# General Practitioner - Dr C

# A Rural Medical Practice

## A Report by the

## Health and Disability Commissioner

## Case 03HDC10394)

## Parties involved

| | |
|---|---|
| Ms A | Consumer |
| Mr A | Complainant, Consumer's father |
| Dr C | Provider / General Practitioner |
| Dr D | Employer, Rural Medical Practice |
| Dr E | General Practitioner |

## Complaint

On 17 February 2003 the Commissioner received a complaint from Mr A regarding the care his adult daughter, Ms A, received from Dr C. The complaint was summarised as follows:

*On 27 July 2002 Dr C did not provide Ms A with services of an appropriate standard. In particular, Dr C:*

- *did not diagnose an obvious vertebral fracture and refer Ms A for further assessment and management*
- *did not refer Ms A for an X-ray to rule out the possibility of a vertebral fracture.*

An investigation was commenced on 19 August 2003.

## Information reviewed

- Information obtained from Mr A, Ms A, Dr C , Dr D, and the General Medical Council (United Kingdom)
- Ms A's records from Dr E and a Public Hospital

Independent expert advice was obtained from Dr Keith Carey-Smith, a general practitioner in rural practice.

## Information gathered during investigation

*Background*
On 27 July 2002 Ms A, a 22-year-old medical student from the United Kingdom holidaying in New Zealand, was involved in a motor vehicle accident on the road in a rural area. She was a



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back seat passenger in a car that skidded on some ice and struck a stationary object. Ms A and one of her companions were taken by some passersby to a rural medical practice (the Practice) where she was seen by Dr C. Dr C, trained and recently arrived from the United Kingdom (UK), was employed at the practice as a locum.

The Practice is an isolated practice covering a large rural area. It is the only facility in the area that provides medical and emergency care. Its X-ray facilities are limited to the evaluation of limb injuries (inadequate for obtaining spinal views). The base hospital for the town is the city hospital, approximately two hours by road. Dr D advised me that if a patient requires inpatient care, specialist opinion or more advanced X-ray investigation, he or she has to be sent to the city by their own transport or ambulance. Due to the distance, the on-call doctor has to carefully consider whether transfer to the base hospital is required.

*Consultation*

Mr A advised me that on presentation at the Practice his daughter was in severe pain and showed signs of "shock" and had "extensive bruising" of her abdomen. Ms A explained to Dr C that she felt severe pain in her lower back at the time of the impact and the pain was worsening. Dr C then performed a "cursory" examination of her back and noted that she had "hardly any movement in any direction". Ms A recalled that during the examination Dr C noted that the vertebral process was "quite prominent" and, according to her father, elicited "point tenderness over the affected vertebra". Mr A advised me that his daughter was then told by Dr C that the nearest X-ray facilities were two hours away (in the city) and that he did not think an X-ray was necessary. She was also told to take a strong pain-killer (dihydrocodeine) and see the Practice's physiotherapist the following day (28 July 2002). Ms A recalled that Dr C did not ask that he review her. She had no further contact with him.

Dr C advised me that he did not feel his examination of Ms A was cursory as alleged by Mr A. He recalled performing a neurological examination, which was normal. He said that Ms A was able to walk around the Practice and did not exhibit signs of shock. He also recalled Ms A saying that she did not feel she had broken her back. In his clinical notes Dr C recorded:

> "Involved in RTA [road traffic accident] back seat passenger between two other[s]. Car spun and hit rock. Her low back hit by hard plastic of seat. In a great deal of pain though able to walk say legs feel normal. OE [on examination] lower back no deformity, tender diffusely but not particularly over bony area. Lower limb neurology NAD [no abnormality detected]. Pethidine 100mg given plus DHC [dihydrocodeine] overnight warned of symptoms of concern."

The notes record that Ms A was provided with a "letter as requested". Ms A acknowledged requesting the letter from Dr C. She no longer had the letter and could not remember exactly what was in it other than that it "vaguely explained I had been in an RTA and had an injury to my back". She asked for the letter detailing her injuries so she could show it to the airline in the hope of getting an upgrade for her return flight to the UK.



