General Practitioner, Dr C

A Report by the

Health and Disability Commissioner

(Case 02/07221)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Ms A	Complainant/Sister of Ms B
Ms B	Consumer
Dr C	General Practitioner/Provider
General Practice	General Practice/Provider
Mr D	Brother of Ms B
Mr E	Acquaintance of Ms B
Mr F	De facto partner of Ms B
Ms G	Niece of Ms B

Independent expert advice was obtained from Dr Chris Wright, general practitioner.

Complaint

On 11 March 2002 the Commissioner received a complaint from Ms A about the services provided by Dr C. The complaint is that:

Dr C, general practitioner, did not provide Ms B with services of an appropriate standard in August 2001. In particular:

- *On 8 August 2001, Dr C did not take adequate steps to diagnose the cause of Ms B's chest pain, breathlessness and vomiting.*
- *On 8 August 2001, Dr C did not provide adequate treatment for Ms B's chest pain, breathlessness and vomiting.*
- *On 9 August 2001, following a phone call from Ms B to say that her condition was deteriorating, Dr C did not advise Ms B to return to the surgery for a clinical assessment.*
- *On 9 August 2001, following a phone call from Ms B to say that her condition was deteriorating, Dr C inappropriately changed Ms B's medication without carrying out a clinical assessment.*

A general practitioner did not provide Ms B with services of an appropriate standard. In particular:

- *A general practitioner inappropriately prescribed Celebrex (celecoxib) for Ms B who had a history of asthma.*

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

Information reviewed

- Letter of complaint from Ms A, received 11 March 2002
- Post mortem findings, dated 13 August 2001
- Senior Constable's deposition, dated 22 April 2002
- Coroner's initial report, dated 22 April 2002
- Response from the General Practice, dated 12 June 2002
- Responses from Dr C, dated 4 July 2002 and 9 October 2002
- Notes from interview with Ms A, dated 17 July 2002
- Notes from interview with Mr E, dated 18 July 2002
- Notes from interview with Mr D, dated 23 July 2002
- Notes from interview with Mr F, dated 23 July 2002
- Notes from interview with Ms G, dated 23 July 2002
- Ms B's medical records, received from the General Practice
- Notes recording Mr D's response to provisional summary of information gathered, dated 21 November 2002
- Ms A and Ms G's response to provisional summary of information gathered, received 28 November 2002
- Dr C's response to provisional opinion, dated 15 November 2002

Information gathered during investigation

Introductory comment
Ms B was a woman in her fifties who lived with her de facto partner, Mr F. Ms B had a close and supportive family, including her sister Ms A, her brother Mr D, and her niece Ms G.

Tuesday 7 August 2001
On Tuesday, 7 August 2001, Ms B felt well and attended her usual indoor bowls game with her brother, Mr D. After the game, she decided not to have a beer with the other players and returned home. Mr D stated that at this time Ms B was "as good as gold". Mr F stated that Ms B was "alright on the Tuesday", although he was working and didn't usually see much of her during the day.

Wednesday 8 August 2001
Mr D stated that on Wednesday 8 August 2001, Ms B rang him at about 9.30am and said "[Mr D] I'm absolutely knackered, my shoulders are sore, I'm having difficulty breathing". Mr D advised that Ms B sounded as though she was in a lot of pain and he advised her to see the doctor straight away.

Ms B went to see her usual general practitioner, Dr C at the General Practice. Dr C had worked as a general practitioner since 1995, and had been employed at the General Practice for around 8 months. As an overseas-qualified doctor Dr C had temporary registration, and was working under the supervision of another doctor.

In her response of 4 July 2002, Dr C advised:

> "[Ms B] had come in to see me for pain in her right lower chest when she took in a deep breath. I had asked her if she had had a recent cold and she said yes. On physical exam she was alert, active and in no acute distress. Her pulse oximetry was 98%. Chest examination revealed tenderness to palpation in the right lower quadrant. Lung exam was clear to auscultation, no rales, ronchi or wheezing. She had partial chest expansion due to her splinting on the right side.
>
> My assessment was that either she had pleuritic type chest pain from her recent cold and when she took in deep breaths she was experiencing the velcro effect one experiences (after a viral infection) when the outer layer of the lung wall rubs up against the inner chest wall layer and thus the pain with deep inspiration; or alternatively she was having muscular chest wall pain (this I inferred from when she was tender when I palpated the right lower chest wall).
>
> I decided to prescribe Panadeine for pain, because it would relieve her pain when she took in deep breaths. The plan of management was for her to return home and rest, take the medication and call me if there was deterioration."

In her response of 9 October 2002, she stated:

> "On 8 August, at the first consultation Ms [B's] respiratory status revealed no distress, that is there was no nasal flaring, no tachypnoea, she was speaking full sentences and was afebrile …"

In the medical notes for 8 August 2002, Dr C recorded:

> "Pain with deep inspiration/recent cold. Phys alert 98% [oxygen saturations] Chest r (right) lower lung tender to palp [palpation] are lungs cta [clear to ausculation]".

