General Practitioner, Dr A / Medical Centre

Opinion – Case 00HDC02054

Complaint

The Commissioner received the following complaint from Constable E, on behalf of the consumer, Ms F's, family:

- *At about 10:50am on 4 August 1999 Ms F was taken to see the general practitioner, Dr A, by her caregiver, as she appeared to be unwell. Dr A did not examine Ms F thoroughly or undertake enough tests into the cause of her problems. Dr A had been Ms F's GP for four years and was familiar with her ways, yet he did not attempt to examine her.*
- *Ms F returned to see Dr A at about 4:15pm on 4 August 1999. Dr A again did not examine Ms F; he only asked the caregiver what had changed since he had seen her that morning. Dr A's attitude was casual and he did not take Ms F's caregivers' concerns about her condition seriously.*
- *Dr A arranged for Ms F to be assessed at the public hospital but he did not organise for an ambulance to transfer her there immediately.*
- *Dr A has no records of the consultations with Ms F on 4 August 1999.*

Investigation Process

The complaint was received on 25 February 2000 and an investigation commenced on 27 March 2000.

Information was received from:

Dr A	Provider / General Practitioner
The medical centre	Provider / Medical Centre
Mrs B	Caregiver, the Home
Mrs C	Caregiver, the Home
Ms D	Caregiver, the Home
Constable E	Inquest Officer, New Zealand Police
Hospital and Health Services	Public Hospital

Relevant medical and post mortem records were also reviewed. Advice was obtained from an independent general practitioner.

General Practitioner, Dr A / Medical Centre

Opinion – Case 00HDC02054, continued

Information Gathered During Investigation

Background

Ms F was a 39-year-old Maori woman who lived at a home for physically and mentally disabled people ("the Home"). Ms F had meningitis as a child and required full-time care due to her resulting severe intellectual disability. Ms F also had a history of epilepsy, which was managed well with medication (Tegretol and Epilim).

Ms F's caregivers described her as a very active lady who was non-verbal but communicated through her body language. Her general health was good apart from the odd ear infection or cold. Ms F was described as being "*always on the go*" and she was lucky to sleep eight hours at night. She had several habitual behaviours including ripping paper and pulling threads or buttons off clothing. She would also go into other residents' rooms and take things without permission. Ms F had no fear; for example, if she saw something bright in the middle of the road she would simply go across to get it. If she was angry or frustrated she would hit herself or gouge the skin on the back of her hands. Even when sitting still, some part of her body, for example toes or fingers, would be moving.

Caregiver Mrs B had worked with Ms F for seven years as her key support worker. They had become very close and Mrs B said that Ms F had become like a daughter to her. They spent much time together both at the Home and at Mrs B's home. On 3 August 1999, Mrs B worked from 7:00am until 3:00pm. She took Ms F to her regular therapy session at the hospital. Mrs B said that during this session Ms F behaved strangely; instead of concentrating on the therapy activities she kept crawling around on the floor.

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General Practitioner, Dr A / Medical Centre

Opinion – Case 00HDC02054, continued

Information Gathered During Investigation ***continued***

Caregiver Ms G had known and worked with Ms F for nine years. Ms G worked the night shift at the Home beginning at 10:00pm on 3 August 1999. In a statement to Constable E, Inquest Officer, New Zealand Police, dated 22 February 2000, Ms G stated that Ms F had been far more active than usual that evening and would not settle down. As the night progressed she noted that Ms F was very cold. When walking Ms F was stooped over and took very small steps. Ms G said that she suspected Ms F might have had something stuck inside her, so checked but found nothing. Ms F was not debuttoning and dethreading garments as she usually did; instead she had her hands closed and fists clenched. Ms F's eyes were darting here and there and Ms G thought there might be something wrong with her. Ms F was given a hot drink, which she drank unusually quickly. Ms G checked Ms F's stomach and said it was firm, but she noticed nothing unusual. At 2:00am or 3:00am Ms G found Ms F lying in another resident's bed with him. She said this was unusual behaviour, as Ms F had never done that before. Ms G took Ms F back to bed and a few minutes later Ms F got into another resident's bed with him. Ms G said that Ms F had not previously approached the male residents like this.

Mrs B arrived for work at the Home at 6:00am on 4 August 1999. Ms G described Ms F's strange behaviour to her, and said that Ms F had been hunched over and cold all night. Ms G stated that Mrs B went to check Ms F's stomach and very gently pressed her lower abdomen. At this point Ms F backed away and her face distorted as if to register pain. Ms G left the Home at about 6:15am.

Mrs B stated that the night staff told her Ms F had not eaten dinner the night before, had slept very little and had been behaving erratically – she would get up, take her clothes off, wander around then sit down and repeat the process. Mrs B said that when she came on duty Ms F was incessantly walking around and her eyes were sunken and rolling around making it hard for her to focus. Mrs B said that she understood Ms F's body language and eye contact and she believed there was something very wrong with her that morning, requiring urgent medical attention.

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General Practitioner, Dr A / Medical Centre

Opinion – Case 00HDC02054, continued

Information Gathered During Investigation *continued*

Visit to the medical centre

Staff decided that Ms F needed an urgent doctor's appointment so they telephoned the medical centre, the general practice that residents at the Home were usually taken to. Mrs B was told that the medical centre's doctors were fully booked that morning but to bring Ms F down and wait for a doctor to be free. Mrs B and Ms F arrived at the medical centre between 9:30 and 10:00am, and saw Dr A just before 11:00am. During the waiting time Ms F was stooped over, could hardly stand or walk, and crawled around on the floor. Crawling on the floor was not normal behaviour for Ms F. Mrs B supposed that she did this because she was in pain. Mrs B had given Ms F a hot water bottle on the way to the medical centre and Ms F simply wanted it left on her stomach.

Dr A is a general practitioner employed at the medical centre in the town. Before 9 August 1999 Dr A had seen Ms F only once, in December 1998, for an ear infection. He advised me that he was not familiar with Ms F's usual behaviour.

Dr A explained that appointments to see the medical centre doctors are usually on a 15 minute basis, but that their usual practice is to do their best to see everyone who comes to the medical centre whether or not they have an appointment. Ms F was seen as an acute unbooked patient. Dr A explained that nursing staff usually assess acute unbooked patients like Ms F before being seen by a doctor. He was not sure why Ms F was not assessed in this way, but assumed that it was likely to be either because of pressure on nursing staff or the difficulties in treating Ms F.

