The Palms Medical Centre Limited

A Report by the
Health and Disability Commissioner

(Case 19HDC00695)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. Between 14 December 2018 and 12 January 2019, a six-year-old girl presented to a doctor four times. Of the four times, three were at The Palms Medical Centre (the Palms), and one was at another medical centre. Her symptoms included intermittent fevers, multiple sore joints with no confirmed history of injury, and weight loss.

2. At her appointments, the girl was treated episodically, and when X-rays showed no musculoskeletal cause for her symptoms, the doctors sought no further investigations to explore the cause. After an appointment with her usual general practitioner on 18 January 2019, she was taken to hospital. One week later she was diagnosed with acute rheumatic fever (ARF) with severe mitral regurgitation. She was kept in hospital on strict bed rest until 13 March 2019.

3. The Commissioner acknowledged the difficulty in making the girl's diagnosis, as her presentation was unusual for ARF. However, he considered that the issue was not the failure to make the correct diagnosis earlier, but rather the failure to investigate the repeat presentations of migratory acute arthritis in the presence of fevers with no convincing history of injury, in a timely manner.

4. This report highlights the importance of critical thinking and continuity of care, particularly when a patient has presented multiple times in a short timeframe.

Findings

5. Despite multiple presentations, no staff member at The Palms considered further investigation of the symptoms, which indicated of a pattern of poor care across the practice, for which ultimately The Palms is responsible. The Commissioner found The Palms in breach of Right 4(1) and Right 4(5) of the Code.

6. The Commissioner made adverse comments about aspects of the care provided to the girl by three general practitioners (GPs).

Recommendations

7. The Commissioner recommended that The Palms: (a) prepare an anonymised case study on the girl's care for training all clinical staff; (b) consider facilitating a regular clinical meeting for review of patients who have seen multiple providers for the same or similar complaints over a short period, or in whom a diagnosis is proving elusive; and (c) provide the girl and her family with an apology.

8. The Commissioner recommended that two GPs attend the Medical Protection Society's "Mastering Your Risk" workshop, and that one GP undertake an online learning module on joint swelling.

Complaint and investigation

9. The Health and Disability Commissioner (HDC) received a complaint from Ms A about the services provided to her daughter, Miss A, at The Palms Medical Centre Limited (trading as The Palms Medical Centre). The following issue was identified for investigation:

- *Whether The Palms Medical Centre provided Miss A with an appropriate standard of care in December 2018 and January 2019.*

10. The parties directly involved in the investigation were:

Miss A	Consumer
Ms A	Complainant
The Palms Medical Centre Limited	Provider/medical centre

11. Further information was received from:

Dr B	Urgent care doctor
Dr C	General practitioner
Dr D	General practitioner
Dr E	General practitioner

12. Independent expert advice was obtained from GP Dr Ian St George, and is included as Appendix A.

Information gathered during investigation

Introduction

13. Miss A, aged six years at the time of events, was a relatively healthy child with an unremarkable medical history, aside from having a family history of type 1 diabetes, and not being up to date with her immunisations.

14. Miss A's mother told HDC that from the beginning of December 2018, Miss A had been complaining of mild pain in her right foot and wrist with no apparent history of injury. Ms A stated that Miss A had no recollection of any event that would have caused the pain. Ms A told HDC: "We were very confused with how this pain seemed to be quite random and would literally come and go day by day." After a few weeks, when the pain seemed to have disappeared completely, Miss A's wrist suddenly became painful again.

15. This report focuses on the care provided to Miss A by multiple providers during the period of 14 December 2018 to 17 January 2019.

Appointment on 14 December 2018

16. Ms A was concerned that Miss A's wrist may have been sprained, and took her to The Palms Medical Centre (The Palms) urgent queue on 14 December 2018. Miss A was not an enrolled patient at The Palms, and Ms A explained that she did not want to wait for an appointment with their usual GP because Miss A was in pain.

17. The triage nurse noted that Miss A presented with a right wrist that was sore with movement, and that the area around her eyelashes was slightly red. Basic observations showed Miss A's temperature as 38°C,[1] pulse 106 beats per minute, oxygen saturation 99%, and weight 20.3kg. She was triaged as a category 5,[2] to await further review by a doctor.

18. Miss A and her mother were seen by GP Dr C. Dr C documented:

> "[Patient] here with mum. Sore right wrist. 4 days.
> Pain with certain movements.
> Did do [sport] Monday.
> Also has blepharitis.[3] Slight fevers. No complaints of illness. Temp 38.
> Right wrist — swollen. Pain with lateral movement.
> Skin ok. Ent throat and ears ok."

19. Dr C considered the possibility of infection in the joint, but noted that the joint was not hot to touch. She queried a fractured wrist accompanied by a viral illness, and requested an X-ray to look for any injury or infection. The X-ray reported soft tissue swelling in the wrist with no fracture or growth plate injury. Dr C completed an ACC form for Miss A's sore wrist, and advised Miss A and her mother to return if the fevers or wrist pain worsened. Miss A was discharged home with paracetamol, eye ointment, and a sling for her wrist.

Appointment on 17 December 2018

20. On 17 December 2018, Miss A was suddenly unable to walk or comfortably put weight on her right foot. Because of the long wait times at The Palms, Ms A took Miss A to another medical centre (Medical Centre 2).

21. After being triaged by a nurse, Miss A was seen by GP Dr D. Ms A explained to Dr D that Miss A had been feeling unwell over the past few weeks, and that previously her wrist had been sore. Ms A told HDC:

> "I explained [Miss A's recent medical history] to the female GP, regarding wrist and really emphasised the 'losing my mind' as one day [Miss A] would seem to be able to walk with very slight pain, to the extreme of unable to put any weight on it at all over the last two weeks but again we had no idea how or why this pain had occurred."

[1] A child's normal body temperature is around 37°C.
[2] A triage category 5 on the Australasian triage scale.
[3] Inflammation of the eyelid.

22. Dr D noted that Miss A's temperature was 37.9°C, consistent with a low-grade fever. Dr D documented:

> "[T]his morning [complaining of] sore [left] foot.
> Mum noted a lump, dog stood on.
> T37.9."

