Public Hospital / Hospital and Health Services / Consultant Physician, Dr B / House Surgeon, Dr G

Opinion – Case 99HDC01780

Complaint

The Commissioner received a complaint from the complainant, Mr A, about services provided to the consumer, Ms H, by a public hospital operated by Hospital and Health Services, the consultant physician, Dr B, and the house surgeon, Dr G. The complaint is summarised as:

Hospital and Hospital and Health Services

- *On 10 June 1997 the consumer, Ms H, was referred to a hospital by the general practitioner, Dr C, with a two-day history of headache, fever, sore throat, vomiting, coughing up white frothy material, some neck stiffness, rapid heart rate and a burning chest front and back. Tenderness of the liver was noted, as well as a past medical history of a viral infection of the liver. The consumer, Ms H, was seen only by a trainee doctor and her liver symptoms were not investigated.*
- *The consumer, Ms H, was discharged without treatment for dehydration.*

The consultant physician, Dr B, and the house surgeon, Dr G

- *On 10 June 1997 the consumer, Ms H, was not admitted to hospital when she presented with a two-day history of fever, sweats, vomiting, and inability to keep fluids down. Ms H's chest x-ray findings were not normal, and blood tests showed a low sodium level and a raised AST level, and the referring general practitioner had noted an enlarged liver.*

Public Hospital / Hospital and Health Services / Consultant Physician, Dr B / House Surgeon, Dr G

Opinion – Case 99HDC01780, continued

Investigation Process

The complaint was received by the Commissioner on 8 February 1999 and an investigation was commenced on 24 August 1999. Information concerning the consumer, Ms H, was obtained from:

The complainant, Mr A
The consultant physician, Dr B
Hospital and Health Services
The general practitioner, Dr C
The general practitioner, Dr D
The public hospital's Clinical Director, Dr E
The Area Manager of the public hospital, Ms F

No information was obtained from the house surgeon, Dr G, who failed to respond to any requests to participate in the investigation process.

Ms H's medical records were obtained from Hospital and Health Services and her general practitioner.

Advice was obtained from an independent general physician.

Information Gathered During Investigation

Ms H, aged 31, became unwell on Sunday 8 June 1997. She was seen by her general practitioner, Dr C, on 10 June 1997. Dr C wrote a referral for Ms H to be seen at a hospital Emergency Department on 10 June for an assessment. The referral note stated:

> "*CLINICAL PROBLEMS*
> *Fever 2/7, headache, burning chest front and back, sore throat. Vomiting and coughing white frothy material. Neck aching. Rigors.*
> *ON EXAMINATION*
> *Temperature 38.4, pulse 128/minute, shivering. Some limitation of forward flexion of neck by pain at the back of it. Kernig's OK – some pain at the back of right knee. Lungs, spleen, lymph nodes, normal. Liver 10cm to percussion, tender. I could not feel edge. Telangiectasia anterior neck and upper chest.*

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Public Hospital / Hospital and Health Services / Consultant Physician, Dr B / House Surgeon, Dr G

Opinion – Case 99HDC01780, continued

Information Gathered During Investigation *continued*

PAST HISTORY
Several operations for endometriosis. Puerperal depression. I have previously heard a soft mid systolic murmur aortic area but could not hear it today (fast rate). Was in hospital [overseas] *for a week for a viral infection of liver.*
CURRENT THERAPY
Only paracetamol.
TESTS/INVESTIGATIONS
Recent chest x-ray at [a hospital].
Lab report attached (copy)."

Ms H was seen at the hospital by two doctors, the house surgeon, Dr G, and the consultant physician, Dr B. Dr G examined Ms H and recorded her history in the clinical records, noting that she had "*vomited several times,* [was] *dry retching,* [had not] *eaten for the past 2 days,* [but was] *able to keep water down*". Dr G's findings were consistent with those of the general practitioner, Dr C, and she also noted a blood pressure of 99/60.

The complainant, Mr A, disagrees that Ms H was able to keep water down. Dr C's records for Ms H, dated 10 June 1997, state that she was "*vomiting frothy white material*".

The consultant physician, Dr B, then examined Ms H and noted in the clinical records her headache, neck stiffness, sweating and shakes. The examination found Ms H's chest, heart and abdomen, including her liver, to be normal. Dr B ordered a blood test, chest x-ray, and electrocardiogram, or ECG (a graphic tracing of the electrical current produced by the contraction of the heart muscle). Hospital and Health Services was unable to find any record of an ECG trace. The blood results (reported 10 June 1997) showed an elevated AST (liver function test) level of 88u/L (normal 5–35) and low sodium levels of 130mmol/L (normal 138–145). Dr B stated that these blood results were "*within the realms of what might be expected in a viral infection such as flu*".