Mrs B said that she took Ms F into the consulting room with Dr A and told him that there was something wrong with her; that she had been unwell since the day before, but had not been vomiting. Dr A asked if Ms F had a temperature; Mrs B replied that she did not think so but he should look and find out for himself. Dr A asked what the problem was, and Mrs B told him about Ms F's symptoms, erratic behaviour, swollen stomach, sunken eyes and lack of appetite. She pointed out that Ms F was stooped over. Mrs B stated that she got Ms F to sit on the table but she would not lie down and got off the table.

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General Practitioner, Dr A / Medical Centre

Opinion – Case 00HDC02054, continued

Information Gathered During Investigation ***continued***

Mrs B said that Ms F was sitting in the chair and she lifted Ms F's clothes so that Dr A could see her stomach. She said that Dr A tried to examine Ms F's stomach but Ms F would not allow him to touch her stomach, so it was a quick and cursory examination; Dr A felt around the top of Ms F's stomach, but not the bottom. He managed to briefly touch Ms F's stomach and put a stethoscope on it. Mrs B stated that Dr A did not attempt to take Ms F's blood pressure or temperature. Mrs B knew that Ms F had cold hands and feet but did not think to mention it to him.

Mrs B asked Dr A if he was going to do any tests on Ms F to find out what was wrong with her. He arranged for some blood and urine tests to be taken later that day at the Home. (Laboratory staff came to the house at about 1:30pm to take blood and urine from Ms F. Staff had to hold Ms F still so that the blood could be taken, and she was very upset during this procedure.)

Mrs B advised me that Dr A told her to take Ms F home, give her Panadol and put her to bed. He said that if she developed a fever or became worse to rush her to the public hospital. Mrs B said that Dr A did not discuss with her the need for any follow-up appointment once blood and urine test results had come through. She stated that no follow-up appointment with him or another doctor at the medical centre was made for later that day.

Dr A stated in a letter to Constable E dated 6 December 1999 (written from memory, as Ms F's records were unavailable) that on the morning of 4 August he saw Ms F and her caregiver. Ms F was unable to give a history herself because of her intellectual impairment. Mrs B told him that Ms F had been unwell over the preceding day, in apparent pain, off her food, restless and distressed with a distended abdomen. She had apparently not been vomiting and the state of her bowel and bladder function was not known. Dr A wrote that on examination Ms F was very restless, and constantly paced around the consulting room, intermittently sitting on the floor cradling her abdomen, making it impossible to examine her beyond making the most basic observations.

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General Practitioner, Dr A / Medical Centre

Opinion – Case 00HDC02054, continued

Information Gathered During Investigation *continued*

Dr A wrote that Ms F was not obviously febrile or dehydrated, her pulse was regular and her blood pressure was not recorded. He later explained to me that Ms F would not sit still for long enough to co-operate with procedures to allow her blood pressure and temperature to be taken. Ms F's temperature was not recorded in Dr A's notes nor did he record an attempt to take it. Dr A stated that during his attempt to examine Ms F, Mrs B was trying to make her feel more comfortable, but the examination was very difficult because of Ms F's distress. She did not appear to have any respiratory distress and her level of consciousness was normal. Dr A further wrote that Ms F's abdomen was distended but it was not possible to detect any localised masses or tenderness or to assess the state of her bowel sounds.

At interview with my staff, Dr A stated that it had not been possible for him to palpate Ms F's abdomen in detail, but she appeared to have no localised tenderness, and her bowel sounds were normal.

Dr A stated in his letter to Constable E that Ms F appeared to have an abdominal problem but her problem was not so acute as to warrant an immediate admission to hospital. Dr A stated to me that he considered but discounted the possibility of a bowel obstruction as there was no history of vomiting and a recent bowel motion was reported by Mrs B. (It was later confirmed to me by another caregiver, Mrs C, that Ms F had a small bowel motion the previous day, which was described as "*hard marbles*".) As there was no history of vomiting Dr A thought that perhaps it was a sub-acute process.

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General Practitioner, Dr A / Medical Centre

Opinion – Case 00HDC02054, continued

Information Gathered During Investigation *continued*

In response to my provisional opinion Dr A explained that his initial impression was that Ms F had a bowel obstruction. However, Mrs B was clear that Ms F had not been vomiting. He wrote:

> "*Acute bowel obstruction classically presents with the triad of pain, vomiting and abdominal distension, and although vomiting may very occasionally be absent, this is usually in frail elderly persons.* [Ms F's] *general demeanour with her restlessness interspersed with periods of holding her abdomen and flexing her hip would be typical of someone experiencing colicky pain, (the sort of pain associated with a number of conditions including obstruction) and she was certainly distended. However I felt that in the absence of vomiting a diagnosis of acute obstruction unlikely. I also reviewed her medical records and there was no mention of any condition, especially previous abdominal surgery, that was likely to predispose to obstruction.*
>
> *The history provided by her caregiver was inevitably non specific, the principal point being that her behaviour was not normal. Out of character behaviour may of course be quite significant, and I was particularly aware of this in* [Ms F's] *case as she was unable to verbally communicate how she felt. However I also had to balance this with the fact that certain behaviours she was exhibiting were normal, namely her restlessness and her response to being examined. I did not have before me then the extent of information that I have now read in your provisional opinion.*
>
> *From the beginning of the consultation it was obvious that* [Ms F] *would be difficult for me to examine especially as we were unacquainted with each other. I was unable to make detailed recordings of her blood pressure or temperature, but I was able to make some general observations of* [Ms F] *and to take her pulse which was regular.*

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General Practitioner, Dr A / Medical Centre

Opinion – Case 00HDC02054, continued

Information Gathered During Investigation *continued*

I carried out a limited examination principally to determine if there were any clinical signs of another acute abdominal condition responsible for her presentation. Although necessarily brief, I was able to determine that [Ms F's] *abdomen, although distended, felt soft with no apparent localised tenderness or masses and that bowel sounds were present. I was reasonably certain therefore that I could also exclude an acute inflammatory process such as peritonitis that would require surgical intervention.*

At this point I was very unsure of the diagnosis and it was obvious that further investigation would be needed. Because of my diagnostic uncertainty I considered there and then referring [Ms F] *to hospital. However in the absence of any clinical evidence of an acute surgical condition, the practical difficulties in obtaining investigations, especially an erect abdominal X ray, and wanting to avoid unnecessary stress on* [Ms F]*, I deferred this decision. On balance I felt it reasonable to initiate some investigations myself and review* [Ms F] *later in the day, a process I estimated would take about four hours.*

I considered discussing [Ms F's] *case with the medical registrar at* [the public hospital] *as it was likely that* [Ms F] *would need admission at some point, but felt that he/she would probably agree with this course of action anyway. Accordingly I made arrangements for routine blood and urine tests and sent* [Ms F] *home to be monitored by her care givers and to see her later that afternoon.*

I instructed [Mrs B] *that, if* [Ms F] *should develop any symptoms such as fever, diarrhoea, and especially any vomiting, before I saw her again in the afternoon, she should be taken to* [the public hospital]*. I said this because I felt that these were objective signs of illness for which an acute admission should be made and that it would save time, in these circumstances, if* [Ms F] *went straight to hospital.*"

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General Practitioner, Dr A / Medical Centre

Opinion – Case 00HDC02054, continued

Information Gathered During Investigation ***continued***

Dr A confirmed that he arranged for some blood tests to be performed and sent Ms F home, to be kept under observation.