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Ms A stated that in her view Dr C should have made arrangements for her to be X-rayed and, if necessary, arranged an ambulance transfer. Dr C advised me that on balance he felt that Ms A had not suffered a bony injury and, as he saw her late at night and the road conditions were not good at the time, he decided not to obtain an X-ray at that point. He considered the fact that the town was the furthest medical centre from a base hospital in New Zealand, in deciding whether to request an admission of a patient to hospital or to obtain spinal films. Dr C commented that:

> "… to ask a volunteer ambulance crew to spend the night on [an] icy road you would have to have a reasonably strong suspicion that an X-ray was required urgently".

*Subsequent events*

From the evidence provided, it appears that Ms A did not attend the physiotherapy appointment scheduled by Dr C for the next day (28 July 2002). Although the parties indicated that no further contact occurred between Ms A and Dr C, the Practice's notes for 28 July record:

> "[Dr C]: Reasonable night now walks better says pain less. Back re-examined vertebrae feel intact advised."

The Practice notes also record that on 29 July 2002 Ms A was prescribed Voltaren tablets (non-steroidal anti-inflammatory analgesic) by Dr …. Ms A did not respond to a request to comment on this apparent discrepancy between her recollection and the Practice clinical records.

*Admission to the Public Hospital*

Ms A continued her travels. On 5 August 2002, after there was no improvement in her symptoms, she consulted Dr E, a general practitioner in another town. In his notes, Dr E recorded:

> "MVA [motor vehicle accident] 8/7 [eight days ago] forced flexion persistent pain PU [passing urine] BM [bowel motions] neuro[logically] OK. O/E [on examination] from L2 [second lumbar vertebra] spinous process min movement ? wedge # [fracture] advised X-rays, Cod Phos 15 ii tds [two tablets three times a day], letter for travel. Has diclofenac [Voltaren]."

Dr E referred Ms A to a radiology clinic where an X-ray of her lumbar spine revealed fractures of the third and fourth lumbar vertebrae. The radiology report stated:

> "Chance fracture of L3. This is potentially unstable injury and orthopaedic assessment is recommended."

The same day, on 5 August 2002, Dr E referred Ms A to the public hospital for further assessment. A CT scan of the lumbar spine was performed and revealed:



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> "Unstable flexion distraction fracture L3 vertebra with failure of the anterior column under compression. Thecal sac distortion reflecting displaced posteriosuperior fragment L3 vertebral body without significant canal compromise."

A decision was made to admit Ms A and treat her conservatively (non-surgically) and with analgesia. Initially she was managed on bed rest. On 9 August 2002, she commenced mobilisation after being fitted with an Optec bivalve spinal brace.

On 19 August 2002 Ms A was discharged from hospital and returned, accompanied, to the United Kingdom where she was to have a follow-up assessment. According to Mr A, on her return to England his daughter wore a "spinal corset" for three months and, at the time of lodging the complaint in February 2003, was experiencing back pain "if she [was] active for any length of time".

*Commissioner's investigation*

On 17 February 2003 the Commissioner received the complaint from Mr A. In his letter Mr A stated:

> "My reason for writing this letter is to inform the [New Zealand] Medical Council about the attitude of [Dr C] towards his patients and the treatment that my daughter received at his hand. I hope that the Medical Council will take some action, as [Dr C's] professional performance and thoroughness seems to be seriously deficient."

On 31 March 2003 the Commissioner wrote to Mr A advising him that Dr C was no longer practising in New Zealand. As it appeared that Dr C had returned to the UK, the Commissioner informed Mr A that he should advise the General Medical Council (GMC) in the UK of his concerns. The Commissioner decided to take no further action on the matter.

On 30 May 2003 the Commissioner wrote to Mr A advising him that he had been informed by the New Zealand Medical Council that Dr C was intending to return to New Zealand, and invited Ms A to contact the Commissioner's Office to discuss the complaint. Ms A was contacted on 2 July 2003 and advised that she would like to have her complaint investigated. Confirmation that Dr C was back in New Zealand was obtained on 8 August 2003 and he was notified of the complaint on 19 August 2003.

On 30 September 2003 the Commissioner wrote to the GMC requesting all the relevant information it had on the case, including the outcome of its decision. The GMC declined the request and, on 28 October 2003, its Casework Manager Fitness to Practise Directorate advised the Commissioner as follows:

> "I am afraid that I cannot provide you with information on the closed complaint, even in a brief summarized state. This is due to the fact that the information concerned has never been made public and as such cannot be made available to anyone other than the GMC, the complainant and the doctor involved."



