GP follow up after hospital discharge

Avoiding the pitfalls

NAOMI LEWIS BA
WALID JAMMAL MB BS, FRACGP, DCH, MHL

Articles in this series highlight common medicolegal issues in general practice. Written by the claims and advocacy team at medical defence organisation Avant, the series is based on actual cases, with some details changed for privacy. Here, the GP's contribution is analysed in the death of a 15-year-old girl who was misdiagnosed in a hospital emergency department and discharged for GP follow up.

MedicineToday 2016; 17(11): 73-75

Ms Lewis is Assistant Claims Manager, Avant Mutual Group, Sydney. Dr Jammal is a General Practitioner; Senior Medical Advisor–Advocacy, Avant Mutual Group; Clinical Lecturer in the Faculty of Medicine, The University of Sydney; and Conjoint Seniour Lecturer in the School of Medicine, Western Sydney University, Sydney, NSW.

Every day, GPs make clinical decisions based on the information provided in hospital discharge summaries. But to what extent should GPs rely on the hospital's assessment? And if the patient subsequently brings a 'failure to diagnose' claim against the hospital, what scrutiny may the GP's care be subjected to?

Case history

Sarah Brown was a 15-year-old who was generally in good health. Her mother was the primary caregiver and accompanied Sarah to all consultations. Typically, Mrs Brown presented quickly with health concerns, was a reliable historian and followed instructions.

One Thursday, Sarah attended Dr Smith with a history of worsening right iliac fossa pain, which had been present for two to three days. From the records, Dr Smith noted Sarah had attended the practice the previous day with right iliac fossa pain. She had been afebrile, with a soft abdomen and no guarding. Her periods were regular, and she was not sexually active. She had been unable to supply a urine sample, and had been advised to return for review in 24 hours with a urine sample.

On examination, Dr Smith found right iliac fossa rebound tenderness and mild guarding. Sarah did not have a fever, and her blood pressure and pulse were normal. She did not bring a urine sample. Dr Smith diagnosed acute appendicitis and referred Sarah to the emergency department at the local hospital for immediate surgical assessment.

At the hospital, Sarah was noted to be afebrile and moving freely with moderate tenderness of the right iliac fossa. An elevated white cell count (15.2 x 10^9 cells/L) and markedly elevated C-reactive protein level (176 mg/L) were recorded. A pelvic

RISK MANAGEMENT TIPS

- It is good practice to verify details of patient contact with other health providers and hospitals.
- It is best practice to re-examine patients who present after hospital discharge.
- It is reasonable to telephone to obtain results of investigations that patients have undergone in hospital.
- Patients should be given enough information to know when and how to seek further review and help.
- It may be useful to consider personal communication between providers and to facilitate 'warm handovers' between hospitals and GPs.

ultrasound examination showed 'significant free fluid … the appendix was not identified'. A urine dipstick analysis showed '++ white cells'. Sarah was treated for a suspected urinary tract infection (UTI) and admitted overnight for review of pain. The following day, she was noted to have no pain or fevers, to be hungry and continuing to improve. She was discharged that afternoon for GP follow up in three days. No instructions regarding medications or surgical follow up were provided.

The following morning (Saturday), Sarah saw Dr Smith. Sarah's mother could not remember whether they were given a discharge summary. She provided a history of Sarah being admitted to hospital and commenced on intravenous antibiotics for presumed UTI. Mrs Brown told Dr Smith that a pelvic ultrasound examination had not detected abnormalities. She also stated they had attended Dr Smith to update him about Sarah's admission, and because she had not been provided with antibiotics on discharge and did not want to be caught out over the weekend.

On examination, Sarah was afebrile and well hydrated. Her abdomen was soft with no masses, distension or swelling. There was no abdominal tenderness, no right iliac fossa tenderness on palpation, and no rebound or percussion tenderness. Sarah reported occasional pain in the right iliac fossa, but that the pain had improved. She was hungry and eating well. Dr Smith's diagnosis was expectant management of symptoms and signs for presumed UTI. Dr Smith provided Sarah with a continued prescription for antibiotics, and advised her to reattend if there were further symptoms.

Three days later, the pain worsened and Sarah presented to hospital. She was diagnosed with an appendiceal abscess, which had ruptured. She developed various complications including septic shock and died three weeks later.

Mrs Brown brought a nervous shock claim against the hospital. The hospital settled the claim and later claimed contribution from Dr Smith on the basis that he should have further investigated Sarah's symptoms following discharge, and re-referred her to hospital.

Discussion

Legal claims

Nervous shock claims

In some circumstances, patients who suffer a psychiatric injury, but no physical injury, as a result of negligence are entitled to seek damages for 'pure mental harm' or 'nervous shock'. Claims for nervous shock can also be brought by a patient's close family members (parent, spouse or partner, children or stepchildren, siblings or half siblings).

