Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Inadequate management of symptoms following diagnosis of deep vein thrombosis

20HDC02286

A report released today by Deputy Health and Disability Commissioner Dr Vanessa Caldwell has found a GP breached the Code of Health and Disability Services Consumers' Rights (the Code) for inadequate management of a woman's symptoms following diagnosis of lower leg deep vein thrombosis (DVT).

The woman, who previously kept good health and had no significant past medical history, presented to her medical centre over a period of 22 months. She was initially diagnosed with DVT in her leg, however, her ongoing symptoms were suggestive of pulmonary embolus (PE). Sadly, she died as a result of acute and chronic PE arising from leg DVT.

The clinical advisor who assisted with the investigation stated that PE was the logical unifying diagnosis for the history presented by the woman, particularly when investigation results were taken into account.

In her report, Dr Caldwell found the doctor breached Right 4(1) of the Code for not providing services to the woman with reasonable care and skill.

The breach covered a number of events over the 22 month period the woman's symptoms were present. During the initial consultation, the doctor failed to pursue a diagnosis of PE. At a later date, the doctor failed to expedite a face-to-face assessment (by way of referral to ED for urgent assessment and imaging). The doctor also failed to review the management decisions after receipt of a declined referral for CT chest scan and to take appropriate steps to exclude PE as a diagnosis.

Dr Caldwell noted that the circumstances the GP was operating in were challenging (due to staffing shortages and COVID-19 restrictions), but said, "collectively the deficiencies in care show inadequate management of the woman's symptoms, resulting in her not receiving the right investigations in a timely manner. The outcome for woman and her whānau was devastating."

Dr Caldwell was also critical that the GP did not inform the woman she'd made an error requesting a CT chest scan, or that this had been declined and why. Accordingly, she found the GP also breached Right 6(1) of the Code, which gives consumers the right to information a reasonable consumer in the circumstances would expect. In addition, this is information the Medical Council of New Zealand advises should be provided.

Dr Caldwell noted that discussing the declined referral with the woman would have provided an opportunity for the GP to reflect on and understand why the scan was declined, and this in turn may have led her to pursue the PE diagnosis by way of the correct investigations. Failure to do this meant the woman was prevented from participating in her own health care and unable to follow up, question the decisions or provide additional information to assist.

In light of the changes already made by the GP, and the fact that she intends to retire from practice in the near future, Dr Caldwell recommended that she undertake further education/training on the diagnosis of PE should she return to general practice.

She also recommended that the second GP, involved in providing care to the woman at the same medical centre, provide evidence that he has revised his knowledge regarding the clinical circumstances in which the PERC rule may be used to exclude PE as a diagnosis. In addition, Dr Caldwell recommended that the medical centre review its policy and processes regarding nursing management of tasks and recalls.

Dr Caldwell expressed her sincere condolences to the family for the loss of their loved one.

25 September 2023

Editor's notes

The full report of this case will be available on HDC's website. Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name providers and public hospitals found in breach of the Code, unless it would not be in the public interest, or would unfairly compromise the privacy interests of an individual provider or a consumer.

More information for the media, including HDC's naming policy and why we don't comment on complaints, can be found on our website here.

HDC promotes and protects the rights of people using health and disability services as set out in the Code of Health and Disability Services Consumers' Rights (the Code).

In 2021/22 HDC made 402 recommendations for quality improvement and providers complied with 98% of those recommendation.

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