Dr C / Public Hospital

Opinion – Case 98HDC16860/VC

Complaint

The Commissioner received the following complaint from Mr A on behalf of his brother, Mr B, about services provided by a public hospital:

- *On Friday, 10 July 1998 Mr B was admitted to a medical ward [of his local public hospital] despite recent neurological surgery at [another public hospital with neurological services] and suffering a fall on 7 July 1998 with subsequent deterioration in his behaviour.*
- *Dr C did not provide services of an appropriate standard.*
- *Dr C diagnosed Mr B with brain damage without doing appropriate diagnostic tests.*
- *Dr C did not take account of Mr B's deteriorating condition over the weekend of 11 and 12 July 1998.*
- *Dr C did not contact [the public hospital with neurological services] despite Mr B's recent neurological surgery at [the hospital] and his suffering a fall on 7 July 1998 with subsequent deterioration in his behaviour.*
- *Dr C did not make any entries on Mr B's medical notes until 16 July 1998.*

Investigation Process

The complaint was received by the Health and Disability Commissioner on 10 September 1998 and an investigation commenced on 6 January 1999.

Information was received from:

Mr A	Complainant / Consumer's brother
Public Hospital	Provider
Dr C	Provider / Consultant Physician
Mrs D	Consumer's mother
Mrs E	Consumer's sister-in-law

The Commissioner obtained advice from an independent physician. Relevant medical records were also reviewed.

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

Dr C / Public Hospital

Opinion – Case 98HDC16860/VC, continued

Information Gathered During Investigation

Mr B was diagnosed with a bi-frontal meningioma (brain tumour) in 1997 when he was 43 years old. This tumour was surgically removed in April 1997 at a public hospital with neurological services. Following this surgery, Mr B received rehabilitation at another public hospital, then ongoing occupational therapy services from his local public hospital.

In May 1998 Mr B returned to the public hospital that originally removed the tumour, for further brain surgery (a bi-frontal craniotomy) and a biopsy, as a scan had showed a possible extension of the tumour. The biopsy did not indicate a recurrence of the meningioma and only scar tissue and debris were removed during this surgery.

After the surgery, in May 1998, Mr B was referred by staff at the hospital to occupational therapy for review and assessment. The hospital occupational therapist wrote to Mr B's local public hospital on 6 July 1998 with the results of an assessment she carried out on Mr B on 5 June 1998, one week before he was discharged from the hospital. The assessment noted that Mr B had been a sickness beneficiary and had lived with his parents since the surgery in April 1997. Mr B was unable to "sustain attention to task" or concentrate for significant periods of time. Mr B had therefore been unable to return to work at his previous occupations, as a meat inspector or a commercial fishing vessel operator, although he remained hopeful of resuming employment. The report noted Mr B had little structure to his day-to-day functioning, and few social contacts, apart from playing golf three times a week.

The tests conducted during the assessment showed Mr B had some features characteristic of a dysexecutive syndrome and residual deficits in his memory. Features of this syndrome included that although Mr B was co-operative and able to give an account of himself during the assessment process, he was unable to work towards specific goals and was aware that he had difficulty initiating new activities. Mr B's planning capability was disorganised and he had difficulty in carrying out intended actions, as he was easily distracted. However, Mr B was aware that he had difficulty performing tasks at a normal speed and he had improved considerably in self-awareness from previous examinations. The report recommended Mr B participate in a therapy program to help him to set goals and initiate and

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Information Gathered During Investigation *continued*

execute desired tasks and behaviours. The letter summarising this assessment from the hospital was included in the copy of Mr B's medical records supplied to the Commissioner by the hospital.

On 7 July 1998 Mr B slipped and fell backwards on a path at his home, hitting the back of his head. Mr B took two Panadol, rested and appeared to be fine. Mr B's mother stated, in her original complaint letter to the hospital of 26 July 1998, that the day after the fall Mr B had a slight headache, and that night he had been up several times to the bathroom running water, and seemed slightly confused.

Mrs D described her son's behaviour on Friday 10 July as "*totally foreign*". At 9.00am Mr B went outside in the pouring rain wearing his pyjamas and slippers to sweep the drive, but could not explain why he was doing this, when she asked. After this, Mr B showered and ate breakfast before Mrs D took him to see his general practitioner, Dr F.

Dr F referred Mr B to the Accident and Emergency Department (A&E) at his local public hospital for assessment. Dr F's referral letter stated that three days earlier Mr B had fallen onto the occipital area (back) of his head and he queried whether Mr B was suffering from a post-concussion syndrome or a fractured skull. He stated that since the fall Mr B had had a headache and was slightly more confused than usual. The recent surgery for Mr B's meningioma was noted and Dr F wrote that he had discussed the case with a neurosurgical registrar at the public hospital with neurological services, who suggested a skull x-ray if Mr B's condition deteriorated over the weekend. Dr F also noted there was no neurological deficit.

The A&E notes of 10 July 1998 recorded an acute admission with Mr B's history being obtained mostly from his family. Notes recorded by Dr G, casualty officer/house surgeon, noted the original meningioma and recent surgery, and that Mr B had been well postoperatively, was usually slightly slow but not confused, and had not been working since his original surgery in April 1997. It was recorded that Mr B had fallen onto steps on 7 July and hit the occipital region of his head but had not lost consciousness. Mr B had complained of a headache for two days, denied

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Information Gathered During Investigation *continued*

any sensitivity to light, had no cough and no urinary symptoms except that he had been incontinent of urine that day, which was unusual for him. Mr B's temperature was 38.3 degrees Celsius. Mr B's cardiovascular, respiratory and gastrointestinal systems were all normal. Nervous system examination demonstrated that his limbs were normal, there was no external wound, his pupils were equally reactive to light, but the ocular fundi could not be examined as Mr B was uncooperative. The notes queried whether a CT scan of Mr B's head would be necessary. It was also noted that Mr B's occupational therapy notes had been obtained. A skull x-ray was performed but did not show a skull fracture. A number of blood and urine tests were performed which returned results within normal limits.

Dr G admitted Mr B to a medical ward at the hospital for observation under the care and supervision of Dr C, consultant physician. Dr G placed Mr B on four-hourly neurological observations. Mr B's vital signs, pulse, blood pressure and level of consciousness remained normal, although Mr B was noted to be incontinent of urine, confused and behaving inappropriately.