As with any claim of negligence, the plaintiff must establish that the doctor owed a duty of care, failed to discharge that duty, and as a result caused the plaintiff to suffer injury, loss or damage.

Additionally, a successful claim for nervous shock must establish the following.

- The impairment is sufficient to be classified as a recognised psychiatric illness. Damages cannot be recovered simply for distress, anger or grief.
- It was foreseeable in the circumstances that if reasonable care was not taken, a person of normal fortitude might suffer a recognised psychiatric illness.

Mrs Brown, who had been diagnosed with major depression following the death of her daughter, succeeded in her claim for nervous shock against the hospital, and the matter was settled at mediation. The hospital then made a claim for contribution against Dr Smith.

Contribution claims

Defendants in negligence claims are entitled to bring a claim for contribution against third parties who would, if they had also been sued, have been liable for the damage suffered by the plaintiff. If the claim is successful then the third party pays a contribution towards the damages awarded or paid to the plaintiff, based on the extent of their liability.

Hospitals may seek contribution from GPs or specialists involved in the patient's care, and individual doctors who are sued may seek contribution from other doctors or the hospital where the patient was treated.

Did Dr Smith act appropriately?

As all GPs know, in some cases the diagnosis of appendicitis can be challenging. The typical signs and symptoms are not always present. Despite the widespread use of tests that are thought to rule in or rule out appendicitis, the history and examination remain the diagnostic cornerstones for evaluating pain in the right iliac fossa. An evaluation of the pros, cons and positive and negative predictive value of tests in these patients is beyond the scope of this article. However, clinical judgement, close follow up, and communication between patients, carers and health professionals are crucial to ensure that no patient 'falls through the cracks'.

In Dr Smith's case, the delayed diagnosis of appendicitis caused Sarah's death (and consequently her mother's major depression). The key legal issue, therefore, was whether any breach of Dr Smith's duty contributed to the delayed diagnosis.

In analysing the claim for contribution, several issues arose as follows.

- Did Dr Smith obtain (and document) an adequate history?
- Did Dr Smith perform (and document)

an adequate examination?
- Should Dr Smith have obtained the discharge summary or contacted staff at the hospital to obtain blood test and urine results?
- Would the outcome have changed if Dr Smith had obtained the results and/or referred the patient to hospital?

Expert peer professional opinion obtained on behalf of Dr Smith was that he had obtained a good history and conducted an appropriate examination of Sarah. His records were thorough.

In the week after Sarah's discharge, Dr Smith's practice received a copy of the discharge summary. It stated: 'USG pelvic NAD, WCC 15, other bloods unremarkable, no fevers, no rigors, obs stable. No pending results. Diagnosis: abdominal pain; appendicitis unlikely.' The elevated C-reactive protein level was not mentioned.

The experts were asked to consider whether obtaining the discharge summary earlier would have made a difference to Sarah's outcome. They considered that the discharge summary was not as accurate as it should have been, and the lack of detail and incompleteness of the information was misleading. Despite this, it would have been reasonable for Dr Smith to accept the information on the discharge summary: that the patient had been assessed, and that appendicitis had been excluded.

In the view of the experts, as Sarah's pain was intermittent, there was no clear reason to re-refer her to hospital or to initiate further investigations. Had Dr Smith been aware of the elevated C-reactive protein level, his actions may well have been different.

Furthermore, on the balance of probabilities, it was unlikely that had Dr Smith referred back to hospital a patient who had been discharged within the previous 24 hours and whose symptoms were improving, the hospital would have admitted the patient for further investigations.

Outcome

The claim for contribution was defended on the basis that the care provided by Dr Smith was consistent with the standard of care expected of a reasonable GP. Ultimately, the hospital agreed to withdraw its claim.

Risk management

This case highlights a very sad medical outcome. From the legal point of view, even though the GP did not bear any liability, there are some important lessons for all GPs (summarised in the Box).

- GPs usually need to take the patient's history on face value. However, it is always good practice to verify details of any contact with other health providers and hospitals to ensure important information is not missed.
- It is best practice to re-examine patients who present after hospital discharge, and avoid false reassurance from the hospital. Had Dr Smith not documented an adequate examination of the patient, his defence to the claim for contribution may have been unsuccessful.
- Although it may not have changed the outcome in this case, it would have been reasonable to telephone the hospital to obtain blood and urine results.
- Poor communication between health providers, and particularly between hospitals and GPs, is a common cause of error and a threat to patient safety. Although the timeliness of hospital discharge summaries has improved over the years, there may be a lot to learn from systems that encourage personal communication between providers and 'warm handovers' between hospitals and GPs.
- As always, 'safety netting' is crucial. It is important to give patients enough information for them to know when and how they should seek further review and help. MT

COMPETING INTERESTS: None.