bowel obstruction and Mr A's rash was probably caused by heat. Dr B decided the pain relief that he had prescribed Mr A the previous day was insufficient and prescribed a combination of morphine syrup and Brufen. Dr B recalls explaining to Mrs A that the morphine would provide Mr A with better pain relief, and that she was to phone him if there were any problems. Mrs A and Dr B also had a discussion about the need for an ambulance to transport Mr A for an x-ray. It was Dr B's view that it was not necessary, as an x-ray would not assist with Mr A's clinical management, which essentially involved pain control. Dr B commented:

> "I explained to the patient's wife that there was no evident underlying medical conditions that could predispose to more serious chest injury than expected, eg no underlying asthma, nor previous pneumothorax, no past history of brittle bones or heart disease etc. Hence, an x-ray would confirm any broken ribs, but it would not treat the problem, which was severe pain."

Wednesday 19 July 2000
Mr A was able to get out of bed on to a chair and back to his bed, but it was very painful, and took him one and half hours, as he had to keep resting. Mrs A advised me that Dr B phoned her at about 2pm that day and she told him that the morphine was not reducing her husband's pain, so she had increased the dose. Dr B told her to ring him regarding doses. This discussion is not recorded in Mr A's medical notes and Dr B claims that he did not hear from Mrs A until two days later, on 21 July 2000. Dr B's receptionist could not recall any telephone calls from Mrs A apart from those made on Tuesday 18 July and Friday 21 July.

Thursday 20 July 2000
Mr A was still unable to move despite the doses of morphine. Mrs A's family and friends were urging her to demand action from Dr B.

Friday 21 July 2000
Mrs A telephoned Dr B at 9.45am and told him that she "wanted something done", specifically an ambulance to take her husband to the Accident and Emergency Clinic. Mrs A advised me that Dr B told her that it would not be possible to get an ambulance, and the Accident and Emergency clinic would not "take responsibility" for Mr A. However, Dr B arranged to review Mr A and arrived at about 1.15pm.

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Dr B advised me that when he reviewed Mr A he noticed that Mr A's quality of pain was different and that it appeared to be worse with pressure, which had not been the case earlier in the week. The pain in Mr A's back had extended upwards to the lower thoracic area. He noted that Mr A was not short of breath. Dr B commented:

> "The patient needed to be referred on because his clinical situation had changed. I had treated broken ribs before, but all prior cases had settled on morphine. Moreover in this case the pain had worsened rather than improved, specifically in his back and back part of the abdomen. At the time I felt the most likely explanations were either a failure to absorb the medication or an aggravation of an underlying fracture. As [the] A& E were closer than hospital, I arranged an ambulance to take him there."

Accident and Emergency Clinic
Mr and Mrs A arrived at the Accident and Emergency Clinic by ambulance at approximately 3pm. Mr A was seen by a doctor, who gave him an injection of morphine and arranged a chest x-ray. The doctor queried whether Mr A's symptoms were caused by paralytic ileus (whereby severe pain leads to reduced gut function and therefore reduced absorption of pain-relief medication), and transferred Mr A to the public hospital for further investigations.

Dr B recalls the conversation he had with this doctor, who advised him that on arrival Mr A was pale and sweaty, and that he thought it was possible that Mr A had had a vasovagal reaction (where excessive activity of the vagus nerve causes slow heart beats, falling blood pressure and fainting) to the pain of being transported to the Clinic. The doctor also advised Dr B that this reaction was consistent with a possible paralytic ileus. Dr B advised me that this was a condition that he had not encountered before because it was uncommon.

The public hospital
Mr A was admitted to the public hospital. Following a CT scan of his abdomen and pelvis a diagnosis of a rib fracture was confirmed. Paralytic ileus and a sub-acute bowel obstruction were also suspected. The CT scan described the following:

> "IMPRESSION
> 1 Right posterior rib fractures involving ribs 5 through 9 which are non displaced with an associated pleural effusion [fluid between the lung and the rib cage/chest wall lining] but no pneumothorax [air between the lung and the rib cage/chest wall lining].
> 2 No evidence of diaphragmatic rupture.
> 3 Multiple distended predominantly large bowel segments with a relative calibre change in the region of the sigmoid colon. Recommendation will be with correlation with colonoscopy to exclude an obstructing mass."