23. Dr D told HDC that Miss A's fever would have prompted her to check for the presence of lymph nodes and neck rigidity, along with a thorough check of Miss A's skin for any unusual rashes or bruises. Dr D stated that she would also have done routine checks of Miss A's throat, ears, and chest, and would have examined her upper and lower extremities to check for concerning features or signs. These assessments were not documented in Miss A's clinical notes, but Ms A confirmed that Dr D did "all the routine checks".

24. Dr D stated:

> "My assessment at the time was that [Miss A] was not clinically unwell. She had a leg/foot pain which was possibly musculoskeletal related, and at the same time had a non-specific viral illness with no focal infection identified."

25. A urine sample was obtained to rule out a urinary tract infection. The test result showed no abnormalities, and subsequently Miss A was discharged with a compression bandage on her foot to relieve the pain. Safety-netting advice was provided for Miss A to see her GP if there were any changes or deterioration.

Appointment on 19 December 2018

26. On 19 December 2018, Ms A took Miss A back to The Palms, as she was experiencing severe discomfort in her right foot. Ms A stated that at this appointment she explained Miss A's history in great detail, including the unexplained high temperatures, sore wrist, her washed-out look and sunken eyes, the bandage being applied on her foot, and the joint pain that would come and go.

27. Miss A was seen by an Urgent Care doctor, Dr B, who performed routine checks and noted that Miss A's vital signs were normal. Dr B documented:

> "Right foot and ankle pain … She woke this morning at 2am [complaining of] pain and not weight bearing. She can not give details of what actually happened …
> Swollen right ankle and big toe. [Temperature] 36.8 …
> Plans: x-ray and review, analgesia."

28. Dr B also documented that recently Miss A had presented to Medical Centre 2 with the same complaint, and that no X-ray had been performed. Dr B's impression was that of a soft tissue injury or a fracture, and she sent Miss A for an X-ray of the ankle and foot to exclude the latter. On review by Dr B, the X-ray showed no sign of a fracture. Ms A was

advised to keep Miss A's foot rested and elevated and to apply ice for the swelling. Ms A told HDC:

> "I got quite upset at this point as we had been repeatedly explaining how things have been over the last month and they just wanted … me to leave with doing the same treatment I applied when all this began around the start of December."

29. Despite there being no sign of a fracture, Dr B suggested applying a back slab to Miss A's sore foot, to be kept on for a week. Dr B told HDC:

> "… I wanted to relieve [Miss A's] pain by immobilising the joint and minimising the risk of any aggravation to her injury. The back slab was intended to be a temporary measure, until the pain improved."

30. Dr B stated that she did not consider ordering blood tests at this appointment, as her impression was that of a traumatic injury, for which a blood test would serve no purpose. She noted that while the mechanism of injury was unknown, she attributed this to Miss A's age. She acknowledged that in the circumstances — a painful joint without a known cause, against a background of a recent presentation with pain in a different joint — bloods should have been ordered.

31. The formal X-ray report on 24 December 2018 noted that Miss A's foot had no injury, arthritis, or infection. Dr B sent a text message to inform Ms A that the X-ray had been reported as normal.

Bloods on 10 January 2019

32. Ms A told HDC that Miss A is part of a study group around preventative treatment for type 1 diabetes. The study includes annual blood tests to screen for particular antibodies, and Miss A's tests were due on 10 January 2019.

33. Ms A rang her family general practice — Medical Centre 3— on 3 January 2019, and spoke to a nurse about the health issues that Miss A had experienced over the last month. She requested that the blood test to be taken on 10 January 2019 check for other measures including iron, Vitamin B12, and C-reactive protein (CRP).[4] A follow-up appointment with Miss A's GP, Dr E, was booked for 18 January 2019[5] to discuss the results.

Appointment on 12 January 2019

34. As Miss A's condition was not improving and she had now developed a cough, Ms A took Miss A back to The Palms for a third time. Ms A stated: "Again, I explained everything in great length and detail around everything that has happened leading up to that day."

35. Miss A was again seen by Dr C, who undertook routine checks of Miss A's throat, lungs, ears, and chest. Miss A did not have a temperature at this time. Her weight was 19.4kg,

[4] A blood test used to check for acute inflammation or infection in the body.
[5] The delay in appointment was caused by the holiday period, and because Miss A was away with her family.

showing almost a 1kg loss since the appointment of 14 December 2018. Dr C stated that it is not uncommon for there to be some fluctuation in weight, depending on what the child is wearing, the scales used, or the time of day.

36. Dr C diagnosed a viral cough owing to the short nature of the illness. She reassured Ms A that the cough would resolve of its own accord, and recommended cough lozenges. In accordance with her usual practice, Dr C advised Ms A to bring Miss A back if she did not improve, or if they had any concerns. Dr C did not request blood tests at this appointment, as she was aware that Miss A's regular GP had already done so.

37. Dr C told HDC:

> "I note that neither I nor the nurse documented the information that [Ms A] is purported to have given us. I believe the nurse took a good history including immunisations, family history etc … The fact that this lengthy history was not documented by either or us, considering we have recorded many other details, leads me to believe that it is unlikely that we were advised of this."

38. In response to the provisional opinion, Dr C told HDC that she was aware of Miss A's recent medical history, from her own knowledge and experience of having treated Miss A previously, and from reviewing the notes. Dr C noted that at this appointment, the issues with Miss A's sore wrist and ankle seemed to have cleared.

Appointment on 18 January 2019

39. On 18 January 2019, Ms A took Miss A to the booked appointment with her GP, Dr E, at Medical Centre 3. Dr E had not received any clinical notes or X-ray results from The Palms regarding Miss A's previous three presentations. Ms A told HDC that she was surprised by this, as each time she presented to The Palms she was asked for the name of Miss A's usual GP. Ms A explained to Dr E Miss A's medical history and everything that they had gone through over the last month.

40. Ms A stated:

> "[Dr E] really listened to everything I had been through and took the time to do a thorough exam and asked us questions and went through and explained potential reason for results [of the] blood test."

41. Miss A's blood test results were abnormal, and showed that she had low haemoglobin and iron levels,[6] a high platelet and neutrophil count,[7] and a high CRP level.[8] Dr E documented:

> "Weight loss and also several joints having tenderness and pain. Anaemia on blood test performed 10/1/19 … Temp 38.0°C … loud heart sounds at left side of chest but

[6] Low haemoglobin and iron levels usually indicate that a person has anaemia.
[7] A high neutrophil count indicates an infection in the body.
[8] An increasing or high amount of CRP in the blood suggests acute inflammation or infection.