Dr C made a diagnosis of pleurisy. She gave Ms B a prescription for 50 Panadeine tablets and advised her to take two tablets four times a day.

Ms B's niece Ms G was with Ms B from around 10am until around 2pm on Wednesday. Ms G advised:

> "I couldn't believe how sick she was. She had a lot of pain in her ribs, she was leaning over holding her ribs making an AAGH noise. She kept trying to do things around the house, but she couldn't. She was having hot and cold sweats. She was out of breath, she was clearly not right, she was finding it hard to breathe."

Ms G tried to persuade Ms B to go back to the General Practice, but Ms B told her that she had been told it was just pleurisy. Ms G stated "I didn't know what pleurisy was, so I couldn't really argue with her."

Ms G's cousin visited Ms B at around 1pm. Ms G stated that when her cousin saw Ms B's condition he said "she should be in hospital".

Mr D rang Ms B that afternoon after Ms G left to see how she was feeling. Ms B told him "I feel bloody worse". Mr D told Ms B to go back to the General Practice. As Ms B had poor vision, she was unable to drive. The General Practice was only a short distance from her home and she set out to walk back to see Dr C again.

On the way, an acquaintance, Mr E, saw her and stopped to offer her a ride. Mr E stated:

> "I saw her walking down the street and she was holding her chest, which isn't like her. I stopped and asked her if she was OK and if she wanted a ride. Usually when I offer her a ride she says 'No, I'm OK it's a good day for it' but this day she jumped in the car. She managed to get in the car OK but was moaning with pain, going AAAAH, and gasping for breath. Fuck, she was in a lot of pain. Her health wasn't usually too good, but this was different, she was doing real deep breaths and gasping for air, holding her chest. I could see by the look on her face that she wasn't right."

Mr E gave Ms B a ride to the General Practice. He stated that:

> "She got out at [the General Practice] and that was the last time I saw her. I thought she would be alright, 'cos you take someone to the doctors and they're alright, but then her niece rang and told me she had died the next day."

The medical record for this second visit stated:

> "Second visit. Can't keep med down because it causes her to vomit".

Dr C stated that she could not recall anything further than what was documented. At this consultation, Dr C prescribed Maxolon (anti-nausea medication) 10mg intramuscularly. Ms B was observed at the General Practice for 20 minutes after the injection, and no further vomiting was observed.

Ms A stated that by the time of this second visit "[Ms B's] family and friends all stated [Ms B] was in terrible shape … My sister should have had an x-ray at her second visit". Dr C stated that she did not consider at that stage that Ms B needed a chest x-ray.

The General Practice stated that: "Dr [C] elected not to obtain an x-ray, which was available in our upstairs radiology department. If Ms [B] had been offered this and had declined on the basis of financial hardship the x-ray could have been arranged elsewhere within the [hospital] service. We feel that the decision not to x-ray was made by Dr [C] on the basis of her own clinical judgement."

Mr F stated that Ms B attended the General Practice "holding her chest and wheezing". He stated that when he picked Ms B up from the General Practice after the second visit "She wasn't feeling too well, she was really down."

Thursday 9 August 2001
Mr F stated that the next day, Thursday 9 August 2001, he noticed that Ms B was still vomiting and she wasn't walking too well. He stated:

> "She didn't complain – that was Ms [B] – she didn't complain. She told me that she felt like her lung had collapsed, 'cos it had happened before so she knew what it felt like". (Ms B had previously been admitted to hospital with a suspected pnuemothorax following a rib fracture).

That morning at around 10am Ms G spoke to Ms B on the phone. Ms G stated:

> "She was making no sense whatsoever. Even though she was talking it was like the words were all jumbled up. She sounded out of breath and I had to ask her to repeat things three or four times. I told her that she should go back to [the General Practice] and she said something like 'Yeah that's what [Mr F] said'".

During the day, while Mr F was at work, Ms B called the General Practice and spoke to Dr C again. In relation to the phone call, Dr C documented: "Vomiting up panadeine/not sleeping". No discussion about a repeat visit for reassessment was recorded.

In her response of 4 July 2002, Dr C stated:

> "Ms [B] called the next day stating she couldn't sleep and had been vomiting and unable to keep her medicines down. I had asked her to please come in and she said she couldn't afford it. I told her not to worry about that (I had not charged her for her previous visit). My clinical assessment over the phone at that time was that she was alert, oriented, speaking full sentences and not sounding winded. I thought that it was the codeine component in the panadeine that was causing the vomiting and thus changed the medicine to diazepam (so she could get some rest) and tramol (for pain control)."

Dr C provided the following further information in her response of 9 October 2002:

> "I asked that she come in to the clinic to see me; she replied that she could not afford it."