Mr A was transferred from the Emergency Department to the Ward that evening. He had an indwelling catheter (to drain urine), and received oxygen via a mask and fluids via a drip. The clinical notes described him as "comfortable when immobile".

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Saturday 22 July 2000
At the ward round in the morning, the following management plan for Mr A was documented:

> "WR [ward round] [Dr …]
> Reasonably comfortable this morning
> No B.M. [bowel motion] ∅ flatus [no wind]
> O/E: afebrile [normal temperature]
> Obs [observations] stable
> Abdo[men] soft, mildly tender
> P: 1) Microlax enema + laxatives
> 2) Clear oral fluids
> 3) Chest Physio for breathing exercises # ribs
> 4) Continue reg[ular] pain relief."

During that day, Mr A received one gram paracetamol, 50mg Voltaren and morphine (as per protocol) for his pain.

Sunday 23 July 2000
Mr A was noted to be more comfortable. His IV fluids were discontinued and he was "drinking well". He was given a Microlax enema and his bowels opened twice. Nursing staff were advised by the physiotherapist to encourage Mr A to mobilise. Mr A was reviewed by the on-call house officer at 1.00pm and noted Mr A not to be short of breath or in severe pain. The nursing notes at 3.15pm recorded that his bowels had opened and describe Mr A as "independent with toileting/shower". He was discharged home the next afternoon, 24 July 2000.

Independent advice to Commissioner

The following expert advice was obtained from Dr Steve Searle, an independent general practitioner:

> "…
> **<u>Documents and records reviewed</u>:**
> Complaint letter, [Mrs A], marked 'A'
> Action note, conversation with [Mrs A] dated 19 September 2000, marked 'B'
> Investigation letter to [Dr B], marked 'C'
> Response from [Dr B], with enclosures, marked 'D'
> Copies of records from [the Accident and Emergency Clinic], marked 'E' – this includes a copy of the ACC 45 form from the 17/7/00.
> Copies of records from [the public hospital], marked 'F'
> Action note of conversation with [Mr A] dated 9 May 2001, marked 'G'
> Copy of letter with questions to [Dr B] dated 30 Apri1 2001, and his written response dated 15 June 2001, marked 'H'.

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Possible missing information:
A better copy of the ACC 45 form could have been useful as it was hard to read – but I have been able to read the diagnostic codes 'S60' (which stands for concussion), 'S572' (which stands for lumbar sprain), and 'S25', which stands for fracture of metacarpal bone (a bone in the hand between the fingers and the wrist). It might have been useful to read the section 'How was the injury caused' (unreadable in the copy I have). Also useful would be being able to read the section on type of treatment provider referred to (I think it might be 'XRay' and 'physio' – indicating that after first seeing the patient [Dr B] was intending to refer [Mr A] for these services at some stage.) I think my inability to read these aspects of the ACC 45 form is unlikely to change my recommendations at this stage.

There are photocopies of the hand written notes from 21/7/00 but in [Dr B's] letter of the 11th December 2000 there is not a transcript of these notes (there are transcripts for the 17/7/00 and 18/7/00). As the complaint centres more around the early management on the 17/7/00 and the 18/7/00 and on the 21/7/00 the patient was referred on, it is unlikely that the absence of these notes will affect my overall recommendations.

From a medical point of view of trying to explain what happened to [Mr A] and why, I have some difficulty in giving an answer in the absence of subsequent notes and results – e.g. what did the subsequent colonoscopy show? (The CT scan showed a probable lesion in the sigmoid colon – it is possible that if he had an underlying bowel lesion (e.g. a growth/tumour/cancer) that this could partly explain the subacute bowel obstruction (the other explanation being that it was simply secondary to his rib fractures and/or his medication).) It is quite possible that [Dr B's] management was reasonable and that an unexpected underlying medical problem meant unexpected complications. However when one considers that the outcome of the case is irrelevant to the standard of care (ref 1.) then it is possible to make an assessment of the standard of care in the absence of this information. Having said this I am concerned that for both [Mr A] and his wife that the absence of this subsequent information may not let me fully explain what has happened to him and why – but this task is probably better dealt with by his current GP.

