

**General Practitioner, Dr B /
A District Health Board**

**A Report by the
Health and Disability Commissioner**

(Case 01HDC04138)

Parties involved

Mrs A	Consumer (deceased)
Dr B	Provider / General Practitioner
Dr C	General Practitioner
Ms D	District Nurse at the public hospital
Ms E	Co-ordinator, Home Help / Personal Care Professionals
Ms F	Registered Nurse
Dr G	Geriatrician and a Clinical Director at the District Health Board

Complaint

On 1 April 2001 the Commissioner received a complaint, forwarded by an Advocate, concerning the standard of care Mrs A (deceased) received from Dr B, general practitioner. As a result of this information the Commissioner commenced an 'own initiative' investigation under section 35(2) of the Health and Disability Commissioner Act 1994. An investigation was commenced on 28 May 2001. The investigation issues were clarified on 11 December 2001 as follows:

- *Dr B failed to provide services of an appropriate standard to Mrs A on 2 November 2000 and in particular:*
 - *Did not adequately assess her condition prior to her discharge home, and*
 - *Did not ensure that appropriate or adequate follow-up services were in place prior to her discharge.*
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Information reviewed

- Mrs A's clinical records from a public hospital
- Independent expert advice from Dr Peter Freeman, an independent emergency medicine consultant.

Information gathered during investigation

Background

Mrs A, aged 60, suffered from multiple sclerosis and partial paralysis of the legs, and had an ileal conduit (a segment of small bowel used to convey urine from the ureters to the exterior), which drained into a urinary collection bag. The Emergency Department notes indicated that she was able to walk with the aid of a walking frame but preferred to use a wheelchair. I was informed by Mrs A's general practitioner, Dr C, that the urinary collection bag leaked, and Mrs A had problems controlling her bowel movements. Mrs A lived alone and was offered home help and showering assistance from the District Nursing Service; however, she refused these offers because she preferred to maintain her independence.

Ms D, district nurse, was the key worker assigned to Mrs A, but an enrolled nurse with the District Nursing Service at the hospital, visited Mrs A most frequently. The records show that the enrolled nurse last visited Mrs A on 30 October 2000.

Ms E informed me that she co-ordinated the home help services for Mrs A. She said that Mrs A's living conditions were "appalling". Mrs A was receiving 10 hours of home help per week – two hours per day Monday to Friday, consisting of one hour of personal care and one hour of home management.

Ms E wrote to Mrs A's second general practitioner, on 8 September 2000 to inform her that Mrs A refused to shower when the caregiver was present, and did not shower when the caregiver left. Ms E informed this general practitioner that she had contacted Supportlinks, the social worker at the hospital, and the district nurses, but they were unable to assist in providing a solution to the problem. She was "at a loss to where I go now". Ms E further informed me that she had recently engaged Ms F, registered nurse, to assist the home aides to care for Mrs A as she thought that Ms F might have more success in encouraging Mrs A with self cares.

Dr C informed me that Mrs A was an "extremely independent and strong willed person" and that her living conditions were "less than ideal". (Two general practitioners are in partnership in the medical practice that Mrs A attended.)

2 November 2000

At 8.00am on 2 November 2000, Ms F called at Mrs A's home to assist her to shower and dress. Ms F informed me that when she arrived at Mrs A's home she found old, blood-stained vomit on the floor of the house. Ms F thought that Mrs A was bleeding from the stomach. She said that Mrs A was an "introverted lady" and it took some time to persuade her to allow the doctor to visit. Mrs A consented and Ms F telephoned the medical practice and arranged for Dr C to visit. She then left the house, before Dr C arrived, to go to her next assignment.

Dr C visited, assessed Mrs A and organised for her to be transported to the hospital by ambulance. His referral note to the hospital stated that Mrs A had been vomiting blood and

suffering malaena (blood in the stools) for 36 hours, her last vomit being at 9.00am that morning. He noted:

“Dreadful hygiene at home (home help + DN) but not co-operative. Adamant wants to remain in own home by herself. Will require geriatric assessment re needs.”