Mr F, Ms G and Mr D all stated that Ms B would never have refused an appointment for lack of money as she knew that they would always be able to lend her some.

Dr C further stated:

> "I told her not to worry about payment and to come in (that is, I would not charge her). However, she refused. From the conversation I formed the impression that Ms [B] was alert, oriented, speaking full sentences and did not sound winded. I considered that is was the codeine component in her medication that was causing the vomiting and thus changed that to diazepam so she could get some rest, and tramal for the pain.
>
> I was certainly not made aware at any time that Ms [B] had previously suffered a pneumothorax, at no stage did she state that she felt as if her lung had collapsed, or any words to similar effect. Had that been the case, I would have insisted on seeing Ms [B]; or that she go to the hospital.
>
> I do not know why Ms [B] refused to attend for an assessment on 9 August notwithstanding my reassurance that she would not be charged. Further, the clinic operates a courtesy van, which Ms [B] would have been able to utilise."

Mr D, Ms G and Mr F strongly dispute that Dr C advised Ms B to return to the General Practice for reassessment. In particular, they stated that Dr C's assertion that Ms B declined reassessment is inconsistent with Ms B's efforts to seek help for her worsening condition, her willingness to attend doctor's appointments, and her comments to the family after the phone call.

Mr D stated that Ms B rang him after she had been to the General Practice. Mr D stated that Ms B told him: "I'm worse. I'm still vomiting". Mr D advised Ms B to see the doctor again but Ms B replied with words to the effect of: "I talked to the doctor, and she doesn't think I need to go in again. The doctor said it's the pills that are making me vomit and she has changed the pills and I have to go and pick them up." Mr D said he had "no doubt whatsoever" that if the doctor had suggested another appointment "she would have rung me up and asked me to jack up a ride. No, actually, [Ms B] was so pig headed that she probably would have walked there herself no matter how sick she was if the doctor wanted to see her again."

Mr F stated that if Dr C had recommended another appointment, Ms B would definitely have gone back to the General Practice. He stated "That's the way she was. She never missed an appointment." He went on to say "She used to have to have these biopsies at the hospital, and that was all the way across town but she always got there. Her and [Mr D] used to go together."

Ms G stated that if Ms B had been advised to return to the General Practice "she would have been there as quick as a flash, she wouldn't even give them a chance to finish the sentence and she'd be down there. [Ms B] was like that. She used to go to the doctors for anything, even when a lemon drink would fix it, she'd go to the doctors".

In relation to the possibility of a home visit, the General Practice "Guide to our Services" pamphlet provides the following information:

> "When medically indicated, the first available doctor will attend to you at home …"

Dr C changed Ms B's medications over the phone, and arranged for the local chemist to dispense 5mg diazepam (sedative) to be taken in the evening for 5 days, and tramadol (strong pain relief) 50-100mg to be taken two to three times a day for pain.

In her response of 9 October 2002, Dr C stated:

> "It was certainly not my usual practice to change prescriptions over the telephone. I have not done so since this incident, and will not do so again."

The General Practice stated:

> "We do not endorse the practice of giving consultation advice over the phone, as was done by Dr [C], and we certainly do not recommend the changing of prescriptions over the phone without inviting the patient in for a consultation. Dr [C] did this on the basis of her own clinical judgement, it is certainly not within our clinic policy to do this."

In relation to the issue of supervision, Dr C stated:

> "I did not contact [my supervising doctor], or my colleagues, in relation to Ms B, as based on her presenting symptoms I did not consider hers to be a difficult case."

Mr D told Ms B not to worry about picking up the new medication, and told her that he would do it for her. When Mr D arrived at the chemist he realised that he had forgotten his wallet, so he went round to Ms B's instead. When he arrived at Ms B's home, Mr F came out to meet him, and offered to go and pick up Ms B's medication.

Mr D stated that when he arrived Ms B was in bed, but she got out of bed to come and see him, as she had some spare cash and wanted to pay him back some money that he had lent her earlier in the week. Mr D stated:

> "She was sweating, and coughing a bit, and hunched over holding her ribcage, trying to support herself. [Ms B] was a strong woman, but you could see from her face that she was in a lot of pain."

Mr D again asked Ms B if she wanted to go back and see the doctor. He advised that Ms B replied "No, its OK, the doctor just wants me to take these new pills and I should give them a chance to work". Mr D left Ms B's place at about 5pm.

Mr F stated that after he had collected the medication he helped Ms B get back into bed and placed a fan at the end of her bed, as she was so hot. He read the labels on the medication

out to her, and told her that one of them was to help her sleep. Mr F advised that Ms B then took the tablets as prescribed.