The next entry in the nursing notes on this date recorded a telephone call from Mr B's mother who explained during the call that since Mr B's original surgery his behaviour and affect (external expression of emotion) had been "*100%*". She told the nurse that Mr B's confused behaviour had become apparent only in the last 24 hours. The medical/nursing notes recorded that Dr C had seen Mr B.

On 11 July 1998 the nursing notes recorded that Mr B required constant supervision and guidance, as his behaviour was abnormal, although his four-hourly neurological observations were satisfactory and stable. Mr B was to be observed for any further changes in his behaviour patterns. That evening, some right-handed weakness was noted. It was also noted that Mr B's behaviour was consistent with dementia. Mr B was incontinent of urine several more times, after having drunk three litres of a cola drink that had been left in his bedside locker.

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Information Gathered During Investigation *continued*

Mrs D recalled in her complaint letter receiving a telephone call from the registered nurse on duty in Mr B's ward on Saturday 11 July, asking her to come in to the hospital and discuss her son's condition with Dr C. Mrs D stated that Dr C informed her that her son was "*brain damaged*" from his previous surgery and that this pre-existing damage explained Mr B's current behaviour. Mrs D stated that she disagreed with Dr C and tried to point out that Mr B's current condition was an acute situation arising from his fall. Mrs D asked Dr C if he had telephoned the neurosurgical registrar at the public hospital with neurological services. She stated that Dr C replied, "*Yes. Your son has brain damage, I will keep him in until Monday.*" Mrs D also said that Dr C stated that there was definitely "*no bleed*". Mrs D advised that when she later telephoned the neurological registrar he had no record of a call from Dr C.

Dr C explained that by describing Mr B as "*brain damaged*", he was referring to the fact that Mr B had previously had a meningioma and two surgical procedures to remove the tumour. These procedures had resulted in a loss of brain tissue, which is clinically defined as brain damage, trauma to the brain, or brain injury, and which results in symptoms similar to those Mr B was experiencing.

Dr C stated that the family's expectations of Mr B's condition were far from realistic and in his opinion the family were not willing to accept Mr B's level of disability. He would not have used the term "*brain damaged*" as a diagnosis, but rather as a description.

On Sunday 12 July the nursing notes recorded that Mr B was still confused and incontinent on occasions. His four-hourly neurological observations continued. At 9.30pm the nursing notes recorded that Mr B seemed less confused and that the neurological observations had been stopped, and that the house surgeon was aware of this. Mr B had not recently been incontinent. However, later that evening Mr B was again incontinent, appeared slower and seemed less able to follow directions.

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Dr C / Public Hospital

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Information Gathered During Investigation *continued*

On Monday 13 July Dr C reviewed Mr B's condition during a ward round. The clinical notes stated that there had been no change during his admission, and that Mr B remained incontinent and afebrile. The plan was for Dr C to discuss the situation with Mr B's family, and for Mr B to be transferred to the Assessment, Treatment and Rehabilitation Ward (ATR) on the following day.

Dr C pointed out an entry in Mr B's medical records from the public hospital with neurological services that indicated urinary incontinence had been an issue following his initial surgery in 1997. Dr C asked Mrs E (Mr B's sister-in-law, who worked as a registered nurse at the hospital) for her opinion, and she told him that Mr B had had problems with urinary incontinence, inappropriate behaviour and concentration since his original surgery. She saw no change in his condition at this point. However, Mr B's mother stated that he had not been incontinent until just before they left home to go to the hospital. Mrs D explained that after the catheter was removed following his original surgery Mr B had had some problems with incontinence, but that these had been resolved during rehabilitation at another public hospital. Mrs D said that she would not have coped with caring for her son at home for that year, if he had been incontinent.

On 13 July Mrs D received another telephone call from the local hospital, as Dr C wanted to discuss Mr B's condition with her and her husband. Dr C also asked that Mrs E also attend the meeting. At the meeting Dr C described to the family some of Mr B's unusual behaviour. Mrs D stated that Dr C described how he had walked into the room and Mr B greeted him with "Hello […]" then proceeded to pour drink into a urinal. Dr C concluded from this incident that Mr B had recognised him from golf. He therefore felt that his diagnosis that Mr B's symptoms were caused by his pre-existing brain damage had been confirmed. Dr C then stated that Mr B could get better, or a lot worse. Mrs D stated that once again Dr C told them that there was no bleed in the brain.

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Information Gathered During Investigation ***continued***

Mrs D was concerned that her daughter-in-law had seen Mr B only briefly postoperatively, yet Dr C asked her what she thought of Mr B's condition prior to admission and relied on her observation. Mrs E told Dr C that she believed Mr B had had difficulty concentrating and could not always complete a task. Dr C told Mrs D that Mr B would be transferred to ATR to give her a rest.

On 14 July Mr B had a fall in the ward at around 10.00am. The nursing notes questioned whether the fall was due to a seizure or to Mr B slipping on coffee that had been spilt on the floor. Mr B had a graze down the left side of his torso and had hit his head on a heater. He complained of a headache and was given Panadol, which seemed to have a good effect. His neurological observations appeared satisfactory and Mr B rested on his bed. The house surgeon checked Mr B and found no abnormality. The house surgeon noted Mr B had felt "OK" before he fell, was not dizzy or weak, there was no seizure activity and although he had not been knocked out, he complained of a sore back. There were no obvious injuries, no double vision and no new paraesthesia (pins and needles). The plan remained to transfer Mr B to ATR.

Mr B was transferred to ATR at around 8.00pm on 14 July 1998 but remained under Dr C's care and supervision. Soon after Mr B's transfer nursing staff heard him fall to the floor and land on his back. No obvious injuries were noted and Mr B denied any pain or discomfort. However, when Mr B was assisted back to bed he was noted to be leaning over backwards when mobilising, yet was unaware that he was doing so. Mr B refused Panadol. Observations were taken and although Mr B's pupils were equal and reacting to light, they appeared sluggish. Mr B remained incontinent and needed to be prompted to get out of bed. The notes record that the house surgeon and the nursing supervisor were notified.

Mrs D was telephoned and informed that Mr B had fallen and grazed his left side, but had not hit his head. Upon visiting her son Mrs D stated that she was shocked to see him standing looking into space with obvious balance impairment, and that he was very tired.