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Following further requests for the information, in a letter of 23 April 2004 the GMC informed the Commissioner that on 6 May 2003 it had received a complaint from Mr A in relation to the standard of care his daughter received from Dr C in New Zealand, and that on 28 May 2003 it notified Dr C of the complaint. Although Dr C was invited to respond to the complaint, he was also advised by the GMC "that he was under no obligation to comment but that any comments or observations which he did provide would be taken into account".

The GMC advised the Commissioner that Dr C did not respond to the complaint. The complaint was then referred to medical and lay screeners to consider "whether a case raises concerns about a doctor that are so serious that they need to be referred to the next stage of the GMC's fitness to practise procedures":

> "… [T]he screeners noted that [Miss A] was seen by [Dr C] on only one occasion and was prescribed pain relief and advised to see a physiotherapist. One week later, [Miss A] consulted another doctor and was sent for an X-ray examination, which revealed a L3 chance fracture. The screeners considered that while the delay in reaching a diagnosis was truly regrettable, [Dr C's] failure to refer [Miss A] for an X-ray on 27 July 2002 was a single isolated failing which did not reach the threshold of serious professional misconduct or seriously deficient performance."

The GMC advised the Commissioner that on 29 July 2003 it wrote to Mr A and Dr C advising them of its decision not to proceed further with the complaint.

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## Independent advice to Commissioner

The following expert advice was obtained from Dr Keith Carey-Smith, an independent general practitioner in rural practice:

> "**Introduction**
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> In order to provide an opinion to the Commissioner on case number 03/10394/WS, I have read and agree to follow the Commissioner's Guidelines.
>
> My opinion is based on my training in medicine and general practice, further training as a PRIME certified rural first-response practitioner, and my experience and ongoing CME as a rural general practitioner in Taranaki for over 30 years.
>
> My qualifications are FRNZCGP, Dip Obstet (NZ) and DA (UK). I am aware of the rural primary care situation in the Fiordland area.



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**Purpose**

To advise the Commissioner whether [Ms A] received appropriate standard of care from [Dr C].

**Background**

On 27 July 2002 Ms A, a 22-year-old medical student on holiday from UK, was involved in a road traffic. She was taken to a [Rural Medical Practice] in [town] where she was seen by [Dr C], a locum doctor also from UK. [Dr C] examined [Ms A] and discharged her on analgesics. No X-ray was performed or requested. [Ms A] continued on her holiday and suspecting she may have a fracture, on 5 August 2002 saw general practitioner in [another town] who referred her for an X-ray. A vertebral fracture (L3) was identified. She was admitted to [the Public Hospital] for the management of the fracture.

**Complaint**

The complaint was summarised as follows:

*On 27 July 2002 [Dr C] did not provide [Ms A] with services of an appropriate standard. In particular, [Dr C]:*

- did not diagnose an obvious vertebral fracture and refer [Ms A] for further assessment and management
- did not refer [Ms A] for an X-ray to rule out the possibility of a vertebral fracture.

**Documents and records reviewed**

- Letter of complaint from [Mr A] to the Commissioner dated 12 February 2003 (pages 1-2) marked “A”
- Record of a telephone conversation with [Mr A] on 11 August 2003 marked “B” (pages 3-4) marked “B”
- Notification letter to [Dr C] dated 19 August 2003 (pages 5-7) marked “C”
- Letter of response from [Dr C] to the Commissioner (undated) received on 26 September 2003 (pages 8-9) marked “D”
- Letter of response from Dr D of [Rural] Medical Practice to the Commissioner dated 17 September 2003 (pages 10-11) marked “E”
- Ms A’s records from the [Rural] Medical practice received on 19 September 2003 (pages 12-13) marked “F”
- Ms A’s records from [Dr E ] received on 1 September 2003 (pages 14-15) marked “G”
- Ms A’s records from [the Public Hospital] (pages 16-56) marked “H”.