Mr F stated that Ms B began to feel tired soon after taking the medication. Ms B tried to get up to go to the toilet, but collapsed in the passage. Mr F helped her to bed and went to bed himself. At that time he noticed that Ms B's breathing was very noisy. Mr F woke again close to midnight and could not hear her breathing, so he called 111. The ambulance service told him to lift Ms B out of bed, place her on the floor and begin CPR, which he did. The ambulance arrived soon after, but efforts to resuscitate her were unsuccessful.

Friday 10 August 2001
Dr C stated:

> "I received a call at approximately 8.30am from the police. They informed me that Ms [B] had passed away early that morning and asking what were they to put in the death certificate. I had told them I was unable to determine the cause of death and enquired as to whether an autopsy could be obtained."

In her response of 9 October 2002, Dr C hypothesised that Ms B may have "consumed large amounts of alcohol the night before her death, causing her to vomit in her sleep and thus causing aspiration into her right upper lobe." Ms B did have a past history of heavy alcohol use. However, Ms B's family advised that Ms B "was really crook" in the days prior to her death and did not drink any alcohol on the day or evening before her death.

Mr D advised that Dr C refused to sign the death certificate, saying she wanted a post-mortem as Ms B may have taken an overdose. Mr D stated that Ms B would never have taken an overdose and that Dr C's comments "really rocked our family for days".

Post-mortem
A post-mortem was performed on 13 August 2001. The right upper lobe of the lung showed changes of pneumonia, and there were fibrous adhesions between the lungs and the chest wall. There was no evidence of any poisoning or violence. The pathologist concluded that the cause of death was pneumonia.

Coroner's Inquest
On 30 April 2002 the Coroner advised the Commissioner that his Inquest into Ms B's death has been adjourned pending the outcome of the Commissioner's investigation.

Subsequent actions by Dr C
Dr C advised the Commissioner:

> "I felt that I had provided her with the appropriate care in the circumstances.
>
> However, in light of this unfortunate event, I have chosen to change my practice of medicine in the following ways:

1. Patients who complain of pleuritic type chest pain must get a chest x-ray. Whilst it would usually be expected to be a clinical discretion rather than clinically essential to do this, I now feel on balance that I would prefer an x-ray diagnosis in all such patients.

2. Patients who are not doing well must come in to be reassessed or alternatively I will call 111 for them to be taken to the hospital for evaluation.

3. In the future I would be reluctant to consider changing medications over the phone unless I reassess the patient in person."

Independent advice to Commissioner

General practitioner, Dr Chris Wright, provided the following expert advice:

"**Background**
Ms [B] attended Dr [C] on 8 August 2001 with chest pain and complaining of breathlessness. Dr [C] noted a pleuritic type of chest pain and prescribed pain relief. Later on the same day, Ms [B] returned to Dr [C] because she felt worse. Further medication to prevent vomiting was prescribed, Ms [B] was observed for a period of time and then allowed to return home.

The next day, Ms [B] called and spoke to Dr [C], who changed the medication over the phone and arranged for the local chemist to dispense the changes to Ms [B].

Ms [B] died at home during the night of Thursday 9 August, the pathologist's autopsy showing pneumonia to be the cause of death.

Opinion
Ms [B] attended Dr [C] on 8 August 2001 with chest pain on deep breathing. She had had a recent cold. Dr [C] states that Ms [B] was in no acute distress although Mr [D] told the Investigation Officer that Ms [B] was complaining of sore shoulders and breathing difficulties that morning. Mr [F], Ms [B's] partner seems to be the only one of the witnesses (apart from Mr [E]) that was with Ms [B] that day and he states that Ms [B] was "really down, … she wasn't feeling too good".

Although there are a number of people stating that Ms [B] was breathless and in considerable pain on 8 August, this is less obvious from Mr [F's] statement and in Dr [C's] own recollection. It is however, agreed that Ms [B] had a chest pain and it is likely that she was breathless, although with this type of chest pain the shortness of breath is often related more to the inability to take a deep breath without pain, and

hence a constant need to breathe shallowly: symptoms which are often described as "breathlessness" by patients.

Ms [B] gave a history of chest pain on deep breathing and described a recent cold. Dr [C] found Ms [B] to be undistressed and alert with a good blood oxygen level. She found her to be tender on the lower right chest wall and when she listened to the chest, there was no abnormality heard. She did not take Ms [B's] temperature nor her pulse rate, nor did she percuss (or 'tap') the chest wall (to determine areas of dullness which may indicate underlying lung disease).

Dr [C] concluded that Ms [B] had a pleural pain from the recent viral upper airways illness she had experienced. Dr [C] prescribed pain relief for this clinical problem. There is no mention in the written notes of planned review if worsening, although Dr [C] states that she gave this information to Ms [B].

As it happened, Ms [B] later felt worse and returned to see the doctor the same afternoon. She was vomiting but attempted the walk to the doctor. Her pain at that stage is well described by Ms [G] and Mr [E].