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Public Hospital / Hospital and Health Services / Consultant Physician, Dr B / House Surgeon, Dr G

Opinion – Case 99HDC01780, continued

Information Gathered During Investigation *continued*

The x-ray taken on 10 June was reported on 13 June and showed that Ms H's heart was not enlarged and her lungs were clear, but noted some asymmetry in the chest contours. Dr B advised me that the "*chest x-ray showed subtle and questionable changes which in fact did not fit with the ultimate diagnosis of viral myocarditis. … The heart shadow was of normal size*."

Dr B diagnosed a viral illness, and did not admit Ms H to the hospital. He advised me that he was "*not sure that it was possible even with hindsight to predict …*" that Ms H would go on to develop viral myocarditis (viral inflammation of heart muscle).

Neither Ms H's blood test results nor her discharge summary was forwarded to her general practitioner after she was assessed at the Emergency Department. There is no copy of a discharge form or any notification to the general practitioner in the records held by Hospital and Health Services.

Ms H's general practitioner's partner, Dr D, saw her at home the following day, 11 June. Dr D recorded in his notes that she had severe pain in the right neck, in addition to vomiting and fever. Her pulse was not elevated, and her blood pressure was 90/60. Ms H was unable to keep down her tablets because of vomiting, so Dr D gave her an anti-emetic injection (Stemetil) and recommended fluids.

Dr D saw Ms H again the following morning, 12 June, and she had had very little sleep. Dr D prescribed diazepam (a muscle relaxant) to assist Ms H to rest, treated her neck pain with acupuncture, and requested that the general practitioner Dr C review her later that day. The general practitioners' Medical Centre was not informed of Ms H's blood results from the hospital, so this was not a factor in Dr D's diagnosis and treatment.

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Public Hospital / Hospital and Health Services / Consultant Physician, Dr B / House Surgeon, Dr G

Opinion – Case 99HDC01780, continued

Information Gathered During Investigation *continued*

Dr C saw Ms H at home on the evening of 12 June. He noted that Ms H was afebrile (did not have a raised temperature) and no longer tachycardic (her heartbeat was no longer excessively rapid). Her primary problems were drowsiness and being unsteady on her feet. No preliminary discharge summary had been received (or arrived subsequently) from the hospital, nor any laboratory results. Dr C recommended that Ms H cease taking the diazepam.

In a letter to the complainant, Mr A, dated 18 November 1998, Dr C stated:

> "*… I had been given no information from the hospital. They usually give a preliminary discharge summary outlining their findings. In this case they had not nor did it arrive subsequently.*"

The following morning (13 June) Dr C confirmed with the chemist that the correct dose of diazepam had been dispensed to Ms H. Later in the morning, Mr A telephoned Dr C requesting that he visit Ms H at home urgently. Dr C phoned and obtained by fax the laboratory results from the blood tests taken (and reported) at the hospital Emergency Department on 10 June.

In his letter to Mr A, Dr C continued:

> "*… I rang the* [hospital] *Laboratory to see if any laboratory tests had been done. I was astonished to find that she had been sent home with a low serum sodium. I immediately arranged readmission.*"

In Ms H's clinical records dated 13 June at 10.15am Dr C wrote:

> "*… Note low sodium and raised AST on 10.6.97.*"

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Public Hospital / Hospital and Health Services / Consultant Physician, Dr B / House Surgeon, Dr G

Opinion – Case 99HDC01780, continued

Information Gathered During Investigation *continued*

Dr C attended Ms H at home, immediately called an ambulance, and referred her to the Emergency Department at the hospital with a written referral. The referral contained the following information:

> *"CLINICAL PROBLEMS*
> *Referred to you 10.6.97. I note you found a low serum sodium and raised SAST. I am surprised at the former as she had not vomited all that amount. ?adrenal insufficiency. Since then has not been particularly febrile. c/o sore head. Now unsteady on feet and confused. Note history puerperal depression. T? HR 108/m BP 85/? Restless. No meningism. Heart and lungs NAD* [no abnormality detected]. *Complains unable to breathe.*
>
> *CURRENT THERAPY*
> *Had a total of 6mg diazepam yesterday. Seemed to react excessively to them (I have checked accuracy of dispensing).*
> *Paracetamol 1G prn qqh*
> *?Microval. Had stopped them but were out."*

The hospital decided that due to her condition Ms H should be transferred by ambulance to another hospital. Ms H died of viral myocarditis at the second hospital on 14 June 1997.