It is common for General Practitioners to keep a medical profile for patients including such information as past history of injuries to the same area, past medical history including medications and allergies, tetanus status, work, hobbies, sports, etc. This information is useful in checking on the safety of medical treatment proposed and also in assessing the impact of the patient's injuries on their life. I do not have a copy of this profile, if it existed, but I think that it is not critical for me in making a decision but I will mention it in my recommendations as I think this type of information would have helped to focus on the issue of what is the patient's function like as a result of this injury?

Quality of provider's records or lack of them
I have reviewed both the transcript of [Dr B's] notes and his hand written notes. On the whole there are good notes covering the history taken and examination undertaken, but some extra information would have been useful. Within the note from the 17/7/00 it would have been useful to record the height of the fall, and any comments on the exact

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mechanism of landing – although this might not have affected the outcome I think it is good clinical practice to record this. Of note his notes state there was no scaphoid or other tenderness of either hand so I am a little uncertain of the basis for the metacarpal bone fracture mentioned on the ACC form. It would have been helpful to record pulse rate and respiratory rate as they can indicate problems such as shock or pain. Blood pressure recording can be useful but it can also be misleading (ref 2.) and I do not consider that needed to be done or would have helped.

The examination notes suggest that he was thorough in his examination. Also in his letter of the 11 December 2000 he states that 'I examined the patient from head to feet' and his notes would tend to mostly support this – head and neurological examination would appear to be fairly thorough, and the chest examined. It is not clear if the spine was examined or the abdomen. Also it is not clear if the patient's functional status was enquired about – could he get himself up and about for example? As a house call was being done this should be an alarm bell that the patient and/or his family did not consider him capable of getting to the surgery and hence this aspect of the examination does deserve attention.

The note from 18/7/00 is fairly thorough and does clearly document abdominal history and examination findings, however once again the amount of movement the patient was capable or not capable of was not clearly documented other than 'unable to turn around in bed due to pain'.

The advice given about change in mental function or level of consciousness would mean going to hospital ([the public hospital]) was good. It is not clear to me about what advice was given about the adequacy of pain relief to be expected.

I entirely agree that x-rays would not assist in the management of fractured ribs unless a complication was suspected. The level of rib fracture and abdominal examination findings would be needed to help determine this, but certainly the fact that this was now the day after the initial injury would make it unlikely there was any immediate complication needing urgent treatment. However the fact that the patient could not get to the surgery (or did not want to go to the surgery) and requested a house call should be an alert that something else other than simple fractured ribs could have been happening. I consider that to leave the patient at home really required documentation of adequate analgesia and adequate amounts of movement to perform daily activities such as going to the toilet. Documenting if the patient could or could not get up and observing how difficult it was would have been helpful.

Describe the care as documented and describe the standard of care that should apply in the circumstances

Safety (probably not needed to be commented on in this case)

Is the patient now in a safe environment (safe from further injury) & is it safe for the provider? This was probably true in this case as the patient at the time of being seen was away from the immediate site of the injury. Thus no documentation of this is acceptable.

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Any Serious Injury?
Is there any life threatening injury – classically 'ABC' are checked for (airway breathing and circulation – documentation of pulse and respiratory rate is required but not done in this case) and then 'D' for disability or neurological function (this was documented). It is important in this case to check that there was not an injury to another part of the body when he fell. This seems to have been covered fairly well in a head to toe examination.

Taking a full history (Previously commented on above under quality of providers records section). To include mechanism of injury, current symptoms (e.g. pain, numbness, loss of use), past history of injuries to the same area, past medical history including medications and allergies, work, hobbies, sports, dominance of limb (if injured) – much of this information may have already been known to [Dr B] given he was the usual GP and thus documentation would not have been needed.

