Dr A

Dr B

A District Health Board

A Report by the

Health and Disability Commissioner

(Case 02HDC08734)

Parties involved

Dr A	Provider / General Surgeon
Dr B	Provider / Casualty Officer
Mrs C	Complainant / Consumer's mother
Master D	Consumer
Dr E	General Practitioner
Dr F	On-call surgeon

Complaint

On 1 July 2002 the Commissioner received a complaint from Mrs C about the services her son, Master D, received at the Emergency Department (ED) at the Public Hospital, on 24 November 2000. The complaint was summarised as follows:

Dr A
Dr A, general surgeon, did not provide services with reasonable care and skill to Master D when he presented to the Emergency Department at the Public Hospital on 24 November 2000. In particular, he failed to:

- *properly assess Master D to determine the nature of the injury to his scrotum;*
- *admit Master D to hospital for immediate exploratory surgery;*
- *diagnose Master D with testicular torsion. Later his right testicle was surgically removed.*

Dr B
Dr B, casualty officer, did not provide services with reasonable care and skill to Master D when he presented to the Emergency Department at the Public Hospital on 24 November 2000. In particular, she failed to:

- *properly assess Master D to determine the nature of the injury to his scrotum;*
- *admit Master D to hospital for immediate exploratory surgery;*
- *diagnose Master D with testicular torsion. Later his right testicle was surgically removed.*

An investigation was commenced on 1 October 2002.

Information reviewed

- Letter of complaint from Mrs C, dated 28 June 2002
- Information provided by Mrs C, via telephone interview, on 16 May 2003
- Response from the District Health Board (DHB), dated 23 October [2002]
- Copy of a "[District Health Board]: Emergency Department Guidelines", relating to acutely painful scrotum
- Position description for "Medical Officer, Emergency Services", at the DHB
- Letter from the DHB, dated 5 June 2003
- Response from Dr A, dated 24 October 2002
- Response from Dr B, received 24 March 2003
- Information provided by Dr E, including Master D's GP notes, ED record, operation sheet, discharge summary and follow-up letter from Master D's surgeon to Dr E
- Accident Compensation Corporation (ACC) file, dated 3 September 2002
- Information provided by ACC, dated 15 October 2002, including decision of the ACC Medical Misadventure Unit, dated 28 May 2002
- Decision of the ACC Medical Misadventure Review Panel, dated 10 October 2002
- Independent report to ACC by Dr Ian Stewart, general surgeon, dated 28 April 2003
- Findings of the ACC Medical Misadventure Review Panel, dated 30 May 2003.

Information gathered during investigation

Injury and consultations, 24-27 November 2000

On Friday 24 November 2000, between 11.00am and 11.30am, Master D, aged 12, was accidentally kicked in the scrotum while on a school swimming trip. Master D became very distressed and the school contacted his family. Mrs C, Master D's mother, recalls that when she first saw Master D, at around 12.15pm, he was in severe pain and was vomiting a lot. She took Master D to his GP, Dr E.

They arrived at Dr E's surgery around 12.30-12.45pm. Dr E was at lunch, and Master D and Mrs C had to wait. Master D was in the worst pain his mother had ever seen him in, and was screaming and vomiting. When Dr E arrived, she noted that Master D was extremely distressed and persistently vomiting. She referred him immediately to the Emergency Department (ED) at the Public Hospital.

Master D and Mrs C arrived at the ED at 1.55pm. Master D was initially assessed by a nurse, who assigned him a triage code of 3, meaning that care is urgent and the patient should be treated in less than 30 minutes. Typically, code 3 indicates moderate trauma. The triage nurse recorded on the first page of the Emergency Department Record (EDR), under "Vital Signs", that Master D's temperature was 36, pulse 56, respiration rate 20, blood pressure 149/97 and oxygen saturation at 97%.

Master D was then seen by the Casualty Officer, Dr B, shortly thereafter. The DHB advised that the Medical Officer, Emergency Services (Casualty Officer) is responsible for the immediate care of patients admitted to the ED, and should aim to be involved in the assessment, investigation and treatment of each patient. They are also required to consult with the Senior Medical Officer on duty for professional advice regarding the treatment and assessment of patients as necessary.