> quiet heart sounds at right side of chest … [Impression]: weight loss and multiple problems ? cause. Plan: [Discussion with] paediatric registrar, [the public hospital], To be see[n] in Child Assessment Unit [the public hospital]."

42. Dr E contacted the registrar at the children's ward of the public hospital and explained what Miss A had been through over the last month and expressed concern. The registrar agreed to admit Miss A to the Child Assessment Unit right away for further investigations.

Admission to hospital

43. Miss A was admitted to the Child Assessment Unit at the public hospital at approximately 7pm on 18 January 2019. Ms A told HDC that this was the first time she felt that her concerns were being heard. The Child Assessment Unit documented an initial impression of a "6 year old girl, non-specifically unwell for months with pallor then monoarthritis[9] [right] ankle with arthralgia[10] of multiple large joints. Recent cough & fevers." Miss A was also found to have a heart murmur.[11]

44. Miss A's diagnosis remained unclear for the first week of her hospital admission, and initially there was no unifying diagnosis to explain all of her symptoms. However, further investigations showed evidence of carditis[12] and arthritis, and an impression of acute rheumatic fever (ARF)[13] became more likely. The public hospital noted that Miss A did not have typical migratory polyarthritis, was the wrong demographic[14] for ARF, and did not live in an overcrowded house, and said that even after further input was sought from a paediatric cardiologist and a paediatric rheumatologist, Miss A was not felt to have met the criteria for ARF until 25 January 2019.

45. On 25 January 2019, a week after her admission to hospital, Miss A was diagnosed with ARF and penicillin was commenced. However, an echocardiogram showed that Miss A had severe mitral regurgitation, and she was kept in hospital on strict bed rest until 13 March 2019.

Further information

The Palms

46. The Palms acknowledged Ms A's concerns that Miss A's ARF was not diagnosed sooner, but believes it was not a diagnosis that could have been made in primary care. The Palms stated:

[9] Inflammation of one joint at a time.
[10] Pain in a joint.
[11] Sound of blood flowing through the heart.
[12] Inflammation of the heart.
[13] Rheumatic fever is an autoimmune disease that causes inflammation of the heart, joints, brain, and skin. If left untreated, it can develop into rheumatic heart disease and cause serious heart problems.
[14] According to the Ministry of Health, causative factors for ARF include economic deprivation, household crowding, poor health literacy, and a lack of access to health care. Rheumatic fever in New Zealand predominantly affects Māori and Pacific young people aged 5–14 years from socioeconomically deprived areas.

> "External pediatricians were consulted but making the diagnosis proved to be a complicated, drawn out process and baffled many of the specialists … It wasn't until one week following admission that [Miss A] was felt to meet the criteria for Acute Rheumatic Fever. Consequently, we do not feel that this was a diagnosis that could have been made in primary care."

47. The Palms said that Miss A's presentation has been very educational, and that her case has been discussed amongst colleagues and at The Palms practice peer review meeting.

48. Regarding Miss A's clinical notes, The Palms told HDC that as an Urgent Care Centre it is a contractual requirement to forward notes to a patient's GP. The Palms acknowledged that this did not occur in Miss A's case, and stated: "We sincerely apologise, as this likely complicated her own GPs management of [Miss A]."

49. The Palms said that it had recently changed its practice management system (PMS), which was a major undertaking for the practice and involved significant background preparation, technological upgrades, data cleansing, and staff training. Staff had had the opportunity to learn some basic aspects of the system before it went live, but specific training on how to send casual notes to another GP was not included in the training. The Palms stated that further training has since been undertaken, and that its primary health organisation has taken steps to ensure that all practices that adopt a new PMS understand how to send notes to other practices.

Dr D

50. In response to this complaint, Dr D told HDC:

> "After a lot of reflection and self-critique, I believe there are improvements and lessons that could be gained from this; to write comprehensive medical records following every interaction with patients, and to endeavour to reduce risk and improve patient outcome."

51. Dr D stated that in April 2019, she asked the Clinical Manager of Medical Centre 2 to perform a random audit of her documentation. The results of the audit were provided to HDC. The audit found Dr D's notes to be excellent, and raised no concerns.

Dr B

52. Dr B told HDC that in retrospect, had she picked up Dr C's note of 14 December 2018 noting that Miss A had been complaining of pain in a different joint and had a history of slight fevers, she would have ordered blood tests to investigate.

53. Dr B stated:

> "The experience has impressed upon me the important learning that even children who are not in the most at-risk category for rheumatic fever are nevertheless susceptible to the illness."

54. Dr B has since modified her index of suspicion of the illness, and stated that should she encounter a situation like Miss A's again — a presentation with a painful joint that cannot be attributed to a specific trauma — she will ensure that appropriate diagnostic tests are done.

Dr C

55. In response to this complaint, Dr C said that she consulted paediatricians about the background of the diagnosis to understand what could have been done better. She has since reviewed the diagnosis and management of rheumatic fever, and has read many articles regarding atypical presentations of rheumatic fever.

Responses to provisional opinion

56. Ms A was provided with the opportunity to comment on the "information gathered" section of the provisional opinion. She reiterated that at the appointment on 12 January 2018 she went into great detail about Miss A's health over the preceding few weeks. Ms A stated: "I 100% know I explained everything."

57. The Palms was provided with the opportunity to comment on the provisional opinion, and its comments have been incorporated into this report where relevant.

58. Dr C was provided with the opportunity to comment on the relevant sections of the provisional opinion, and her comments have been incorporated into the report where relevant.

59. Dr D was provided with the opportunity to comment on the relevant sections of the provisional opinion, and had no comments to make.

60. Dr B was provided with the opportunity to comment on the relevant sections of the provisional opinion, and told HDC that she accepts the Commissioner's findings and recommendation.

Opinion: Introduction

61. Between 14 December 2018 and 12 January 2019, Miss A became increasingly unwell and saw a doctor four times. At her appointments, Miss A was treated episodically. X-rays revealed no musculoskeletal cause for her symptoms, and no further investigations were sought by the doctors to explore her symptoms. On 25 January 2019, one week after her admission to hospital, Miss A was diagnosed with ARF and severe mitral regurgitation. She was kept in hospital on strict bed rest until 13 March 2019.

