Medical Practitioners Disciplinary Tribunal

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DECISION NO.: 7/97/3C

NAME OF RESPONDENT

NOT FOR PUBLICATION

(Refer NOTE at conclusion of DECISION)

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

IN THE MATTER of a charge laid by a Complaints Assessment Committee pursuant to Section 93(1)(b) of the Act against **JOSEPH RABIDASS SAMI** registered medical practitioner of Palmerston North

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mr P J Cartwright (Chairperson)
Dr J M McKenzie, Dr M-J P Reid, Dr A F N Sutherland
Mrs H White (Members)
Ms G J Fraser (Secretary)
Mr J D Howman (Legal Assessor)
Mrs G Rogers (Stenographer)

Hearing held at Palmerston North on Thursday 5 June 1997

APPEARANCES: Mr M McClelland for the Complaints Assessment Committee ("the CAC").

Mr M Parker for Dr Sami ("the respondent").

DECISION:

1. THE CHARGE:

THE respondent is charged with professional misconduct, or in the alternative if such conduct is found not to amount to professional misconduct, with conduct unbecoming a medical practitioner and that conduct reflects adversely on the practitioners fitness to practice medicine. The basis of the charge is that the respondent's examination of C on Sunday 23 June 1996 was inadequate in one or more of the following respects:

(a) Failure to obtain an adequate history of the patient, having regard to the concerns expressed by the patient's GPs, and/or the patient's parents.

(b) Failure to conduct an adequate physical examination of the patient.

(c) Failure to give adequate advice to the parents of the patient.

2. BACKGROUND:

2.1 **C** was born on 1 February 1995. She died of meningitis on 24 June 1996.

2.2 **SHORTLY** after 8 am on Sunday 23 June 1996 and some time after breakfast, C vomited over her father, A (" Mr A"), and the floor. He put C into the bath where she was sick again. He became worried about C and telephoned his partner and C's mother, B ("Ms B"), who was at work at the time.

2.3 **MS** B came home from work and they both took C to the xx at xx, xx. This was some time after 10 am. C was again sick in the waiting room before seeing the doctor.

2.4 **C** who was normally quite a lively and healthy baby was, in the opinion of her parents, fairly lifeless and drowsy when she was first seen by Dr D, duty general practitioner.

2.5 **DR** D examined C and recorded in his notes amongst other things that C was: "limp and drowsy, a tearful, alert child; pulse rate 160 per minute; temperature 37.5_C; respiratory rate 48 breaths per minute". He recorded the diagnosis as "fever of unknown origin, acute onset, moderately unwell". Dr D prescribed Paracetamol and fluids and also applied a urine collecting bag. He asked the parents to return the sample to him and to bring C back if she was no better in 3-4 hours.

2.6 **AT** the time, although Dr D could find nothing specific on examination, he was particularly concerned with C's pulse rate as it was out of proportion to the brief history of illness and the parent's description of C as being limp. Because there was no specific site of infection, Dr D was concerned as to whether C had a serious condition.

2.7 **THE** consultation with Dr D lasted approximately 40 minutes.

2.8 **MR** A and C returned home at about 11.45 am and Ms B went back to work. C went to bed and woke up again at about 3.00 pm. By this time Ms B had returned home from work. C had still not passed urine. At about 3.30 pm C drank some Milo but was immediately sick. Mr A and Ms B took her straight back to Dr D arriving there at about 3.45 pm.

2.9 **THE** parents told Dr D that C had not passed urine, that she had become more lethargic and that she continued to vomit.

2.10 **DR** D considered the fact that C had not passed urine may have been an indication of developing dehydration. On examination Dr D found C to be less alert, her pulse remained high and in Dr D's view she was more unwell. She appeared lethargic and less alert in contrast to the earlier consultation and her pulse rate and respiratory rate had risen.

2.11 **DR** D's notes record, amongst other things, that C's temperature at the second consultation was 39.1_C and her pulse rate was greater than 160 per minute. Because C had a worsening illness and he could not make a definite diagnosis, Dr D believed that there was a definite possibility of a serious occult infection. For this reason Dr D was of the view that C warranted admission to hospital.

2.12 **DR** D discussed the possibility of meningitis or pneumonia with C's parents. He told them that the hospital would probably start C on antibiotics or at the very least observe her for the next hour or so.

2.13 **DR** D wrote a referral note which he gave to C's parents to take to the hospital. In it he recorded C's history and noted that C was lethargic, continued to vomit, had not passed urine, had a temperature of 39.1_C, had a pulse rate greater than 160 per minute and had a respiratory rate of 60 breaths per minute. Under the heading "Listed Known Sensitivities" Dr D noted:

"? viral illness

? occult bacterial infection"

2.14 **DR** D also telephoned the paediatric registrar at xx Hospital, the respondent, and outlined to him his concerns, particularly given the duration of the illness, and that C was more unwell than could be expected if she simply had flu or another viral illness. He told the respondent that he wanted a second paediatric opinion at the hospital.

2.15 **MS** B and Mr A arrived at the A & E Department with C at about 4.28 pm. The respondent saw C at about 4.49 pm and the examination was completed by 5.00 pm.

2.16 **MS** B and Mr A took C home and at about 5.30 pm her temperature was 39_C. At about 7.00 pm her temperature was 38.1_C.

2.17 **BEFORE** putting her to bed, Ms B took C's clothes off and washed her. She took her urine bag off (which had still not been used) and at this time noticed about a dozen red marks on C's legs and groin.

2.18 **BETWEEN** 7.30 pm and 9.30 pm Mr A checked C twice; Ms B checked her again at about 11.00 pm and Mr A checked her between 1.00 am and 2.00 am. All seemed well.