Dr B completed the Clinical Notes form (page two of the EDR) as follows (Dr B's comments in italics):

> "SEEN BY DOCTOR: *[Dr B]* TIME:
>
> *S: 12 yo boy was kicked in the testes today. + very tender, crying, vomiting.*
>
> *O: Alert [No Abnormality Detected]*
> *[Scrotum] swollen very tender.*
> *R testis [no] free fluid.*
> *L testis OK.*
>
> *A/P: L Testicular haematoma/contusion*
> *Rest*
> *Analgesia,*
> *[Follow-up] GP Monday.*
>
> *Discussed [with] [Dr A]*
>
> SIGNATURE: *[Dr B]* TIME:*"*

On page one of the EDR, under "Drugs/Fluids", Dr B recorded that she ordered 25mg pethidine and 5mg Maxolon. This was given by a nurse, although no times are recorded.

After the pethidine and Maxolon were administered, Master D became less distressed and dozed off. At around 2.30pm, while Master D was dozing, Mrs C left to collect her daughter from school. She returned by 3pm. Mrs C recalls that, at some point between 3pm and 4pm, Dr B returned and told her that Master D probably had a haematoma that would resolve with a few days' rest. She almost certainly did not mention the possibility of torsion or any other possible injury.

Mrs C and Master D left the ED by 4pm. By the time they got home Master D was again in a lot of pain and was vomiting.

Dr A, general surgeon, arrived in the ED at around 4pm to see another patient and did not see Master D.

On Saturday, 25 November, Dr E rang to check up on Master D. By this time Master D was still in pain but had stopped vomiting. Dr E advised them to see her first thing on Monday.

On Monday, 27 November, Mrs C took Master D back to Dr E. She referred Master D back to the ED because of his ongoing pain and swelling.

At the hospital, Master D had an ultrasound, which revealed no blood flow to his right testicle and a haematoma at its lower pole. Master D underwent surgery that afternoon. Unfortunately, due to the lack of blood flow, the testicle had died and was removed.

Master D has recovered from the operation. However, it has had a profound effect on him. Since the incident, Master D has had to overcome his anger and embarrassment about losing his testicle and to cope with his physical difference. He has become more cautious in his physical activities, so as to protect his remaining testicle. Master D faces the possibility of further surgery to have a prosthetic testicle inserted.

Telephone discussion between Dr B and Dr A

A key issue in this case is the content of the telephone call Dr B made to Dr A on Friday afternoon, 24 February 2000. The ED record completed by Dr B states "discussed with [Dr A]". This comment appears to have been written at the same time as the rest of Dr B's notes as, although it is several lines below the rest of her notes, it is above her signature. However, there is no way to tell when Dr B wrote her notes as she left the two spaces on the record blank where the doctor should record when she saw the patient and when she signed her notes. The DHB has no telephone records for the call.

Dr B advised me:

> "The attending surgeon was contacted shortly after [Master D's] arrival. His injury and condition were relayed to the surgeon on duty, [Dr A]. The surgeon made no recommendations for admission, surgery or further evaluation with ultrasonography.
> …
>
> I was hired at the [Public Hospital] for a period of six months. My area of expertise is with adult patients with multiple medical problems. I was assured, prior to accepting this position, that there would be specialists on call who would be available for cases where I felt my experience was more limited (specifically paediatrics). There were numerous occasions where I sought the consultant's expert recommendation, including the case above."

Dr A advised me:

> "I was not aware of [Master D's] attendance in the Casualty Department at the time. However, during the course of the afternoon [Dr B] rang to ask for my help with a different patient attending at the Casualty Department with an acute abdomen. [Dr B] also mentioned in passing a boy with a minor blow to the scrotum and told me of the management plan that [had been] enacted. I was not asked to see the boy and, in fact, I understood that he had already been discharged. I was in effect presented with a *fait accompli* and I did not recommend a change to this plan."