Do an appropriate full examination
Other than not documenting pulse and respiratory rate this seems to have been done and documented in the classic traditional medical manner. But in my view noting more fully the functional status of the patient after traditional medical examination is very useful – can they sit up or get up with or without assistance, how easily can the walk? Etc.

Order appropriate investigation – I do not think any investigations were strictly needed initially. I agree with [Dr B] that x-rays for fractured ribs are not usually helpful unless complications are suspected.

Decide on appropriate management and implement this or seek advice and/or refer on for such management. The initial pain relief prescribed was appropriate but I think a clear explanation to the patient of how quickly and how well it should work is needed as well as discussing side effects – I am unsure if this happened on the first visit. Usually with the type of injuries suspected time will allow the patient to heal themselves without any special treatment other than pain relief. The second house visit was acknowledged by [Dr B] to be because the patient's wife said the pain was no better. He also noted that the patient was 'unable to turn around in bed due to pain'. I think at this point there were only two acceptable options:

- Refer him to hospital immediately for pain management (I think that failure of appropriate pain relief out of hospital is an acceptable reason for admission and/or another opinion).
- Try managing the pain with strict time limited guidelines (by this I mean an objective measure such as the patient being able to get up and walk within a certain time period). Leaving [Mr A] at home could have been acceptable at this point if there was an early follow up to check he was functioning better – e.g. a phone call by the doctor to [Mr A] or [Mrs A] a few hours after the house call.

Give the patient appropriate advice on follow up, and any complications to watch out for that might need earlier follow up. There was good consideration and advice on

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head injury. However advice on adequacy of analgesia and the expected level of functioning that should occur as a result of the analgesia was probably lacking.

Have appropriate systems in place to reduce errors

This is where there is great potential to improve the management for all patients. Doctors are human and errors can occur – however they can be minimised and/or the effects of these errors reduced or mitigated by having systems in place to check for errors and if possible to take action to prevent harm or to prevent sub-optimal outcomes for patients. I believe that a patient centred method of consultation has been demonstrated to reduce errors and patient complaints and was in this case the most likely single thing to have resulted in a better outcome for [Mr A] – see my recommendations.

Describe in what ways if any the provider's management deviated from appropriate standards and to what degree

This has already been discussed in some detail in the above sections but to conclude the following are what I would see as the key issues:

- It would have been useful to record the height of the fall, and any comments on the exact mechanism of landing.
- The patient's pulse and respiratory rate should have been recorded.
- Documenting more fully the patient's level of function and allowing for this in the management plan is essential and did not occur.

Answering Questions put to me by the Commissioner's Office

Were [Dr B's] examinations of [Mr A] appropriate and complete?

Yes with the exception of the comments above under the section 'Describe in what ways if any the provider's management deviated from appropriate standards and to what degree.'

Was there any indication that [Dr B] should have referred [Mr A] sooner?

I believe that at the point of the second visit either referring [Mr A] or organising more detailed follow up would have resulted in him being admitted to hospital sooner, which may well have made him more comfortable sooner (possibly largely because of nursing care rather than anything medical as such), but would not necessarily have resulted in a different overall outcome. As explained below the exact cause of [Mr A's] complications is hard to determine, but it could well be that either giving him no pain relief or inadequate pain relief would have caused problems re not being able to breath deeply enough, or that giving him even more pain relief could have caused problems by the side effects of stronger pain relief which include suppressing deeper breathing and often slowing down bowel function. In other words even if [Mr A] had been sent to hospital sooner it may well be that the initial injury was severe enough, or in just the right place, or combined with some underlying co-incidental problem (e.g. the possible bowel lesion seen on CT to be followed up by colonoscopy) to cause problems no matter how he was managed initially.