2.19 **AT** about 7.40 am on Monday 24 June 1997 Mr A found that C had died.

2.20 **A** post-mortem was carried out by Dr E. He concluded that C died as a result of meningococcal meningitis. C was found to have a widespread haemorrhagic rash which was most pronounced over the anterior chest wall and upper arms.

3. PARTICULAR (a) OF THE CHARGE:

Failure to obtain an adequate history of the patient, having regard to the concerns expressed by the patient's GPs, and/or the patient's parents.

EVIDENCE:

AT the hearing the evidence was directed to specific periods and incidents approximately in the sequence of the three particulars of the charge. The Tribunal will adopt the same format in this decision.

Evidence for the complainant:

3.1 Dr D:

3.1.1 **D** is a registered medical practitioner practising as a general practitioner in xx.

3.1.2 **BECAUSE** C had a worsening illness and he could not make a definite diagnosis, Dr D sent her to the A & E Department at xx Hospital. He said that he considered that the information that her parents had given him in conjunction with his examination findings indicated a definite possibility of a serious occult infection. At the time he said he considered that C's condition was serious enough to warrant admission but not dangerous enough to require an ambulance provided her parents were happy to take her to Accident and Emergency in their care.

3.1.3 **AFTER** C's second consultation Dr D wrote the following referral note:

"Referral note

A, C, Date of Birth 01/02/95.

Reason for referral - Febrile illness, vomiting, lethargic, early dehydration, temperature 39.3_C.

Sudden onset of vomiting this morning. Was limp and drowsy. Seen 1000 hours - alert. Pulse rate 160 per minute, temperature 37.5_C, ears, nose, throat normal. Chest normal. Abdomen normal. Throat normal.

Diagnosis - fever of unknown origin, sent home with paracetamol and urine collecting bag.

Review now - lethargic, has continued to vomit. Has not passed urine.

Temperature 39.1_C. Pulse greater than 160 per minute. Respiratory rate 60 breaths per minute.

? viral illness

? occult bacterial infection".

3.1.4 **BEFORE** the parents left for A & E Dr D explained that he spoke to the paediatric registrar at xx Hospital. He was unsure when interviewed by the police whether he had spoken to the paediatric Registrar but by the time of the hearing was confident it was the respondent. He said he explained to him his concerns, particularly given the duration of the illness that C was more unwell than could be expected if she simply had the flu or another simple viral illness. He said he told the respondent he wanted a paediatric hospital opinion as to whether there was something more than influenza. The respondent told him that he would see C. He said he would have expected that the registrar would have taken a history of the illness from C's parents before he examined her and admitted her for observation. He explained the agreement between GPs and xx Hospital staff is that a GP may refer to Accident & Emergency for assessment any patients whom they consider to be ill enough to warrant admission.

It is of course within the discretion of the assessing hospital doctor whether or not the patient is admitted.

3.1.5 **DR** D said he concluded that C warranted admission on the combination of the parent's history, the time course of the illness and his findings. He said from the parents' history he was concerned that their description of C being limp and drowsy early on in an illness, even though he found her at the first consultation to be alert, he considered that she ought to be reviewed if she did not improve. By the time of the second consultation he said he was concerned at the parents' report that C remained lethargic and continued to vomit. From the time course of the illness and his findings, Dr D explained he was concerned initially at the high pulse rate which was out of proportion to the temperature early in the illness. He said he was concerned later at the level of lethargy he observed and the even higher pulse rate and respiratory rate. These factors together led him to believe that C warranted admission.

3.2 **Ms B:**

MOST of the evidence given by Ms B is encapsulated in the background particulars which appear at the commencement of this decision. Consequently it does not need to be repeated here.

3.3 **Mr A:**

MR A gave evidence which was similar to that which was given by Ms B. In the context of particular (a) of the charge it is unnecessary to record any of the evidence given by Mr A.

Expert Medical Evidence:

3.4 Professor Grimwood:

3.4.1 **THE** expertise of Keith Grimwood who was called by Mr McClelland was accepted. Professor Grimwood is an experienced specialist paediatrician with a particular specialty area within paediatrics of infectious diseases.

3.4.2 **PROFESSOR** Grimwood explained, as with other types of bacterial meningitis, that the symptoms and signs in young children are initially non-specific, but the key feature is their unwell appearance. He explained further:

"The usual history includes fever, vomiting, poor feeding and progressive lethargy or drowsiness. Seizures occur in as many as 20% of patients. Signs of meningitis in the young include fever, an altered conscious state and often a pale and mottled appearance. The classical signs of a bulging fontanelle (the open piece of skull covered by skin present in infants) and neck stiffness is present in only a minority of children younger than two years of age. The purpuric rash, classically associated with meningococcal disease, is present in less than one in five patients at their initial presentation and develops in a little over a half during the course of the illness.

The clinical course of severe meningococcaemia is rapidly progressive, with the time from onset of fever until death on some occasions as short as 12 hours. The initial symptoms are non-specific and consist of fever, vomiting, weakness and older children complain of headache, abdominal pain and muscle aching. The characteristic purpuric rash is initially subtle, often appearing as a viral-like rash with red spots before developing the typical brown and bruise-like skin lesions of meningococcal

disease. In these patients the rash usually begins when the patient's mental status is normal. If the disease is recognised and treated early, patients may recover without progression of disease. Alternatively patients may progress rapidly to circulatory collapse, multiple organ failure and coma followed by full recovery, recovery with sequelae or death."

3.4.3 **PROFESSOR** Grimwood had examined the statements made by C's parents, Dr D, and the respondent. In addition he had seen copies of the medical records made by both doctors and the hospital emergency department staff.

