

A bad day at the office

An HDC decision published today highlights the need for special care when seeing an elderly, unwell patient for the first time — and the risk that your behaviour on “a bad day at the office” may later be the subject of a complaint and official inquiry.

An elderly, unwell patient

Mrs A, a previously fit and well 79-year-old, experienced a severe, sudden onset headache at 5pm on 29 August 2007. Around 6pm, she attended an Accident and Medical clinic accompanied by her daughter. She took all her regular medications with her.

Dr B, a medical practitioner with general registration working in Accident and Medical practice, promptly saw Mrs A and her daughter. Although the clinic was fairly busy (Dr B had seen 11 patients from 3pm to 6pm), Dr B spent half an hour in the consultation with Mrs A and her daughter.

Mrs A was understandably anxious and it was not easy for Dr B to elicit her relevant history. Dr B interrupted Mrs A’s account of her symptoms, listened to the daughter’s explanation of her mother’s history and symptoms, and documented a history of sinusitis, hypercholesterolaemia and mild hypertension. He also recorded the onset of a severe frontal headache that afternoon.

Dr B undertook and documented a thorough physical examination (checking temperature, pulse and neck suppleness — all normal). He noted tenderness and warmth over the frontal sinuses and found that the headache was exacerbated by percussion over the right frontal sinus. Her pupils were equal and reactive to light, and her limb reflexes were normal. Dr B detected no signs of a stroke such as altered power, sensation, speech, or visual disturbances.

Dr B did not take Mrs A’s blood pressure, and failed to document a cranial nerve examination. Nor did he elicit that Mrs A’s headache had come on suddenly. Dr B diagnosed “right front sinusitis”, explained this to Mrs A, and reassured her that she was not having a stroke. However, he said that she should go to the hospital if she was concerned. Dr B also told Mrs A to see her regular GP the next morning, and documented this advice.

Deterioration and death

Mrs A deteriorated overnight and was diagnosed by a CT scan at North Shore Hospital the next day as having suffered a “large right fronto-parietal-temporal haemorrhage” (a stroke). Hospital staff elicited and documented a finding that the headache had an acute onset “like a thunderclap”. Her condition deteriorated and she died a few weeks later.

Lack of care

I considered that Dr B had undertaken a careful examination of Mrs A and kept a good record of his findings. The fact that a doctor in a busy A&M, seeing a new patient for the first time, misdiagnoses a stroke (in the absence of signs of visual or speech disturbance or altered power) as sinusitis is not in itself evidence of a lack of care and skill.

However, Dr B had failed to exercise reasonable care and skill in taking Mrs A’s history. There were important clues to her stroke, including the sudden onset of her severe headache, her lack of

history of severe headache, her age (79) and her medication for high blood pressure. The lack of any recent history of sinusitis was also not elicited. Even if Mrs A was confused, her daughter was well informed and capable of providing a full history for Dr B. As noted by my accident and medical expert, Dr Simon Brokenshire, “it certainly behoves a doctor to carefully tease out the history”. Dr B failed in this basic medical skill.

In failing to record Mrs A’s blood pressure, Dr B overlooked “an important observation in an elderly woman with headaches” (in the words of Dr Brokenshire). As noted by my GP advisor, Dr Stuart Tiller, “the blood pressure recording was mandatory but was omitted”.

Dr B also failed to document his cranial nerve examination. I noted Dr Brokenshire’s advice: “[A] thorough neurological examination should have been conducted and documented as any subtle neurological deficit may have raised some concern in the doctor’s mind.”

Because he failed to elicit the history of sudden onset headache, Dr B failed to take reasonable steps to eliminate the possibility of intracranial bleed from the differential diagnosis.

If Dr B did harbour a suspicion of a stroke, he needed to take a more precautionary approach. As noted by Dr Tiller:

“Cerebral haemorrhage is a medical emergency and where there is a mild to moderate degree of possibility of such a diagnosis, discussion with a hospital medical registrar or consultant should be undertaken. A doctor should take greater care when a potential diagnosis could have serious, if not fatal, consequences. Failure to correctly diagnose sinusitis could wait until ‘GP review mane’ but a diagnosis of possible cerebral haemorrhage cannot wait until ‘GP review mane’.”

Dr B did not exercise reasonable care and skill in diagnosing sinusitis. As noted by Dr Tiller, “It would be most unusual for an isolated episode of sinusitis to present with a headache of acute onset ‘like a thunderclap’ and in the absence of prodromal respiratory symptoms.”

Rude behaviour

Ms A’s complaint highlighted the fact that, during the consultation, Dr B had thrown her mother’s medications on the floor. Dr B claimed that he had “gently dropped” them on the floor from midcalf, in a misguided attempt to refocus the consultation, but I found this hard to believe. Dr B had also engaged in a conversation in which he bemoaned the state of the health system and the fact that doctors are “grossly underpaid”.

I concluded that Dr B had been rude and disrespectful in throwing Mrs A’s medication on the floor. This was highly unprofessional behaviour and could not be excused as banter and an attempt at “a small piece of theatre”. It was also insensitive for Dr B to spend time during a consultation with an anxious, unwell elderly woman and her daughter, bemoaning the state of the health system and the level of doctors’ incomes. The Medical Practitioners Disciplinary Tribunal has recognised that failing to treat a patient with sensitivity and respect is unacceptable behaviour that may warrant disciplinary sanction: *Re Frizelle* (MPDT 219/02/94D, 3 December 2002), paras 68, 71.

Nor could Dr B’s conduct during the consultation be excused by work pressure at the clinic. Although the clinic was busy, he had been working for only three hours and had seen a steady flow

of 11 patients. He was able to spend 30 minutes in the consultation with Mrs A. Whatever concerns Dr B had expressed to management about work pressure in the past, there was no evidence that it was a significant factor on the evening of 29 August 2007. In any event, work pressure would never justify rude and disrespectful behaviour during a consultation with a patient.

HDC findings

I concluded that Dr B breached Rights 4(1) and 1(1) of the Code of Rights, by his lack of care and his rude behaviour. He did not meet the standard of care and communication expected of a doctor working in an Accident and Medical clinic.

Even though an earlier admission to hospital may not have prevented Mrs A's ultimate death, Dr B needed to be held accountable for his inadequate care and his unprofessional behaviour. I also considered that his competence (clinical and communication skills) needed to be reviewed by the Medical Council.

Narrow escape from discipline

The case was clearly borderline for a referral to the Director of Proceedings. Dr B did not meet the high standard expected of a medical practitioner. Although his lack of care (especially in history taking) may not have met the threshold for disciplinary action, in my view his rude behaviour was an example of conduct "likely to bring discredit to the profession" (see the Health Practitioners Competence Assurance Act 2003, s 100(1)(b)).

However, I took account of Dr B's acknowledgment of his failures during the consultation, his assurance that he had learnt from this investigation, and his willingness to undergo a performance assessment by the Medical Council. In my view the public interest in denouncing his conduct and highlighting appropriate professional standards was sufficiently achieved by holding him accountable for breaching the Code, and publishing an anonymised version of the report on the HDC website (see www.hdc.org.nz, Opinion 07HDC16428). Little more would be achieved by the additional step of disciplinary proceedings.

Ron Paterson
Health and Disability Commissioner

NZ Doctor, 10 September 2008