Mrs C does not recall hearing Dr B say anything about having discussed Master D with Dr A. However, in a letter to ACC in August 2001, Mrs C noted:

> "[Dr B] rang a General Surgeon, [Dr A], to get advice. [Dr A], after considering the information he received, decided not to come and see Master D for himself."

Where Mrs C obtained this information is not clear.

I note that Dr B states that she contacted Dr A "shortly after admission", which occurred at around 2pm. Dr A recalls that Dr B rang him "during the course of the afternoon" and that he attended the ED some time after the telephone call. Dr A arrived at the ED around 4pm. Dr B did not record when the telephone call was made. It appears that the call probably occurred some time between 2pm and 3pm.

I am satisfied that during the phone conversation Dr B told Dr A about Master D's injury and condition, and related her management plan, but did not specifically ask him to attend. Dr A appears to have gained the mistaken impression that Master D had already been discharged.

ACC medical misadventure decision
The Accident Compensation Corporation Medical Misadventure Unit initially accepted (by decision dated 28 May 2002) that Master D had suffered a medical error, on the basis of expert advice from a paediatrician (that "a more experienced practitioner might have recommended surgical exploration", in light of the "intense pain and associated vomiting" that "might have been considered unusual" for a "relatively trivial injury"), and a urologist (that, if an ultrasound examination was not possible at the Public Hospital, "a low threshold of surgical exploration should be considered particularly where the possibility of testicular rupture, or potential torsion may be part of the diagnosis"). ACC's advisor later clarified that "a differential diagnosis had to be considered", but noted that in his opinion "it is not possible to allocate responsibility" for the medical error that occurred. By decision dated 10 October 2002, the ACC Medical Misadventure Review Panel stated that a medical error had occurred, and attributed the error to Dr A, on the basis he was the consultant on call and "his advice clearly was sought by Dr B whilst Master D was still in the Emergency Department in the Public Hospital" and that he "failed to exercise a standard of care and skill reasonably to be expected in the circumstances".

ACC subsequently sought further independent advice from a general surgeon stated that "[h]ad [Dr A] specifically asked to see [Master D] or [Dr B] had indicated to him she was unhappy with her findings or management then there was an obligation for [Dr A] to see [Master D]. … Had [Dr A] not responded to a plea for assistance from [Dr B] then failure to see the patient would constitute medical error". The ACC advisor noted that Master D had a possible diagnosis of torsion in view of his swollen tender scrotum, but his age (12) meant that this was less likely. The association between blunt scrotal trauma and testicular torsion is very unusual (less than 1%). The advisor stated that the history of trauma, although real, was misleading and this diversion was compounded by the fact that Master D allegedly responded very well to analgesia and anti-nausea treatment. The ACC Medical Misadventure Review Panel, in findings dated 30 May 2003, has requested further

information about the content of Dr B's conversation with Dr A, and about the availability of ultrasonography and a radiologist at the Public Hospital at the time.

Independent advice to Commissioner

Surgical advice

The following independent expert advice was received from Dr Stephen Kyle, general surgeon.

"**Sequence of Events**

[Master D] received a kick to the scrotum while swimming on Friday 24.11.2000. There is no indication as to the time of the injury. There is no description as to the possible force of injury. [Master D] was taken to his General Practitioner, [Dr E], who found him to be distressed and vomiting. A swollen right testis was noted and the possibility of a haematoma documented. [Master D] was referred on to the Emergency Department where he arrived at 1355 hrs. [Dr B], A&E officer, assessed him. She recorded [Master D] as having a very tender swollen right testis. He was noted to be crying and vomiting. A diagnosis of testicular contusion or haematoma was made. It was recommended he go home for rest and pain relief and be seen again by his General Practitioner the following Monday.

During his stay in the Emergency Department, he received 25mg of IM Pethidine.

In the Emergency Dept Clinical notes, it is stated that [Master D's] case was discussed with [Dr A].