3.4.4 **PROFESSOR** Grimwood noted that C's GP, Dr D, while unable to make a diagnosis, recognised that she was sicker than expected for a non-specific childhood viral infection. In Professor Grimwood's opinion Dr D was wise to review C within a few hours and when he noted that there was no improvement, in fact some deterioration, to refer her to the hospital. It was also appropriate that Dr D also took time to speak with the paediatric registrar at xx Hospital.

3.4.5 **IN** his opinion the important features of C's illness identified by Dr D included the history of fever, vomiting, becoming limp, and C's high pulse rate. While there could be several explanations for a high pulse rate, e.g. very high fever, being extremely upset, exercise, pain, and some drugs, that none appeared to be present in C. Professor Grimwood considered that there was a possibility of hypovolaemia from severe dehydration or a serious infection turned sepsis. A high pulse rate is an early sign of sepsis and it is frequently out of keeping with the child's clinical state, and as

such it should act as a warning sign. Professor Grimwood said this is something Dr D appeared to recognise. Other causes for his concern were C's continued vomiting, failure to pass urine and possible deteriorating conscious state.

3.4.6 **AT** face value in summary Professor Grimwood's opinion was that these were very worrying symptoms and signs raising the possibility of a serious bacterial infection. Professor Grimwood concluded that the information supplied by C's parents and Dr D suggested that C was at risk of serious bacterial infection. In his opinion the presence of fever, persistent vomiting, poor urine output, lethargy, and increased pulse suggested the possibility of "an underlying severe infection". Professor Grimwood described the referral note as being "... a letter which one would respond to rapidly".

3.4.7 **WHENEVER** a young child is referred in these circumstances to a paediatric registrar, in Professor Grimwood's opinion one would expect an accurate history and thorough physical examination to be conducted and all pertinent details recorded. The salient features of the presenting illness, the child's previous health, immunisation status, infectious contacts, and whether taking medication should be recorded. An inquiry into the family's social circumstances, including possession of a telephone and access to transport, may in Professor Grimwood's opinion be relevant if the child is sent home with an undiagnosed febrile illness.

3.5 Dr Aickin:

3.5.1 **MR** Parker produced a six page brief of evidence of Dr Richard Paul Aickin without opposition from Mr McClelland. His qualifications include FRACP (Paediatrics) 1993. In his brief Dr Aickin is introduced as a Specialist Paediatrician with advanced

training in Paediatric Emergency Medicine, having been employed fulltime as Clinical Director, Children's Emergency Department, Starship Hospital since August 1993.

3.5.2 **DR** Aickin's brief acknowledges, having read the opinion of his colleague, Professor Grimwood, agreement with him that Dr D's initial management of C was entirely appropriate. Also Dr Aickin's brief contains an acknowledgement of his agreement with Professor Grimwood's concerns regarding the completeness of hospital documentation. However the brief explains that Dr Aickin's perspective on the clinical assessment and subsequent events is somewhat different.

3.5.3 **THERE** is no doubt about the expertise of Dr Aickin who was not a witness at the hearing. His evidence was not able to be tested under cross examination, consequently the Tribunal has placed greater reliance on the evidence of Professor Grimwood.

Evidence for the Respondent:

3.6 Respondent:

3.6.1 **THE** respondent acknowledged the need to err on the side of caution and the importance of keeping notes as a baseline for monitoring future progress. Dr D's opinion as an experienced and respected GP was also of fundamental importance. The respondent disagreed however with the assertion that he had failed to appreciate the significance of the material in the referral note. It was for him as paediatric registrar to make a proper diagnosis and if necessary to seek a consultant's advice. Nonetheless, he was obliged to acknowledge that he could not now recall taking a full history from C's parents and that, significantly, there is no full history recorded in his notes.

3.6.2 **THE** respondent said he did not recall specifically the telephone conversation with Dr D but he did recall that an opinion had been sought as to whether there was something more than influenza and he agreed to see the child. It was the respondent's recollection that Dr D did not mention meningitis at that stage, but in any event, with a child presenting with the symptoms as in this case, the respondent said he was alive to that possibility.

3.6.3 **THE** respondent went on to acknowledge it is of significance when a GP is sufficiently concerned to refer a child to a paediatric registrar. A paediatric registrar sees a large number of children referred to A & E. It is therefore for him to assess the symptoms presented in the light of the history reported and to determine whether admission is appropriate or not. In fact he and his colleagues see a lot of children with similar symptoms who are not admitted. While acknowledging the 'flu epidemic' with which xx Hospital was "struggling", he would not have overlooked the importance of C's illness, the gravity of which was obvious from the referral note.

3.6.4 **IN** summary it was the respondent's recollection that he did speak to C's parents about her history but he did not record it as he did not consider it significant at the time. He said he was aware of C's symptoms arising during the day, both from the referral note from Dr D and his discussion of matters with C's parents.

3.7 DISCUSSION AND FINDING:

3.7.1 **THE** respondent is not charged with failing to admit C to hospital. That is a diagnostic issue. He is criticised on three counts the first of which is failure to obtain a proper history.

3.7.2 **DR** D examined C twice on 23 June and wrote a referral note for the respondent. He also discussed the case with the respondent on the telephone. Mr Parker submitted that there is little that C's parents could have told the respondent in addition to what was stated in Dr D's note.

3.7.3 **THE** respondent's note of C's history of symptoms was "acute onset of fever and vomiting this morning". Mr Parker has asked the Tribunal to bear in mind that Dr D's referral note remained on the hospital file.