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Information Gathered During Investigation *continued*

On Wednesday 15 July Mr B was still incontinent and confused. Mr B's balance continued to be impaired and he needed a lot of assistance with activities such as eating and showering. When asked, Mr B said that he had no aches or pains following the previous day's falls.

On Thursday 16 July Mrs D telephoned the hospital to see how Mr B was, and stated that she was informed that he had deteriorated dramatically since the weekend. That morning Mrs D telephoned the public hospital with neurological services and spoke to Dr H, neurosurgical registrar, and told him of her concerns about Mr B's wellbeing. Mrs D said Dr H asked her to ask Dr C to phone him. Mrs D stated that she contacted the ATR Ward and left a message for Dr C to telephone the public hospital with neurological services. In her letter to her local hospital Mrs D expressed her concern that there was no documentation of this phone call in Mr B's clinical record. Dr C reviewed Mr B's condition that morning. Mr B was still incontinent and confused, his gait was ataxic and he had poor balance, falling backwards easily.

Dr C then called the neurosurgical registrar at the public hospital with neurological services and relayed information about Mr B's condition, including the fact that Mr B's sister-in-law thought that his confusion was not new. The neurosurgical registrar was to organise for Mr B to travel to the hospital for a CT scan and assessment, possibly during the following week.

An occupational therapist assessed Mr B on 16 July, and concluded that there appeared to have been a deterioration in Mr B's physical function since he had been seen by the occupational therapist following the neurosurgery on 2 June 1998.

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Information Gathered During Investigation *continued*

Mr B was transferred to the public hospital with neurological services on the morning of 17 July 1998. The referral letter requested further assessment of Mr B's postoperative confusion and listed his symptoms, but made no mention of the head injury he had sustained on 7 July. A CT scan was carried out when Mr B arrived at the hospital, which showed that he had a subdural haematoma. A subdural haematoma is an accumulation of blood within the tissues of the brain that clots to form a solid swelling. This can result from a head injury when veins are torn where they cross the space between or beneath the dura.

The subdural haematoma was surgically drained on 24 July 1998 at the hospital. Mr B had an uncomplicated recovery from this surgery, after which his orientation and appropriateness improved. However, he is no longer able to function at the level he was functioning at before his head injury. Mr B now requires full-time care and is living in a rest home.

Mr B's family was not satisfied with the care that [he] received from their local public hospital and Dr C. Mrs D wrote to the local hospital on 26 July 1998 setting out the family's concerns. The hospital replied on 25 August 1998. Mr B's family was not satisfied with the reply and complained to the Health and Disability Commissioner. Specifically, Mr B's family was not satisfied with the delay in diagnosing Mr B's subdural haematoma, and with the treatment he received at their local public hospital.

Dr C advised the Commissioner that while Mr B was in hospital all active investigations were carried out to determine the cause of his presentation. This included extensive blood examinations and urine analysis as well as discussion with the family and a skull x-ray, which showed no fracture. Dr C stated that when it became clear Mr B was not improving, and was developing urinary incontinence and balance problems, he was referred to the public hospital that removed the tumour, for a CT scan and neurosurgical opinion. Dr C noted that the CT scan showed a subdural haematoma, which was drained seven days after the scan. Mr B's condition was not one that placed him in imminent danger. Mr B's family advised the Commissioner that the surgery had been delayed in order to give Mr B time to stabilise.

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Information Gathered During Investigation *continued*

Dr C also advised the Commissioner that Mr B was admitted to hospital with global neurological impairments such as confusion, disorientation, lack of concentration and poor attention, but did not show focal neurological symptoms. He explained that these symptoms are quite compatible with brain injury, whether the injury is due to surgery or trauma. Dr C stated that Mr B's condition deteriorated over the weekend of 11-12 July, in terms of incontinence and imbalance, and that those symptoms are known in patients with brain trauma. Dr C stated that as he had not seen Mr B in the past it was difficult for him to judge Mr B's changing level of cognitive functions.

Dr C stated that there was no CT scanner available in the hospital, and the decision to transfer a patient to another region for a CT scan was not one to be taken lightly. Dr C explained that the journey from one region to the other is inconvenient and stressful for patients and families so clinical judgement must be exercised when arranging such journeys. He also stated that had CT facilities been available at the hospital, Mr B would have been scanned in preference to the conventional skull x-ray. Dr C subsequently clarified that he does not consider financial costs when considering whether clinical investigations are appropriate. Cost was not an issue in Mr B's case.

The hospital's response to the Commissioner explained that there was no CT scanner on site at the hospital. The hospital had a contract with a private hospital in another region for the provision of CT scans. However, the public hospital emphasised that the decision to refer a patient for a CT scan was not one that was taken lightly, as the trips to the other region were inconvenient and stressful for both patients and families.

Mr B's family pointed out that the stress of travelling to the other region for a scan would have been minimal compared to the stress of watching Mr B's deterioration and lack of recovery.

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Dr C / Public Hospital

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Information Gathered During Investigation ***continued***

In a letter dated 7 December 1998 Dr I, neurosurgeon at the public hospital that removed the tumour, wrote to the Accident Compensation Corporation as follows:

"*1. Following this man's developing his meningioma and the surgery to remove this meningioma he has slight but significant impairment of brain function in terms of frontal lobe functions in that he tends to be somewhat disinhibited and has difficulties with recent memory and concentration and has a mild paraparesis. Taken together these neurological deficits are sufficient to prevent him from returning to work as a fisherman either in the short term, medium term or indeed in the long term in other words permanently.*

2. There would be an expected improvement in his overall brain and neurological function over the year or eighteen months following surgery but he will be left with a permanent deficit.

3. The subdural haematoma was not related to his previous surgery as the fall that caused the subdural haematoma was an accident in wet weather.

4. His current incapacity is namely due to the meningioma and the surgery to remove this meningioma but there is a small but significant component that is attributable to his subdural haematoma – probably 25% of his disability. With a little more time the subdural haematoma contribution should lessen but may never disappear completely.

5. If it had not been for his fall/accident in which he sustained a chronic right subdural haematoma he would be functioning at the level he was prior to the fall ie independently and with a little more time I would hope that this level of functioning would return but it may take several more months yet."