Information was requested from the first hospital relating to its policies for informing general practitioners of relevant test results and the outcome of examinations taking place at the hospital.

The area manager for the hospital, Ms F, advised me that "[the] *hospital does not have a protocol/policy for* [notifying referring General Practitioners of details of assessments/discharge policies]".

Ms F and the Clinical Director, Dr E, advised me of common practice in the Emergency Department, both in 1997 and today.

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Public Hospital / Hospital and Health Services / Consultant Physician, Dr B / House Surgeon, Dr G

Opinion – Case 99HDC01780, continued

Information Gathered During Investigation *continued*

Generally a form is completed in triplicate for every person who presents to the Emergency Department (whether or not the person is admitted to hospital). This form is a basic casualty form and is referred to by hospital staff as an NCR ("no carbon required"). It is this form that is usually sent to the patient's general practitioner. Ms F advised that one copy of the form is kept for the Emergency Department, one copy is given to the patient, and the other is sent to the GP. If the patient lives out of the area, and the hospital does not have a postal address for the GP, the patient is advised to take a copy of the NCR to his or her doctor. Patients may also elect to do this in the first instance.

Dr E advised that the NCR form includes a section where the Emergency Department doctor's examination notes are recorded. Where it is obvious that a patient will be admitted to hospital, regular clinical notes may be used instead.

Conflicting advice was received in relation to notification of general practitioners of their patient's test results. Dr E commented that there was a weakness in the NCR form. Where laboratory results come back before the consumer is discharged, they are included on the NCR form. Where results come back after the consumer is discharged, "*a fault with the NCR form is that … there is no automatic mechanism to ensure the results are conveyed to the GP*".

Ms F stated:

> "*All test results actioned through the Emergency Department are returned to the department. These are placed in the hospital doctor's folder and they are required to sign off laboratory results and notify the general practitioners/patients if required. Please note, all results are usually known prior to discharge from the Emergency Department and documented on the Emergency Department triplicate sheet.*"

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Public Hospital / Hospital and Health Services / Consultant Physician, Dr B / House Surgeon, Dr G

Opinion – Case 99HDC01780, continued

Information Gathered During Investigation *continued*

It is not clear who has responsibility for notifying a patient's general practitioner of Emergency Department assessment and test results. Dr E advised me that where there is a written referral and both a house surgeon and a consultant physician see a patient, he could not tell whose specific responsibility it would be. Ms F stated:

> "*This can be a shared responsibility between the patient and the Emergency Department doctor depending on the situation – i.e. if there are any concerns about future care, the Emergency Department doctor will notify the general practitioner which is done by mailing a copy of the Emergency Department sheet to the general practitioner or the patient may take a copy to their general practitioner. If concerns are raised by the laboratory results, the MOSS* [Medical Officer Special Scale] *will contact the general practitioner.*"

It appears, therefore, that test results, and indeed Emergency Department assessments, are not automatically forwarded to general practitioners (referring or otherwise). It is not clear from the existing "usual practice" whether responsibility for ensuring the notification of test results or emergency assessments rests with junior Emergency Department doctors or consultant physicians. Nor is it clear who determines the circumstances in which notification should occur.

Dr E further advised me that the hospital Emergency Department is staffed adequately to meet the demands of an average day, but that when things become especially busy procedures may be overlooked. The summer months are particularly busy, with large numbers of holidaymakers in the area. However, where a general practitioner has made a written referral to the Emergency Department, Dr E would expect a written response to be sent answering the general practitioner's questions.

Public Hospital / Hospital and Health Services / Consultant Physician, Dr B / House Surgeon, Dr G

Opinion – Case 99HDC01780, continued

Independent Advice to Commissioner

The following advice was obtained from an independent general physician:

"*The circumstances surrounding this case are outlined and can be summarised as follows.* [Ms H] *became unwell on Sunday, 8th June 1997, with an illness characterised by fever, vomiting, headache, a burning sensation in her chest and back pain.*

She first attended her general practitioner on 9th June 1997 where she complained of being feverish and a feeling that her chest felt tight and that she had some stabbing pains in the left lower back. Her general practitioner was unable to find any abnormal physical signs and made a diagnosis of viral illness. He prescribed paracetamol for her.