Dr [C] wrote in her medical notes the Ms [B] was vomiting because of the Panadeine and therefore gave her an injection of Maxolon for the vomiting and Maxolon and Diazepam 2mg tablets for ongoing use. She kept Ms [B] under observation for 20 minutes, during which time she did not vomit again, and then discharged her home. There appears to have been no further examination of Ms [B] at this visit.

The next day, Ms [B] continued to have chest pain and called Dr [C] for advice. The written notes stated that Ms [B] was vomiting up the Panadeine and had not slept well that night. Dr [C] recollects that Ms [B] did not sound breathless over the phone and that she believed the vomiting to be caused by the codeine in the Panadeine. As a result, she changed the pain relief and gave a higher dose of Diazepam for sleep. At that conversation Dr [C] states that she asked Ms [B] to return for reassessment but that Ms [B] said she could not afford to pay. Dr [C] goes on to say that she told Ms [B] not to worry about the cost. There is considerable family belief that if Ms [B] had been asked to attend again, she would have done so. Needless to say, there is a considerable gap in these two possible scenarios. Dr [C], however, is the only one apart from Ms [B] that was involved in that particular conversation.

Ms [B] continued to deteriorate that evening and collapsed when going to the toilet. Mr [F] woke in the night to find that she had died.

The pathologist's post mortem examination showed pneumonia of the right upper lobe of the lung to be the cause of death.

A diagnosis is achieved by history taking and an examination. In General Practice it is often not possible to obtain a clear diagnosis in the early stages of an illness and

differential diagnoses must be considered. I would agree with Dr [C] that the pleuritic chest pain described here at the first visit was due to inflammation of the lung lining causing pain at each breath. The next step in the consultation would be to try and establish why this pain was occurring. Although infection (viral or bacterial) of the pleura (and possibly also of the underlying lung) would be common in the list of differential diagnoses, other possibilities exist, including pulmonary embolus (clot on the lung) and pneumothorax (spontaneous leakage of air from the lung into the pleural space).

Dr [C] has made a judgement that the pleuritic pain was due to a viral infection of the pleura. It is unclear if other possibilities were considered, but is possible that she did so and it would not necessarily have formed part of the written record. Ms [B] did not have a cough and this would lessen the suspicion of chest infection or pneumonia. However, Ms [B] was a smoker in her mid 50s and this would make the chances of a more significant chest infection, and indeed more serious illness in general,' more likely. I did not see any reference to her smoking in the computer notes but appreciate that this may have been noted elsewhere on the file. I presume Dr [C] was aware of this fact.

An examination that included pulse rate and temperature as well as percussion of the chest may have helped with the diagnosis, or at least may have given Dr [C] a clearer picture as to how unwell Ms [B] was. It is possible they may not have helped in this way but their measurement would have been seen as part of a more complete examination.

Summary
I am critical of the level of examination given to Ms [B] at the first visit, in particular, non-measurement of pulse rate and temperature, and lack of percussion of the chest. As already stated, it is impossible to know if this added examination would have helped Dr [C] with diagnosis, but such an examination is a basic one when faced with Ms [B's] presenting symptoms. There is no written record of whether Ms [B] had a cough or not. Dr [C] seems to have appropriately ascertained the type of chest pain Ms [B] was complaining of and reasonably believes that her 'breathlessness' was occurring because of pain on deep breathing.

It is difficult to judge whether a chest X-ray was clinically indicated at the first visit because of a degree of incompleteness of the consultation but in suspected pleurisy without evidence of underlying pneumonia, pulmonary embolus or pneumothorax, it may not be indicated. In the presence of a history or signs suggesting any of the above, a chest X-ray would have been appropriate.

The treatment of pain was appropriate and most simple analgesia, like Panadeine, would have been acceptable. I believe that in the scenario of Ms [B's] problem, with pleuritic pain, splinting of the chest wall, a clinical working diagnosis of inflammation

of the lung lining, in a smoker; even without the absent temperature/pulse measurements; antibiotics may have been considered as part of therapy.

I am moderately critical of the lack of temperature and pulse measurement, of some missed history and some absent examination findings. It is not possible to determine if a chest X-ray was indicated at this point. I believe initial treatment to be adequate as long as temperature/pulse were not elevated, and the patient were asked to return if worsening. If temperature/pulse were elevated, there would have been more suspicion of an infective process.

Dr [C] has stated herself that she asked Ms [B] to call her if there was deterioration. Ms [B] went one step further and reattended the surgery.

Ms [B's] second visit to Dr [C] is not mentioned in Dr [C's] letter of reply. The clinical record is brief and there was no examination. The main problem was vomiting, attributed to the medication by either Ms [B] or Dr [C] (see medical notes). I assume that Dr [C], who had seen Ms [B] only a few hours previously, felt there was little change in condition. However, in this case the patient had returned and her condition was either no better or had worsened. It is always important to re-examine or reconsider the original diagnosis when this happens but Ms [B] was given symptomatic treatment of her vomiting without a reassessment.