Contrary to Mrs B's statement that no follow-up appointment was made for later that day, Dr A advised me that he organised a follow-up appointment for 3:30pm that afternoon when the blood test results would be available, and told Mrs B to return then so he could reassess Ms F's situation. In response to my provisional opinion Dr A explained that having advised Mrs B that he would reassess Ms F after her test results had returned, he left the arrangements as to the next appointment's timing to be organised by Mrs B with reception. Dr A stated that this is usual practice at the medical centre, and he assumed that Ms F would be fitted in to see him that afternoon, as she had been that morning.

Dr A explained that he intended to reassess Ms F's situation in light of the blood and urine test results. He expected to receive the results within two or three hours of the samples being taken. If the test results were abnormal he planned to refer Ms F as an acute abdomen to hospital, but if the results were normal he would give her pain relief and make a non-acute referral to hospital. Dr A said that he told Mrs B to return if there was any change in Ms F's condition; specifically if there was any vomiting, diarrhoea or fever she was to return immediately. Dr A stated that he gave no instructions about pain relief.

In Ms F's medical records Dr A recorded that she had been restless the night before and that morning and seemed to be in pain. She was walking stooped over and had a decreased appetite but no vomiting. She was passing urine and had had a normal bowel motion the day before. On examination Ms F was extremely restless so he had been unable to examine her properly. Her abdomen was distended, bowel sounds normal, and he wrote "*?no localised tenderness*". She was afebrile (no fever). He recorded that blood test and midstream urine tests had been ordered and that she was to return if vomiting, diarrhoea or fever commenced. There is no record of a follow-up appointment having been organised.

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General Practitioner, Dr A / Medical Centre

Opinion – Case 00HDC02054, continued

Information Gathered During Investigation ***continued***

Mrs B's impression was that Dr A could not be bothered to examine Ms F thoroughly because she was different: non-verbal and handicapped. He did not question her on her view of Ms F's condition. Dr A advised me that his examination was as thorough as was possible under the circumstances. He was concerned at having to rely on Ms F's history as given by her caregivers and queried whether or not it was an accurate history. Ms F's deterioration on second consultation was so marked that Dr A wondered if there had been diarrhoea or vomiting that the caregivers had failed to note.

Afternoon visit to the medical centre

Ms D, caregiver, came on duty at the Home at about 1:00pm on 4 August 1999. Ms D had known Ms F for approximately four years and was familiar with her normal behaviour. Ms D stated that when she arrived Ms F was lying on the couch and looked seriously unwell. Ms D said that Ms F was walking around but was hunched over, and that her body language indicated she was in pain. Ms F would normally be very active in walking around yet at that time she was going into her bedroom to lie on the floor, which was abnormal behaviour.

Ms D was told by Mrs B that Ms F had been to the doctor that morning. The doctor had given her pain relief and told them to push fluids. Ms D stated that she discussed making another doctor's appointment with Mrs B, as no follow-up appointment had been organised for that afternoon. Ms D was sure that there was not already a follow-up appointment with Dr A organised for that afternoon. Ms D telephoned the medical centre and said that she wanted a second opinion from another doctor. The medical centre was again fully booked, but she was told to bring Ms F in and that the medical centre would try to fit her in. Mrs B stated that they asked specifically for a second opinion, as they did not want to see Dr A again. Mrs B stated that when she left work at 2:00pm on 4 August 1999 Ms F was the same, stooping over with her eyes rolling. Her hands were still cold.

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General Practitioner, Dr A / Medical Centre

Opinion – Case 00HDC02054, continued

Information Gathered During Investigation *continued*

When asked to confirm when Ms F's second appointment with Dr A had been organised, the medical centre explained that Ms F's afternoon appointment with Dr A was "*booked*" at 4:41pm on 4 August 1999. The medical centre explained that this probably meant that Ms F had been seen during Dr A's afternoon tea break which was scheduled for 3:30pm, and that her appointment was entered into the computer system after she had been seen.

Ms D and Mrs B described Ms F's normal behaviour during a doctor's appointment. On occasions when Ms F was taken to a general practitioner for examination, Ms F would normally not let the doctor physically examine her. Caregivers would have to be present to hold Ms F's hand and assist the doctor as she would kick out against a physical examination. Usually doctors' appointments were for problems with Ms F's ears. Ms F would carry on with life as usual even when she was sick and thought to be in pain, for example, from an ear infection. Staff would only know she had an ear infection once an ear abscess had burst. Ms F had a very high pain threshold, and caregivers would know something was definitely wrong if she pushed them away.

Mrs C, another caregiver at the Home, began work at about 2:30pm that day. Mrs C had worked with Ms F for about seven or eight years, and was therefore also very familiar with her usual behaviour. When she arrived Ms F was in bed. Mrs C lifted Ms F's pyjamas and noticed that her whole stomach was distended with the skin stretched taut. Ms F flinched away from any touch on her stomach. Her eyes were sunken and her body was icy cold and dry, even though her electric blanket was on and she had two hot water bottles in bed with her. Mrs C stated that Ms F was giving low moans which was the first time Mrs C had heard her verbalising in that way. Upon being disturbed Ms F immediately got out of bed and her behaviour appeared a lot more erratic than usual to Mrs C. Ms F went and hopped into other residents' beds, which was unusual, as normally she would pick at their clothes.

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General Practitioner, Dr A / Medical Centre

Opinion – Case 00HDC02054, continued

Information Gathered During Investigation *continued*

Mrs C and Ms F left the Home for the medical centre at 3:30pm. Mrs C stated that while in the waiting room at the medical centre, Ms F kept lying on the floor, and the medical centre staff told Mrs C that Ms F had done that on her first visit as well. Mrs C therefore took Ms F outside to wait in the van. While in the van Ms F kept leaning on Mrs C, which was very unusual behaviour as Ms F would normally not want physical contact with other people. There was a long wait before the receptionist came out to the van to tell them that they were to see Dr A again. Mrs C questioned whether or not they were getting a second opinion, but Ms F ended up seeing Dr A again as he had organised the original blood tests.