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Public Hospital / Hospital and Health Services / Consultant Physician, Dr B / House Surgeon, Dr G

Opinion – Case 99HDC01780, continued

Independent Advice to Commissioner *continued*

She was seen again the following day (10th June 1997) when he noted that she still had a burning sensation in the front and back of her chest, sore head, and had vomited some frothy white material. She had also coughed up some sputum but the nature is not described. She also complained of a sore throat and her neck ached. On examination he noted that she was feverish with a temperature of 38.4, pulse was 128 beats/min, her throat was normal and a chest examination was also normal. He noted some telangi-ectasia on the front of the neck and upper chest. The liver size was normal (being 10cm). He referred her to a hospital where she was seen by [the house surgeon, Dr G] *who elicited a very similar history to that that the general practitioner had noted.* [Dr G] *also noted that the temperature was elevated at 39°, her pulse was 120 beats/minute and blood pressure was 99/60. According to the history the patient had vomited several times with some dry retching. However, it is noted that she had been taking regular paracetamol. Her chest examination was clear and the impression was that she had a viral illness. She was seen by* [the consultant physician, Dr B], *who noted that she had a headache with some mild neck stiffness and some sweats and shakes. Her chest was clear, her heart was normal to auscultation and her abdomen was normal. He believed that she had a flu-like illness and that there was no reason to admit her. A full blood count taken on that day showed haemoglobin of 134, platelet count of 172 and a white cell count of 9.1. These are all within normal limits. Liver function tests showed an elevated AST of 88 (upper limit being 35). Her serum sodium was low at 130mmol/L, the normal lower limit being 138. There were no other abnormal blood tests at that time. According to* [Dr B] *an ECG was performed but this is not noted in the notes, nor is there a record provided for review. A chest x-ray was performed which was reported on 13th June. This notes that 'there is a soft tissue opacity projected in the subcarinal region of the mediastinum. This is shown displacing the azygo-oesophageal line to the right. There does not appear to be any significant enlargement of the left atrium to explain this and therefore there is a possibility of lymphadenopathy. There is asymmetry in the chest contours and hypolucency of the right chest with asymmetrical soft tissue contours in this region, which appear reduced on the left compared to the right. The lungs themselves appear clear. Is there any asymmetry in the chest wall clinically?' Thus there was no sign of cardiac abnormality, nor any sign on the chest x-ray of pneumonia. The patient was discharged home with a diagnosis of viral influenza.*

Public Hospital / Hospital and Health Services / Consultant Physician, Dr B / House Surgeon, Dr G

Opinion – Case 99HDC01780, continued

Independent Advice to Commissioner *continued*

She was next seen by her general practitioner on 11th June 1997 at 7 o'clock because of severe pain, vomiting and fever. She was unable to keep her Panadeine down. On examination she was noted to be distressed but apyrexial at this time. A pulse of 80 per minute and blood pressure of 90/60. There was no sign of meningitis and [Dr D] *(who was the general practitioner reviewing her) apparently gave her an intramuscular injection of prochlorperazine and suggested that she use a wheat germ bag for her sore neck. On the following day she was reviewed again by* [Dr D], *who noted she still had a very sore neck. She was apyrexial and still having trouble sleeping. He prescribed diazepam. She was reviewed once again on 12th June 1997 when she had already taken 6mg of diazepam. She had become confused, drowsy and unsteady on her feet. At this time she was reviewed by her usual GP,* [Dr C]. *He reviewed her again on the following day, when he noted that she was dry retching and complained of a sore head and had become almost uncommunicative. He noted the abnormal biochemical findings from* [the hospital].

She was re-referred to [the hospital] *on 13th June as her condition had deteriorated markedly. She still complained of a sore head and it was noted that she had a tachycardia of 108 beats per minute, blood pressure taken by the GP was 85/?. He noted that she also complained that she had difficulty breathing. There is a note from the ambulance officers noting low oxygen saturation of 79%, a pulse of 114 and blood pressure of 90/50. She was taken to* [the hospital] *and it was felt that she required to be treated in Intensive Care and was therefore transferred to* [another hospital] *but her condition deteriorated further. Blood tests done on 13th June showed that her serum sodium had fallen markedly to 119mmol/L and her liver function tests were grossly abnormal involving the ALT and AST, and she also had low plasma albumin and low total protein. Despite intensive care this patient did not recover and died on 14th June. The cause of death was recorded as left ventricular failure due to acute myocarditis.*

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Public Hospital / Hospital and Health Services / Consultant Physician, Dr B / House Surgeon, Dr G