Admission to the hospital

Mrs A was admitted to the hospital’s Emergency Department at 12.02pm on 2 November. Mrs A’s clinical records show that she was assessed by Dr B, the medical registrar on call that morning. Dr B informed me that Mrs A advised him that she had been to the RSA the evening of 1 November and had vomited three times on her way home. She did not complain of abdominal pain, chills or fever, and stated that she had loose stools for three days with no blood.

Dr B advised me that he then performed a physical examination of Mrs A, noting that she was not emaciated or jaundiced, her abdomen was soft and non-tender and no masses were palpable. He wrote:

“abd[omen]:

soft non tender

no masses – colostomy bag R draining urine

PR [per rectum] no masses, brown stools – not loose”.

Dr B summarised his examination of Mrs A by concluding that there was no evidence of a gastro-intestinal bleed. His treatment plan was to try Mrs A on oral fluids and, if she was able to tolerate fluids, she could be discharged.

At 1.35pm Dr B reviewed Mrs A in the Emergency Department and noted that she was able to tolerate oral fluids. Mrs A’s blood test results showed that her haemoglobin was 153g/L. (The normal haemoglobin range for a female is 115 to 165g/L.) Dr B noted that Mrs A could be discharged but would need follow-up from her general practitioner.

Mrs A was discharged at 2.45pm. The discharge summary noted: “Prefers to go home by ambulance. Contacted support networks to notify them of discharge. Will probably visit tomorrow.”

In his response to my investigation, Dr B informed me that during his examination he noted that Mrs A had no pain, was not constipated and had no abdominal distension. All other signs, such as bowel sounds, hydration, pulse and blood pressure were normal. Dr B stated that all the signs and symptoms pointed to gastro-enteritis. When he reassessed Mrs A and found that she was able to tolerate oral fluids, he considered the issue of Mrs A living alone. Dr B said that he discussed this aspect of discharge with Mrs A and the nurse who was with her, and both agreed that discharge was appropriate.

Ms F advised me that she did not accompany Mrs A to the hospital. She said that she was under the impression that Mrs A went to hospital by ambulance, alone. Ms F said that Mrs

A should not have been living alone, and that if she had been consulted about Mrs A being discharged home on 2 November, she would not have agreed.

Ms D informed me that she did not accompany Mrs A to the hospital on 2 November, and that no other person employed by the District Nursing Service accompanied Mrs A to the hospital or met her in the Emergency Department.

Discharge

Ms E informed me that she received a telephone call at around 4.00pm on 2 November, from someone she assumed was a nurse at the hospital, to inform her that Mrs A had been discharged back to her home. Ms E said that at that time of the day she was unable to organise any of her home help personnel to call on Mrs A. She said that she was assured by the hospital that Mrs A was “alright to be discharged”.

At 9.00am on 3 November a Home Help caregiver, called at Mrs A’s house to perform routine domestic duties. The caregiver found Mrs A in bed. It appeared that Mrs A had died during the night. She found bloodstained vomit on the doorstep, bed and in a plastic container beside the bed. The caregiver notified her supervisor, who advised the Police.

The post-mortem report by the pathologist found that Mrs A died as a result of a small bowel obstruction and pulmonary infarction (death of part or whole of the lung due to artery blockage). The report noted:

“In the abdomen, the stomach was grossly distended with brown fluid, and the lining showed some autolysis. The upper loops of the bowel were also markedly distended with fluid. This being a small bowel obstruction. The lower loops of the small bowel, together with portions of the colon, were impacted into the hernial sac, extending from the abdomen on the right side.

...

The lower right abdomen showed a hernial bulge, which measured 10cm across. The skin overlying this was ulcerated. This measuring 4cm across.”

Independent advice to Commissioner

The following expert advice was obtained from an independent emergency medicine specialist, Dr Peter Freeman:

“Failure to provide services of an appropriate standard to [Mrs A] on 2 November 2000 and in particular:

1. Did not adequately assess her condition prior to her discharge home.
It is my opinion that [Dr B] did not adequately assess her condition prior to her discharge home.
2. Did not ensure that appropriate adequate follow up services were in place prior to her discharge.
It is my opinion that the discharge plans were appropriate for the diagnosis made.