62. I acknowledge the difficulty in making Miss A's diagnosis. Miss A's presentation was unusual for ARF, and this is evidenced by the time it took paediatric specialists to make the correct diagnosis. However, the issue in this case is not the failure to make the correct

diagnosis earlier, but rather the failure to investigate Miss A's repeat presentations of migratory acute arthritis in the presence of fevers with no convincing history of injury, in a timely manner.

Opinion: The Palms Medical Centre Limited — breach

Introduction

63. Out of Miss A's four presentations, three were to The Palms Medical Centre. Large medical facilities such as The Palms make it more likely that a patient will be seen by different providers over the course of their presentations. As I have emphasised in previous cases, continuity of care is vital, and it is essential for staff at such medical centres to think critically and work together effectively in order to facilitate continuity. When providers treat patients episodically instead of looking at the big picture, important diagnostic clues can be missed.

Deficiencies in care

64. Miss A was not a registered patient of The Palms, and presented to the urgent queue three times. She was seen by Dr C on 14 December 2018 and 12 January 2019, and by Dr B on 19 December 2018.

65. Both doctors at The Palms treated Miss A episodically, aiming to treat her presenting symptoms without taking into account her previous presentations. As my expert advisor, GP Dr Ian St George, stated: "It is the history that is important." Dr B admitted that at the 19 December 2018 appointment, had she picked up Dr C's previous note, which remarked that Miss A had been complaining of pain in a different joint and had a history of slight fevers, she would have ordered blood tests to investigate. Dr C believes that it is unlikely that she was advised of Miss A's clinical history at the 12 January 2019 appointment. However, Miss A's clinical history as recorded at The Palms appointments of 14 and 19 December 2018, as well as the appointment at Medical Centre 2 on 17 December 2018, is documented clearly in Miss A's clinical notes, which were available to Dr C.

66. Both doctors at The Palms failed to think critically when Miss A presented multiple times, and her previous medical history and presentations were not considered. Neither Dr C nor Dr B thought to request further investigations after the X-rays undertaken revealed no musculoskeletal cause for her symptoms. It is concerning that Ms A had to take matters into her own hands and request a blood test herself. Once the results of Miss A's blood test were received, it became clear that Miss A was clinically unwell and that specialist care was needed.

67. My expert advisor, Dr Ian St George, considers that there were departures at each of the appointments. He stated that the departures were significant and serious in terms of the delayed diagnosis and possible development of carditis, but are understandable in terms of the rarity of ARF. I accept this advice.

68. The Palms acknowledged Ms A's concerns that Miss A's ARF was not diagnosed sooner, but believes that it was not a diagnosis that could have been made in primary care. As stated above, the issue in this case is not the failure to make the correct diagnosis earlier, but rather the failure of doctors to investigate Miss A's repeat presentations appropriately in a timely manner.

69. The doctors at The Palms failed to think critically, work together effectively, and look at the bigger picture when providing care to Miss A. Dr St George stated that this case highlights a lack of continuity of care. He advised:

> "[N]o one doctor appreciated the importance of the developing syndrome typical of the disease. Those who saw [Miss A] did so afresh each time and were unable to see the developing pattern of symptoms and signs. That is because care was fragmented, because adequate records were not transferred to her general practitioner and because she had not complained of sore throat and did not fit a preconceived socioeconomic and ethnic stereotype."

70. The failure of The Palms Medical Centre and its staff to investigate Miss A's multiple deteriorating presentations meant that she was denied the opportunity for earlier diagnosis and treatment. Dr St George considers that important clues were missed or misinterpreted at these appointments.

71. This case highlights the shortcomings of treating patients episodically, and the importance of critical thinking when a patient presents multiple times in a short timeframe, particularly when multiple providers are involved. Critical thinking and good inter-provider communication are essential.

Sharing of clinical notes

72. Despite Miss A presenting to The Palms Medical Centre three times and undergoing two X-rays, none of the clinical records or X-ray results were sent to Miss A's registered GP, Dr E. Regarding the accepted practice of note sharing between medical practices, Dr St George advised:

> "There should be a full record of every consultation, including findings, diagnosis and management, conveyed electronically the same or next day to the general practitioner with whom the patient is registered …"

73. The Palms told HDC that as an Urgent Care Centre, it is contractually required to forward notes to a patient's GP. The Palms stated that at the time of these events it had recently changed its PMS, and specific training on how to send notes to another GP was not included in the training provided before the new system went live. Unfortunately, this resulted in Miss A's notes not being forwarded to her GP.

74. The Palms sincerely apologised for this, and acknowledged that the omission likely complicated Dr E's management of Miss A. Dr St George advised that had Miss A's notes been forwarded to Dr E, "this may well have alerted the GP to the pattern of recurrent

fever and migratory polyarthropathy and may have suggested an earlier synthesising explanation". Communication between providers is an essential aspect of continuity of care, and I consider that by failing to share Miss A's notes with her GP, The Palms further hindered the care provided to her during the period in question.

75. The Palms told HDC that further training on how to send notes to other GPs has since been completed, and that its primary health organisation has taken steps to ensure that all practices that adopt a new PSM understand how to send notes to other practices.

Conclusion

76. In my view, the quality and continuity of Miss A's care was hindered by the failures of the doctors at The Palms to think critically about Miss A's presentations, look at the big picture, and work effectively both together and with Miss A's GP. These failures deprived Miss A of the opportunity for earlier investigations and interventions that potentially could have prevented the severity of her condition.

77. I acknowledge that there were individual failures in the care provided to Miss A over this period (discussed further below). However, after multiple presentations, no staff member at The Palms thought to investigate further, and this is indicative of a pattern of poor care across the practice, for which ultimately The Palms is responsible. For the above reasons, I find that The Palms Medical Centre Limited failed to provide Miss A with services with reasonable care and skill and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code). [15] In addition, the doctors at The Palms failed to co-operate effectively with each other and with Miss A's GP to ensure that Miss A was provided with quality and continuity of services. Accordingly, I find that The Palms Medical Centre Limited also breached Right 4(5) [16] of the Code.