Opinion – Case 99HDC01780, continued

Independent Advice to Commissioner ***continued***

Question 1:

Was the assessment performed by **[the consultant physician, Dr B]** ***and*** **[the house surgeon, Dr G]** ***on 10th June 1997 appropriate and complete?***

Answer:

[Ms H] *had a full history and examination performed on her attendance at* [the hospital]. *In addition blood tests and a chest x-ray were performed. According to* [Dr B], *an ECG was also performed. In my opinion the assessment performed was appropriate and complete.*

Question 2:

Did **[Dr B, Dr G, or Hospital and Health Services]** ***have a responsibility to notify*** **[Ms H's]** ***general practitioner of the laboratory results and provide a preliminary discharge summary?***

Answer:

I presume [the hospital] *has a protocol for dealing with patients who are discharged from the Accident and Emergency Service following a referral from a general practitioner. This may take the form of a telephone call or a letter, either way it is important for the general practitioner to be informed of the conclusions that the referring team has come to. In regard to the laboratory results, these particular results were only slightly abnormal and certainly in keeping with a viral infection. I would have expected them to be included in a short letter or have been mentioned if the doctor responsible had phoned the general practitioner.*

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Public Hospital / Hospital and Health Services / Consultant Physician, Dr B / House Surgeon, Dr G

Opinion – Case 99HDC01780, continued

Independent Advice to Commissioner ***continued***

Question 3:

Did* [Dr B and Dr G's] *documentation meet professional standards?* [Dr B] *did not appear to have commented on the chest x-ray or low sodium.

Answer:

I believe that [Dr B and Dr G's] *documentation does meet professional standards. The abnormality on the chest x-ray was minor and may have been accepted as within normal limits. I note that this report would have been forwarded to* [the general practitioner, Dr C] *but he would not have received it before 13th June as that is when the x-ray was reported. In relation to the low sodium, a level of 130mmol/L is unlikely to cause alarm in a patient with a viral infection so it does not surprise me that* [Dr B] *has not mentioned it on the clerking sheet.*

Question 4:

Was it an acceptable decision that* [Dr B and Dr G] *did not admit* [Ms H] *or treat her for dehydration?

Answer:

There is no evidence either from the general practitioner's referral or from the hospital notes that [Ms H] *was severely dehydrated. Her symptoms and signs are those that would be expected with a viral infection. It is unusual to admit patients of this age who are healthy and who present with a viral infection. Thus, from the findings presented I would think that most physicians would have discharged this patient from an Accident and Emergency Department.*

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Public Hospital / Hospital and Health Services / Consultant Physician, Dr B / House Surgeon, Dr G

Opinion – Case 99HDC01780, continued

Independent Advice to Commissioner *continued*

Question 5:

Was the diagnosis and treatment made by* [Dr B] *appropriate?

Answer:

Yes, this patient obviously had a flu-like illness and indeed, although she developed complications from this and died from probable overwhelming viral illness, the diagnosis of a viral illness was compatible with her clinical picture. The usual treatment for viral infections are simple analgesics, such as paracetamol or aspirin, together with fluids and in the event of high temperatures a fan. It is very unusual to provide antiviral therapy for an individual with a normal immune system unless they have encephalitis and that was not part of the differential diagnosis here.

Question 6:

Are there any other matters relating to professional or ethical standards which you believe are relevant to this complaint?

Answer:

In regard to [Dr B and Dr G], *I believe that they behaved in a professional and ethical manner. Although I do not believe that earlier referral would have made any difference to the outcome for this unfortunate patient, one may question why she remained at home for a further three days before being returned to the hospital when her condition was deteriorating.*"

In response to a later question about the advice provided in response to question one, the independent general physician informed me that even if it was accepted that an ECG was not performed on 10 June 1997, in his opinion the assessment performed by Dr B and Dr G on this date was still appropriate and complete.

Public Hospital / Hospital and Health Services / Consultant Physician, Dr B / House Surgeon, Dr G

Opinion – Case 99HDC01780, continued

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.

…

5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

Opinion: No Breach

House surgeon, Dr G

Right 4(1)

In my opinion Dr G did not breach Right 4(1) of the Code.

On 10 June 1997 Dr G undertook an examination of Ms H which included the history of her illness, the presenting symptoms, her past medical history, current medications, allergies, social history, and a full physical examination. The physical examination assessed Ms H's cardiovascular system, respiratory system, central nervous system, neck region, and abdomen.