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**Expert advice requested:**

*To advise the Commissioner whether, in your opinion, [Dr C] provided care of an appropriate standard.*
*In addition:*

- *What specific professional and other relevant standards apply in this case and did [Dr C] follow them?*
- *Was the examination and assessment of [Ms A] by [Dr C] adequate and appropriate?*
- *Should [Dr C] have arranged for [Ms ]A to have an x-ray or referred her elsewhere for a second opinion or further assessment?*
- *Was [Dr C's] management of [Ms A's] presenting symptoms appropriate and did he provide [Ms A] with appropriate advice and follow-up?*
- *Are there any other issues that arise from [Dr C's] response and other information provided?*

**General comments:**

I consider the Background statement above to be a factual basic account of the scenario. However there is discrepancy regarding detail between the Letter of Complaint (A) and the records received from the Rural Medical Practice] (F) as follows:

- [Mr A] states that [Dr C] 'pointed to a prominence in her back and asked if she had noticed it before' and that [Dr C] stated 'some people just have prominent vertebrae'. However the records state 'lower back no deformity'. I also note that [Dr E] in [a town] on 5 August (9 days later) recorded 'prom[inent] L2 spinal process'. It is possible that with the passage of time comments made by [Dr E] have been confused with those made by [Dr C]. It is possible that initial bruising obscured the prominence at the initial examination.

- Similarly [Mr A] states that point tenderness was elicited over the affected vertebra, whereas [Dr C's] notes record 'tender diffusely but not particularly over bony area', and the next day 'vertebra feel intact'. [Dr C] also states from memory that he 'felt on balance she had not suffered bony injury'. [Mr A's] observations are difficult to understand as he was not present at the time the examination and comments were made by [Dr C].

- [Mr A] indicates that his daughter was sent away and asked to attend the physiotherapist the following day, and that [Dr C] did not see her again. However the notes (which appear to be an accurate reprint of notes made at the time) indicate that [Dr C] checked his patient the next day ($28^{th}$) (there is no mention of a physiotherapist), that she 'walks better (and) says pain less', and that he re-examined the back. The notes also indicate a prescription issued the following day ($29^{th}$) for Voltaren suggesting further communication with [Ms] A by the Medical Practice.



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On balance, considering the time interval ([Mr A's] letter was written six months after the injury) and the fact that the information he supplied was second-hand, I consider that the records made at the time carry the greater weight and I will primarily use these for my advice.

**Specific advice requested:**

- **What specific professional and other relevant standards apply in this case and did [Dr C] follow them?**

In assessing a patient injured in a suspected deceleration motor vehicle accident, significant injury must be ruled out by a full history and examination, whether or not the patient is mobile. A high index of suspicion of fracture is essential[1].

Spinal injury requires examination for loss of motion, local tenderness or palpable deformity, and for neurological lower limb abnormalities (sensory and motor)[2]. Lack of spinal tenderness and the presence of normal spinal motion in general excludes significant spinal injury[3]. However lack of lower limb neurological deficit does *not* exclude significant fracture.

If a fracture is suspected from the history of injury, symptoms, or examination, or the accident victim has significant pain, I would consider X-ray examination to be mandatory[1]. If the patient is haemo-dynamically stable with no neurological compromise, a decision to delay imaging because of unavailability, distance or lack of transport, would be acceptable if the patient receives appropriate advice about permitted activity and danger signs, and is under appropriate supervision. I would suspect that **stable** wedge fractures of the lumbar spine (not requiring urgent X-ray) would be seen much more commonly than unstable fractures by general practitioners at the 'coal-face'.

Appropriate analgesia is that sufficient to provide reasonable pain relief without risk of significant sedation or further injury. If there is suspicion of fracture the spine should be supported (eg a lumbar brace) until unstable fracture has been excluded [1, 2].

- **Was the examination and assessment of [Ms A] by [Dr C] adequate and appropriate?**

[Dr C's] notes indicate an inspection and palpation of the lower back, and a lower limb neurological check. No detail is given, but a GP record such as this usually indicates palpation or percussion for local spinal tenderness, and brief examination sufficient to exclude significant lower limb neurological abnormality. No note is made of the range of spinal motion; however [Mr A's] letter implied that the examination included back

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[1] Apleys System of Orthopaedics and Fractures, Solomon & others; 8th edition, 2001. Arnold.
[2] Manual for the PRIME Training Course, November 2001, Christchurch School of Medicine.
[3] Emergency Medicine: The Principles & Practice Ed G Fulde 1988 MacLennan & Petty.