To advise the Commissioner whether in your opinion the services received by [Mrs A] were provided with reasonable care and skill and of the appropriate professional standard for a medical registrar. In addition:

- What specific professional and other relevant standards apply in this case and did [Dr B] meet those standards?
The right to appropriate standards of service was not met. A Medical registrar would be expected to recognise bowel obstruction to the degree identified at post mortem.
- Can you comment on [Mrs A’s] presenting symptoms on 2 November 2000 and [Dr B’s] examination and diagnosis?
[Mrs A] presented with dark vomiting and diarrhoea since the night before. The examining doctor made thorough clinical notes. A significant omission from these notes is comment about distension and bowel sounds. No mention is made of the 10cm hernial swelling with overlying skin ulceration noted at post mortem. The diagnosis documented was GE (gastro-enteritis). No differential diagnosis is documented. Bowel obstruction does not always present in a textbook fashion – particularly in the elderly. Subtle signs are often the rule rather than the exception in the over 60 age group and clinical signs need to be sought in combination with a high index of suspicion. It is difficult to see how the post mortem findings would not have been present on the day of her death.
- In your opinion was [Dr B’s] assessment of [Mrs A’s] condition adequate and in accordance with proper professional practice?
[Dr B] has ma[d]e thorough notes of the history and examination – however the possibility of bowel obstruction is not documented despite comments in a subsequent letter (undated – marked ‘C’). In my view the examination and documentation of the patient’s abdomen was inadequate.

- Given the presenting symptoms was [Dr B’s] decision to discharge [Mrs A] reasonable in the circumstances?

I can sympathise with the decision to discharge [Mrs A] considering the working diagnosis of gastro-enteritis and the fiercely independent nature of the patient. However I believe the diagnosis of bowel obstruction was missed and that vital clinical signs were not sought. This error I believe was due to inexperience rather than negligence.

- Was [Dr B’s] treatment and discharge advice in accordance with proper professional practice? In particular, did [Dr B] ensure appropriate and adequate follow-up services were in place prior to [Mrs A’s] discharge?

Having made an erroneous diagnosis of gastro-enteritis the discharge advice was appropriate for the condition [Dr B] thought he was treating.

- Any other issues raised by the supporting documentation.

No.”

Response to Provisional Opinion

The District Health Board responded to my provisional opinion as follows:

“Thank you for giving [the District Health Board] the opportunity to respond to your provisional opinion into the investigation regarding the delivery of healthcare to the above consumer.

[The District Health Board] believes that it is essential that we continue to supervise, support and teach all employees and learn from investigations such as this. However, I take the opportunity to comment on your finding that [the District Health Board] is vicariously responsible. [Dr B] will be responding on his own account.

I have discussed this opinion with [Dr G] – a geriatrician and clinical director for [the District Health Board].

[Dr B] is in his second year of advanced training for geriatric medicine having already completed 4 years as a general medical registrar and 6 years in general practice. [Dr G] is one of the Senior Medical Officers (SMOs) [Dr B] reports to.

I wish to respond first to your recommendation that [the District Health Board] remind junior medical staff in the Emergency Department that bowel obstruction in the elderly often presents with subtle clinical signs, and a high index of suspicion is needed in combination with careful clinical examination.

With regard to this particular case [Dr G] informs me that the basic understanding of bowel obstruction is taught at Medical School and reinforced during house-surgeon training. All doctors are very familiar with the presentation of bowel obstruction in

younger adults. Ongoing education is done within the hospital setting. Much of this takes an apprentice type approach. During the last 18 months [Dr B] has been in advanced training in geriatric medicine, he has had the opportunity to become aware of the subtle presentation of bowel obstruction in the elderly person. [Dr G] describes [Dr B] as a very experienced acute and geriatric medicine registrar and in reviewing the clinical notes of this case, believes [Dr B] was looking for those subtle signs of bowel obstruction on examination. Given the clinical presentation, examination as recorded and the clinical investigation results, [Dr G] believes it was reasonable [Dr B] did not seek advice from the SMOs on call. However it would have been appropriate for him to have communicated his findings and investigation results to the referring GP, who had requested [Mrs A's] admission, prior to discharging her home.