My expert advisor stated that Dr G's examination of Ms H on 10 June 1997 was "*appropriate and complete*". I accept that in the circumstances Dr G did not breach Right 4(1) of the Code.

Public Hospital / Hospital and Health Services / Consultant Physician, Dr B / House Surgeon, Dr G

Opinion – Case 99HDC01780, continued

Opinion: Breach

In my opinion Dr G breached Right 4(5) of the Code.

House surgeon, Dr G

Right 4(5)

Ms H was entitled to expect co-operation between the providers involved in her care necessary to ensure she received quality and continuity of care.

My advisor expected that the hospital would have a protocol for follow-up when a patient presents with a written referral from a GP. My advisor suggested that contact by either a telephone call or letter may be appropriate, but "*either way it is important for the general practitioner to be informed of the conclusions that the referring team has come to*". Laboratory results should be conveyed in a telephone call or short letter. However, neither the conclusions of the examination, nor the test results were conveyed by Dr G to either of the general practitioners involved in Ms H's care.

Hospital and Health Services informed me that it was usual practice for the NCR form, which is in triplicate, to be completed and forwarded to the general practitioner. Dr G saw Ms H first, and therefore would have selected and commenced the paperwork she considered appropriate. Dr G has not supplied any evidence to me that she completed an NCR form in relation to Ms H on 10 June 1997, or that she notified the referring general practitioner of the findings from the examination. There is no copy of an NCR form or any notification to the general practitioner in the records held by Hospital and Health Services.

Although Dr G did not have the ultimate responsibility for Ms H's overall care, in my opinion she had a shared responsibility to ensure that necessary information was conveyed to Ms H's GP.

I accept my advisor's comment that an earlier re-referral of Ms H to hospital probably would not have affected the outcome for her. However, Ms H still had the right to co-operation between her treatment providers to ensure she received quality and continuity of care.

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Public Hospital / Hospital and Health Services / Consultant Physician, Dr B / House Surgeon, Dr G

Opinion – Case 99HDC01780, continued

Opinion: Breach House surgeon, Dr G *continued*

Dr G has not provided any information regarding the usual practices within the Emergency Department at the hospital, or what happened in Ms H's case in particular. My conclusions therefore have been made without the benefit of hearing from Dr G, as she has failed to respond to any requests to participate in the investigation process.

In my opinion, Dr G did not co-operate with Ms H's general practitioners when she failed to inform either Dr C or Dr D of the conclusions of Ms H's attendance and examination at the Emergency Department on 10 June 1997, and therefore breached Right 4(5) of the Code.

Public Hospital / Hospital and Health Services / Consultant Physician, Dr B / House Surgeon, Dr G

Opinion – Case 99HDC01780, continued

Opinion: No Breach Consultant physician, Dr B

Right 4(1)

In my opinion Dr B did not breach Right 4(1) of the Code.

Dr B assessed Ms H after Dr G's examination. He performed a further examination and ordered blood tests and an x-ray. Dr B also believes an ECG was performed, although no documentation of this exists. My advisor stated that even if the ECG was not performed on 10 June 1997, the assessment performed was still appropriate and complete.

My advisor also stated that the decision not to admit Ms H for dehydration was an acceptable one:

> "*There is no evidence either from the General Practitioner's referral or from the hospital notes that* [Ms H] *was severely dehydrated. Her symptoms and signs are those that would be expected with a viral infection. It is unusual to admit patients of this age who are healthy and who present with a viral infection.*"

My advisor confirmed Dr B's comments that the blood results were "*within the realms of what might be expected in a viral infection such as flu*". In the opinion of my advisor, "*from the findings presented I would think that most physicians would have discharged this patient from an Accident and Emergency Department*".

I accept the opinion of my advisor that Dr B's assessment of Ms H on 10 June 1997 and his decision to discharge was both "*appropriate and complete*". For these reasons, in my opinion, Dr B did not breach Right 4(1) of the Code.

Public Hospital / Hospital and Health Services / Consultant Physician, Dr B / House Surgeon, Dr G

Opinion – Case 99HDC01780, continued

Opinion: Breach

In my opinion Dr B breached Right 4(5) of the Code.

Consultant physician, Dr B

Ms H was sent to the hospital for assessment by her general practitioner, who provided a written referral.

My advisor informed me that it was important for Ms H's general practitioners to be informed of the conclusions the hospital had come to, whether this occurred by a telephone call or letter. My advisor would also expect the laboratory test results to be conveyed to the GP. Dr B did not convey this information to either of the GPs involved in Ms H's care.