3.7.4 **THE** respondent did not record C's past history of any other illnesses or admissions to hospital and family and social history, and nor can he now recall C's parents' response to inquiries of this nature, but he assumes that having asked for that information and having received it, there was nothing of significance to record. Mr Parker has asked the Tribunal to accept that whilst the respondent did not record the answers to his inquiries, that does not mean that the information was not sought and provided. Mr Parker observed that note taking can be extremely variable between doctors. He said the respondent may have not made a full note of his findings but he had made clinical notes of his examination and that this should be taken into account. In light of the information presented to the respondent, Mr Parker submitted that he did have details of an adequate history of the patient as that history was expressed by C's GP and her parents.

3.7.5 **IN** this case there are a number of issues where there is a marked difference between the account of C's parents on the one hand and that of the respondent on the other. Principally these relate to all three particulars of the charge one of which is that the respondent failed to obtain an adequate history of C, having regard to the concerns expressed by her GP and her parents.

3.7.6 **THE** Tribunal accepts that C's parents have every reason to recall in detail the events of Sunday 23 June 1996. To some extent their recollection is supported or corroborated by other independent evidence before the Tribunal. For example, their account of the two consultations with Dr D is similar to Dr D's recollection; there may be a few differences as to time etc, but these are minor. This does show that the parents' ability to recollect events, even of a medical nature, is reliable.

3.7.7 **SIMILARLY** the parents' evidence as to the brevity of the respondent's consultation is entirely consistent with the times recorded (independently) in the medical notes. Equally their description of the consultation and the lack of history is entirely consistent with the notes, both for what is in those notes and what is not.

3.7.8 **THE** Tribunal finds that where there is a conflict, the evidence of the parents and Dr D is to be preferred.

3.7.9 **THE** respondent should have been well aware of the serious concerns that Dr D as the referring GP had about C. The referral note highlights symptoms which are entirely consistent with meningitis. The referral note also plots C's deterioration over

a relatively brief period. The referral note actually identified meningitis as being a possible diagnosis and one to be excluded. As Professor Grimwood commented, the referral note required an urgent response.

3.7.10 **IN** addition the respondent had had a telephone conversation (which he cannot recollect) with Dr D in which Dr D reinforced his concerns. Against this background the Tribunal considers that the respondent was under an obligation to do all that was necessary to exclude as far as possible, a disease which can be both fast acting and fatal.

3.7.11 **GIVEN** the potential seriousness of C's diagnosis, the paucity of the medical notes is regrettable. This is a view shared by Professor Grimwood and Dr Aickin. The respondent's suggestion that his notes are of necessity clinical and brief seems to the Tribunal to be a poor excuse for what are in fact inadequate notes. In the Tribunal's view the notes reflect that the respondent fell well short of the standards expected of a competent paediatric registrar faced with a similar situation. This was a fundamental flaw in his assessment of C.

3.7.12 **THE Tribunal finds that the respondent failed to obtain an adequate history of C, having regard to the concerns expressed by her GP and/or her parents.**

4. **PARTICULAR (b) OF THE CHARGE:**

Failure to conduct an adequate physical examination of the patient:

EVIDENCE:

Evidence for the Complainant:

4.1 Ms B:

4.1.1 **WHEN** the parents arrived at xx A & E, a nurse took C's temperature through her ear by using a device which looked something like a hearing aid. C's temperature had risen to 39.3. On the respondent's instructions the nurse gave C some Paracetamol to bring her temperature down.

4.1.2 **BY** the time the respondent examined C she was flushed/hot, drowsy, lifeless, droopy, and gave the impression of being very unwell. C spent the time slumped on her mother's knee.

4.1.3 **THE** respondent made the following checks according to Ms B's evidence:

(i) He took off C's jersey and skivvy. He used the stethoscope on top of C's singlet at the front and back but did not lift her singlet to look at her chest. He said C's chest was OK. He did not appear to take C's pulse or heart rate because he did not use a watch or clock as Dr D had done.

(ii) He looked at C's ears with a light and said they were fine, which Dr D had earlier confirmed.

(iii) He squeezed C's hand and arm and told them that C was not dehydrated, although Ms B thought that Dr D had mentioned dehydration.

(iv) He turned C's head, presumable to check for stiffness of the neck.

(v) He did not check the urine bag.

(vi) He did not check C's mouth saying "I don't want to upset her". The respondent's entire examination took place while C was sitting on Ms B's knee.

4.1.4 **MS** B recalled at some stage during the examination that Mr A had told the respondent that Dr D had thought it might be meningitis.

4.2 Mr A:

MR A recalled he had said to the respondent something along the lines of "Her temperature is rising, is it meningitis or pneumonia?" He said he told the respondent that Dr D thought it might be meningitis or pneumonia.

Expert Medical Evidence:

4.3 Professor Grimwood:

4.3.1 **PROFESSOR** Grimwood explained that the physical examination must help determine whether the child is at risk of a serious infection and localise any site of infection which adequately explains the nature of the presenting illness. Initially, Professor Grimwood said this is achieved by carefully looking at the patient, determining the level of consciousness or arousal by seeing whether they make eye contact with their parents, take notice of their surroundings and interact with the examiner. The temperature, pulse and respiratory rates are recorded and particular attention is paid to the appearance and warmth of the extremities which serve to act as an indicator of the circulation. Any respiratory difficulty is noted. Abnormalities detected in the conscious state (e.g. drowsiness or limpness), the circulation (cool or mottled limbs) or respiration (e.g. rapid sighing or grunting breathing) indicates the

infant is at high risk of serious infection. Professor Grimwood said the examiner then carefully examines the head and neck, ears, throat, eyes, trunk, abdomen, back, buttocks, limbs, and skin structures searching for evidence of infection which explains the child's clinical state.