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Dr C / Public Hospital

Opinion – Case 98HDC16860/VC, continued

Independent Advice to Commissioner

The Commissioner received advice from an independent physician as follows:

"***Question 1:*** *Was [Dr C]'s diagnosis of brain damage a reasonable one in the circumstances? Was it reasonable for him to exclude an intra-cerebral bleed as a likely diagnosis?*

(a) It is obvious that [Mr B]'s behaviour was inappropriate (this was the major reason for this admission). Furthermore, in the recent past he had had two neurosurgical procedures, firstly to remove a tumour and secondly to remove debris. It is claimed that he was disabled from his previous illness and surgery (see the Occupational Therapy report). Therefore, [Mr B] was literally brain-damaged. However, such a description could also imply that the present deterioration was due to his previous illness and was to be expected. If this were the interpretation, further investigation would not be indicated. It was an unfortunate description to use as plainly the caregivers were unsure what the consequences of such a diagnosis would be. If this is what [Dr C] meant, then it required far greater explanation for the family. It would seem that [Dr C] spoke to a family member who was not fully familiar with [Mr B]'s clinical state prior to this injury. Brain damage as such is not a diagnosis but rather more a description of the patient's clinical condition.

(b) In answer to the second part of the question: there was a sudden change in [Mr B]'s behaviour and he became incontinent. Taking [Mr B]'s history into account one would need to rule out an intracranial cause for this change in behaviour and incontinence. Intracerebral bleeding would need to be excluded. I can understand why it was not initially considered as a main diagnosis: there were no 'localising signs', namely, no localised weakness

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Dr C / Public Hospital

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Independent Advice to Commissioner ***continued***

to one side of the body or to both lower limbs, occurrence of new seizures, sensory changes and so on. Furthermore, [Dr C] mentioned that one family member had not noticed any change. However, more notice should have been given to the main caregiver's descriptions and concerns.

Question 2: *Was it appropriate to admit [Mr B] to a medical ward?*

The purpose was initially to observe [Mr B] and a medical ward is an appropriate setting to do this. Many hospitals, particularly in the United Kingdom, place head injury patients in a medical ward initially unless there is a clear reason for the patient to be in a surgical ward: an example would be someone who was going to require urgent neurosurgery or a patient who has a fractured skull or major lacerations.

Question 3: *Were the observations undertaken and treatment offered to [Mr B] appropriate in the circumstances?*

The observations undertaken were appropriate – there was no sign of raised intracranial pressure and when [Mr B] was admitted he was able to walk and generally look after himself. In such circumstances, 4-hourly neurological observations are quite appropriate. Although no formal fluid balance charts were kept, the nursing notes recorded his eating and drinking habits and his episodes of incontinence were also noted. His treatment consisted of paracetamol when required. He also received physiotherapy and occupational therapy during his spell in the Assessment and Rehabilitation Unit. These were appropriate. However, no attempt was made to investigate his confusion or incontinence. Although it may have been thought that this may have been due to a urinary tract infection initially, this was soon ruled out with normal urine and negative blood cultures.

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Dr C / Public Hospital

Opinion – Case 98HDC16860/VC, continued

Independent Advice to Commissioner *continued*

Question 4: *Should [Dr C] have initiated further examinations of [Mr B] to determine the cause of his confusion? In particular, should he have ordered a CT scan or consulted with neurologists at [the public hospital with neurological services] any sooner than he did? If so, when and why?*

The confusion and incontinence were major changes in [Mr B]'s clinical state. Such a combination may suggest systemic infection (for which he was investigated) or intracerebral pathology for which only a skull x-ray was performed. As his temperature settled rapidly, and urine test was negative, a systemic infection would have been excluded easily. Therefore the main decision was what to do about his ongoing clinical state which seemed to deteriorate. Further investigations should have been performed. If [Dr C] was unsure that there was an intracerebral cause for [Mr B]'s clinical state, he should have rung the Neurosurgical Unit for advice. This could have been performed about 24 hours after admission to [his local public hospital]. Alternatively, he could have requested that a CT scan be performed. I think a CT scan should have been requested at least by the day following admission when it was clear that [Mr B]'s condition was not improving.

Question 5: *Was it reasonable for [Dr C] not to have diagnosed a subdural haemorrhage?*

Yes it was reasonable not to diagnose a subdural haematoma although it should have been considered in the differential diagnosis of this patient. As mentioned earlier, a number of conditions could produce confusion and incontinence. [Mr B] may also have had a condition such as occult hydrocephalus which would also be excluded by a CT scan.

Dr C / Public Hospital

Opinion – Case 98HDC16860/VC, continued

Independent Advice to Commissioner *continued*

Question 6: *Would it have been appropriate to keep a fluid balance record?*

It would have been appropriate to keep a fluid balance chart, but it would have been inaccurate because of the frequent episodes of urinary incontinence. For accuracy a urinary catheter would have been necessary. I do not think that this was indicated in this particular case. Indeed, [Mr B] may have tried to pull such a catheter out with consequent urethral damage. It could be argued, however, that the frequent passing of urine and increased thirst may have indicated that this patient had developed diabetes insipidus. If that diagnosis is being considered, then a fluid balance record is mandatory.

Question 7: *Was the response to [Mr B]'s change in presentation during his admission to [his local public hospital] appropriate?*

Where there has been a change in a patient's clinical condition, it is important to seek a diagnosis. The main thrust with this particular patient seems to have been to exclude infection which was done fairly rapidly. Thereafter, no further effort was made to come to a diagnosis, despite [Mr B]'s clinical condition deteriorating. It was only after consultation with the Department of Neurosurgery at [the public hospital with neurological services] that further investigation was instigated.

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Dr C / Public Hospital

Opinion – Case 98HDC16860/VC, continued

Independent Advice to Commissioner *continued*

Question 8: *Can you comment on the influence of the falls that [Mr B] suffered while an inpatient on his condition? Was the medical response to these falls appropriate in view of [Mr B]'s neurological history?*

It is likely that the falls were due to a subdural haematoma. Whether they caused any further bleeding is difficult to assess, although it was noted in the A&R Unit that he was having difficulty with balance. This observation was noted within six hours of his arriving there and this followed a fall. He was examined after the fall on the 14th July 1998, but no abnormality was noted besides the fact that [Mr B] complained of a sore back. However, it is not clear if the nervous system was examined fully and whether his balance was tested (see [Dr J]'s note). A full examination should have been performed. If it were normal, then he may very well have had a further bleed following that initial fall. He continued to deteriorate after it was first noted that [Mr B] was having difficulty with his balance, so that by the time of discharge he was plainly very ataxic. With the addition of falls, bizarre behaviour and incontinence, one would have expected neurological investigations to have been performed. In this particular case a CT scan should have been ordered after the 14th July if it hadn't been done previously.