The hospital did not have clear guidelines in place to indicate who had the ultimate responsibility to notify Ms H's general practitioners of her examination findings or blood test results. The Clinical Director of the hospital, Dr E, advised that he could not tell whose specific responsibility this would be. However, Dr E indicated that where a general practitioner makes a written referral, as happened in Ms H's case, he would expect a written response answering the general practitioner's questions to be sent.

As the consultant physician who saw Ms H on 10 June 1997, Dr B had the ultimate responsibility for Ms H's care. In my view, this included a shared responsibility to convey to her GP any information relevant to her ongoing treatment. There is nothing in the hospital's medical records to indicate that the appropriate information was conveyed.

In my opinion, Dr B did not co-operate with Ms H's general practitioners when he failed to inform either Dr C or Dr D of the conclusions of Ms H's attendance and examination at the Emergency Department on 10 June 1997. Although I do not believe that this lack of co-operation had any effect on the ultimate outcome, in my opinion Dr B was nevertheless in breach of Right 4(5) of the Code.

Public Hospital / Hospital and Health Services / Consultant Physician, Dr B / House Surgeon, Dr G

Opinion – Case 99HDC01780, continued

Opinion: No Breach Hospital and Hospital and Health Services

Right 4(1)

In my opinion the public hospital and Hospital and Health Services under which it operates did not breach Right 4(1) of the Code.

On 10 June 1997 Ms H was assessed in light of her presenting symptoms. Her liver function was investigated with blood tests and the results were consistent with the viral infection that was diagnosed. Ms H was not exhibiting signs of dehydration at that stage, and it was therefore appropriate that she was not treated for this.

Ms H was seen and assessed by two doctors, a house surgeon and a consultant physician, who appropriately investigated her presenting symptoms.

For these reasons, in my opinion, the public hospital and Hospital and Health Services did not breach Right 4(1) of the Code.

Public Hospital / Hospital and Health Services / Consultant Physician, Dr B / House Surgeon, Dr G

Opinion – Case 99HDC01780, continued

Opinion: Breach Hospital and Hospital and Health Services

Right 4(5)

In my opinion the public hospital and Hospital and Health Services breached Right 4(5) of the Code.

Laboratory results

An unclear and unreliable "usual practice" has been, and continues to be used at the hospital as to when and how test results are notified to general practitioners.

The Clinical Director, Dr E, advised me there is a weakness in the frequently used NCR form. Where laboratory results come back before the consumer is discharged, they are included on the NCR form. Where results come back after the consumer is discharged, "*there is no automatic mechanism to ensure the results are conveyed to the GP*". Where a house surgeon and consultant physician were both involved in a patient's care, Dr E could not tell who would have specific responsibility to convey test results to the GP.

The Area Manager of the hospital, Ms F, stated that:

> "*All test results actioned through the Emergency department are returned to the department. These are placed in the Hospital doctor's folder and they are required to sign off laboratory results and notify the general practitioners/patients if required. Please note, all results are usually known prior to discharge from the Emergency Department and documented on the Emergency Department triplicate sheet*."

Ms F advised that the Emergency Department doctor will notify the GP "*if there are any concerns about future care*" and that the doctor shares this responsibility with the consumer. Ms F advised that if concerns are raised by the laboratory results the Medical Officer Special Scale (senior doctor) will contact the GP. I accept my advisor's opinion that in Ms H's case, the results of the blood tests alone would not have caused undue alarm.

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Public Hospital / Hospital and Health Services / Consultant Physician, Dr B / House Surgeon, Dr G

Opinion – Case 99HDC01780, continued

Opinion: Breach Hospital and Hospital and Health Services *continued*

The information provided by the hospital does not specify in which situations there is a specific requirement to notify the GP of results, or how the results should be conveyed. It is also unclear who has the ultimate responsibility to ensure this occurs.

Discharge notification

The Area Manager, Ms F, advised that while the hospital does not have a protocol/policy for discharge notification, the common practice is to post a copy of the NCR form to the patient's general practitioner.

According to the Clinical Director, Dr E, an NCR form is not completed in every case, and sometimes the clinical notes may be written on instead. It is unclear how discharge notification occurs in this scenario.

It is also unclear who has ultimate responsibility for completing the NCR form and sending it to the notifying general practitioner. Dr E advised me that where there was a written referral and both a house surgeon and a consultant physician saw the patient, he could not tell whose specific responsibility this would be. Ms F stated that "*this can be a shared responsibility between the patient and the Emergency Department doctor depending on the situation*".