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movement. As far as I can judge from the records, this examination is appropriate in a patient complaining of low back pain after a road accident. Further assessment including abdomen and chest is not mentioned, but should be carried out briefly when a history of a possible high impact accident such as this is obtained. Sufficient analgesia was supplied (pethidine injection and strong oral analgesia), and the notes imply recall for further checking the next day, at which time the back was re-examined. In my opinion this is also appropriate management.

- **Should [Dr C] have arranged for [Ms A] to have an x-ray or referred her elsewhere for a second opinion or further assessment?**

A spinal X-ray would appear to be indicated in the situation described, but not necessarily immediately if the patient is stable, mobile and without abnormal neurological features. The consultation carried out by [Dr C] the next day noted improvement in pain and mobility, and further examination apparently reassured [Dr C] that no serious vertebral injury was likely. It would appear that [Dr C], as confirmed in his letter (p 009), did not believe that [Ms A] had sustained a fracture. If he had suspected bony injury, it is unlikely that he would have discharged her the next day without arrangements for further assessment including X-ray in a larger centre.

However in my opinion fracture could **not** be excluded by the findings, constituting a deficiency in [Dr C's] diagnostic skills. Arrangements should therefore have been made for [Ms A] to proceed to a facility where X-rays were available and could be interpreted before undertaking any significant further physical activity. Since she had already tolerated a drive from the accident site in a car without spinal compromise, I consider it reasonable to allow her to be driven in a private vehicle rather than using an ambulance for the journey. Ideally however she should have been placed in a back brace for the journey. Clear instructions and responsible supervision would be required. The documentation provided does not indicate what instructions Ms A was given.

- **Was [Dr C's] management of [Ms A's] presenting symptoms appropriate and did he provide [Ms A] with appropriate advice and follow-up?**

[Dr C's] initial management, including analgesia and follow-up the next day, is considered to be appropriate. However as stated above, [Dr C's] failure to consider bony injury in a patient with a significant chance of having a fracture (even in the absence of localised tenderness and neurological deficit), resulted in his decision not to refer or arrange imaging. The notes indicate that [Dr C] advised [Ms A] presumably about the warning symptoms for which medical advice should be sought, and that further advice (nature unspecified) was provided the next day. In the absence of further detail either from the notes, other staff, or from [Ms A] herself, I am unable to determine whether the advice given was appropriate. There is no indication that further follow-up was advised or arranged, but detail about this is often omitted from GP records.



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- **Are there any other issues that arise from [Dr C's] response and other information provided?**

It should be remembered that comments provided in retrospect by both parties are made with the benefit of hindsight. Some allowance should be made for the diagnostic deficiency by the fact that [Ms A], although in considerable pain, apparently walked into the surgery, and appeared to be improved the next day. In addition, the rural location necessitating a 2 hour ambulance trip for an ambulant patient without serious complications, adds considerably to the weighting in favour of conservative management in this situation. In retrospect, this option was shown to be the wrong one.

I would draw attention to the fact that the records kept by [Dr C] (at the [Rural] Medical Practice) are extremely brief, do not include important history and clinical items (negative as well as positive), and lack clarity about the advice given to the patient. Appropriate written patient information for common injuries such as back pain would have supported any verbal advice given, and indicated that correct practice had been followed.

I would suspect that this case, and the subsequent valid concerns raised by the family, will result in an increase in [Dr C's] competence and safety for his future clinical practice, and improved documentation and patient advice provided at [the Rural Medical Practice].

**CONCLUSION**

**Did [Ms A] receive an appropriate standard of care [from Dr C]?**

I consider that [Dr C] performed an adequate clinical assessment, and that his initial management was appropriate for a patient without likely bony injury. However he exhibited a deficiency in diagnostic skills in his failure to consider the significant possibility of a fracture (even in the absence of definite signs), and thus made inappropriate further management decisions. I consider that in this respect [Dr C] failed to meet the standard of care reasonably expected of a rural general practitioner assessing trauma cases. However, due to the extenuating circumstances mentioned, I consider the failure to be minor; likely to incur the mild-moderate disapproval of his peers."



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## Code of Health and Disability Services Consumers' Rights

The following Right in the Code of Health and Disability Services Consumers' Rights is 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.*

## Opinion: No breach

*Examination*
Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) states that every consumer has the right to have services provided with reasonable care and skill.