I feel that there is more in this second visit to be critical about than the first. The return of a sick patient on the same day should result in a review of the initial diagnosis and at least evidence from the doctor that this diagnosis has been reconsidered. This is not evident from the notes, which are quite inadequate for this visit.

The next day there was a conversation between Ms [B] and Dr [C]. Ms [B] had been vomiting and had not slept well. Dr [C] describes Ms [B] as not sounding breathless and prescribed further pain relief and sedatives for her symptoms. It is common for doctors and nurses to conduct telephone consultations with patients and intrinsically, there is nothing wrong with this practice. Care must be taken by the practitioner, as there is no ability to observe or examine the patient, the only information available being that given verbally by patient or relative/friend. This was the third consultation in 24 hours, and extra care was needed by Dr [C] in this situation.

Care needs to be observed when conducting a telephone consultation. Often patients will want phone advice for a problem but this can be potentially medically dangerous for a medical practitioner to agree to. If there is an acute or semi-acute problem, it is important to try and see the patient to make an accurate diagnosis. In Ms [B's] case, this was a third presentation and increased care was needed. Dr [C] has presumed that the vomiting was secondary to her current medication and seems to have failed to recognize the possibility that Ms [B's] vomiting may have been due to a progressing illness. If she had asked Ms

[B] to attend, this would have allowed Dr [C] the chance to reassess her condition. Even at this later stage in the illness, such a request would have been seen as appropriate management, albeit considerably belated. If Ms [B] had not been asked to return, and her concerns simply answered by a change of medication over the telephone, this would, in light of the previous presentations and the presenting problems on 9 August, be seen as a serious departure from the appropriate standards of care. The actual prescribing of medications over the telephone by Dr [C] without seeing Ms [B] added to the reduced quality of care.

There has been a further request from the Health and Disability Commissioner to look at the prescribing of Celebrex by Dr [C] to Ms [B] (25 May 2001) in the presence of Ms [B's] asthma. "The General Practice" note that Ms [B] had received anti-inflammatory medication in the past (Brufen in 1998 and both Brufen and Naproxen in 2001, prior to the Celebrex being prescribed. I have no concerns about the prescribing of Celebrex in this situation as Ms [B] had not had asthmatic responses to the other anti-inflammatory drugs and was therefore extremely unlikely to do so with Celebrex."

In response to Dr C's apparent concerns about the validity of comments made by family members, I sought further independent expert advice from a respiratory physician at a Public Hospital in relation to the correlation of the reported symptoms and the post-mortem findings:

"The family's description of the patient experiencing hot and cold sweats, having a cough, complaining of pain on taking a breath, and holding her ribs suggest a lower respiratory tract infection with associated pleuritic pain. These symptoms are entirely consistent with the post-mortem finding of right upper lobe pneumonia.

Regardless of the examination findings, a patient presenting to a GP with these symptoms would warrant further investigation with a chest x-ray and full blood count and the GP should have a low threshold for prescribing antibiotics."

I also sought the respiratory physician's comment on Dr C's assertion that a medication change from codeine to tramadol was appropriate, in that she hoped to alleviate the vomiting. He stated:

"This patient's respiratory function was probably already compromised by her history of smoking and asthma/chronic obstructive airways disease. It is likely that sudden consolidation in the right upper lobe of her lung resulted in a ventilation perfusion defect with associated hypoxia. Both diazepam and tramadol are known to cause respiratory depression, and the combination of the two can be dangerous in a patient whose respiratory function is already compromised. Tramadol is a second or third line

pain relief medication and should not be used without careful thought and a thorough clinical assessment, particularly in a patient complaining of pleuritic pain."

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

1) Every consumer has the right to have services provided with reasonable care and skill.

Opinion: Breach – Dr C

It is my opinion that, for the reasons set out below, Dr C breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights.

Failure to take adequate steps to form diagnosis
On 8 August 2001, Dr C saw Ms B during two separate consultations.

In relation to the adequacy of Dr C's history taking and examination at the first consultation, my expert advisor stated:

> "I am critical of the level of examination given to Ms [B] at the first visit, in particular, non-measurement of pulse rate and temperature, and lack of percussion of the chest. As already stated, it is impossible to know if this added examination would have helped Dr [C] with diagnosis, but such an examination is a basic one when faced with Ms [B's] presenting symptoms. There is no written record of whether Ms [B] had a cough or not."

In her response to my provisional opinion, Dr C stated that she did assess Ms B's pulse and temperature and noted no cough, though she failed to record these findings. The medical notes indicate that some form of respiratory examination was carried out during this consultation and I am prepared to accept Dr C's statement that she assessed Ms B's vital signs as part of the first examination.

