

**Death of 14-year-old boy one week after rugby injury
(01HDC11702, 17 May 2004)**

General practitioners ~ General practice registrar ~ Sports injury ~ Spinal injury ~ Standard of care ~ Rights 4(1), 4(4)

A 14-year-old boy sustained an injury, apparently to his shoulder, during rugby practice on a Thursday evening; the actual mechanism of the injury was unclear, although it may have occurred during contact with a goalpost or tackle bag. Initially the boy experienced little pain but on awakening the next morning could not move his arm. He was taken to a medical centre and examined by a general practice registrar, as the family's regular GP was not available. The registrar diagnosed a rotator cuff problem, prescribed pain relief and advised the boy to return if there was no improvement. The boy's pain increased over the next two days and, on Saturday evening, he returned to the accident and medical clinic and was examined by a GP. An X-ray of the shoulder was taken, which indicated a possible fracture of the neck of humerus. There is some dispute over exactly what treatment options were offered, in particular a referral to an orthopaedic specialist that night. The boy's shoulder was immobilised in a sling, and he was given pain relief and advised to see his regular GP for review in two days' time, when the radiologist's report would be available.

The boy's pain increased over the next two days, and he stayed at home. On Tuesday he was seen again at the accident and medical clinic by a second GP with experience in sports injuries. The GP reviewed the X-ray and radiologist's report, which stated: "no fractures or subluxations are detected". The GP felt that a fracture could still be present and arranged for an ultrasound scan of the shoulder that Thursday. However, overnight the boy's condition deteriorated and he returned to the clinic the following day. The same GP was at the clinic, but only to attend a meeting. However, he briefly reviewed the boy and arranged for an injection of morphine and Maxolon. At home later that afternoon the boy's breathing became shallow; he collapsed early on Thursday morning after complaining of a sore chest, and died a few hours later despite attempts to resuscitate him. A subsequent autopsy determined that the cause of death was respiratory failure secondary to bruising of the spinal cord in the neck and dislocation of neck vertebrae. A complaint was made that the doctors failed to appreciate the seriousness of the boy's medical condition, and to provide services of an appropriate standard.

It was held that there was no breach of the Code by the registrar or the first GP; assessment, diagnosis and follow-up actions were reasonable given the presenting symptoms, and the issue of whether an immediate orthopaedic referral was offered was of limited significance in assessing the GP's management.

With regard to the second GP, it was held that there was no breach at the first consultation on the Tuesday; the GP's physical examination indicated no reason to suspect a neck injury. His follow-up action of arranging an immediate ultrasound scan (with a possible follow-up X-ray), and enquiring about the need for further pain relief, was appropriate. At the second consultation, however, it was held that the GP breached Right 4(4) in that his services did not minimise potential harm to the boy: given the evidence of increasing pain and distress six days after the initial injury, the GP should have undertaken a further physical examination, rechecked the history, checked vital signs, and referred him for specialist orthopaedic assessment to investigate the possibility of a serious underlying problem. It was not sufficient simply

to prescribe morphine in the face of the boy's escalating pain. If the severity of the boy's pain was such that it necessitated the use of narcotic analgesia, it was essential to review the working diagnosis.

Even though technically the GP was not on duty, he was still obliged to provide appropriate care once he agreed to see the boy.