4.3.2 **IF** a child is judged to be ill or at risk of serious infection, a series of investigations are initiated, treatment with antibiotics may be commenced and the child admitted to hospital. Whenever there is any doubt over whether to admit or investigate a febrile young child, in Professor Grimwood's opinion the prudent registrar will discuss the patient with a senior colleague, usually the Paediatric Consultant on call.

4.3.3 **IN** Professor Grimwood's opinion a young child who presents with a febrile illness, but without an obvious source, is at low risk of a serious bacterial infection if certain criteria are fulfilled. Professor Grimwood noted them as being that the child must be in prior good health, be alert, respond appropriately to the parents, environment and examiner, have warm extremities without signs of compromised circulation and not be in any respiratory distress. Furthermore Professor Grimwood explained, the child will be drinking well, passing urine and not have a haemorrhagic rash. Children who fail to fulfill these criteria are, in Professor Grimwood's opinion, at increased risk of serious infection and require further evaluation and at the very least a period of close observation.

4.3.4 **IN** Professor Grimwood's assessment he would expect a Paediatric registrar at xx Hospital, as a minimum, to order blood and urine tests and recommend admission to

hospital for close observation. If a deterioration in clinical or conscious state developed she would then undergo lumbar puncture to sample spinal fluid to diagnose meningitis. Intravenous antibiotics would then be started immediately until the final results of her investigations became available.

4.4 Dr Aickin:

DR Aickin also considers that a careful clinical examination is necessary for a 16 month old child presenting with C's symptoms. In his opinion a proportion of children presenting with fever and vomiting at C's age would require some investigations at the time of the initial assessment such as blood tests and a lumbar puncture. He said these would be the children who looked particularly unwell. A lumbar puncture would be performed in around 20% of children under two years with high fever in Dr Aickin's department. Bacterial meningitis would be diagnosed in less than one in ten of those who had a lumbar puncture. At 16 months Dr Aickin explained a chest x-ray would only be indicated if abnormal clinical respiratory signs were present.

Evidence for the Respondent:

4.5 Respondent:

4.5.1 **THE** respondent said that in addition to speaking with the parents, he carried out a physical examination of the child. He was accompanied for part of the time by a staff nurse whose notes appear in the bundle of agreed documents.

4.5.2 **THE** respondent took issue with the statement of C's parents that she was lifeless and drowsy when he examined her. By reference to the staff nurse's note C was a

"flushed looking child, quiet". It was also his recollection of C that she did not appear distressed, sleepy, or cyanosed. He described C as being "alert and looking around and responsive to me". She did not appear to him to be toxic looking or having the look of a very sick child.

4.5.3 **HIS** notes "CNF - no meningism", is a record that he carried out the appropriate central nervous system tests which included neck stiffness and flexibility, fullness of fontanelle and Kernig's sign.

4.5.4 **THE** respondent said that it is not his normal practice to use his stethoscope on top of a child's singlet to examine their chest. He always lifts the clothing when using a stethoscope.

4.5.5 **ACKNOWLEDGING** that a pathologist in this case noted there was a widespread haemorrhagic rash present which was most pronounced over the interior chest wall and upper arms, the respondent said that during the course of his examination he was looking for a purpuric rash as this is a classic symptom of meningococcal infection. although not occurring in all cases.

4.5.6 **HE** was positive that he saw no such rash on C when he examined her. If he had he would not have sent C home with her parents. He did not remove C's nappy to check her groin, but otherwise he did carry out a thorough inspection of her skin.

4.5.7 **ALTHOUGH** C was unwell, having reviewed her history and examined her thoroughly, the respondent said he did not consider her to warrant admission to hospital. If her symptoms had appeared serious he would without hesitation have admitted her.

4.5.8 **AT** the time he examined C, the respondent was of the view that she had a straight forward viral illness which was best treated at home with Paracetamol.

4.5.9 **AT** the time guidelines were in place in the Emergency Department at xx Hospital. New guidelines for Emergency Department management at xx Hospital relating to undiagnosed fever in children under two years were put in practice in October 1996. In the respondent's opinion the new guidelines are far more specific than those that were in place at the time he examined C.

4.6 DISCUSSION AND FINDING

4.6.1 **BOTH** experts in this case, Professor Grimwood and Dr Aickin, agree that symptoms of meningitis in its early stages are non-specific and a doctor must have regard to the overall appearance of the child.

4.6.2 **OBVIOUSLY** the respondent's recollection of his examination of C differs from that of C's parents. Acknowledging that C's parents are caring and attentive and knew their child well, Mr Parker suggested it may be that their recollection is somewhat clouded by their grief. The respondent accepts however that he made no note of the general appearance of C.

4.6.3 **THE** respondent did not remove C's nappy when examining her, and accepts that he should have done. However, when Ms B saw a rash later that evening it was on both the child's groin and legs. Mr Parker submitted there is no evidence to suggest that there was any rash on C at the time the respondent examined her. It is more than likely in his submission that the rash that developed on her groin and legs, developed after she had been seen by the respondent.

4.6.4 **THE** respondent has significant experience in diagnosing meningitis. Mr Parker submitted, therefore, that the respondent's view of C's overall appearance was genuinely held.

4.6.5 **A** 16 month old child presenting with a high fever and vomiting could, on the evidence, have any of a wide variety of diagnoses. Dr Aickin made the point that a careful clinical examination and screening test for urine infection is the starting point for decision making. The careful examination should include checking all of the skin which, Dr Aickin explained, is often done by sequentially uncovering and recovering areas of the body to prevent small children becoming cold or frightened.