In relation to the second consultation, Dr Wright advised:

> "The clinical record is brief and there was no examination … I feel that there is more in this second visit to be critical about than the first. The return of a sick patient on the same day should result in a review of the initial diagnosis and at least evidence from the doctor that this diagnosis has been reconsidered. This is not evident from the notes, which are quite inadequate for this visit."

Shortly before the second consultation, Ms B told her brother that she felt "bloody worse" compared with when she visited the doctor that morning. Ms G and Mr E gave first-hand evidence that by the time of the second consultation Ms B had a cough, hot and cold sweats, was holding her ribs and was complaining of severe pain on inspiration. (The respiratory physician advised me that these observations are all consistent with the post-mortem finding of right upper lobe pneumonia.) Dr C did not document any of these symptoms and there is no record of any physical examination.

Dr C initially advised that she could not recall anything about this second consultation further than what is documented. In her response to my provisional opinion she stated that it is her invariable practice to conduct a physical examination and the fact that her assessment was not specifically noted indicates there was nothing significant or concerning.

I do not accept this explanation. Based on the evidence before me, I am satisfied that Dr C did not take an adequate history or perform a careful examination during the second consultation. Had she done so, Ms B's symptoms alone (as clearly described by family members and an acquaintance) would have alerted her to the fact that Ms B's condition had deteriorated compared with earlier in the day. She should then have reconsidered her initial diagnosis and considered the need for further investigations including a chest x-ray.

In her response to my provisional opinion, Dr C stated that "Your view that Ms [B's] condition had deteriorated between the first and second consultations can only be based on comments made by family members, rather than the clinical observations of Dr [C]". Ms G and Mr E (not a family member) gave detailed first hand evidence of Ms B's condition on the afternoon of Wednesday 8 August 2001.

It is my opinion that Dr C's failure to take adequate steps to diagnose the cause of Ms B's chest pain, breathlessness and vomiting on 8 August 2001 amounted to a failure to provide services of an appropriate standard, in breach of Right 4(1) of the Code.

Failure to provide adequate treatment

At the first consultation, Dr C prescribed Panadeine for pain relief, and advised Ms B to contact her if she deteriorated. My expert advisor made the following comments on this management plan:

> "I believe initial treatment to be adequate as long as temperature/pulse were not elevated, and the patient were asked to return if worsening. If temperature/pulse were elevated, there would have been more suspicion of an infective process."

I accept Dr C's statements that Ms B was afebrile at this time and that there was no tachypnoea, tachycardia or cough. However, I note with some concern that these base recordings were not mentioned in the contemporaneous record, and nor were they raised in Dr C's initial response. They only came to light in response to specific questions posed by my Office prior to Dr C's second response of 9 October 2002 and in her response to my provisional opinion.

In the light of Dr Wright's advice, it is my opinion that Dr C's management plan at the time of the first consultation was adequate.

However, I am critical of Dr C's failure to keep an adequate record of her consultations with Ms B. The New Zealand Standard for Health Records (NZS 8153:2002) states that "people have the right to expect their health records to be a complete, thorough and accurate record of past and current consultations". Dr C's clinical notes for all three consultations are brief and incomplete and do not comply with this standard.

At the second consultation, Dr C gave Ms B an injection of metoclopramide (Maxolon) to prevent vomiting. There is no evidence that she considered the need for antibiotics or a chest x-ray at this time. In relation to this visit, Dr Wright stated that:

> "It is always important to re-examine or reconsider the original diagnosis when this happens but Ms [B] was given symptomatic treatment of her vomiting without a reassessment."

For the reasons set out above, I am satisfied that Ms B's condition had deteriorated by the time of the second consultation, and it was not appropriate to simply treat her vomiting as an isolated symptom without carrying out a more thorough reassessment. It is my opinion that Dr C's failure to review her initial diagnosis and management of Ms B's chest pain at the second consultation amounted to a breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights.

Failure to advise reassessment
On 9 August 2001, Ms B rang Dr C complaining that she was still vomiting and not sleeping. My expert advisor commented:

> "Care needs to be observed when conducting a telephone consultation. Often patients will want phone advice for a problem but this can be potentially medically dangerous for a medical practitioner to agree to. If there is an acute or semi-acute problem, it is important to try and see the patient to make an accurate diagnosis. In Ms [B's] case, this was a third presentation and increased care was needed. Dr [C] has presumed that the vomiting was secondary to her current medication and seems to have failed to

> recognize the possibility that Ms [B's] vomiting may have been due to a progressing illness. If she had asked Ms [B] to attend, this would have allowed Dr [C] the chance to reassess her condition. Even at this later stage in the illness, such a request would have been seen as appropriate management, albeit considerably belated."