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<u>The complaint that [Dr B] did not diagnose the injuries</u>.
Often an exact diagnosis is either not possible and/or not needed. In this case I think the problem was not one of lack of or incorrect diagnosis of the injury, but was a problem of lack of recognition of the impact of the injury on the patient's function. Certainly the initial diagnosis of concussion was a good one to ensure that possible complications of head injury were thought of and looked for. Although not on the ACC form it seems clear from both [Dr B's] notes and his letter of explanation that fractured ribs were diagnosed correctly. I do not believe that the diagnosis of the paralytic ileus or subacute bowel obstruction could have been made any earlier as it is a condition that takes time to develop – it is a recognised complication of fractured ribs (ref 2) but in my experience uncommon. The lung problems are discussed below but also probably took some time to develop and almost certainly would not have been clinically evident on the first visit. Whilst it would have been possible to diagnose the complications on the final visit (the day of admission to hospital) it is not really possible to say at what point in time before that it would have been possible to diagnose them clinically – but once again I would point out that the patient's lack of function should have triggered either an earlier admission or closer follow up.

<u>Whether there is any evidence of injury or collapse of [Mr A's] lung(s)</u>?
There was clinical evidence on the day of admission – hospital doctors noted decreased breath sounds at his right lung base. It is not possible to say at what point in time before this it would have been possible to diagnose this. The CT scan of the abdomen and pelvis (which would have included the lower part of the lungs) was reported as showing 'Lung bases demonstrate a small right sided pleural effusion overlying a site of multiple nondisplaced posterior rib fractures including ribs 5 through 9. There is no associated pneumothorax. The lung parenchyma otherwise demonstrates bibasilar atelectasis/consolidation.' The 'no pneumothorax' (air between lung and the rib cage/chest wall lining) means there was not a missed potentially severe early complication. The pleural effusion (fluid between the lung and the rib cage/chest wall lining) was small, and likely to resolve on its own, and probably not clinically diagnosable at an early time. The bibasilar atelectasis/consolidation is probably where the confusion about lung 'collapse' has come from – atelectasis does mean 'collapse' but is usually used in the sense of a small or particular part of the lung 'collapsing' – it does not usually mean, and in this case in particular does not mean that the whole lung collapsed. The partial 'collapse' in this case was probably secondary to [Mr A] not being able to breathe very deeply. This means that by the time [Mr A] was admitted some minor lung complications had developed – either secondary to the pain directly or from lack of ability to breathe deeply secondary to the pain from the ribs and/or secondary to the pain from the bowel obstruction and/or secondary to the effects of pain relief. There was certainly no 'burst' lung.

<u>Any other matters relating to professional or ethical standards that I believe are relevant to this complaint</u>?
The major problem as I see it was not using 'The Patient-Centred Clinical Method'. A more detailed description of this method can be found in various classic general practice texts (e.g. ref 3). There is increasing evidence that the use of this method need not be

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more time consuming and helps avoid medical errors and patient complaints. It does not mean replacing 'the doctor's agenda' but rather making sure that the patient's agenda is recognised as well as the doctor's one. Emergency medicine doctors would now think in terms of the patient's function and adequacy of pain relief – they would at the point of considering sending a patient home ensure the patient could walk for example – in the past it was not uncommon for them to send patients home at all times of the day or night when they had not considered these things and problems arose. However I think GPs, and perhaps eventually all doctors, should be using Patient-Centred medicine and that it goes beyond patient function and adequacy of pain relief and includes concepts such as the patient's (or their relatives) feelings, ideas, function, expectations, and understanding of illness. Also I find trying to imagine what it would be like to be this patient is very helpful – I for example find myself thinking when I look at this case what it must have been like for this man to have been in pain at home and simply trying to eat or go to the toilet. [Dr B] in his letter of 15 June 2001 notes 'At no stage did the patient express dissatisfaction in the form of fears, worries or objections to anything that I had said' which shows he recognises these things can be important issues – however I think it is clear from his notes, his explanatory letters, and the nature of the complaint that these things and other aspects of patient centred medicine were not specifically asked about or planned for – simply relying on the patient to volunteer these things is not enough – if they are not volunteered they need to be asked about in the same way that other aspects of the medical history are enquired about – opened ended questions first followed up by more closed questions if needed. The temptation is often to abandon the Patient-Centred approach with apparently simple clinical problems like an injury, and just do the 'doctor thing' or even leave out some aspects of the patient's past history – in my experience this process of leaving things out often leads to problems.