4.6.6 **THE** extent of the examination carried out by the respondent is the critical issue. In the Tribunal's view the parents' description of the consultation undertaken by the respondent, the lack of history, the brief and casual examination is entirely consistent with the brevity of the notes.

4.6.7 **MR** McClelland invited the Tribunal to consider the respondent's conduct in context. He submitted that his conduct fell well short of accepted professional standards. In part, it might be explained (but in no way justified) by the fact that xx Hospital was busy. There has been anecdotal evidence that the hospital beds were full to overflowing and there might be a reluctance in such circumstances to admit further patients unless in extreme or acute situations. Against the background of what Mr McClelland described as a flu epidemic of mammoth proportions, he submitted the obvious inference is that the respondent, whether intentionally or unintentionally, formed a view that C's case was more likely than not a case of flu rather than meningitis or some other hidden infection and that Dr D as the general practitioner was over-reacting. The brevity of the respondent's consultation, the paucity of the note taking and the inadequacy of his assessment and advice to the parents becomes, in Mr McClelland's submission, explicable but by no means acceptable.

4.6.8 **IN** the Tribunal's assessment it would not have been possible to take an appropriate history, give C Paracetamol, carry out a full examination (as described by Dr Aickin and Professor Grimwood), record the history and findings in the notes, give C water, reach a definitive diagnosis, and give the parents appropriate advice in the ten minutes which the respondent spent with C. The Tribunal is aided in this view by the evidence that Dr D's first consultation took up to 40 minutes.

4.6.9 **NOR** is there a record in the respondent's notes of C's appearance. The expert evidence (and the new guidelines promulgated at xx Hospital in October 1996)

emphasise that the overall appearance or the degree of unwellness is a matter of the utmost importance.

4.6.10 **DESPITE** his claim that he carried out a thorough examination looking for, amongst other things, a rash, the respondent made no observation of that part of C which was covered by a nappy. The Tribunal finds that this is in itself an omission of some significance.

4.6.11 **ALL** in all, the Tribunal is bound to conclude that the respondent's examination of C was seriously flawed and totally inadequate in the circumstances.

4.6.12 **THE Tribunal finds that the respondent failed to conduct an adequate physical examination of C.**

5. PARTICULAR (c) OF THE CHARGE:

Failure to give adequate advice to the parents of the patient.

EVIDENCE:

Evidence for the Complainant:

5.1 Ms B & Mr A:

5.1.1 **IT** was the parents' evidence that they were relieved when the respondent told them that C had picked up the flu virus and, "that there was a lot of this going around". C was to have Paracetamol every four hours to bring her temperature down and that she would be better off at home. The respondent never discussed the possibility of

admitting C. At no stage did the respondent ask for a second opinion. He handled the whole consultation himself and did not perform any other tests. He did not give C any antibiotics. Ms B said she did not tell the respondent that Dr D had been concerned about meningitis or that Dr D had said they would either put C on antibiotics or observe her at least for an hour because when the respondent told them it was a flu virus, their defences dropped.

5.1.2 **THEY** were given a green consultation form which had written on it, amongst other things, "non-meningism". During the ten minutes consultation the respondent was with them most of the time. He was "very laid back and casual". The respondent did not tell them what to do if C didn't improve and nor did he mention red spots.

5.1.3 **THEY** returned home from the hospital between 5.15 and 5.30 pm, and C's temperature at about 7.00 pm had dropped to 38.1. They then set about putting C to bed. Ms B said she took off all C's clothes, washed her and took off the urine bag which still had not been used. She explained that she noticed about a dozen red marks on C's legs and groin. She described them as being "like little spots which looked like measles". Her evidence was that she had not seen these on C before. None of the doctors had told her that red spots were a symptom of meningococcal disease. She presumed C must have the measles. She put a clean nappy on C even though the old one was not wet. She then put C's pyjamas on and gave her about 5 ml of Paracetamol and a drink. C would have been in bed about 7.30 pm.

5.1.4 **MS** B rang a friend who worked with her and told her the good news that it was not meningitis, but looked like a good dose of the measles. Mr A checked C twice between about 7.30 pm and 9.30 pm. Ms B did not touch C when she checked her because she appeared to be asleep. She got up at about 11.00 pm and C seemed to be sleeping peacefully. She touched C's head and she did not appear to be hot. When Mr A went into check on C before 8 o'clock the next morning the next thing she heard was Mr A cry out and she said she knew that something was wrong with C.

Expert Medical Evidence:

5.2 **Professor Grimwood:**

PROFESSOR Grimwood's evidence is important. Once an examination such as was undertaken by the respondent of C is completed, Professor Grimwood indicated that a plan of management should be made in the notes and if the child is judged to be at a low risk of serious infection and a decision is made to send the patient home, the parents must be given clear instructions on what to do if there is any deterioration in the child's clinical state. Professor Grimwood's recent experience, working as a Consultant in a large Paediatric Emergency Department which saw 80,000 patients a year, was that parents under such circumstances received written instructions before leaving the Emergency Department.

5.3 **Dr Aickin:**

5.3.1 **DR** Aickin explained it was necessary to consider what instructions and advice were given to C's parents at the time they went home. This advice would ideally include a minimum intake of fluids to aim for, to watch for increased drowsiness and for the

appearance of a rash. If there were problems with any of these, the parents should have been advised to return immediately to the doctor.

5.3.2 **DR** Aickin noted, however, that unfortunately the respondent's note did not document the advice given at the time of discharge. Dr Aickin also noted that unfortunately he had found limited information in the hospital notes. He expressed his belief that a more detailed description of the respondent's assessment and discharge advice should have been recorded at the time.