The hospital's "usual practice" is unreliable and unlikely to prevent any omission to notify general practitioners of necessary information, such as happened in this case. It is not clear who has responsibility, and in what circumstances. In my opinion, Hospital and Health Services and the public hospital did not have adequate policies in place to facilitate co-operation between the providers involved in Ms H's care. As a result, Ms H did not receive quality or continuity of care. The public hospital and Hospital and Health Services breached Right 4(5) of the Code.

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Public Hospital / Hospital and Health Services / Consultant Physician, Dr B / House Surgeon, Dr G

Opinion – Case 99HDC01780, continued

Opinion: Breach Hospital and Hospital and Health Services *continued*

Vicarious Liability

Employers are vicariously liable under section 72(2) of the Health and Disability Commissioner Act 1994 for ensuring that employees comply with the Code of Health and Disability Consumers' Rights. Under section 72(5) it is a defence for an employing authority to prove it took such steps as were reasonably practicable to prevent the employee from taking, or omitting to take, the action that breached the Code.

In my opinion, Hospital and Health Services has not shown that it took reasonably practicable steps to prevent the omission that occurred at the hospital. The Area Manager of the hospital, Ms F, advised me that the hospital "*does not have a protocol/policy*" for notifying general practitioners of details of assessments undertaken or discharge summaries. Furthermore, no mechanism has or does exist to ensure the patient's GP is notified of laboratory tests that were ordered by the Emergency Department where the patient is discharged before results are available.

In my opinion, Hospital and Health Services did not take reasonably practicable steps to prevent the house surgeon, Dr G, or the consultant physician, Dr B's, breach of Right 4(5) of the Code. The hospital's Emergency Department in 1997 and today still relies on a "usual practice" which lacks clarity and certainty.

Public Hospital / Hospital and Health Services / Consultant Physician, Dr B / House Surgeon, Dr G

Opinion – Case 99HDC01780, continued

Other Comments

I note that over the summer months the potential for omission and error at the hospital is magnified. The Emergency Department becomes particularly busy owing to the increase in visitors to the area. It is particularly important that at such times the hospital does not continue to rely on these faulty and confusing "usual practices".

I also note the comment made by my advisor that "*one may question why* [Ms H] *remained at home for a further three days before being returned to the hospital when her condition was deteriorating*". This issue has been addressed in a separate aspect of my investigation. Advice was obtained from an independent expert advisor with experience in non hospital-based general practice. I formed the opinion that the actions of the providers concerned were reasonable in the circumstances, and did not breach the Code.

Public Hospital / Hospital and Health Services / Consultant Physician, Dr B / House Surgeon, Dr G

Opinion – Case 99HDC01780, continued

Actions

House surgeon, Dr G
I recommend that Dr G take the following action:

- Apologises in writing to the complainant, Mr A, for the breach of the Code in relation to the lack of co-ordination of services for the consumer, Ms H. This apology is to be sent to the Commissioner and will be forwarded to Mr A.

Consultant physician, Dr B
I recommend that Dr B take the following action:

- Apologises in writing to the complainant, Mr A, for the breach of the Code in relation to the lack of co-ordination of services for the consumer, Ms H. This apology is to be sent to the Commissioner and will be forwarded to Mr A.

Hospital and District Health Board
I recommend that the hospital and the District Health Board (the legal successor to Hospital and Health Services) take the following actions:

- Apologises in writing to the complainant, Mr A, for the breach of the Code in relation to the lack of co-ordination of services for the consumer, Ms H. This apology is to be sent to the Commissioner and will be forwarded to Mr A.

- Produces written protocols and policy guidelines regarding the processing of consumers in the Emergency Department. This information should include the procedures to be followed to ensure that general practitioners are informed of test results, clinical assessments and discharge information. The protocol should also clarify who has the ultimate responsibility to ensure this information is properly conveyed to the appropriate party(ies). A copy of these protocols and guidelines should be supplied to the Commissioner.

- Provides in-service training for all the hospital Emergency Department Clinicians to ensure they are fully informed of new protocols and guidelines.

Public Hospital / Hospital and Health Services / Consultant Physician, Dr B / House Surgeon, Dr G

Opinion – Case 99HDC01780, continued

Other Actions

- An anonymised copy of this opinion is to be sent to the New Zealand Faculty of the Australasian College for Emergency Medicine, the Royal New Zealand College of General Practitioners, the Chief Executive Officers of all District Health Boards in New Zealand, and to the Director-General of Health.

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