I also wonder about what it was like for [Dr B] to go and do a house call to see this man? The fact that he did several house calls is to be commended. At no stage do I think there was any major clinical fault in the sense of classic medicine as taught and practised in medical school, in fact his notes suggest he took some time to examine the patient fairly thoroughly. I could go into all the details about the exact diagnoses and the clinical findings and various types of appropriate management at the various points in time that [Dr B] saw [Mr A] but I really think focusing on at what stage should this patient have been x-rayed or sent to hospital based on classic clinical history and examination findings is unhelpful. The main thing that could have made a difference was better attention to the Patient-Centred clinical method.

Conclusion:

I think this case is somewhat difficult in that the complication of bowel obstruction from rib fractures is unusual, and also because that complication along with the other minor lung complications may well not have been avoidable no matter what was done – even if [Mr A] had been sent to hospital on the very first day, or even if he had gone to hospital directly himself. However as previously stated the outcome of the case is irrelevant to the standard of care (ref 1.) – it may be that there was no departure from the accepted standards but the care still resulted in an adverse outcome for the consumer. Conversely

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there may have been no adverse outcome for the consumer but the care may have been substandard.

It is my opinion that [Mr A] would probably have suffered the same complications no matter what was done at any stage, but that an early admission to hospital was possible on the grounds of inadequate pain relief and patient functional status, and that such an earlier referral would possibly have resulted in better comfort for [Mr A] in terms of earlier access to full nursing care.

It is my opinion that discussing the exact clinical findings (history of injury, subsequent symptoms, and examination findings and their correlation with the final hospital diagnosis and management) and their presence or absence at various times is largely unhelpful in this case. There is certainly no indication that overall [Dr B's] findings or interpretations of these findings were in any way deficient. However lack of attention to 'The Patient-Centred Clinical Method' and in particular [Mr A's] level of function, was the major problem.

Certainly at the point of the second visit given the decision was made to try further pain relief at home a more detailed follow up plan was needed.

Recommendations:

[Mrs A's] letter states 'The quality of service we received from St Johns Ambulance, [the Accident and Emergency Clinic] in [a suburb] and [the public hospital] was outstanding and I am very grateful for the help and care they gave to my husband.' – I think we should get [Mr A] and [Mrs A's] permission to feed this 'praise' back to these health providers as it is always good to get good feedback and I think this is important to help keep up 'morale' in the health system.

I think that there was no major problem with [Dr B's] examinations as documented other than the common mistake of not recording pulse and respiratory rate findings. All doctors including [Dr B] need reminding about this.

The major problem as I see it was not using 'The Patient-Centred Clinical Method'. I am fairly certain that the use of this clinical method would have avoided the problems seen in this case and I think this should be drawn to [Dr B's] attention. It should also be drawn to the attention of all GPs, accident and medical doctors, and emergency department doctors that 'The Patient-Centred Clinical Method' has benefit both in terms of better patient outcomes and less complaints occurring.

References

1) Statements about Health and Disability decisions: I would note that one of the principles of giving advice to the Health and Disability Commissioner is that the 'outcome of care is irrelevant' – it may be that there was no departure from the accepted standards but the care still resulted in an adverse outcome for the consumer. Conversely there may have been no adverse outcome for the consumer but the care may have been substandard.

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2) ATLS (Advanced Trauma Life Support for Doctors) – Student Course Manual 1997 – Copyright the American College of Surgeons. ISBN 1-880696-10-X
3) A Textbook of Family Medicine – Ian R. McWhinney – Oxford Press – Copyright 1981, 1989; ISBN 0-19-505986-7."

Responses to Provisional Opinion

Dr B

Dr B disagreed with the conclusions reached in my opinion in respect to his management of Mr A's pain, level of functioning and attention to a patient-centred approach to assessment.

Dr B disputed my advisor's criticism that he did not adequately consider Mr A's reduced level of functioning at his visit on 18 July 2000 or put in place an adequate monitoring plan. Dr B advised that he visited Mr A on 18 July in response to the concern expressed by Mrs A that her husband's pain relief was not adequately controlled. Dr B stated that he significantly increased Mr A's pain relief by prescribing morphine, Codalax (to prevent constipation which can be a side effect of morphine) and metoclopramide (for nausea associated with taking morphine).