Evidence for the Respondent:

5.4 Respondent:

5.4.1 **BOTH** in his initial statement provided to the police and his statement given at the inquest, the respondent said he informed C's parents that if at any stage they were still worried or fever persisted, to bring her back to hospital. The respondent said that the parents appeared happy with that advice. The respondent could only say that their respective recollections differ because he would not send a patient home without giving that advice.

5.4.2 **REFERRING** to new guidelines promulgated at xx Hospital in October 1996, the respondent noted that they now provide that if a child is to be discharged without antibiotics, that parents are to be given precise written instructions. The protocol in force at the time of his examination of C was not specific as to the nature of the advice to be given to parents upon sending them home with their child. However with the benefit of hindsight, and although he considered his advice was consistent with the

protocol in force at the time, the respondent accepted that it would have been preferable, having discounted meningitis as a cause for C's symptoms, to give specific instructions to her parents for rapid deterioration in C's condition and the appearance of a rash. In either event the respondent acknowledged that the advice should be to seek urgent medical treatment.

5.5 DISCUSSION AND FINDING:

5.5.1 **THE** respondent discounted meningitis as the cause for C's symptoms. Mr Parker submitted that it is understandable, though possibly not permissable, that the respondent did not tell the parents to watch C for the onset of a purpuric rash. Mr Parker noted that in the respondent's mind, there was no danger to C who was merely suffering from a viral infection.

5.5.2 **WHEN** Ms B initially gave a statement to the police, she could not recall whether the respondent had given her any advice or not. Mr Parker noted she had revised her opinion stating at the hearing that the respondent gave them no advice.

5.5.3 **IT** was the respondent's recollection that he told C's parents that if at any stage they were still worried or fever persisted, they should bring C back to the hospital. Mr Parker submitted that C's parents are mistaken in their recollection that the respondent gave them no advice on sending them home with C. However Mr Parker conceded, if there is any criticism of the respondent's advice, it is that he did not warn C's parents to look out for a purpuric rash.

5.5.4 **MR** Parker further submitted, with the benefit of hindsight, it is easy to criticise the respondent for his failure to give specific advice, that the advice he did give was consistent with that expected of most doctors in keeping with guidelines then in force at xx Hospital. Mr Parker argued it is for the profession as a whole to improve those standards and guidelines as expertise develops, rather than for the respondent to shoulder the blame for his failure to give specific advice.

5.5.5 **IT** is the Tribunal's judgement, at the very least, that the respondent should have told the parents what his tentative (rather than firm) diagnosis was, discussed the other possibilities including meningitis and what they should have been on the look out for and what they should do if other symptoms developed or C otherwise deteriorated.

5.5.6 **WHILE** the respondent claimed that he told C's parents that if at any stage they were still worried or fever persisted, they should take her back to hospital, in the Tribunal's assessment this is not consistent with the hospital notes and nor is it consistent with the parents' evidence as to the advice which they received.

5.5.7 **EVEN** on the respondent's evidence, if it were accepted, it is clear to the Tribunal that he did not give the sort of advice which Dr Aickin considers to be essential (as to minimum intake of fluid, to watch for increased drowsiness and for the appearance of a rash).

5.5.8 **IT is the Tribunal's finding that the respondent failed to give adequate advice to the parents of the patient.**

6. DETERMINATION:

6.1 **THE** respondent is charged with professional misconduct, or in the alternative, if such conduct is found not to amount to professional misconduct, with conduct unbecoming a medical practitioner.

6.2 **THE** Tribunal has the power to amend the charge during the hearing pursuant to Clause 14 of the First Schedule of the Act. To be noted in the 1995 Act is an added requirement, in the case of conduct unbecoming a medical practitioner, that the Tribunal is only entitled to make orders as to penalty where that conduct reflects adversely on the practitioner's fitness to practise medicine (Section 109(c)).

6.3 **THE** burden of proof is on the CAC to establish that the respondent is guilty of the charge, and to produce the evidence that proves the facts upon which the charge is based.

6.4 **IT** is well established in professional disciplinary cases that the civil, rather than the criminal, standard of proof is required, namely proof to the satisfaction of the Tribunal, in this case the Medical Practitioners Disciplinary Tribunal on the balance of probabilities. At the same time, however, the cases recognise that the degree of satisfaction which is called for will vary according to the gravity of the allegations.

6.5 **THE** Tribunal must determine whether the facts alleged in the charge have been proved to the required standard. That standard having been proved in this case, it is now necessary for the Tribunal to go on to determine whether the conduct established by the proven facts amounts

to professional misconduct or conduct unbecoming which reflects adversely on the practitioners fitness to practise medicine.

6.6 **CLAUSE** 6 of the First Schedule provides that the Tribunal may receive as evidence any statement, document, information or matter that may in its opinion assist it to deal effectively with the matters before it, whether or not it would be admissible in a Court of Law.

6.7 **THE** Tribunal is required to observe the rules of natural justice at each hearing.

6.8 **IN** *B v The Medical Council* (High Court, Auckland, HC 11/96, Elias J, 8 July 1996), the Judge recognised that the scheme of the Medical Practitioners Act 1968 established a hierarchy of conduct for disciplinary purposes. In ascending order of gravity, the categories were conduct unbecoming, professional misconduct, and disgraceful conduct.

6.9 **AT** page 15 of the Judgement Elias J stated:

"There is little authority on what comprises "conduct unbecoming". The classification requires assessment of degree. But it needs to be recognised that conduct which attracts professional discipline, even at the lower end of the scale, must be conduct which departs from acceptable professional standards. That departure must be significant enough to attract sanction for the purposes of protecting the public. Such protection is the basis upon which registration under the Act, with its privileges, is available. I accept the submission of Mr Waalkens that a finding of conduct unbecoming is not required in every case where error is shown. To require the wisdom available with hindsight would impose a standard which it is unfair to impose. The question is not whether error was made but whether the practitioner's conduct was an

acceptable discharge of his or her professional obligations. The threshold is inevitably one of degree. Negligence may or may not (according to degree) be sufficient to constitute professional conduct or conduct unbecoming ....."