Opinion: Dr C

14 December 2018 appointment

78. Miss A presented to The Palms for the first time on 14 December 2018 with arthralgia in the wrist, blepharitis, and a fever. She was seen by Dr C, who queried a fractured wrist and a viral illness. An X-Ray was requested to look for any injury or infection. The X-ray report noted soft tissue swelling in the wrist with no fracture or growth plate injury. Dr C discharged Miss A home with paracetamol, eye ointment, and a sling for her wrist.

79. My expert advisor considers it unwise to diagnose injury without a history of injury. However, at this appointment it was noted that Miss A had played sport the previous

[15] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."
[16] Right 4(5) of the Code states: "Every consumer has the right to co-operation among providers to ensure quality and continuity of services."

Monday, and this coincided with the start of her sore wrist. I acknowledge that at this appointment, Dr C considered that there was in fact a history for Miss A's injury.

80. Dr St George also advised that it is unwise to make two separate diagnoses (injury and viral illness) instead of looking for a unifying explanation, and I remind Dr C of this.

12 January 2019 appointment — adverse comment

81. Miss A was seen by Dr C again on 12 January 2019. This appointment was Miss A's fourth presentation to a medical centre in one month, and her third presentation to The Palms. On this occasion, Miss A presented with a cough and a recent clinical history of migratory sore and inflamed joints and fevers. Ms A told HDC that she relayed Miss A's full medical history to Dr C at this appointment.

82. Dr C disagrees with this, and told HDC:

> "I note that neither I nor the nurse documented the information that [Ms A] is purported to have given us. I believe the nurse took a good history including immunisations, family history etc … The fact that this lengthy history was not documented by either of us, considering we have recorded many other details, leads me to believe that it is unlikely that we were advised of this."

83. Regardless of what Dr C was or was not told by Ms A, Miss A's history from both The Palms appointments of 14 and 19 December 2018, as well as the appointment at Medical Centre 2 on 17 December 2018, is clearly documented in Miss A's clinical notes. Dr C told HDC that she was aware of Miss A's recent medical history, from her own experience and knowledge from having treated Miss A previously, and from reviewing her notes.

84. At the 12 January 2019 appointment, Dr C undertook routine checks of Miss A's throat, lungs, ears, and chest. Miss A did not have a temperature at this time, but a check of her weight revealed a loss of almost 1kg since the appointment of 14 December 2018. Dr C diagnosed a viral illness and recommended cough lozenges. She did not request blood tests, as she was aware that Miss A's GP had already done so.

85. Dr St George advised: "[T]he assessments and tests undertaken at this consultation were inadequate and inappropriate, given Miss A's presenting symptoms …"

86. Miss A's presentation on 12 January 2019 may have appeared to be that of a short-term "viral" cough; however, when paired with a background of multiple recent presentations of fevers, migratory sore and inflamed joints, and weight loss, critical thinking should have been applied, and further investigations should have been made. Whilst I acknowledge that Dr C did not request blood tests at this appointment as she was aware that Miss A's GP had already done so, I consider that Dr C could have sought further investigations, for which I am critical.

Opinion: Dr D — adverse comment

Appointment of 17 December 2018

87. Ms A took Miss A to see Dr D at Medical Centre 2 on 17 December 2018, as Miss A was suddenly unable to walk or comfortably put weight on her right foot. When she presented, Miss A also had a low-grade fever of 37.9°C.

88. While Dr D did not have access to Miss A's clinical records from The Palms of her 14 December 2018 appointment, Ms A told HDC that she explained Miss A's recent medical history, including her previous presentations to The Palms with a sore wrist and a fever. Dr St George advised that access to previous clinical notes is not as important as what the patient says, and I agree.

89. Routine checks of Miss A's skin, ears, nose, throat, and chest were undertaken, and Dr D examined Miss A's upper and lower extremities to check for concerning features or signs. A urine test was performed to rule out a urinary tract infection, and a compression bandage was applied to Miss A's foot to relieve the pain. The urine test showed no abnormalities, and Dr D discharged Miss A with advice to see her GP if there were any changes or deterioration.

90. Although Miss A presented to Medical Centre 2 with only one sore joint, Dr D was aware that previously Miss A had seen a doctor for pain in a separate joint. Dr St George stated that with any presentation of joint symptoms, it is important to ask about other joints — it is the history that is important.

91. Dr D told HDC:

> "My assessment at the time was that [Miss A] was not clinically unwell. She had a leg/foot pain which was possibly musculoskeletal related, and at the same time had a non-specific viral illness with no focal infection identified."

92. As stated above, Dr St George advised that it is unwise to diagnose an injury without a history of injury. Further, he said that it is unwise to make two separate diagnoses (injury and a viral illness) instead of looking for a unifying explanation. With the knowledge that a few days previously Miss A had presented to The Palms with fevers and pain in a different joint, further investigations should have been undertaken. Dr St George advised that while possibly Miss A's symptoms could have suggested a viral illness with associated reactive arthropathy, the persistence of Miss A's symptoms suggested a more serious cause. A patient's clinical history and a view of the bigger picture are important to avoid treating a patient episodically.

93. My expert advisor considered that appropriate blood tests should have been ordered at this appointment, and I am critical that Dr D omitted to order these tests to investigate Miss A's symptoms further.

Documentation

94. Dr D told HDC that at this appointment she would have conducted a thorough check of Miss A's skin, throat, ears, and chest, as well as the upper and lower extremities. Ms A confirmed that Dr D performed the routine checks on this occasion; however, Miss A's clinical record contains no documentation of any assessments undertaken at this appointment.

95. Dr St George advised that "there should be a full record of every consultation, including findings, diagnosis and management". The Medical Council of New Zealand's publication "Managing patient records" states that patient records are a crucial part of medical practice, as they help to ensure good care of patients, and clear communication between doctors and other health practitioners. This is particularly important when multiple providers are involved. I am critical of the lack of documentation at this appointment, and remind Dr D of the importance of keeping comprehensive clinical notes at every consultation. I acknowledge the subsequent self-initiated audit of Dr D's clinical notes, and am pleased that the results of the audit indicate an improvement in her documentation.