Dr A explained that he received Ms F's test results mid afternoon, and shortly after this Ms F was brought in to see him. Dr A stated that he was not aware that Ms F and Mrs C had been waiting to see him for a long time or why they had had to wait. Dr A also stated that it would have been appropriate in the circumstances for Ms F to have been brought in to see him immediately.

Mrs C stated that when she took Ms F into the consultation room Dr A asked her what had changed. She replied that she did not know what had happened that morning but she had noticed Ms F was shallow breathing, she was very cold, was stooping to one side, had no temperature, and her stomach was rock hard and swollen. Dr A confirmed with Mrs C that there had been no vomiting or diarrhoea. Mrs C stated that Dr A told her that these were the same symptoms he had noted that morning, and the blood test results showed only a urinary tract infection (UTI). She replied that a UTI did not explain a distended abdomen and Ms F's other symptoms, and she re-emphasised that Ms F's behaviour was very strange. Mrs C said that Dr A then attempted to examine Ms F but she pulled away. He did manage to take her temperature through her left ear, which registered 34.7 degrees. At this stage Ms F's skin was pale, her lips were just about white, her eye sockets dark and her eyes bulging.

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General Practitioner, Dr A / Medical Centre

Opinion – Case 00HDC02054, continued

Information Gathered During Investigation ***continued***

Dr A stated that when he saw Ms F again that afternoon her general condition had deteriorated, in that she was more subdued, noticeably lethargic and strikingly dehydrated. He found the sudden dehydration difficult to understand in the light of the fact that no vomiting was reported and he had not noticed dehydration during the morning appointment. Dr A stated that no physical examination was necessary at the second appointment, as Ms F's dehydration was so obvious, and reflected in the laboratory results. Dr A stated that as the laboratory test results showed gross abnormalities he decided to refer Ms F straight to hospital. Dr A stated in response to my provisional opinion that as it was immediately obvious to him that Ms F required an urgent hospital admission, he only examined her abdomen briefly at this second appointment so that he could update his findings to pass on to the public hospital staff.

Dr A contacted the surgical registrar at the public hospital to arrange Ms F's admission on the basis that she had an "*acute abdomen with the exact diagnosis uncertain*". In response to my provisional opinion Dr A stated that he followed the standard procedure for acute admissions. He telephoned the on-call medical registrar, advised her that Ms F was acutely unwell but with an uncertain diagnosis, and advised her of his clinical findings and the laboratory results. Dr A stated that he also advised the admitting officer, wrote a referral letter to the registrar, and ensured transport to hospital was organised.

Mrs C said that Dr A appeared to be seeking a second opinion, put his feet up on a chair, and was very casual during the conversation. Dr A clarified that he put his foot on a chair as he had recently injured it, and stated that he was indeed taking the situation seriously. He explained to Mrs C that he was sending Ms F to the public hospital's Acute Assessment Ward to be hospitalised overnight.

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General Practitioner, Dr A / Medical Centre

Opinion – Case 00HDC02054, continued

Information Gathered During Investigation *continued*

Dr A wrote a referral letter but made no notes in Ms F's clinical records. His referral to the public hospital was not marked as being urgent, and it stated that Ms F was referred to the medical clinic. Dr A wrote:

> "*Intellectual handicap since childhood – post meningitis – in full time care – usually independent with toiletting/feeding but unable to communicate – epileptic.*
> *Found last night restless lying on floor. Has continued to be restless and in apparent discomfort today – appetite ↓ –* [no] *vomiting – taking small amounts of fluid –* [no] *vomiting – normal* [bowel motion] *yesterday.*
> [On examination] *Distressed. Afebrile.* [Very] *difficult to examine. Abdo distended and rigid. ?* [Bowel sounds.] *Hydration ↓↓. Haematology Biochem attached. ? UTI. ?surgical abdomen. Thank you for reviewing.*"

Dr A asked if Mrs C wanted an ambulance to transfer Ms F to hospital. Mrs C said no, she would prefer to take Ms F there by van. Mrs C is not sure why she chose to do this, but she knew Ms F would be afraid if she was not with her. Mrs C said that at this point she was very angry with Dr A; she had not wanted to see him in the first place and just wanted to get something done for Ms F as soon as possible. Mrs C commented that transport by ambulance probably would not have changed the outcome in this case but it may have been a more appropriate mode of transport.

Dr A stated that as Ms F's clinical condition did not necessitate an ambulance it was agreed that her caregiver transport her to hospital. When last seen by Dr A, Ms F was able to walk unassisted. Dr A noted that for the caregiver to take Ms F directly to hospital herself was probably the quickest way of doing it at that time of day (late afternoon). He did not judge Ms F's condition was acute enough to need an ambulance en route, and he understood they were going straight to the hospital from the surgery.

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General Practitioner, Dr A / Medical Centre

Opinion – Case 00HDC02054, continued

Information Gathered During Investigation *continued*

In response to my provisional opinion Dr A clarified his decision as follows:

> "*In view of* [Ms F's] *deterioration, I was anxious to get her to hospital as soon as possible, I considered calling an ambulance and offered this to* [Mrs C]. *I was aware that in an ambulance* [Ms F] *would be able to receive an I.V. infusion to counter her dehydration, but as it was nearly 4:30pm, I was concerned that any delay would result in* [Ms F] *getting caught up in peak hour traffic.* [Ms F's] *condition did not warrant calling a life support unit and in my experience an ambulance for acute admissions usually takes about 20 minutes to arrival, and the time taken to hand over patient, another 10 minutes. As* [Mrs C's] *vehicle was immediately available I allowed her to take* [Ms F] *on the assumption that it would prove the faster option. I discussed the alternatives with* [Mrs C] *at the time who indicated to me that she was willing to transport* [Ms F] *there herself.*"

On the way to the hospital Mrs C called in at the Home to pick up Ms F's documentation and diary. Ms F left the van and went inside to her bedroom, lay on the floor and refused to get up. Mrs C said that normally the first thing Ms F would have done was to escape from the van, out of the gate and up the road. She said that Ms F did not want to go to the hospital. She lifted her feet up off the floor and had to be carried out of the house and put into the van, and resisted this process.

Mrs C said that Ms F was already very icy cold. In the van Ms F had a hat on and two hot water bottles and the heater was turned up so high that Mrs C was sweating from the heat. Mrs C held Ms F's hand and rubbed it to try and warm her up as they were driving to the hospital.