Mr A and his daughter alleged that at the time of the consultation Dr C noted and enquired about a prominence on her back, and that he dismissed its significance. Mr A also alleged that Dr C elicited from his daughter that she had tenderness over the affected area and that she "could not move or bend her back in any direction". Dr C's notes record that Ms A was in a "great deal of pain" and "tender diffusely but not particularly over bony area". His notes make no reference to a lower back deformity or any restricted movement in her back.

My advisor noted the apparent discrepancy in the above accounts provided by Mr A and Dr C and that when Dr E examined Ms A on 5 August 2002, he recorded "prominent L2 spinal process". It is possible that bruising at the initial examination obscured the prominence of the spinal process and that with the passage of time comments made by Dr E have been confused with those of Dr C.

My advisor also noted the apparent discrepancy between the account provided by Mr A and the Practice clinical records in respect of the number of consultations Ms A had with Dr C. Whereas Mr A alleged that his daughter saw Dr C on only one occasion (27 July 2002) and Dr C stated that "if she [Ms A] had re-attend[ed] medical centre as requested it may have ended differently", the Practice notes record that Ms A saw Dr C the next day (on 28 July) and another doctor at the Practice on 29 July when Voltaren tablets were prescribed to her. The notes of 28 July record "back re-examined vertebrae feel intact".

In my view, given that Mr A's letter was written six months after his daughter's injury and the information he supplied was secondhand (Mr A was not present at the consultation), and that Dr C's response was made without the benefit of the clinical notes he made at the time, I consider that the contemporaneous clinical records are more likely to be accurate.



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My advisor stated that for a patient complaining of low back pain after a road accident, the examination of Ms A by Dr C was appropriate. No lower back deformity was noted and there were no indications of a neurological deficit. Ms A was provided with sufficient analgesia and was asked to return the following day for a check-up. When re-examined the next day Dr C noted that there was some improvement in her symptoms and no observable vertebral deformity.

I am satisfied that Dr C undertook an appropriate examination and did not breach Right 4(1) of the Code.

## Opinion: Breach

*Failure to refer*

The Rural Medical Practice had only limited X-ray facilities suitable for the assessment of limb injuries. More specialised imaging, including spinal X-rays, is available at the city hospital, some two hours away.

Dr C acknowledged that he did not arrange for Ms A to have a spinal X-ray taken. In his view one would have to have a "reasonably strong suspicion that an X-ray was required urgently" and he did not think that Ms A had suffered a bony (spinal) injury. Other considerations were that it was late at night, the roads were icy, and the nearest hospital where the X-rays could be performed was two hours away.

My advisor stated that in assessing a patient injured in a suspected deceleration motor vehicle accident a high index of suspicion of fracture is essential. If a fracture is suspected (based on history of the injury, clinical examination and the presenting symptoms including significant pain), an X-ray is considered mandatory. Where a distance from an X-ray facility or lack of transport are factors, a delay in spinal imaging is acceptable provided that the patient is haemodynamically stable, has no neurological deficit, is given appropriate advice about permitted activity and danger signs, and is under appropriate supervision.

My advisor, a rural general practitioner, considered that in Ms A's case Dr C's findings could not exclude a fracture and that a spinal X-ray was indicated. Although there was probably no need for urgent imaging, arrangements should have been made for Ms A to go to a facility where X-rays could be undertaken before she could be cleared to resume normal physical activities. As Ms A had already tolerated a drive from the accident scene without any ill effects, it would have been reasonable for her to be driven to the city in a private car with clear instructions and supervision. There is no evidence to suggest that Dr C made such arrangements.



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My advisor commented that Dr C "exhibited a deficiency in diagnostic skills in his failure to consider the significant possibility of a fracture (even in the absence of definite signs) and thus made inappropriate further management decisions" (not to refer for imaging). Accordingly, the standard of care provided to Ms A fell short of a standard to be reasonably expected of a rural general practitioner assessing trauma cases. In these circumstances, Dr C breached Right 4(1) of the Code.