Opinion: Dr B — adverse comment

96. Miss A was seen by Dr B on 19 December 2018 at The Palms Medical Centre. This appointment was Miss A's third presentation to a medical centre in one week, and was her second presentation to The Palms. At each previous appointment, Miss A had presented with a sore joint (wrist or ankle) with no apparent mechanism of injury, and a history of fevers.

97. Dr B noted that Miss A's ankle was swollen, and that although she had presented to Medical Centre 2 a few days earlier with the same complaint, no X-Ray had been undertaken. Dr B requested an X-Ray to rule out a fracture. The X-Ray showed no injury, arthritis, or infection but Dr B applied a back slab to Miss A's foot to immobilise the joint, and sent her home.

98. Dr St George stated:

> "[C]lear polyarthopathy, again sprain (of two joints!) diagnosed in the absence of injury; rheumatic fever investigations should have been thought of. Use of plaster backslab inexplicable."

99. Dr B explained that she used a back slab to immobilise Miss A's painful joint to minimise the risk of any aggravation to her injury.

100. I consider that placing a back slab on Miss A's foot and sending her home was inappropriate for her presentation, and that once the X-ray showed no fracture in Miss A's foot, more should have been done to investigate the reason for her pain.

101. Dr St George advised that appropriate blood tests should have been ordered at this appointment to investigate the cause of Miss A's symptoms. Dr B told HDC that she did not consider ordering blood tests at this appointment, as her impression was that of a traumatic injury, for which a blood test would serve no purpose. She noted that while the mechanism of injury was unknown, she attributed this to Miss A's age. Dr B acknowledged that in the circumstances — a painful joint without a known cause, against a background of a recent presentation with pain in a different joint — bloods should have been ordered.

102. Dr St George advised that the departure from the accepted standard of care at this appointment was significant and serious in terms of the delayed diagnosis, but stated that it is understandable in terms of the rarity of ARF. Dr B told HDC that had she picked up Dr C's note of 14 December 2018, which recorded that Miss A had been complaining of pain in a different joint and had a history of slight fevers, she would have ordered blood tests to investigate. In my view, Dr B needed to read Miss A's previous notes to the extent necessary to satisfy herself that she had all of the relevant background clinical information. I would expect this to include Miss A's recent presentations to The Palms.

103. It is clear that there was a lack of critical thinking at this appointment, as well as a failure to review Miss A's previous clinical notes. Had Dr B been aware of Miss A's previous presentations and symptoms, this information would have guided her to investigate Miss A's symptoms further, and potentially could have provided Miss A with an earlier opportunity for diagnosis. As stated above, reviewing patient notes is a vital and basic aspect of care, and I am critical that Dr B omitted to do this adequately.

Recommendations

104. I recommend that The Palms Medical Centre Limited:

a) Prepare an anonymised case study on Miss A's care for training of all clinical staff. Evidence that this has been done is to be sent to HDC within six months of the date of this report.

b) Consider facilitating a regular clinical meeting for the purpose of collegial case review of patients who have seen multiple providers for the same or similar complaints over a short period, or in whom a diagnosis is proving elusive. The outcome of this consideration is to be communicated to HDC within three months of the date of this report.

c) Provide Miss A and her family with an apology for the breach of the Code identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding.

105. I recommend that Dr C and Dr D attend the Medical Protection Society's "Mastering Your Risk" workshop. They are each to report back to HDC within eight months of the date of this report, with details of the content of the training and evidence of having attended the workshop.

106. I recommend that Dr B undertake the online *British Medical Journal* learning module "Hospital presentations: joint swelling". Evidence that this has been done is to be sent to HDC within six months of the date of this report.

107. In light of the results of the documentation audit performed subsequent to these events, I do not make any recommendations in relation to Dr D.

Follow-up actions

108. A copy of this report with details identifying the parties removed, except the expert who advised on this case and The Palms Medical Centre Limited (trading as The Palms Medical Centre), will be sent to The Royal New Zealand College of General Practitioners and the primary health organisation and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from GP Dr Ian St George:

"Dear Sir

re **The Palms Medical Centre and [Medical Centre 2], your reference C19HDC00695**

I have read the *Guidelines for independent advisers* and abide by them.

I am Ian Michael St George **MD FRACP FRNZCGP FLS**, a vocationally registered general practitioner. I am a Distinguished Fellow of the RNZCGP, having held various offices in that organisation, including that of Chief Censor. I was for many years a Senior Lecturer in General Practice at Otago University and was Postgraduate Dean at its Wellington School of Medicine. I was an appointed, then an elected member of the Medical Council of New Zealand and was its Vice-President and chair of its Education Committee. I have been editor of the *NZ Family Physician* and of eleven editions of *Cole's medical practice in New Zealand* (Medical Council of NZ 1999–2012), as well as author of over 100 medical papers, chapters and books, including *Assessing doctors' performance* (Medical Council of NZ 2005). I am an expert adviser to the Accident Compensation Corporation and a Designated Doctor and member of the Medical Appeals Board of the Ministry of Social Development.

You ask me to comment on whether the care provided by the Palms Medical Centre and [Medical Centre 2] to [Miss A] was reasonable in the circumstances. In particular you ask me to comment on the following issues:

1. Whether assessments and tests undertaken at each consultation were appropriate, given [Miss A's] presenting symptoms.
2. Whether any further investigations were warranted in light of [Miss A's] persistent joint pain.
3. Whether there was any indication to seek specialist input.
4. The adequacy of the clinical documentation and information sharing with [Miss A's] regular GP practice, [Medical Centre 3].
5. Any other matters I consider amount to a departure from accepted standards.

You ask me to advise, for each issue,

a) What is the standard of care/accepted practice?

b) If there has been a departure from the standard of care or accepted practice, how significant a departure I consider this to be?

c) How it would be viewed by my peers?

d) Recommendations for improvement that may help to prevent a similar occurrence in future.

I will answer these to the best of my ability, and state here that these are my opinions, based on my experience and knowledge of what is good practice and on accepted standards. This was a case of delayed diagnosis of a progressive disease: I have tried therefore not to be biased by hindsight from my knowledge of the eventual diagnosis.