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General Practitioner, Dr A / Medical Centre

Opinion – Case 00HDC02054, continued

Information Gathered During Investigation *continued*

Mrs C described heavy rush hour traffic on the way to the public hospital. While they were driving Ms F leant forwards a couple of times and appeared to be alert. She grabbed a flannel from the console and tried to dethread it. When Mrs C parked the van she got a wheelchair out of the back and took it to Ms F's door. She then realised Ms F was not breathing and had no pulse so she drove to the front door of Accident and Emergency, went in and spoke to the receptionist who sent a nurse out to assist. Hospital staff took over from this point. Mrs C does not know exactly when Ms F died.

Ms F was confirmed dead at 6:20pm on 4 August 1999 by Dr J at the public hospital. No medical records were available from the public hospital. A post mortem was carried out at the city Mortuary on 5 August 1999. The pathologist's opinion was that Ms F's death resulted from the effects of bowel obstruction due to an internal hernia. His description of Ms F's alimentary system is as follows:

> "*The oesophagus was normal. The stomach was enormously dilated and extended to the pelvis. It contained a very large volume (over 2 litres) of faeculent fluid. The duodenum and proximal small intestine were also distended by similar fluid to a point about 30cms from the ileo-caecal junction. The bowel was obstructed at this level by an internal hernia into a paracaecal recess. This released on moving the stomach from the pelvis. The entire large bowel was collapsed and empty. About 100mls of bloody fluid were in the left para-colic gutter. The mesentery and pancreas were normal. External biliary passages were normal. The liver was normal. The liver weighed 826 grams.*"

The Coroner, with the assistance of the Police, began an inquiry into the circumstances surrounding Ms F's death. In response to the Coroner's inquiry Dr A advised that he was unable to provide a copy of Ms F's medical records as they had been misfiled and he was unable to locate them. Dr A subsequently advised me that Ms F's records had been found, and that the medical centre's medical records system was being reviewed to reduce the possibility of records being misplaced in the future.

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General Practitioner, Dr A / Medical Centre

Opinion – Case 00HDC02054, continued

Information Gathered During Investigation *continued*

Dr A advised me that the day after Ms F's death he went around to the Home, in part to apologise and also to find out what had happened after Ms F had left the medical centre. Dr A has also offered to meet with Ms F's family and caregivers to discuss what happened to her and answer any questions that they might still have.

Independent Advice to Commissioner

The following expert advice was obtained from an independent general practitioner, Dr H:

> "*This is a complaint by the mother of* [Ms F] *against* [Dr A]. *As outlined in your background letter* [Ms F] *was 39 years of age, had severe intellectual disabilities, epilepsy and was unable to speak.* [Ms F] *lived in* [the Home] *for Physically and Mentally Disabled People and she had caregivers looking after her who knew her well and were very concerned about her.*
>
> *On the morning of 4th August 1999 the caregivers looking after* [Ms F] *were concerned about her because she was unwell. She was taken to see* [Dr A] *about 10.50am.* [Dr A] *made notes (which I assume are from that consultation because it is not clear whether this was the consultation in the morning or the notes are of the subsequent consultation that same afternoon).*
>
> *Assuming that these notes refer to the morning consultation, they are somewhat brief. He notes that 'the abdomen distended – no localised tenderness'. Given the intellectual disabilities that* [Ms F] *had, it would be difficult to ascertain whether or not there was any localised tenderness.*
>
> [Ms F] *was sent back to* [the Home] *but the caregivers noticed a deterioration in her condition and so she was taken back to her GP, blood tests having been taken in the afternoon.* [Dr A] *obviously felt concerned and arranged for her to be admitted to* [the public hospital]. *She died in the caregiver's car on the way to hospital.*
>
> *I will deal first of all with the issues that you have raised.*

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General Practitioner, Dr A / Medical Centre

Opinion – Case 00HDC02054, continued

Independent Advice to Commissioner *continued*

1. Was [Dr A's] *initial examination of* [Ms F] *on the morning of 4 August 1999 adequate and thorough, in the circumstances?*

While the examination may have been thorough the notes were not. I would have expected that some comment about the degree of hydration be written in the notes as well as her actual temperature, pulse and blood pressure being recorded. The caregiver [who] *took her to that appointment that morning, a* [Mrs B]*, stated that the examination performed was cursory and, if that was the case, the examination was in fact unsatisfactory.*

2. Were there any other examinations or tests that would have been appropriate for [Dr A] *to undertake or order?*

Other examinations and tests would have been to measure her temperature, pulse and blood pressure. These needed to be recorded and as well the degree of hydration should have been ascertained. This can be done either by looking at the lips, tongue or examination of the skin. Listening to the bowel with a stethoscope is another examination that is usually done and, looking at the notes made at the time, this was not done because if bowel obstruction occurs you can normally hear a high pitched bowel sound.

Continued on next page

General Practitioner, Dr A / Medical Centre

Opinion – Case 00HDC02054, continued

Independent Advice to Commissioner *continued*

3. Was [Dr A's] *advice to give* [Ms F] *Panadol every four hours and to take her to* [the public hospital] *if any diarrhoea or vomiting developed reasonable advice in the circumstances?*

I do not believe this was reasonable advice because [Ms F] *was clearly very unwell at this stage. She needed to be admitted to hospital at that time and, even with the argument that this is retrospective, it is nevertheless I think inappropriate to send this sort of patient who is clearly distressed and who has a distended abdomen home. If a distended abdomen is seen gastroenteritis is not the first diagnosis that is thought of but an intestinal blockage is certainly one that is. If an intestinal blockage was considered this woman needed to be admitted forthwith to hospital.*

4. When [Ms F] *returned to* [Dr A] *later that afternoon, were the actions he took reasonable in the circumstances?*

I do not have any notes of what actions [Dr A] *took that afternoon and all we have to go by is the letter that he wrote and the affidavit from the caregiver who was with her at the time. The affidavit states that he did try to examine her and said that her symptoms were due to a urinary tract infection.*

In fact the urinalysis that was there might have been consistent with a UTI but it was not definitely indicative of one. Thus her quite unwell state required her to be admitted to hospital and really required her to be admitted to hospital forthwith by ambulance.

5. Would it have been appropriate for [Dr A] *to have referred* [Ms F] *to* [the public hospital] *any earlier than he did?*

It certainly would have been appropriate for this to take place and really he should have referred her at that first visit in the morning. In view of the abdominal distension that was present and, presumably the physical condition she was in, admission would have been warranted.