[Dr A] was on call for General Surgery on the day of [Master D's] presentation. There is no on-site specialist Urological or specialist Paediatric Surgical service at the Public Hospital. [Dr A] states that he was contacted by [Dr B] and told of [Master D's] problem (in passing) while discussing another patient who had an acute abdomen. [Dr A] states that [Dr B] informed him that the blow to the scrotum was minor and he was informed of [Dr B's] management plan for rest, analgesia and General Practitioner follow up. He was under the impression that at the time he was informed, the boy had already been discharged. The time of discharge from the Emergency Department is not given.

[Master D's] General Practitioner, on 27.11.2000, reassessed [Master D] as recommended by [Dr B]. [Master D's] scrotum was found to be more swollen and his testicular pain to have persisted. He was further referred to the Emergency Department at the Public Hospital. An ultrasound scan was requested. The findings were consistent with a right testis that had lost its blood supply. There were also findings consistent with a scrotal haematoma.

[Master D's] case was referred to [Dr F], the on call Surgeon at that time. He performed a scrotal exploration confirming that the testis was not viable, consequent upon testicular torsion. The testicle had twisted upon its blood vessels compromising its blood supply.

The dead testis was removed. The remaining left testis was sutured to the scrotal muscle obviating torsion on that side.

Health and Disability Commissioner Advice Sought

On the basis of the information provided, did [Dr A] provide services with reasonable care and skill to [Master D] on 24.11.2000?

Significant diagnoses to be considered in the context of blunt trauma to the testis with subsequent severe pain and vomiting are:

- haematoma, either within or around the testis,
- rupture of the testis or
- possibly torsion.

Contemporary management of significant intrascrotal haematomas is evacuation as they may compromise the vascularity of the testis. Rupture of the testis is best repaired to optimise preservation of testicular function. Torted testis requires de-torsion and if viable fixation of the testis and contralateral testis to prevent recurrence. Torted testes will die within a few hours if not released.

[Dr B] the acting A&E officer, not being a qualified Emergency Department Practitioner and not having surgical experience, disadvantages [Dr A]. There is also no Registrar support.

Presumably [Dr B] related to [Dr A] the comments she made in the Emergency Department notes. [Master D] was in significant pain, was vomiting, and had a swollen painful right testis. [Dr B's] management plan in this situation was inappropriate; [Master D] should have been admitted and further assessed.

Being one of three General Surgeons providing a wide range of surgical services to the public with no junior support would mean that [Dr A] would receive numerous requests for advice. However, discussion of an A&E patient by an A&E Officer to a Specialist Surgeon while on call, even though it may seem as being in passing, carries a transfer of responsibility.

If [Dr B] passed on the comments that she recorded in her notes a reasonable action by [Dr A] would have been to disapprove of [Dr B's] management plan. If [Master D] had left the Department then it would have been reasonable to have the Emergency Department Staff attempt to telephone the … household requesting his re-attendance for [Dr A's] assessment.

Many Surgeons in this situation would find a scrotal ultrasound desirable in an effort to clarify the diagnosis. If this were not available, standard practice would be to proceed directly to exploration of the scrotum.

[Dr A's] failure to disagree with [Dr B's] management plan and attempt to remedy the situation would invoke moderate disapproval from General Surgical peers.

The difficult environment that [Dr A] has to work in should be noted. Providing a broad range of General Surgical services with unqualified inexperienced Emergency Department medical staff and no Registrar support is exceedingly difficult. In addition to normal duties, being available for advice and emergencies on a one in three roster with such minimal support could lead to these sorts of errors."

Emergency medicine advice
The following independent expert advice was received from Dr Chip Jaffurs, emergency medicine specialist.

"The case can be summarised briefly as follows:

A twelve year old boy was kicked in the scrotum while swimming. He saw his GP the same morning and was sent with a referral note to the Emergency Department (ED). He arrived at 1355, triaged to category 3 suggesting he be seen within 30 minutes of arrival. He was evaluated by [Dr B], an Adult Internal Medicine Specialist locuming as a Casualty Officer in ED at the Public Hospital. She provided analgesia and at some point discussed the case with General Surgeon on call [Dr A]. The patient was discharged. Presumptive diagnosis of testicular contusion/ haematoma is recorded on the ED record. On day 3 following injury, the boy represented to his GP, was referred to the hospital again where he underwent ultrasound and surgical exploration revealing a torsed and infarcted testicle. His remaining good testicle was stabilised surgically. He is reportedly recovering though has some issues with his injury and initial treatment.