SMOs are on call twenty four (24) hours to advise and support registrars if and when required. In [Dr G's] opinion [Dr B] is very aware of the subtle clinical signs of bowel obstruction in the elderly and that he did carefully clinically examine, investigate and document his findings appropriately on the case in question. The investigation results were also satisfactory and gave no indication of the seriousness of [Mrs A's] clinical condition. It is worth noting that the very experienced referring GP also did not suspect or find signs of bowel obstruction after his clinical examination. The suspected diagnosis being haematemesis and malaena in his referral letter and phone call to [Dr B].

[The District Health Board] will accept your recommendation of reminding junior staff in the Emergency Department and this will be arranged through [the] Clinical Director, Emergency Department.

With regard to your second recommendation, to ensure that junior medical staff in the Emergency Department are provided with appropriate supervision and support, [the District Health Board] appointed [the Clinical Director], a Fellow Australasian College of Emergency Medicine, in August 2001. We are very privileged to have a practitioner with his knowledge and skills. His role very much includes that junior medical staff in the Emergency Department are provided with appropriate supervision and support. In addition, consultant staff are available on call at all times to advise and assist when consultation is requested.

[The District Health Board] believes the apprenticeship style of training registrars gives opportunity for continued education on all clinical presentations including bowel obstruction. It is confirmed by [Dr G] that [Dr B] is an experienced acute medical registrar in his second year of advanced training for geriatric medicine, and is aware of the subtleties of the clinical presentation of bowel obstruction in the elderly, and in fact sought those signs in his examination of [Mrs A]. We also have assurance that junior medical staff in the Emergency Department are provided with appropriate supervision and support and we will continue to provide and improve in doing that.

I trust that you will consider these comments when you are finalising your opinion on this case and find [the District Health Board] not vicariously liable.”

Dr B did not submit a written response to my provisional opinion. He advised my Office that he had decided not to make a written response. Dr B said that he arranged for an independent review of the file and had taken advice as a result. He said that the District Health Board had “full confidence in his ability” and that he would await a response from the Medical Council after they receive the final opinion.

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.*
 - 2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.*
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Other standards

New Zealand Medical Association ‘Code of Ethics’ (1989)

Standard of Care

...

3. Ensure that every patient receives a complete and thorough examination into their complaint or condition.

Patient’s Right

...

9. Recognise one’s professional limitations and, when indicated, recommend to the patient that additional opinions and services be obtained.

Opinion: Breach – Dr B

In my opinion Dr B breached Rights 4(1) and 4(2) of the Code of Health and Disability Services Consumers' Rights in relation to his assessment of Mrs A's medical condition.

Rights 4(1) and 4(2)

Dr B did not adequately assess Mrs A's condition prior to discharging her home

Right 4(1) states that every consumer has the right to have services provided with reasonable care and skill. Right 4(2) states that every consumer has the right to have services provided that comply with legal, professional, ethical and other relevant standards.

Rights 4(1) and 4(2) of the Code are supported by the New Zealand Medical Association's 'Code of Ethics' (1989), which states that patients have the right to a complete and thorough examination and that the doctor should recognise his/her professional limitations and, where appropriate, seek advice from more senior colleagues.

Mrs A was referred to the hospital with a 36-hour history of gastro-intestinal bleeding at 9.00am on 2 November 2000. At approximately 12.30pm Mrs A was examined by Dr B at the Emergency Department of the hospital, monitored, diagnosed with gastro-enteritis and discharged home two and a half hours later. Mrs A was found dead on the morning of 3 November.

Dr B informed me, as part of my investigation, that during his examination of Mrs A all signs such as bowel sounds and hydration were normal, and there was no abdominal distension. My independent advisor, Dr Peter Freeman, found that although overall the examining doctor made thorough notes in relation to the critical abdominal examination, the appropriate observations were not recorded. He commented:

“... A significant omission from these notes [Mrs A's clinical records] is comment about distension and bowel sounds. No mention is made of the 10cm hernial swelling with overlying skin ulceration noted at post mortem. The diagnosis documented was GE (gastro-enteritis). No differential diagnosis is documented. Bowel obstruction does not always present in a textbook fashion – particularly in the elderly. Subtle signs are often the rule rather than the exception in the over 60 age group and clinical signs need to be sought in combination with a high index of suspicion. It is difficult to see how the post mortem findings would not have been present on the day of her death.