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General Practitioner, Dr A / Medical Centre

Opinion – Case 00HDC02054, continued

Independent Advice to Commissioner *continued*

6. Is it possible that earlier hospital intervention could have changed the outcome in this case?

Yes, it is very possible that earlier hospital admission could have changed the outcome as abdominal surgery to relieve the blockage would have been life saving.

7. Would it have been appropriate for [Dr A] *to have arranged for an ambulance to transfer* [Ms F] *to* [the public hospital]*?*

Yes, it would have been appropriate for this to have taken place and I think to hand this sort of situation to a non-medical person was inappropriate.

8. Any other issues raised by this supporting documentation?

I feel this was a possible preventable death. Certainly I would agree that it is always hard to examine anyone who is non-verbal and who is not able to communicate the symptoms to you. But great care and attention needs to be taken of the people that normally care for such an individual and the caregivers were all uniformly of the opinion that [Ms F] *was severely unwell. In any event, from* [Dr A's] *own notes from that consultation in the morning, he did recognise that* [Ms F] *had a distended abdomen and thus if for no other reason than that reason alone, she should have been admitted to hospital.*

Often it can be said that with retrospective knowledge it is easy to be wise after the event. However, in this particular situation I do feel that [Ms F] *was not well served by* [Dr A] *and her life could have been saved if the salient features had been recognised early and treatment initiated appropriately.*

Thus it is my opinion that [Dr A] *did not exercise reasonable care and skill in providing services to* [Ms F] *that comply with professional, ethical and other relevant standards.*

Continued on next page

General Practitioner, Dr A / Medical Centre

Opinion – Case 00HDC02054, continued

Independent Advice to Commissioner *continued*

..."

Dr H subsequently clarified the following points, during a telephone conversation with my staff:

- High pitched bowel sounds are expected to be audible once the bowel is 60% to 70% obstructed. It can take a few minutes of listening with a stethoscope in order to hear them.
- It is not possible on the available evidence to determine whether or not Dr A did assess the state of Ms F's bowel sounds at the morning appointment. However, given the extreme pain that Ms F was in and her other symptoms, it is very probable that her bowel was very obstructed when assessed by Dr A at the morning consultation.
- Ms F's very cold temperature described by her caregivers was evidence of peripheral shutdown. Blood is diverted from the extremities to major internal organs, leaving the skin extremely cold. This is an indication of a significant clinical problem.

Response to Provisional Opinion

In response to my provisional opinion Dr A made several factual submissions which have been included in the information gathered. He also commented on Dr H's advice, as follows:

> "*I would like to comment on some of the statements made by* [Dr H]*, especially as his assessment seems to have formed a large part of your provisional opinion.*
>
> *– 1: 'it is difficult to ascertain localised tenderness in those with intellectual disabilities.' This needs to be qualified. Tenderness can be deduced by observation of non verbal cues whilst palpating the abdomen, such as facial features, along with noting voluntary guarding of the abdominal wall and movement away from the examining hand. These same signs are present when examining fit subjects but we don't pay as much attention to them because we can communicate verbally.*

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General Practitioner, Dr A / Medical Centre

Opinion – Case 00HDC02054, continued

Response to Provisional Opinion *continued*

– 2: The examination I conducted was not a thorough one and nowhere in your findings is it stated to be so. It was a difficult and limited one as I have already indicated but anyone examining [Ms F] *would have had the same problems whether in a hospital or out of one. It is mischievous of* [Dr H] *to complain about the lack of recordings in my notes when he knows that these were impossible to obtain.*

– 3: Alleged failure to listen to bowel sounds. The fact that I listened for and heard bowel sounds is recorded in my clinical notes. Further [Ms F's] *caregiver has written that she saw me do this. The bowel sounds that I heard sounded normal. Having said this I was only able to listen to them briefly and to properly evaluate bowel sounds they do need to be listened to for a reasonable period of time. The bowel sounds in acute obstruction are usually greatly exaggerated, so called borborygmi. The high pitched (and tinkling) bowel sounds referred to by* [Dr H] *are associated with a paralytic ileus of the bowel rather than acute obstruction.*

– 4: Intestinal obstruction is only one of many diagnoses [to] *be considered when confronted with a distended abdomen (the word intestinal blockage is a lay term). Therefore it is not possible to 'presume' what someone's physical condition is simply because they have abdominal distension.* [Dr H] *is misleading and incorrect in implying I considered gastroenteritis as a diagnosis.*

– 5: [Dr H] *is offering only conjecture as to when and whether surgery would have made any difference to the outcome.*

I am concerned that you have sought the opinion of a general practitioner, however experienced, as I believe that a surgical opinion as to the presentation and management of bowel obstruction would be more appropriate, or at least considered alongside [Dr H's] *view.*

…

Continued on next page

General Practitioner, Dr A / Medical Centre

Opinion – Case 00HDC02054, continued

Response to Provisional Opinion *continued*

With the benefit of hindsight and given the tragic outcome of this case, I of course wish that I had referred [Ms F] *to* [the public hospital] *at the time of her initial consultation. However I am still of the opinion that it was not inappropriate to investigate* [Ms F] *further prior to admission. Acute obstruction without vomiting is very unusual and there was uncertainty regarding the diagnosis and hence the most appropriate referral. The cause of* [Ms F's] *obstruction, an internal hernia is also a rare occurrence.*

I was aware of the caregivers' concerns but that alone is insufficient to warrant acute admission, the clinical condition of the patient is really the paramount consideration. Although I did not have a diagnosis and she was certainly unwell, her general condition did not appear acute, even acknowledging the limitations experienced in examining [Ms F]. *It is possible that earlier hospitalisation could have changed the outcome, but that is far from certain.*"

Dr A sought advice from a surgeon, Dr I, who made the following comments:

"*... I agree with* [Dr H] *that the general appraisal of the abdomen in such patients is quite difficult and it must have been particularly difficult to determine whether or not there was localised tenderness.*

... While accepting that the signs of dehydration may not have been elicited it is, to be fair, not a clinical enquiry that would be made in the absence of symptoms that would lead to dehydration, such as vomiting, diarrhoea or blood loss. His assertion that dehydration can be assessed by examination of the lips, tongue and skin is only partly correct. These areas may show dehydration but they are regarded as notoriously unreliable as objective, clinical signs. ...