The following information is missing and may have some bearing on the case:

- What time did the injury occur?
- What time did the patient see his GP?
- There is no identifying information on the ED record for this patient.
- What time was the patient discharged from ED and what was his condition on discharge?
- What time was the case discussed with the consulting Surgeon, [Dr A]?
- Although there is probably no way of really knowing, what exactly was said when the case was discussed with the on-call surgeon?
- What discharge advice was given to the patient and his family after their initial ED visit?
- What transpired during the period of observation in the Emergency Department?
- How long was this?

[Further information, included in the 'Information gathered' section of this report, has been obtained since Dr Jaffurs provided his advice.]

Opinion

Question:
Did [Dr B] adequately examine [Master D]?

Answer:
In short, yes. The diagnosis of testicular torsion by history and physical exam alone is of limited value. Testicular position might have been noted as a pertinent negative but, the elevated horizontal testicle referred to as the 'bell-clapper' deformity is not pathognomonic. Indeed, no physical sign is.

Question:
Was it reasonable for [Dr B] not to have diagnosed [Master D's] testicular torsion on the basis of the examinations she did conduct?

Answer:
The **critical decision** for [Dr B] was to appreciate the **possibility of a Surgical Emergency**. I would not expect [Dr B] to make a specific diagnosis on the basis of the physical exam. In fact, most emergency physicians would have suspected testicular rupture, rather than traumatic torsion, which is rare. At some point the case was discussed with the on call General Surgeon (when?) This is confirmed in the medical record. If the content of the medical record by [Dr B] was **conveyed** to the Surgeon, the possibility of a Surgical Emergency would hopefully have been appreciated by the Consulting Surgeon. The critical decision in this situation is deciding to call the surgeon, not deciding on a specific diagnosis.

Question:
Was the extent of [Dr B's] contact with [Dr A] reasonably sufficient in the circumstances?

Answer:
There are two issues here. I would expect that the surgeon would be called within 30 minutes of seeing the patient. This is unclear from the materials provided. Time is of importance because rates of testicular salvage diminish with elapsed time to surgery. Rates of salvage up to 80-100% are reported in those treated within 4-6 hours of onset and fall to 20% if corrected in 24 hours (Emergency Medicine Reports; Vol 23, No.2, January 2002).

[Dr B] states in her letter that 'His injury and condition were relayed to the surgeon on duty, [Dr A]. She also states 'the attending surgeon was contacted shortly after his arrival' referring to the patient.

The Surgeon, [Dr A], indicates in one of his letters dated 10 July 2002:

> '[they] also mentioned, in passing, [Master D], and [they] told me of the management plan [that they] had enacted. I was not asked to see the boy, and I was presented with a fait accompli and my understanding that the boy had already been discharged, I did not recommend a change to this plan'.

My opinion is that [Dr B's] contact with [Dr A] was reasonably sufficient in the circumstances, allowing for some remaining uncertainty pertaining to the time course.

Question:
What further actions if any, should [Dr B] reasonably have undertaken in the circumstances?

Answer:
[Dr B] evaluated [Master D], provided analgesia and observation in accordance with a working diagnosis of scrotal contusion/ haematoma and discussed the case at some point with the on call Surgeon. Presumably this was to get advice, since [Dr B] was not acting as a Surgical House Officer to [Dr A], but rather as an Emergency Physician consulting an on call Surgeon.

I do not think it reasonable to expect [Dr B], a locum Casualty Officer with background in adult medicine, to have necessarily recognised the need for urgent surgery. Other actions such as obtaining ultrasound or admission to hospital would have simply delayed diagnosis further. Perhaps after obtaining advice from a consulting surgeon, the patient could have been recalled to the Emergency Department, but again the outcome of the consultation did not appear to warrant such action.