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Dr C / Public Hospital

Opinion – Case 98HDC16860/VC, continued

Independent Advice to Commissioner *continued*

Question 9: *Was it appropriate to transfer [Mr B] to the Assessment and Rehabilitation Unit on 14th July 1998?*

The clinicians felt that his condition was stable and this is noted in the clinical record on 13th July 1998. It was obviously felt by the clinicians at that time that [Mr B] would benefit from rehabilitation. With hindsight one can see that this was an inappropriate decision, although it was after the transfer to the Assessment and Rehabilitation Unit that it was noticed that his balance was poor and he was more confused. This finally led to more rapid referral to [the public hospital with neurological services]. Although the stimulus for the call to [the hospital] came from the persistence of [Mr B]'s caregivers, it is clear in the notes that further disabilities were being described.

Question 10: *Can you comment on the standard of clinical documentation and record keeping?*

In regard to the clinical documentation, these can be arbitrarily divided into doctors' notes and nursing notes.

(i) Doctors' notes
The patient was clerked in on 10th July 1998 by the house surgeon. The history seems to have been obtained from the family and the patient. The events leading to the admission are adequately described. [Mr B]'s pre-morbid state is described as slightly 'slow' but not confused. The examination of the nervous system was cursory and no mention was made as to whether the patient was orientated, or whether he was confused. No formal testing of higher mental function was reported. With [Mr B]'s history, one would have expected this area of the nervous system to have been examined in detail. According to the notes, the next occasion when [Mr B] was seen by a medical practitioner was on 13th July

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Dr C / Public Hospital

Independent Advice to Commissioner *continued*

1998. This was at the time of the consultant ward round. If an examination took place, it was not recorded. The notes state: 'No change during admission. Remains incontinent. Afebrile.' The plan was that [Dr C] would discuss the case with the family. There is no written record of this meeting having taken place.

[Mr B] was next seen on 14th July 1998 by [Dr J] after the first fall. The history leading to the fall is recorded. It seems that the patient slipped on some lemonade. The patient was apparently conscious and alert and had no obvious injuries, but there is a lack of documentation with regard to a nervous system examination.

There is a further note of 16th July 1998 noting that there had been discussion with the neurosurgical registrar at [the public hospital with neurological services]. A neurological examination is mentioned and it was found that power in all his limbs was good but his gait was ataxic. There was poor attention span and poor concentration. This is the first time that these parameters were mentioned by the medical staff. In general, the documentation by the medical staff was poor and should be improved.

(ii) Nursing notes
The nursing notes are much more comprehensive and give a fair idea of [Mr B]'s condition throughout his stay in the hospital. His functional state is best described when he was in the Assessment and Rehabilitation Unit.

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Dr C / Public Hospital

Opinion – Case 98HDC16860/VC, continued

Independent Advice to Commissioner *continued*

Question 11: *Any other issues raised by the supporting documentation?*

The major problems in this case relate primarily to poor communication. Some of the problems could have been overcome with relatively simple procedures. For example, there is no record relating to [Mr B]'s pre-morbid state, ie: what he could do prior to his latest head injury. If this was not known by the clinicians, the notes from his last admission to [the public hospital with neurological services] should have been requested. His behaviour in the ward pointed to a frontal lobe disorder, yet this does not seem to have been considered adequately; if it was, it is certainly not recorded in the notes. There is also no record of any meeting between the doctors, nurses, physiotherapists and occupational therapists. I am sure such meetings must have taken place to decide on further management of this patient, but there is no such record present. Communication with the family was also unsatisfactory. All of these matters could be easily resolved in the future.

The vexed question of transfer of patients for scanning is noted. I can understand the pressure that [Dr C] and his colleagues were probably put under not to request such tests because of time of transfer and also costs to the hospital. However, in this case, a CT scan or equivalent should have been requested within 12-24 hours of his being admitted. Perhaps this situation will not arise again as CT scanning is to be made available in [the local public hospital].

The standard of the medical notes was poor. In the final analysis, it is the consultant's responsibility. Better documentation is required. Simply checking random folders at the end of a ward round, perhaps once a week, should overcome this problem."

Dr C / Public Hospital

Opinion – Case 98HDC16860/VC, continued

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

1) *Every consumer has the right to have services provided with reasonable care and skill.*
2) *Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.*
3) *Every consumer has the right to have services provided in a manner consistent with his or her needs.*

…

5) *Every consumer has the right to co-operation among providers to ensure quality and continuity of services.*

Opinion: No Breach Public Hospital

Right 4(3)

On 10 July 1998 Mr B was admitted to a medical ward at his local public hospital for observation following a head injury. My advisor noted that Mr B was admitted for observation and that a medical ward is an appropriate setting to undertake observations. My advisor continued that many hospitals place head injury patients in medical wards initially, unless there is a clear reason for the patient to be in a surgical ward. The advisor suggested that a surgical ward would be appropriate for a patient requiring urgent neurosurgery, or a patient who has a fractured skull or major lacerations. At the time Mr B was admitted there was no indication that urgent neurosurgical intervention was required and an x-ray had established that Mr B did not have a skull fracture.

In my opinion by placing Mr B in a medical ward, the hospital provided services in a manner consistent with Mr B's needs and did not breach Right 4(3) of the Code.

Dr C / Public Hospital

Opinion – Case 98HDC16860/VC, continued

Opinion: No Breach Dr C

Right 4(1)

My advisor advised me that the following aspects of Mr B's care were provided with reasonable care and skill. In my opinion Dr C did not breach Right 4(1) of the Code with regard to these aspects of the care provided to Mr B.

Observations
When Mr B was admitted on 10 July 1998 to the medical ward at his local public hospital the admitting house surgeon ordered four-hourly neurological observations. After Mr B was admitted to the ward the nursing/medical notes stated that Dr C had seen Mr B and reviewed his condition. As the consultant physician with responsibility for Mr B, Dr C had the responsibility for ensuring that all tests and observations ordered were appropriate. My advisor noted that on admission Mr B showed no signs of raised intracranial pressure and that Mr B was able to walk and, to a certain extent, look after himself. My advisor concluded that, in these circumstances, the four-hourly neurological observations that were ordered were appropriate.