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## Other comments

*Record keeping*
My advisor noted that the records kept by Dr C at the Rural Medical Practice were "extremely brief", did not contain important history and clinical information, and lacked clarity about what advice and instructions were given to Ms A. I draw to Dr C's attention the Medical Council of New Zealand "Guidelines for the Maintenance and Retention of Patient Records" (October 2001) which state:

"1. Maintaining patient records

a) Records must be legible and should contain all information that is relevant to the patient's care.
b) Information should be accurate and updated at each consultation. Patient records are essential to guide future management, and invaluable in the uncommon occasions when the outcome is unsatisfactory."

*Sharing of information by registration authorities*
This case essentially involved a patient and a doctor from the UK – one on holiday and the other working in New Zealand as a medical practitioner on a temporary basis. As Ms A had returned to the UK, and at the time Mr A's complaint was received Dr C was no longer practising in New Zealand (he too had returned to the UK), the Commissioner initially decided to take no further action on the matter and advised Mr A to inform the GMC of his concern, which he duly did. The decision to investigate the complaint occurred only after the Commissioner learned that Dr C had returned and was practising in New Zealand.

Dr C's response to the complaint was brief because he considered that the matter had "already been addressed by the GMC in the UK and by the Medical Council in New Zealand".

I am not aware that any steps have been taken by the Medical Council of New Zealand in respect of this matter. As required by law (under section 86 of the Medical Practitioners Act 1995) the Council is awaiting the result of this investigation to decide what action, if any, to take in respect of the complaint made against Dr C.



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However, the GMC did undertake a preliminary investigation of the complaint, albeit in the absence of a response from Dr C. The GMC considered that "the delay in reaching diagnosis [by Dr C] was truly regrettable", but that his failure to refer Ms A for spinal imaging "was a single isolated failing which did not reach the threshold of serious professional misconduct or seriously deficient performance". Accordingly, the GMC decided not to proceed further with the complaint.

Medical practitioners are increasingly mobile and it is common for them to obtain registration and work in several countries. Where, as in the case of the United Kingdom and New Zealand, there are reciprocity arrangements between the registration authorities (the GMC and the Medical Council of new Zealand respectively), it is important that the authorities facilitate the provision of relevant complaint, investigation, prosecution and other registration information to statutory bodies handling complaints about medical practitioners. The timely provision of relevant information to such bodies helps ensure that patients in those jurisdictions are protected.

In response to my provisional opinion, the GMC advised me that it "concurred entirely" with my comments about the need for registration authorities to share information and stated:

> "Substantial work in this area is being undertaken by registration authorities around the world, including both the GMC and the MCNZ."

The Medical Council of New Zealand provided the following information:

> "The International Association of Medical Regulatory Authorities (IAMRA) is a body that supports medical regulatory authorities worldwide in protecting the public interest by promoting high standards of physician education, licensure and regulation, and facilitating the ongoing exchange of information among medical regulatory authorities. IAMRA is currently working towards facilitating a network for the regular exchange of medical licensing and disciplinary information."

The Council noted that legislative requirements and individual Board or Council policy decisions impact on the exchange of information, and commented:

> "The Council endorses self regulation and respects orders and decisions made by other medical registration bodies and tribunals."

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## Opinion: No breach – A Rural Medical Practice

*Vicarious liability*

Employers are responsible under section 72(2) of the Health and Disability Commissioner Act 1994 for ensuring that employees comply with the Code of Health and Disability Services Consumers' Rights. Under section 72(5) it is a defence for the employing authority to prove



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that it took such steps as were reasonably practicable to prevent the employee from doing or omitting to do the thing that breached the Code.

Dr C was an employee of the Rural Medical Practice. It was in this capacity that he assessed and treated Ms A.

Although Dr C breached Right 4(1) of the Code by failing to refer Ms A for spinal imaging, this was a clinical decision of an individual practitioner, and was not reasonably foreseeable or preventable by the Rural Medical Practice.

The Rural Medical Practice is therefore not vicariously liable for Dr C's breach of Right 4(1) of the Code.

## Recommendations

I recommend that Dr C:

- Apologise in writing to Ms A for his breach of the Code. This apology is to be sent to the Commissioner's Office and will be forwarded to Ms A.
- Review his practice in relation to management of patients presenting with suspected spinal injuries, in light of this report.

## Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand, the General Medical Council in the United Kingdom, and the Royal New Zealand College of General Practitioners.
- A copy of this report, with identifying features removed, will be sent to the Rural General Practice Network and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.



*Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name*