In conclusion for 'Your Decision Required', [Dr B] provided services with reasonable care and skill commensurate with her expertise as an Adult Internal Medicine Specialist locuming in a Base Hospital Emergency Department; inherent to this situation is a reliance on an on call roster of specialists to procure the best possible advice for cases presenting to the Emergency Department. Risk of delayed diagnosis and intervention is high in this model because of the need for clear and timely communication amongst health professionals and the broad knowledge required of doctors involved who are neither specialist in Emergency Medicine or Urology.

Finally as an addendum, I would suggest the following for [the Public Hospital's] Emergency Department:

1. Doctors be urged to fill in the time they first encounter the patient.
2. Interventions, procedures, and periods of observation should be documented with timed notes.
3. A mechanism for providing written discharge instructions to patients should be implemented.
4. The 'Painful Scrotum Protocol' adopted from should be revised to include Scrotal Injury if it is to be of any use at all in future similar situations.

5. The Emergency Department record should have patient identifying information on it."

Responses to provisional opinion

Dr A

In response to my provisional opinion Dr A advised that he did not agree with my provisional finding that he breached the Code. He said that a scrotal injury is very common and usually managed by a general practitioner or a casualty officer without the involvement of a specialist.

Dr A also stated that Dr B had not "fully impressed upon" him the severity of Master D's symptoms, otherwise he would have assessed him. The reason for Dr B's telephone call appeared to be about another patient who was admitted at the same time as Master D (2pm) because that was the main topic of their conversation. Master D's case "was mentioned in passing". Dr A stated that he could readily have assessed Master D when he assessed the other patient in the ED at 4pm. Dr A requested that I reconsider the independent advice to ACC in relation to his communication with Dr B.

Dr A also advised that Dr B was satisfied with Master D's condition and her management plan to discharge him. He understood that Master D had already been discharged prior to his conversation with Dr B.

Dr A further advised that his work as a general surgeon in the Public Hospital is "very onerous". He is on call every three days and at the time did not have the assistance of a surgical registrar, an emergency medicine specialist, a full-time radiologist or an ultrasonographer. Additionally, he provided consultancy for general, vascular, plastic and urology surgery, emergency neurosurgery and burns. This resulted in an inordinate number of daily enquiries from a whole range of medical and para-medical staff.

Dr A noted that emergency surgical admissions result in a reduction of elective surgery because the Public Hospital has a severe limitation of available beds. Clinical decision-making can be influenced by a "severe restriction of resources". He acknowledged that he had reviewed his practice since Mrs C's complaint and as a result had drastically reduced his threshold for emergency admission to hospital for assessment of potential surgical emergencies.

Dr A noted that he was "sorry for Master D and his family", but commented that he "did not believe the perfection of practice expected" of doctors is achievable in view of "overall work circumstances" and stated that he has resigned from the Public Hospital.

Dr B

In response to my provisional opinion Dr B advised that she definitely contacted Dr A within half an hour after Master D's arrival at the Emergency Department.

The District Health Board
The Board advised in response to my provisional opinion that it accepted my proposed recommendation to continue reviewing its Emergency Department practices and policies, including the recommendations made by Dr Jaffurs.

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.*

Opinion: No Breach – Dr A

Duty of care
Having reviewed all the available evidence, I am satisfied that Dr B advised Dr A of Master D's injury and condition, including the information recorded in her notes, and related her management plan.

I accept my expert advice from Dr Kyle (a general surgeon who is a peer of Dr A) that when this information was relayed to Dr A by Dr B, it was sufficient to raise the possibility of a haematoma (either within or around the testis), rupture of the testis, or possibly torsion. The appropriate clinical options were to arrange an ultrasound or, if this was not available, to proceed directly to surgical exploration of the scrotum. I acknowledge the comment of ACC's advisor that Master D was unlikely to have testicular torsion. Nevertheless, in light of the possible diagnosis in this case, further investigation was warranted.