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General Practitioner, Dr A / Medical Centre

Opinion – Case 00HDC02054, continued

Response to Provisional Opinion *continued*

... [Dr H] *is incorrect in his belief that the first cause of the distended abdomen is a bowel obstruction (the word intestinal blockage is a lay term). If abdominal distension was a hard and fast sign of bowel obstruction then I doubt that our surgical services would cope with the amount of patients that would fulfil this criterion of bowel obstruction.*

... It is difficult to say what [Ms F's] *outcome might have been with surgery. I note from the post mortem report that there is no comment on the viability of the bowel. This is an important point. If there was death of the bowel, this would mean that her symptoms had been persistent for at least the time that* [Dr A] *had been involved with her. Internal hernias, particularly in the region of the terminal ileum, have a great tendency to be intermittent.*

Given that she had normal bowel sounds, that there was no history of vomiting and she had passed, albeit a constipated bowel motion 12 hours earlier, there was little historical evidence to suggest that she was indeed suffering from a bowel obstruction.

The assessment of those folk with an intellectual impairment that have a surgical problem is notoriously difficult. Bowel obstruction from internal hernias is an additionally rare problem and the conjunction of intellectual impairment and rare internal hernias makes the diagnosis of bowel obstruction in such people difficult.

I offer these comments solely from a surgical perspective. [Dr H] *may have valid areas of concern on the general practice management that* [Dr A] *offered and I am not qualified to comment on that. I comment merely as the director of the service to whom this patient would have come had she survived.*"

General Practitioner, Dr A / Medical Centre

Opinion – Case 00HDC02054, continued

Further Independent Advice to Commissioner

Dr H reviewed his advice in light of Dr A's response to my provisional opinion, and commented as follows:

"*Regarding the points that* [Dr A] *has raised in his letter.*

1. *I still believe it is more difficult to ascertain tenderness in any part of the body of a person who is intellectually disabled. Certainly facial cues do help but it has to be harder to ascertain the degree of tenderness where somebody cannot communicate with their caregiver.*

2. *The point is made by* [Dr A] *that there were no recordings in his notes because it was impossible to obtain those recordings. My view would be that because it was impossible to ascertain and obtain the recordings then perhaps this would have pushed towards an earlier admission to hospital. Clearly if the examination could not be done this would have been another reason to feel that you could not be confident of your findings and push you to an earlier admission.*

3. *I accept that* [Dr A] *did listen to the bowel sounds and I also accept that he felt these were normal. However, I must admit that it is hard to understand how they could be normal at that examination in the morning whereas she was so sick and eventually died later in the day.*

4. *From a general practitioner's point of view I feel that abdominal distension is always an important sign and certainly I would accept that intestinal obstruction is only one of a number of diagnoses that can lead to abdominal distension. Nevertheless it is probably the most important one and one that needs to be thought of first.*

5. *Clearly it can only be conjecture as to whether or not surgery would have made any eventual difference to the outcome for* [Ms F].

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General Practitioner, Dr A / Medical Centre

Opinion – Case 00HDC02054, continued

Further Independent Advice to Commissioner *continued*

Finally I would like to make a comment about the letter written by [Dr I]. *The question of what abdominal distension signifies has been raised in this letter. I would have to agree with* [Dr I's] *expertise that this is not a hard and fast sign of a bowel obstruction but it does need to be considered. Where a person has a significant intellectual disability and is unable to communicate adequately with her caregiver and her medical practitioner then bowel obstruction clearly needs to be considered as a very real clinical possibility. I would have considered it prudent to have admitted this patient to hospital because of this very real possibility and this very difficult clinical situation.*

The point that [Dr I] *makes of the intermittent nature of internal hernias is however a proper one and I suppose that it could be possible that when* [Ms F] *was examined in the morning by* [Dr A] *there were no clinical signs of obstruction, but these became apparent again in the afternoon.*

All this needs to be balanced however against the very real distress that [Ms F's] *caregiver stated that she was in. There is quite a wide and varying opinion here between what* [Dr A] *thought he saw and what* [Ms F's] *caregivers observed.*"

Code of Health and Disability Services Consumers' Rights

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

RIGHT 4
Right to Services of an Appropriate Standard

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

...

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

General Practitioner, Dr A / Medical Centre

Opinion – Case 00HDC02054, continued

Opinion: Breach General Practitioner, Dr A

In my opinion Dr A breached Rights 4(1) and 4(5) of the Code of Health and Disability Services Consumers' Rights as follows:

Right 4(1)

I accept my advisor's opinion that Dr A did not exercise reasonable care and skill in providing services to Ms F.

Assessment

My advisor stated that while Dr A's initial examination of Ms F may have been thorough, his record of the consultation was not. There was no comment in her medical notes about her degree of hydration, temperature, pulse and blood pressure. It would have been expected that Dr A recorded Ms F's temperature, pulse and blood pressure as well as ascertaining her degree of hydration. If it was not possible to undertake these assessments, then that fact should have been documented.

Dr A explained that Ms F was very difficult to examine and that he was therefore unable to undertake a detailed assessment of her condition. He was left unsure of a diagnosis so decided to initiate further investigations then reassess Ms F's condition.

Ms F was described as being very cold by her caregivers. This was evidence of peripheral shutdown in which blood is diverted from the extremities to major internal organs, leaving the skin extremely cold. This indicated a significant clinical problem, which does not appear to have been noticed or acted upon by Dr A. Even though Dr A took Ms F's pulse and attempted to physically examine her, he did not appear to notice that Ms F was very cold.

Follow-up

I accept that Ms F was difficult to examine. However, this should have precipitated and not postponed a hospital referral. Ms F was clearly unwell, and the cause of her illness could not be readily ascertained. It would therefore have been prudent for Dr A to have sent Ms F to hospital where the resources and expertise were available to meet her needs; to have erred on the side of caution when presented with a non-verbal patient who was clearly unwell.

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General Practitioner, Dr A / Medical Centre

Opinion – Case 00HDC02054, continued

Opinion: Breach General Practitioner, Dr A *continued*

In my opinion Dr A's decision to send Ms F home following the morning consultation was not reasonable. My advisor stated that she needed to be admitted to hospital in the morning, as she was clearly unwell, was distressed and had a distended abdomen. If an intestinal blockage was considered as a possibility, which it should have been, Ms F needed to be admitted to hospital straight away. Hospital admission was warranted at that time in any event, because of Ms F's abdominal distension and her general physical condition.

I do not accept Dr A's assertion that at the morning appointment he organised a follow-up appointment for that afternoon. The caregivers are all clear that they telephoned the medical centre that afternoon to organise a second opinion, as they were unhappy with Dr A's assessment and treatment, and were worried about Ms F's condition. Dr A only recorded in her notes that she was to return if fever, diarrhoea or vomiting began. The records in the computer booking system at the medical centre are also inconsistent with Dr A's assertion; they show that the afternoon appointment was not organised in the morning.