Dr B said that he expected the morphine to resolve Mr A's pain over a 24-hour period and that Mrs A was to telephone him if this did not happen. He stated that he did not hear from Mrs A until three days later, on 21 July. Dr B said he routinely advises his patients to telephone him, or request a home visit, if they have any concerns. He is adamant that he would have given this instruction to Mrs A on 18 July, just as he had when he visited on 17 July. Dr B pointed out that he undertook three home visits at considerable inconvenience to himself (as a sole practitioner). He would not have hesitated to visit Mr A and review his management at any stage if this had been requested or if he had been told that the pain relief was not effective.

Dr B informed me that morphine has an accumulative effect and it is therefore important to take the medication regularly to build up to a therapeutic (pain-free) level. He submitted a document, in Mrs A's handwriting, which lists the medications she gave to her husband each day during the period of 17-21 July. Dr B advised me that he received this document from the Accident and Emergency clinic some time after Mr A's discharge from the public hospital. He drew my attention to the low number of morphine doses Mrs A recorded giving to her husband (no more than two doses a day). Furthermore, there is no record of Codalax being given. Dr B maintains that the treatment plan he put in place was appropriate but was not adhered to by Mrs A.

Mrs A

Mrs A responded in writing to the 'Facts Gathered' section of my provisional opinion. She restated her concerns about the adequacy of Dr B's examination of her husband and Dr B's failure to diagnose Mr A's fractured ribs or arrange for an x-ray. Mrs A provided me with

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her photocopy of Dr B's notes of her husband's assessment and a bottle of Codalax with approximately one dose missing.

Mrs A was asked about the document listing the medications given to her husband. Initially, she could not recall such a list. However, when shown the list, Mrs A confirmed that it was in her handwriting and recalled writing it. She advised that she wrote the list contemporaneously so she could keep track of the different medications and doses her husband was taking. Mrs A also recalled that she had taken the list of medications to the Accident and Emergency clinic to "help the doctors".

With regard to the morphine, Mrs A stated that she knew "by Wednesday" (the day after Dr B prescribed it) that the morphine "wasn't working" despite giving her husband between 5 and 8ml as suggested by Dr B. My investigation officer drew Mrs A's attention to the low number of morphine doses she recorded. Mrs A stated that if the morphine was meant to have been given four-hourly, she is sure that she would have done so. Mrs A is unsure why she did not record more doses.

In respect to the Codalax, Mrs A recalled giving her husband one dose. However, she did not give her husband any more of the Codalax as they were both concerned about his ability to get to the toilet in time.

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 services provided with reasonable care and skill.*

…

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.*

Opinion: No breach – Dr B

Introduction
Under Right 4(1) of the Code Mr A had the right to receive medical services provided with reasonable care and skill. Right 4(4) of the Code states that "[e]very consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises

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the quality of life of, that consumer". "[O]ptimises the quality of life" can be defined as "taking a holistic view of the needs of the consumer in order to achieve the best possible outcome in the circumstances".

X-ray
Mrs A was concerned that Dr B did not obtain an x-ray for her husband in a timely fashion. Dr B advised me that he believed Mr A would have certainly fractured several ribs as a result of the fall; however, he did not consider that there was any complication evident and therefore made the clinical decision that a chest x-ray would not be helpful in terms of treatment options. Dr B considered that the nature of Mr A's injuries were such that he could be safely treated in the community. His experience in the past had been that fractured ribs settled with appropriate analgesia.

My advisor agreed with Dr B that x-rays for fractured ribs are not necessary in the absence of complications. Dr Searle commented:

> "I entirely agree that x-rays would not assist the management of fractured ribs unless a complication was suspected. The level of rib fracture and abdominal examination findings would be needed to help determine this, but certainly the fact that this was now the day after the initial injury would make it unlikely there was any immediate complication needing urgent treatment."

I accept my expert advice that Dr B's decision not to refer Mr A for x-rays was appropriate. Accordingly, Dr B did not breach Right 4(1) of the Code.