6.10 **THE** definition of professional misconduct is well established. In *Ongley v Medical Practitioners Disciplinary Committee* [1984] 4 NZAR 369, at 374 to 5, Jefferies J stated in the context of the 1968 Act:

"to return then to the words "professional misconduct" in this Act. ..... In a practical application of the words it is customary to establish a general test by which to measure the fact pattern under scrutiny rather than to go about and about attempting to define in a dictionary manner the words themselves. The test the Court suggests on those words in the scheme of this Act in dealing with a medical practitioner could be formulated as a question. Has the practitioner so behaved in a professional capacity that the established acts under scrutiny would be reasonably regarded by his colleagues as constituting professional misconduct? With proper diffidence it is suggested that the test is objective and seeks to gauge the given conduct by measurement against the judgment of professional brethren of acknowledged good repute and competency, bearing in mind the composition of the tribunals which examine the conduct. Instead of using synonyms for the two words the focus is on the given conduct which is judged by the application to it of reputable, experienced medical minds supported by a lay person at the committee stage. ..... the Court does, and ought to, give due and proper weight to the expressions of opinion by tribunals composed largely of medical men. ....."

6.11 **THE** Tribunal upholds Mr McClelland's submission that the test for professional misconduct established in *Ongley* should be the same under the new 1995 Act, despite the altered composition of the Tribunal.

6.12 **THE** basis of the charge is that the respondent's examination of C on Sunday 23 June 1996 was inadequate in one or more of three respects. The particulars of the charge relate clearly to the respondent's examination of C and not the conclusions reached by him in determining a diagnosis. These charges can be distinguished from the respondent not diagnosing meningitis as he is not charged with that. That is so even though, however regrettably, the respondent discounted meningitis in diagnosing C with a viral illness, and subsequent to the respondent's examination of C, she died.

6.13 **FURTHERMORE** the respondent is not charged with failing to admit C to hospital. That is a diagnostic issue. He is criticised for failing to obtain a proper history, adequately to physically examine her, and give her parents adequate advice as to follow up care.

6.14 **THE** respondent has conceded some shortcomings in his treatment of C and has expressed sincere sorrow for those shortcomings. The respondent has expressed his apologies and condolences to C's parents. While the respondent accepts that he should have taken some further steps, the Tribunal acknowledges that the case against him is not that he actually caused C's death.

6.15 **FOR** the CAC Mr McClelland submitted that the evidence establishes in relation to the charge that the respondent acted in a manner which would be reasonably regarded by his colleagues

as constituting professional misconduct. When such conduct is considered objectively and measured against the judgement of the respondent's professional brethren of acknowledged good repute and competency, Mr McClelland argued that the Tribunal must conclude that such conduct amounts to professional misconduct.

6.16 **ON** behalf of the respondent Mr Parker submitted that this is not a case which amounts to professional misconduct. However in light of the concessions by the respondent that there were aspects of his examination of C that the Tribunal may consider fell below the standard expected of him, Mr Parker submitted that those failures constitute conduct unbecoming a medical practitioner rather than professional misconduct.

6.17 **AT** the conclusion of the hearing the Chairperson announced the Tribunal's findings and its determination, based on those findings, that the conduct of the respondent as established by the proven facts, amounts to professional misconduct. It is now necessary to explain the basis on which that determination was made. The Tribunal hearing determines the respondent's examination of C was inadequate in all of the respects set out in the charge, then turns to determine whether such failings warrant a disciplinary sanction. The Tribunal accepts that the tests set out by the High Court in *Ongley's* case and in *B v Medical Council* are appropriate. In applying those carefully to the circumstances in this matter the Tribunal is of a view that the respondent's failing fell well below that reasonably expected of a prudent paediatric registrar and therefore requires sanction. The Tribunal is of the view that the failings fall into the category of professional misconduct. The findings of the Tribunal and this determination were unanimous.

7. PENALTIES

7.1 **IN** making orders in this case, the Tribunal is bound by the transitional provisions of Section 154(f) (i) and (ii) of the Act.

7.2 **THE** Tribunal invites submissions from counsel as to penalties. The timetable for making submissions will be as follows:

7.2.1 **COUNSEL** for the CAC should file submissions with the Secretary and serve a copy on counsel for the respondent not later than 10 working days from receipt of this decision.

7.2.2 **IN** turn counsel for the respondent should file submissions in reply with the Secretary and serve a copy on counsel for the CAC not later than 10 working days from receipt of CAC counsel's submissions.

7.3 **THE** Tribunal wishes counsel to know that one of the penalties under consideration, subject to compliance with the transitional provisions of the Act, is the making of an order under Section 110(c). In this context the Tribunal considers a valid option would be to make an order that the respondent's competence be reviewed under Part V of the Act. Counsel is requested to address this aspect in their further submissions.

8. NOTE:

8.1 **THE** Order made on 21 April 1997 that no written statements of evidence be circulated to any person except the Tribunal, the parties and their counsel, either prior to or in the course of the hearing, was vacated at the conclusion of the hearing.

8.2 **HOWEVER** the other Order made on 7 May 1997 that publication of the name of the respondent, directly or indirectly, in connection with the treatment or death of C be prohibited until further order, remains in effect.

DATED at Auckland this 15th day of July 1997

.....

P J Cartwright

Chairperson

Medical Practitioners Disciplinary Tribunal