Bowel sounds

My advisor expected that Dr A would have listened to Ms F's bowel with a stethoscope to ascertain the state of her bowel sounds, as a high-pitched bowel sound can normally be heard if there is a bowel obstruction. My advisor explained that high-pitched bowel sounds are expected to be audible once the bowel is 60% to 70% obstructed. It can, however, take a few minutes of listening with a stethoscope in order to hear them. I note that Ms F was extremely restless during the consultation, and was very reluctant to co-operate with any kind of examination.

Dr A provided conflicting information about his abdominal examination. He initially advised the Inquest Officer that it had not been possible to assess Ms F's bowel sounds, yet subsequently advised me, once he had had access to Ms F's records, that her bowel sounds had been normal. Dr A wrote in Ms F's notes that her bowel sounds had been normal. This seems an odd conclusion to reach, given that such an examination takes a few minutes, yet Ms F would not sit still long enough for her pulse or blood pressure to be taken. Dr A himself said that he was only able to listen for Ms F's bowel sounds briefly.

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General Practitioner, Dr A / Medical Centre

Opinion – Case 00HDC02054, continued

Opinion: Breach General Practitioner, Dr A *continued*

Given the extreme pain that Ms F was in and her other symptoms, it is very probable that her bowel was already significantly obstructed at the time of the morning appointment. On the available evidence, I am not satisfied that Dr A undertook a thorough and accurate assessment of the state of Ms F's bowel sounds at the morning appointment.

Second appointment
Although the blood test results were consistent with a urinary tract infection, my advisor stated that these results were not definitely indicative of one.

When Dr A did refer Ms F to hospital for further investigations after the second appointment, he referred her to the medical clinic. The documentation accompanying Ms F to hospital shows that Dr A did not attach any urgency to the referral.

I note my advisor's opinion that it was very possible that an earlier hospital admission could have saved Ms F's life, as abdominal surgery to relieve the intestinal blockage could have been life saving.

Transport
My advisor stated that in her unwell state Ms F needed to be admitted to hospital by ambulance and that it was inappropriate to let Mrs C transport Ms F to hospital, given her severe condition. Dr A has explained that in the circumstances he believed this would be faster than waiting for an ambulance to arrive, and that he discussed this with Mrs C who was agreeable to taking Ms F to hospital herself. However, he conceded that IV fluids, needed to address Ms F's severe dehydration, would only be available in an ambulance.

In my opinion it was not appropriate for Dr A to leave Mrs C to transport Ms F to hospital, even though she was happy to do so. Ms F was seriously ill, the cause was unknown, and she needed urgent medical attention.

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General Practitioner, Dr A / Medical Centre

Opinion – Case 00HDC02054, continued

Opinion: Breach General Practitioner, Dr A *continued*

Surgical opinion

Dr A sought comment on this case from a surgeon, who disagreed with my conclusions and those of Dr H. The surgeon stated that there was minimal clinical evidence that Ms F was suffering from a bowel obstruction, that a bowel obstruction caused by an internal hernia is a rare condition, and that this condition can be an intermittent one. A bowel obstruction was not the only cause of the symptoms that Ms F was experiencing, and surgery would not have guaranteed her survival.

It is important to note that Dr A is not being held accountable for failing to diagnose Ms F's bowel obstruction. Rather, the question is whether Dr A's actions in providing general practitioner services were reasonable in the circumstances. To assist me to determine this, advice was sought from a peer of Dr A's, another general practitioner, concerning the actions that would be expected of a reasonable general practitioner in those circumstances. I accept my advisor's opinion that Dr A's treatment of Ms F was not of an acceptable standard; not because he failed to diagnose a (possibly intermittent) hernia and resultant bowel obstruction, but because he failed to take reasonable actions to ensure she received adequate medical attention, in response to her presentation.

Conclusion

In my opinion, Dr A's initial assessment of Ms F's condition was not adequate, and he did not act appropriately on the information available that showed Ms F to be very unwell and in urgent need of hospitalisation. He did not organise appropriate follow-up care and failed to arrange Ms F's transport by ambulance to hospital when this was indicated. In my opinion Dr A failed to provide Ms F with medical services with reasonable care and skill and therefore breached Right 4(1) of the Code.

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General Practitioner, Dr A / Medical Centre

Opinion – Case 00HDC02054, continued

Opinion: Breach General Practitioner, Dr A *continued*

Right 4(5)

I accept that Ms F was very difficult to examine and was unable to tell Dr A how she was feeling. However, in such circumstances attention must be paid to the accounts of caregivers. Ms F's caregivers had known her for a number of years and were very familiar with her normal behaviour. Mrs B and Mrs C both clearly stated to Dr A that Ms F was significantly unwell and behaving abnormally. Dr A was unfamiliar with Ms F and her usual behaviour. It was therefore all the more important that he paid careful attention to what her caregivers were saying. However, Dr A did not take proper account of her caregivers' views that her behaviour was unusual and indicative of a serious problem.

Ms F had the right to co-operation among those caring for her, to ensure quality and continuity of care. Ms F's caregivers realised she had a significant problem and was seriously unwell, so they took her to Dr A for advice and treatment. They explained their concerns about her to him. However, Dr A did not take their concerns seriously and questioned whether the history they provided was accurate, given that no vomiting was reported. He failed to take appropriate action as a result.

I consider this to be unacceptable. Ms F's caregivers, who knew her well, observed that something was wrong and gave Dr A information about her condition. Dr A failed to co-operate with Ms F's caregivers and appears to have discounted their observations and concerns.

In my opinion this failure meant that Dr A provided Ms F with inadequate care, and amounted to a breach of Right 4(5) of the Code.

General Practitioner, Dr A / Medical Centre

Opinion – Case 00HDC02054, continued

Opinion: No Breach
Medical centre

Rights 4(1) and 4(5)

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

The medical centre employed Dr A as a general practitioner. Ms F consulted Dr A at the medical centre in his capacity as a general practitioner there.

As discussed above, I do not consider that the care Dr A offered Ms F was of an acceptable standard. However, the medical centre had no control over how Dr A conducted his consultations.

I therefore do not consider that the medical centre is vicariously liable for Dr A's breaches of Rights 4(1) and 4(5) of the Code.

Actions

I recommend that Dr A review his practice in light of this report.

Other Actions

- A copy of this opinion will be sent to the Medical Council of New Zealand with a request that a review be undertaken of Dr A's competence to practise medicine.
- A copy of this opinion will be sent to the Auckland Coroner.
- A copy of this opinion with identifying features removed will be sent to the Royal New Zealand College of General Practitioners for educational purposes.

Director of Proceedings

I will refer this matter to the Director of Proceedings under section 45(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any action should be taken.