Examination on 17 July 2000
Mrs A is concerned that Dr B's examination of her husband on 17 July was brief and inadequate and that he failed to diagnose Mr A's injuries.

Dr B advised me that he thoroughly examined Mr A from head to toe and has provided me with his clinical notes detailing his findings. I am satisfied that Dr B gave Mr A a full examination. I note that he also made several house calls, driving into the country to see Mr A, to spare his patient the pain and inconvenience of travel to the surgery. Dr B's service to his patient is commendable.

My advisor noted that Dr B's head and neurological examinations were thorough and that Dr B gave good advice about concussion. Mr A's chest was examined and the clinical notes were documented appropriately. Dr B did not record Mr A's pulse, although my advisor noted that this was a fairly common omission.

My advisor considered it unlikely that the complications of bowel obstruction (an acknowledged but relatively rare risk of rib fractures) and lung collapse were evident on the first occasion that Dr B examined Mr A. Both conditions take time to develop.

On balance, I consider Dr B's initial examination was adequate in the circumstances and consistent with Mr A's needs. Accordingly, Dr B did not breach Right 4(1) of the Code.

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Diagnosis of injuries
Mrs A is concerned that Dr B did not correctly diagnose Mr A's injuries from the fall (fractured ribs/collapsed lung/sub-acute bowel obstruction).

Dr B considers that he did diagnose and correctly treat Mr A's fractured ribs and appropriately referred Mr A to hospital when it was apparent that his clinical situation had changed.

Dr Searle advised me that Dr B's initial diagnosis was correct in that he considered concussion and diagnosed fractured ribs in his notes. Mr A's bowel and lung complications would have taken time to develop and were unlikely to be clinically evident at that time. Mr A's notes from the public hospital indicate a partial collapse and not a "burst lung".

It is difficult to say when the complications should have been diagnosed. My advisor commented that if Dr B had adopted a patient-centred method of assessment, he would have noted that Mr A's level of functionality was not improving. This should have triggered either an earlier admission to hospital or closer follow-up. Also, he considered Dr B failed to alter his treatment plan in response to Mr A's level of functionality.

In responding to my provisional opinion, Dr B advised me that he considered his approach to Mr A's condition to have been patient-centred and holistic. As the pain relief he had initially prescribed was not adequately managing Mr A's pain, Dr B prescribed stronger pain relief in the form of morphine. Dr B submitted new evidence (Mrs A's medication list) that his instructions in respect to Mr A's pain relief and bowel management were not adhered to.

Dr B is adamant that he expected an improvement in Mr A's symptoms within a 24-hour period and, had this not eventuated, Mrs A knew she could request a further visit. Dr B stated that he would not have hesitated to visit and revise his management plan.

I am persuaded by Dr B's response. I consider that he took reasonable steps to manage Mr A's pain. In particular, at Dr B's second home visit he prescribed Mr A morphine, which had in his experience satisfactorily resolved severe pain in other patients with similar conditions during a 24-hour period. Furthermore, Dr B responded to Mrs A's requests to visit her husband at home on three occasions. I have no doubt that Dr B would have attended earlier had he been aware that his treatment was not effective. However, Dr B was not to know that the morphine and Codalax he prescribed was not being administered as per his instructions. He cannot be criticised for the adequacy of this aspect of his management when his treatment plan was not being adhered to. In these circumstances, Dr B did not breach Right 4(4) of the Code.

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Other comment

Patient responsibility

My advisor was critical of aspects of Dr B's management of Mr A's pain and reduced function. However, my advisor made his comments unaware of the existence of the contemporaneous medication record made by Mrs A. As I have discussed above, this list shows that Mrs A did not adhere to Dr B's management plan. She did not administer her husband's morphine and Codalax as prescribed. It is not surprising, therefore, that Mr A's condition did not improve.

In these circumstances, when a general practitioner prescribes a course of treatment, I consider that patients and/or their caregivers have a responsibility to ensure medications are taken as prescribed. This did not occur in this case, and the question arises whether there may have been a different outcome for Mr A had he received morphine four-hourly and the Codalax for prevention of constipation.

Further actions

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

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