In my opinion by approving the house surgeon's decision to order four-hourly neurological observations on Mr B, Dr C provided services with reasonable care and skill and did not breach Right 4(1) of the Code.

Continued on next page

Dr C / Public Hospital

Opinion – Case 98HDC16860/VC, continued

Opinion: No Breach Dr C *continued*

Fluid balance record
While Mr B was in hospital between 10 July 1998 and 17 July 1998 no fluid balance chart was kept. This was of concern to Mr B's family. Dr C reviewed Mr B's condition regularly during his admission to hospital and as the consultant with the ultimate responsibility for Mr B's care, should have ordered that a fluid balance chart be kept if at any stage he considered this was clinically necessary. My advisor concluded that it would have been clinically appropriate to keep a fluid balance chart, particularly given the fact that Mr B was frequently passing urine and was very thirsty as these symptoms can be signs of diabetes insipidus, but that the fluid balance would have been inaccurate because of Mr B's frequent episodes of urinary incontinence. The advisor noted that because of this the only way to ensure accuracy would have been to insert a urinary catheter. The advisor noted that in Mr B's case the insertion of a catheter was not indicated. Indeed, Mr B may have attempted to pull it out causing urethral damage. My advisor also noted that although a formal fluid balance chart was not kept, the nursing notes recorded Mr B's eating and drinking habits and episodes of incontinence.

In the circumstances I consider that the failure to keep a fluid balance chart was reasonable, although I note my advisor's concerns about a possible diabetes diagnosis. In my opinion Dr C provided services with reasonable care and skill and did not breach Right 4(1) of the Code.

Initial diagnosis
Upon Mr B's admission to the hospital Dr C did not diagnose Mr B as having a subdural haematoma. My advisor considers that it was reasonable for Dr C not to have diagnosed Mr B's subdural haematoma on admission as a number of conditions could have produced Mr B's symptoms of confusion and incontinence. In my opinion Dr C provided Mr B with services with reasonable care and skill in this respect, and did not breach Right 4(1) of the Code.

Dr C / Public Hospital

Opinion – Case 98HDC16860/VC, continued

Opinion: Breach Dr C

In my opinion Dr C breached Rights 4(1), 4(2) and 4(5) of the Code of Health and Disability Services Consumers' Rights as follows:

Right 4(1)

Mr B had the right to receive services from Dr C that were provided with reasonable care and skill. In my opinion Dr C did not meet this standard in relation to the following services that he provided to Mr B.

Clinical investigations
I am advised that the initial investigations Dr C initiated into Mr B's condition were appropriate. Confusion and incontinence were major changes in Mr B's clinical state. These symptoms suggested a systemic infection, which was investigated and ruled out, or intracerebral pathology, for which only a skull x-ray was performed. Once a systemic infection had been excluded as the cause of his problems (as Mr B's temperature settled rapidly and his urine and blood tests for infection were negative), further investigations should have been performed to determine the cause of his ongoing deterioration. My advisor stated that Dr C should have considered a differential diagnosis of subdural haematoma, and if he was unsure whether there was an intracerebral cause for Mr B's clinical state he could have requested advice from the neurosurgical unit, or a CT scan. My advisor concluded that advice should have been requested or a CT scan ordered within 24 hours of admission, when it was clear Mr B's condition was not improving.

Continued on next page

Dr C / Public Hospital

Opinion – Case 98HDC16860/VC, continued

Opinion: Breach Dr C *continued*

Conflicting information was provided to me during the investigation. Dr C has explained that he relied heavily on Mrs E's observation that Mr B's behaviour had not deteriorated following his fall. However, Mr B's parents, his principal caregivers, stated to Dr C that this was unusual behaviour, and that Mr B had been continent and not confused before he fell and hit his head. Mrs D is certain that Mr B's incontinence and confusion only developed after his fall and had not been present following surgery. The reason that she took her son to the doctor was to have the cause of his unusual behaviour investigated. The occupational therapist's letter from the hospital described Mr B's abilities before his fall and this information was available to Dr C. The nursing notes record a history of increasing confusion and incontinence. In my opinion, Dr C should have noted and responded appropriately to the change in Mr B's presentation. He did not do so.

When there has been a change in a patient's clinical condition it is important to seek a diagnosis. Once infection was excluded as a cause of Mr B's problems no further effort was made to discover the problem. My advisor stated that brain damage as such is not a diagnosis but rather a description of the patient's clinical condition. My advisor stated that Mr B's behaviour on the ward indicated a frontal lobe disorder, yet this possibility did not seem to have been considered adequately.

I was advised that it is likely that Mr B's subsequent falls were due to the effect of the subdural haematoma. Mr B fell several times, was behaving bizarrely and was incontinent, and my expert advised that he would have expected neurological investigations to have been performed in light of these changes. The clinical record does not show whether the nervous system was fully examined or Mr B's balance was tested.

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Opinion: Breach Dr C *continued*

CT scan
Mr B was in the public hospital from 10 to 17 July 1998, when he was transferred to the public hospital with neurological services. During this time Mr B's clinical condition continued to deteriorate. My advisor stated that Dr C should have requested a CT scan or its equivalent within 12 to 20 hours of Mr B's being admitted. On 14 July after Mr B had fallen and had showed signs of balance impairment, incontinence, bizarre behaviour and falls, a CT scan should have been ordered if it had not been done previously.

Dr C advised that there was no CT scanner available in the region, and the decision to transfer a patient to another region for a CT scan is not one to be taken lightly, as the journey from one region to the other is inconvenient and stressful for patients and families. Therefore, clinical judgement must be exercised when arranging such journeys. He also stated that had CT facilities been available at the hospital, Mr B would have been scanned in preference to the conventional skull x-ray.

Mr B's family pointed out that the stress of travelling to another region for a scan would have been minimal compared to the stress of watching Mr B's deterioration and lack of recovery.

Although it was appropriate for Dr C to take into account the inconvenience and stress of the trip to another region, ultimately, if a scan was clinically indicated (and I am advised that it was) he should have organised one. In my opinion by not ordering a CT scan 12 to 24 hours after Mr B was admitted, Dr C did not provide services to Mr B with reasonable care and skill.