I derive these opinions from the papers you have provided including [Miss A's] mother's clinical diary 3 December 2018 to 18 January 2019: [Dr B's] letter dated 23 May 2019; [Dr D's] letter dated 15 May 2019; the clinical records for [Miss A] from the Palms Medical Centre for 12, 14 and 19 December 2018 and 12 January 2019 with variably relevant attachments; clinical records for [Miss A] from [Medical Centre 2] for 17 December 2018 with variably relevant attachments but including a discharge letter from [the public hospital] dated 10 April 2019 and signed by […]; [a] letter dated 2 May 2019 with clinical records from [Medical Centre 3], including [Dr E's] referral letter of 18 January; clinical records from [the DHB] relating to [Miss A's] [public hospital] admission; [The Palms'] letter of 17 May 2019 with variably relevant attachments.

The history

[Miss A's] mother has detailed the sequence of events and the following sequence relies on her accounts and on the contemporary clinical records.

14 Dec 18: *Palms*; arthralgia wrist, blepharitis and fever; [Dr C] diagnosed sprain ('?fracture') despite no injury and '?viral illness'.

17 Dec 18: *[Medical Centre 2];* wrist pain continues on and off; unable to bear weight from foot arthropathy, fever; [Dr D] did not detail her findings in the foot in her letter but suggested applying a Tubigrip and diagnosed 'nonspecific viral illness' to explain the fever.

19 Dec 18: *A&E*; foot pain severe; unable to wait.

19 Dec 18: *Palms*; extreme foot pain, fever, sore wrist; [Dr B] found swollen big toe and ankle; diagnosed ankle and foot sprain; below knee plaster back slab applied; symptoms improved with immobilisation but recurred; anorexic.

12 Jan 19: *Palms*: [Dr C], cough diagnosed as continuation of 'viral'.

Developing further fever, anorexia, weight loss, polyarthralgia, malaise.

18 Jan 19: [Medical Centre 3]: [Dr E] admitted [Miss A] to hospital where rheumatic fever was diagnosed a week later.

Three different primary care provider organisations, four doctors.

My opinion

New Zealand has the highest incidence of rheumatic fever in the developed world, largely in (but not confined to) genetically susceptible low socioeconomic ethnic groups. Nonetheless a case of acute rheumatic fever is a rare event in general practice: the numbers work out at one case per GP every 20 years.

The question here is purely clinical: should the doctor(s) have suspected acute rheumatic fever at an earlier time? There are criteria for the *diagnosis* of acute rheumatic fever [1] but these do not have to be met for the condition to be *suspected*.

That would require a high index of suspicion, clinical experience, acumen and assessment skill; it has little if anything to do with the adequacy (or audit) of clinical records, the management of test results, risk management workshops or practice policies, difficult patients or delicate scenarios.

It has also to do with continuity of care.

1. Whether assessments and tests undertaken at each consultation were appropriate, given [Miss A's] presenting symptoms.

a) What is the standard of care/accepted practice?

14 Dec: it is unwise to diagnose injury without a history of injury and it is unwise to make two separate diagnoses (injury + viral illness) instead of looking for a unifying explanation.

17 Dec: there were now symptoms of polyarthropathy (wrist and foot) with fever; rheumatic fever investigations should have been thought of.

19 Dec: clear polyarthopathy, again sprain (of two joints!) diagnosed in the absence of injury; rheumatic fever investigations should have been thought of. Use of plaster backslab inexplicable.

18 Jan: [Dr E] did everything correctly.

b) If there has been a departure from the standard of care or accepted practice, how significant a departure I consider this to be?

There were departures, in my opinion, on 14, 17 and 19 December. They are significant and serious in terms of the delayed diagnosis and possible development of carditis, but are understandable in terms of the rarity of this condition.

c) How it would be viewed by their peers? With guarded sympathy.

d) Recommendations for improvement that may help to prevent a similar occurrence in future.

Clinical alertness to uncommon conditions is learned behaviour and these experiences should have been educational in themselves; nonetheless there has been the suggestion that [Miss A's] presentation was 'quite atypical for ARF' because she had not had a sore throat and was not in a high risk group. [Dr D] wrote, furthermore, 'she did not have typical migratory polyarthritis' when quite clearly she did. [Miss A] was a six year old child with migratory large joint arthropathy; her presentation may have been a little unusual but it was by no means atypical.

2. Whether any further investigations were warranted in light of [Miss A's] persistent joint pain.

a) What is the standard of care/accepted practice?

Migratory polyathropathy in a six year old. Possibly a viral illness with associated reactive arthropathy, but that would have been shortlived. Its persistence suggested a more serious cause. Appropriate blood tests (ESR, CRP, ASOT) should have been ordered on 17 and 19 December.

b) If there has been a departure from the standard of care or accepted practice, how significant a departure I consider this to be?

a/a

c) How it would be viewed by their peers?

a/a

d) Recommendations for improvement that may help to prevent a similar occurrence in future.

a/a

3. Whether there was any indication to seek specialist input.

a) What is the standard of care/accepted practice?

The ability to determine that which is self limiting from that which is progressive is the clinical essence of the specialty of general practice; pediatric or cardiologic input would be sought (as it was by [Dr E]) only when rheumatic fever was suspected.

b) If there has been a departure from the standard of care or accepted practice, how significant a departure I consider this to be?

n/a

c) How it would be viewed by his peers?

n/a

d) Recommendations for improvement that may help to prevent a similar occurrence in future.

n/a

4. The adequacy of the clinical documentation and information sharing with [Miss A's] regular GP practice, [Medical Centre 3].

a) What is the standard of care/accepted practice?

There should be a full record of every consultation, including findings, diagnosis and management, conveyed electronically the same or next day to the general practitioner with whom the patient is registered.

b) If there has been a departure from the standard of care or accepted practice, how significant a departure I consider this to be?

I note a sketchy record of the 17 December consultation received by [Dr E] on 18 December from [Dr D], but no other communication to him from Palms or [Medical Centre 2].

c) How it would be viewed by his peers?

With some alarm.

d) Recommendations for improvement that may help to prevent a similar occurrence in future.

Brief records of every consultation, written by the doctor, of symptoms and findings on examination, diagnosis and management, should be conveyed electronically the same or next day to the general practitioner with whom the patient is registered. In [Miss A's] case this may well have alerted the GP to the pattern of recurrent fever and migratory polyarthopathy and may have suggested an earlier synthesising explanation.