There is a factual dispute over whether Dr C advised Ms B to return to the General Practice to be reassessed. Dr C states that she did advise reassessment. Several members of Ms B's family gave convincing evidence that Ms B would have returned to the General Practice to be reassessed if Dr C had advised her to do so. I also note Mr D's evidence that when he advised Ms B to see the doctor again she replied with words to the effect of: "I talked to the doctor, and she doesn't think I need to go in again. The doctor said it's the pills that are making me vomit and she has changed the pills and I have to go and pick them up." Later that afternoon when Mr D asked Ms B if she wanted to go back to the doctor, Ms B replied "No, its OK, the doctor just wants me to take these new pills and I should give them a chance to work".

Dr C stated that during the telephone call Ms B did not repeat the symptoms discussed earlier. However, the fact that Dr C prescribed tramadol, a strong pain-killer, in response to this phone call indicates that Ms B made it clear that she was still experiencing significant pain.

Any doctor who carries out a telephone assessment has a responsibility to take an appropriate patient history and exercise sound clinical judgement before deciding on the appropriate course of action. On the evidence before me, I am satisfied that Dr C failed to adequately assess Ms B's condition during the telephone consultation and failed to clearly communicate to Ms B the importance of a further clinical assessment. For the reasons set out above, I do not accept Dr C's statement that she did request Ms B to return.

Consequently, it is my opinion that Dr C breached Right 4(1) of the Code by failing to ensure that Ms B's condition was adequately reassessed. In particular, I note that extra care was needed in this situation, as this was the third consultation within 24 hours.

Change in medication without clinical assessment
On the basis of this phone call on 9 August 2001, Dr C changed Ms B's medication. The General Practice stated:

> "We do not endorse the practice of giving consultation advice over the phone, as was done by Dr [C], and we certainly do not recommend the changing of prescriptions over the phone without inviting the patient in for a consultation."

Dr Wright provided the following advice on this aspect of the complaint:

> "If Ms [B] had not been asked to return, and her concerns simply answered by a change of medication over the telephone, this would, in light of the previous presentations and the presenting problems on 9 August, be seen as a serious departure

from the appropriate standards of care. The actual prescribing of medications over the telephone by Dr [C] without seeing Ms [B] added to the reduced quality of care."

In response to my provisional opinion, Dr C stated that she "considered a medication change from codeine to tramadol appropriate, in that she hoped to alleviate Ms [B's] vomiting". The New Ethicals Journal states that nausea and vomiting are known side effects of both tramadol and diazepam. The respiratory physician advised that: "Both diazepam and tramadol are known to cause respiratory depression, and the combination of the two can be dangerous in a patient whose respiratory function is already compromised. Tramadol is a second or third line pain relief medication and should not be used without careful thought and a thorough clinical assessment, particularly in a patient complaining of pleuritic pain."
In the light of this evidence I cannot accept Dr C's assertion that the medication change was appropriate. It is my opinion that Dr C breached Right 4(1) of the Code by changing Ms B's medication over the telephone.

Cause of death
Dr C hypothesised that Ms B's death may have been related to excessive alcohol consumption on the evening of her death. The post-mortem found that Ms B died as a result of pneumonia, with no evidence of poisoning leading to the death. Based on the evidence before me I am satisfied that Ms B's medical condition had been steadily deteriorating over two to three days and that she did not consume alcohol on the evening of her death.

I accept Dr C's statement that any offence caused by her comments on the cause of death is regretted and was not intended.

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Prescription of Celebrex
My expert advisor stated that he has no concerns about the prescription of Celebrex even though Ms B had a history of asthma. My advisor stated that, according to Ms B's medical record, she had not had asthmatic responses to other anti-inflammatory drugs and was therefore extremely unlikely to do so with Celebrex.

I am satisfied that, in relation to this aspect of the complaint, there has been no breach of the Code.

Vicarious liability
It is my opinion that the General Practice, as Dr C's employer, took such steps as were reasonably practicable to prevent a breach of the Code, and accordingly are not vicariously liable for Dr C's breach of the Code.

Actions

- I recommend that Dr C apologise in writing to the family for breaching the Code. This apology is to be sent to my Office and will be forwarded to the family.

- I recommend that Dr C review her practice in the light of this report.

- A copy of this opinion will be sent to the Medical Council of New Zealand with a recommendation that a review of Dr C's competence be undertaken.

- I have decided to refer this matter to the Director of Proceedings in accordance with section 45(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any further action should be taken in relation to Dr C.

- A copy of this opinion with all identifying details removed will be forwarded 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.

Addendum

The Director of Proceedings laid before the Medical Practitioners Disciplinary Tribunal a charge alleging professional misconduct. The charge was upheld by the Tribunal and it imposed a penalty of censure and ordered payment of $18,470.71 (50% of the Tribunal's costs of the hearing) plus $12,919.02 (30% of the Director of Proceedings' costs relating to the hearing). An order lifting interim name suppression was made.

Dr C appealed the Tribunal's decision. On 15 September 2004 the District Court reversed the findings of the Tribunal as to professional misconduct and therefore penalty. Dr C was granted permanent name suppression.