...

A Medical registrar would be expected to recognise bowel obstruction to the degree identified at post mortem.

...

I believe the diagnosis of bowel obstruction was missed and vital clinical signs were not sought. This error I believe was due to inexperience rather than negligence.

...

In my view the examination and documentation of the patient's abdomen was inadequate."

I accept my expert's advice that Dr B's examination and documentation of Mrs A's condition was not adequate. In my opinion, Dr B breached Rights 4(1) and 4(2) of the Code by his failures to:

- a) carefully examine the abdomen and document his findings;
 - b) recognise bowel obstruction;
 - c) develop a differential diagnosis; and
 - d) seek further assistance from his consultant.
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Opinion: No breach – Dr B

In my opinion Dr B did not breach Rights 4(1) and 4(2) of the Code of Health and Disability Services Consumers' Rights in relation to Mrs A's discharge.

Rights 4(1) and 4(2)

Dr B did not ensure that appropriate or adequate follow-up services were in place prior to discharging Mrs A

Dr B assessed Mrs A on her admission to the Emergency Department at 12.30pm on 2 November and concluded that Mrs A was suffering from gastro-enteritis. He instructed:

“Plan:1 blood tests

2 try oral fluids – if can tolerate it she can be discharged.”

My independent expert stated: “Having made the erroneous diagnosis of gastroenteritis the discharge advice was appropriate for the condition [Dr B] thought he was treating.”

Dr B informed me that he discussed his findings and plans for discharge with Mrs A and her accompanying nurse, who agreed to the proposed discharge. Based on the information provided, Dr B could not have discussed his proposal to discharge Mrs A to her home with any other nurse apart from those employed at the hospital, as Mrs A was unaccompanied when at the Emergency Department.

I am satisfied, however, that Dr B discussed his diagnosis and plan for discharge with Mrs A. Given the information gathered relating to Mrs A's personality, it seems reasonable to assume that Mrs A strongly advocated on her own behalf to return home. Although there were no support people with Mrs A as Dr B alleges, it appears that arrangements were made by nursing staff to ensure that services would be put in place to support Mrs A on her discharge. It is unfortunate that further enquiries were not made by the doctor and/or the nursing staff in Emergency Department that afternoon, to ensure that Mrs A was discharged

with appropriate support. This seems to have occurred as a result of miscommunication and erroneous assumptions leading to the discharge of an unwell 60-year-old disabled woman into an environment described as “less than ideal”, in circumstances where there was to be no support for her until the following morning. Nevertheless, in all the circumstances, in my opinion, Dr B did not breach Rights 4(1) and 4(2) of the Code in relation to Mrs A’s discharge.

Opinion: Breach – The District Health Board

Vicarious liability

I commend the District Health Board on the steps that it has taken since this incident to ensure that junior medical staff in the Emergency Department are properly supervised and supported. However, I am not satisfied that, in November 2000, the District Health Board had taken such steps as were reasonably practicable to prevent the omissions by its employee, Dr B. Accordingly, I conclude that the District Health Board is vicariously responsible under section 72(2) of the Health and Disability Commissioner Act 1994, for Dr B’s breaches of the Code.

Actions taken

- Dr B has undertaken an independent review of his assessment of Mrs A and taken advice as a result.
- The District Health Board has:
 - arranged for the Clinical Director of the Emergency Department to supervise and support junior medical staff in the Emergency Department;
 - reminded junior medical staff in the Emergency Department that bowel obstruction in the elderly often presents with subtle clinical signs, and a high index of suspicion is needed in combination with a careful clinical examination.

Other actions

- A copy of this opinion will be forwarded to the Medical Council of New Zealand with a recommendation that the Council determine whether a review of Dr B's competence to practise medicine is indicated.
- A copy of this opinion, with identifying details removed, will be sent to the Australasian College for Emergency Medicine (New Zealand Faculty) and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.