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Dr C / Public Hospital

Opinion – Case 98HDC16860/VC, continued

Opinion: Breach Dr C *continued*

In Dr C's response to my provisional opinion he agreed that there had been a delay in diagnosing Mr B's subdural haematoma, but explained that it was due to the difficult and unusual nature of Mr B's clinical problems and the conditions prevailing at the time. He also submitted that Dr F had consulted with the neurosurgical registrar at the public hospital with neurological services on the day of admission, and a skull x-ray had been recommended, not a CT scan. The x-ray had been carried out at the hospital so Dr C had in fact followed neurosurgical advice, albeit conveyed via Mr B's general practitioner. But, as my advisor stated, once the obvious causes for Mr B's deterioration had been ruled out Dr C should have initiated further investigations and sought further advice.

Conclusion

In my opinion, by continuing to manage Mr B's condition conservatively and not initiating further investigation into the cause of Mr B's abnormal behaviour and increasing incontinence and confusion, and in particular by not organising a CT scan once it was indicated, Dr C did not provide Mr B with services with reasonable care and skill. In my opinion Dr C therefore breached Right 4(1) of the Code.

Right 4(2)

Mr B had the right to have services provided to him that complied with professional standards. My advisor stated that is the consultant's responsibility to ensure that the clinical records kept by medical staff comply with professional standards. My advisor advised me that, having reviewed both the nursing and medical records that relate to Mr B's hospital admission, the standard of clinical documentation by medical staff was poor and not of an acceptable standard. Dr C was the consultant physician who had the responsibility for Mr B's care.

My advisor noted that the notes recorded on 10 July 1998 showed a cursory examination of Mr B's nervous system and no mention was made of Mr B's degree of orientation and no formal testing of higher mental function was recorded.

Continued on next page

Opinion – Case 98HDC16860/VC, continued

Opinion: Breach Dr C *continued*

A medical practitioner saw Mr B on 13 July 1998 during the consultant ward round. If an examination took place it was not recorded. The notes stated that Mr B's condition had not changed during the admission, and that he remained incontinent and afebrile. The plan was for Dr C to discuss the case with the family, but there is no written record of this meeting.

On 14 July after Mr B had fallen, Dr C's house surgeon examined Mr B and recorded his findings. My advisor stated that there was a lack of documentation with regard to a nervous system examination.

On 16 July it was noted that there had been a discussion with the neurosurgical registrar at the public hospital with neurological services. A neurological examination is mentioned. The examination found that power in Mr B's limbs was good but his gait was ataxic. Mr B had a poor attention span and concentration. The advisor noted that this was the first time that these parameters had been mentioned in the clinical notes by medical staff.

In Dr C's response to my provisional opinion he explained that in the past there was a lack of junior doctors due to difficulties in recruitment, and that such an environment was not conducive to ideal clinical note-keeping. This was by way of explanation rather than excuse.

My advisor concluded that, in general, documentation by the medical staff was poor. By not ensuring that Mr B's clinical records were full and comprehensive, Dr C did not fulfil his responsibilities as a consultant to ensure that clinical records completed by medical staff complied with professional standards. In my opinion Dr C therefore breached Right 4(2) of the Code.

Continued on next page

Dr C / Public Hospital

Opinion – Case 98HDC16860/VC, continued

Opinion: Breach Dr C *continued*

Right 4(5)

Mr B had the right to co-operation between providers to ensure quality and continuity of services. In my opinion Dr C breached Right 4(5) of the Code in relation to the following matters.

Ascertaining information from other providers
My advisor informed me that the major problems with Mr B's care related to poor communication. The advisor stated that there was no record of Mr B's pre-morbid state, ie what he could do before he suffered the head injury. Although Dr C received advice from the family that Mr B's behaviour since his head injury was uncharacteristic, Dr C considered that the family's expectations were far from realistic and that the family was unable to accept Mr B's degree of disability.

Dr C asked Mrs E, Mr B's sister-in-law, for her opinion of Mr B's pre-head-injury state, notwithstanding that she had seen Mr B on relatively few occasions since his operations. Dr C accepted her opinion over that of Mr B's principal caregivers, and explained that the emphasis he gave to her observations was instrumental in forming his opinion that Mr B's condition had not deteriorated.

In my opinion, Dr C should have taken more notice of concerns expressed by Mr B's parents, who were his primary caregivers since his operations and who therefore had the most information about Mr B's pre-accident condition.

Continued on next page

Dr C / Public Hospital

Opinion – Case 98HDC16860/VC, continued

Opinion: Breach Dr C ***continued***

In a situation such as this, where there is a clear history of prior brain injury and impairment, information relating to a consumer's pre-morbid state is important to assess any deterioration in condition as a result of a fall. Even if Dr C believed that Mr B's family did not have realistic expectations about Mr B's condition, in my opinion it was essential for him to seek the views of other providers about Mr B's pre-head-injury capabilities. There is nothing in the clinical records to show that Dr C asked any of the other providers who had been involved in Mr B's care, such as his general practitioner or the neurological team at the public hospital with neurological services, for their professional assessment of Mr B's pre-injury condition. This omission occurred despite express requests from Mr B's mother that Dr C contact the neurosurgical team at the public hospital with neurological services. At the very least, Dr C should have requested Mr B's notes from his last admission to the public hospital with neurological services.

In my opinion Dr C should have more carefully evaluated and considered Mr B's pre-accident capabilities and the subsequent changes in his presentation, namely his confusion and incontinence. Information about Mr B's pre-accident capabilities was clearly available in his clinical record and from his family. It was not appropriate to rely so heavily and exclusively on Mrs E's observations. I note that the reason Mr B had been referred to hospital in the first place was because of a change in his behaviour. To then accept an observation that in fact nothing had changed, from a relative who was not in daily contact with Mr B, is not acceptable. Further information could have been obtained from other health professionals to ensure that Mr B received care that took into account the impact his previous operations had had on his pre-accident capabilities, and to assess his pre-accident capabilities against his current condition. In my opinion by failing to obtain such information Dr C breached Right 4(5) of the Code.

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

Opinion – Case 98HDC16860/VC, continued

Opinion: Breach Dr C *continued*

Lack of information to primary caregivers
Mr B had the right to co-operation between providers to ensure quality and continuity of services. Mr B's parents had been caring for Mr B since he was discharged from the public hospital with neurological services. Mr B's parents were effectively providing their son with a disability support service. It was at all times envisaged that Mr B would continue to be cared for by his parents when he was discharged from hospital.