5. Any other matters I consider amount to a departure from accepted standards.

This case highlights a lack of continuity of care.

In some such consultation sequences fragmentation of care is inevitable, but people should understand the importance of accurate diagnosis of one doctor observing a developing pattern of symptoms over several consultations.

The recognition of such a pattern is aided by the transfer of good brief clinical notes, but is greatly enhanced when the same doctor sees the patient each time.

In summary

In the circumstances involving the care of [Miss A] about which I have information, the diagnosis of acute rheumatic fever appears to have been delayed because no one doctor appreciated the importance of the developing syndrome typical of the disease.

Those who saw her did so afresh each time and were unable to see the developing pattern of symptoms and signs.

That is because care was fragmented, because adequate records were not transferred to her general practitioner and because she had not complained of a sore throat and did not fit a preconceived socioeconomic and ethnic stereotype.

Yours sincerely

Ian M St George."

Reference

https://www.heartfoundation.org.nz/shop/marketing/non-stock-resources/diagnosis-management-rheumatic-fever-guideline.pdf.

Table 3: New Zealand Guidelines for the Diagnosis of ARF

	Diagnostic Requirements	Category
Initial episode of ARF	2 major **or** 1 major **and** 2 minor manifestations **plus** evidence of a preceding GAS infection*	Definite ARF
Initial episode of ARF	1 major and 2 minor with the inclusion of evidence of a preceding GAS infection* as a minor manifestation (Jones, 1956)[62]	Probable ARF
Initial episode of ARF	Strong clinical suspicion of ARF, but insufficient signs and symptoms to fulfil diagnosis of definite or probable ARF	Possible ARF
Recurrent attack of ARF in a case with known past ARF or RHD	2 major **or** 1 major and 2 minor **or** several† minor **plus** evidence of a preceding GAS infection* (Jones, 1992)[4]	Recurrent ARF
Major manifestations: modified‡ from Jones 1992 (see Table 5 for key points in identifying major manifestations)	Carditis (including evidence of subclinical rheumatic valve disease on echocardiogram)§ Polyarthritis‖ **or** aseptic monoarthritis (with or without a history of NSAID use) *See footnote to* ***Table 4*** Chorea (can be stand-alone for ARF diagnosis) Erythema marginatum Subcutaneous nodules	
Minor manifestations: (see Table 6 for key points in identifying minor manifestations)	Fever Raised ESR or CRP Polyarthralgia‖ Prolonged P-R interval on ECG	

The following further advice was sought from Dr St George:

> "You ask,
>
> *A. Regarding the appointment of 17 December, [Medical Centre 2] stated that they did not have access to [Miss A's] notes from her previous presentation of 14 December (The Palms), and in the clinical notes there was no mention of [Miss A] having a sore wrist. I went back to [Medical Centre 2] to clarify if [Dr D] remembered [Miss A] presenting with a sore wrist as well as a sore foot, please find her response* ***attached****. Can you please advise if this response changes your initial advice regarding the 17 December 2019 appointment?*
>
> [Miss A's] mother states she mentioned the sore wrist and you now tell me [Dr D] recalls it having been mentioned. With any presentation with joint symptoms it is important to ask about other joints. Access to previous notes is not as important as what the patient tells you, but ready exchange of notes is important in attaining at least some semblance of continuity of care.
>
> *B. In point 1a, you also appear to have missed out the appointment of 12 January 2019, [Miss A's] last presentation to The Palms. For the appointment of 12 January 2019, can you please advise:*
>
> *a) What is the standard of care/accepted practice?*
>
> *b) If there has been a departure from the standard of care or accepted practice, how significant a departure you consider this to be?*
>
> *c) How it would be viewed by your peers?*
>
> *d) Recommendations for improvement that may help to prevent a similar occurrence in future.*
>
> The 12 January 2019 appointment notes suggest it was for an unrelated chest infection so I did not comment further on it. I note however that [Miss A's] mother says she 'explained in great length and detail around everything that had happened leading up to that day. They did the routine checks, throat, lungs, ears, chest however she did not have a high temperature this time. I mentioned also the fact she was really starting to feel bony and was worried about her weight. I recalled her weight from the first visit with the sore wrist being 20.3kg so was interested to see what it was now. I asked the nurse if we could weigh her as I was interested as she just felt so skinny and wanted to know if her weight was ok. She was now weighing 19.4kg. I queried if that was normal to lose a kilo and they said they would check her height and check it on the scale chart. They were using some tool on the computer to work this out but they actually came back saying, she's fine and weight was within the right scale and it was just slightly under the line but nothing to worry about. They even said that she was one of those "lucky ones who was tall and lean". I also mentioned the history of type 1 diabetes in all the appointments as was wondering if that was reason for weight loss but she didn't show any other symptoms and I had bloods few days beforehand which

HBa1c. She was still looking washed out still and again said they agreed she did but then this was assumed it was due to the "viral" bug she apparently had for the third time now. She had no chest infection and we were sent away again with another "viral" diagnosis.'

If that is the case then the diagnosis of viral chest infection seems contrary to the statement 'She had no chest infection'. Further the issue was not whether [Miss A's] weight was within the accepted limits for her age and sex, but why she had lost almost a kilogram (5% of her body weight); [The Palms] is wrong to suggest that different clothing could explain a 1kg loss noted by a child's mother. Further the 'explanation at great length and detail around everything that has happened leading up to that day' was not noted at all. In my opinion the assessments and tests undertaken at this consultation were inadequate and inappropriate, given [Miss A's] presenting symptoms, and constitute a significant departure from the standard of care of accepted practice. Our peers would be concerned.

Ian St George."

The following further advice was sought from Dr St George:

"I have reviewed these responses and have no further comment to make except to point out that migratory arthritis means just that — it comes and goes, *migrates,* so may not be present when the child is examined. *It is the history that is important*.

Of course her presentation was not entirely typical, *of course* this is still a rare condition in general practice — and I acknowledge that the paediatricians took time to reach the diagnosis late in the course of the illness.

Most of us would have a great deal of sympathy for the doctors who were faced with this situation and are now faced with the realisation in hindsight that they were seeing a progressive and serious illness.

Nonetheless, I believe important clues were missed or misinterpreted, as I outlined in my report.

Ian St George"