As Mr B's primary caregivers, [Mr B's parents] needed to receive a full and comprehensible explanation of their son's condition, diagnosis, and prognosis so that they could continue to provide him with the care and support he needed once he was discharged from hospital.

Dr C did speak with Mr B's parents. He described Mr B's condition to them as "*brain damaged*". Dr C advised me that Mr B was admitted to hospital with a global neurological impairment, the features of which were quite compatible with brain injury, whether due to surgery or trauma. Dr C advised that whether the condition is called "*trauma to the brain*", "*brain injury*" or "*brain damage*", Mr B had had brain surgery twice previously with loss of brain tissue, which met that definition. He stated that Mr B's level of disability was caused by the meningioma and the subsequent surgical procedures to remove that tumour, and that the family's expectation of Mr B's condition was unrealistic, as they were not willing to accept his level of disability.

Mrs D stated that she was confused by Dr C's statement that her son had brain damage. Dr C told her that there was "*no bleed*" and Mrs D stated that she could not understand how this diagnosis was made and why no CT scan was ordered. At a meeting on 13 July 1998 Dr C discussed Mr B's condition with his parents and told them that Mr B's unusual behaviour confirmed his diagnosis of brain damage, and that Mr B could get better or worse. Dr C then informed them that Mr B would be transferred to the Assessment, Treatment and Rehabilitation Ward.

Dr C / Public Hospital

Opinion – Case 98HDC16860/VC, continued

Opinion: Breach Dr C *continued*

My advisor said that Dr C's description of Mr B as "*brain damaged*" could imply that the present deterioration was due to his previous illness and was to be expected, and that no further investigation was indicated. My advisor explained that brain damage is not a diagnosis as such, but rather a description of the patient's clinical condition. Dr C advised that he used the term descriptively rather than as a diagnosis. If this was Dr C's meaning then it required additional explanation for the family.

In my opinion Dr C did not co-operate with Mr B's parents to ensure that, as his primary caregivers, they understood their son's condition and deterioration so that they could provide ongoing care to their son in the future. In my opinion Dr C therefore breached Right 4(5) of the Code.

Opinion: Breach Public Hospital

In my opinion, the public hospital breached Rights 4(1) and 4(2) of the Code of Health and Disability Services Consumers' Rights as follows:

Right 4(1)

There were no CT scanning facilities available in the region in 1998. The hospital advised me that it had a contract with a private hospital for the provision of CT scans. The hospital stated that the decision to refer a patient for a CT scan was not one that was taken lightly, as trips to another region were inconvenient and stressful for consumers and their families. However, in Mr B's case the clinical need for a CT scan to diagnose the cause of his ongoing deterioration was clear and outweighed considerations such as stress and inconvenience. In my opinion, there should have been clear guidelines available to medical staff as to when it was appropriate to request a CT scan. I have seen no evidence that the hospital had such guidelines in place.

Continued on next page

Opinion – Case 98HDC16860/VC, continued

Opinion: Breach Public Hospital *continued*

The hospital stated that my advisor's observation that there may have been pressure on Dr C not to request CT scans because of the time and cost involved in the transfer, did not accurately represent the situation. The hospital stated that at no time was such an instruction given, and no pressure of this sort was placed on physicians by management. Dr C was clear that he does not consider the cost, if a clinical investigation is warranted.

In my opinion, the hospital breached its duty to provide Mr B with services with reasonable care and skill, as it had no system in place to guide doctors' decision making processes to ensure appropriate referrals for CT investigation were made. In these circumstances the hospital breached Right 4(1) of the Code.

Right 4(2)

Employers are vicariously liable 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 an employing authority to prove 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, and the other medical staff involved Mr B's care, were employed by the hospital.

Continued on next page

Dr C / Public Hospital

Opinion – Case 98HDC16860/VC, continued

Opinion: Breach Public Hospital *continued*

My advisor advised me that the standard of clinical documentation by medical staff was unacceptably poor. Although my advisor concluded that the supervising consultant bore responsibility for ensuring the medical notes were of an acceptable standard, I do not accept that this absolves the hospital of responsibility for also ensuring that medical notes were of an acceptable standard. Medical notes are an important means of ensuring that patients receive continuity of care. As Mr B's medical documentation was clearly substandard, and the hospital has not shown that it took reasonably practicable steps to ensure that clinical documentation was of an acceptable standard, in my opinion the hospital is vicariously liable for Dr C's breach of Right 4(2) of the Code.

In response to my provisional opinion the hospital agreed that the medical documentation was not of a high standard. Accordingly an annual programme of medical documentation audits has been instigated, with the development of action plans when deficiencies are noted. A mandatory education programme for staff has also been established, which encompasses the legal and professional standards for medical documentation.

Dr C / Public Hospital

Opinion – Case 98HDC16860/VC, continued

Actions

I recommend that Dr C:

- Apologises to Mr B and his family in writing. The apology is to be sent to the Commissioner and will be forwarded to Mr B and his family.
- Reviews his practice in light of this report, and in particular ensures that:
  - accurate and comprehensive records of the condition of all patients under his care are kept and referred to as part of ongoing medical assessments;
  - he takes into account the pre-morbid state of all his patients when assessing their condition and considering differential diagnoses;
  - he takes appropriate action in response to a change in a patient's clinical condition, in particular that appropriate referrals for further investigations are made;
  - he communicates effectively with consumers and their families.

I recommend that the hospital:

- Apologises to Mr B and his family in writing. The apology is to be sent to the Commissioner and will be forwarded to Mr B and his family.
- Reviews medical record keeping practices at the hospital and ensures that staff are aware of how to keep adequate records.
- Implements a system to ensure that the quality of medical records is regularly reviewed and improvements made where necessary.
- Implements a system to ensure clear guidelines are available to clinicians to guide their decisions about referrals to other facilities for assessment.

Opinion – Case 98HDC16860/VC, continued

Other Actions

- A copy of this opinion will be sent to the Medical Council of New Zealand.
- A copy of this opinion will be sent to the Royal Australasian College of Physicians with a request that the College consider whether Dr C should undertake additional educational activities.
- Copies of this opinion will also be sent to the Ministry of Health and Quality Health New Zealand.