As a casualty officer, Dr B's job description required her to work independently, but to seek advice from other practitioners, including on-call consultants, when appropriate. When Dr B discussed Master D's case with Dr A, it was undoubtedly because she wanted to consult him about the care of Master D, and to seek his advice on her management plan. It seems very unlikely that Dr B would have mentioned Master D's case to Dr A if she did not want his professional opinion.

Despite Dr A's statement that Dr B mentioned Master D's case "in passing", I accept my expert advice that, in the circumstances, this call from a casualty officer to a specialist surgeon carried with it a transfer of responsibility. Dr B was not required to "fully impress" her concerns or to specifically seek Dr A's attendance or "plead" for his assistance. When

Dr B phoned Dr A and conveyed Master D's injury and condition, and her management plan, responsibility for Master D's care passed to him, as the on-call consultant.

Extenuating circumstances
I acknowledge the statement made by Dr A in response to my provisional opinion that he faced a heavy workload and resource constraints, including a lack of adequate support staff. My advisor, Dr Kyle, also noted the difficulty for Dr A in being one of three general surgeons providing a wide range of surgical services to the public, with no senior support.

It is a defence for any clinician to prove that he or she acted reasonably in the circumstances (clause 3 of the Code). Resource constraints are highly relevant circumstances in a small, provincial public hospital. Dr A's heavy workload, and in particular the large amount of information (from a variety of disciplines) that he was required to assess each day, no doubt significantly increased the risk of an error. Other relevant circumstances in this case are Dr A's genuine, albeit mistaken, failure to appreciate that Dr B was seeking his advice, and the fact that testicular torsion in a 12-year-old boy (who had suffered a trauma but was responding well to medication) was very unlikely.

Having regard to all the relevant circumstances, I have concluded that it would be unduly harsh to single out Dr A as responsible for the misdiagnosis of Master D's condition. Accordingly, Dr A did not breach Right 4(1) of the Code.

Opinion: No breach – Dr B

I note the comments of my emergency medicine specialist that, as a locum casualty officer with a background in internal medicine, Dr B could not reasonably have been expected to have recognised that Master D's injury required urgent surgery and that her treatment plan was inappropriate. I accept my expert advice that the assessment and diagnosis Dr B made was reasonable in the circumstances. I note my expert's comments that most emergency physicians would have suspected testicular rupture, rather than traumatic torsion, which is rare, and that the critical factor for Dr B was to appreciate the possibility of a surgical emergency (and therefore the need to call a surgeon).

In these circumstances Dr B took the correct action and sought the advice of the on-call surgeon, and accordingly provided services with reasonable care and skill.

However, my expert has indicated that, as testicular injuries require urgent assessment, Dr B should have sought Dr A's advice within 30 minutes of assessing Master D. I acknowledge Dr B's statement in response to my provisional opinion that Dr B did contact Dr A within half an hour after Master D's arrival at the ED, although Dr B did not record the time in her notes.

Dr B was required to "keep clear, accurate, and contemporaneous patient records" (*Good Medical Practice: A Guide for Doctors* (Medical Council of New Zealand, 2000)). Dr B's

job description required her to "maintain adequate medical records". An adequate medical record notes the date and time the record is made.

In seeking consultant advice about Master D's care, Dr B acted appropriately (although it would have been wise to record the time of the call) and did not breach the Code.

Opinion: No breach – The District Health Board

Employers are potentially vicariously liable for ensuring that their employees comply with the Code of Health and Disability Services Consumers' Rights. It is a defence for an employing authority to prove that it took reasonable steps to prevent the employee from breaching the Code.

Dr A and Dr B were employees of the District Health Board. As I have found that Dr A and Dr B did not breach the Code, no question arises of vicarious liability on the part of the Board. However, I am left with significant concerns about the heavy workload imposed on Dr A and his general surgeon colleagues at the Public Hospital.

Other comments

Emergency Department services at the Public Hospital

I note Dr Jaffurs' advice that staff in the ED at the Public Hospital could improve their services by:

- improving the quality of their records, by ensuring that:
  - doctors record when they first encounter a patient;
  - all interventions, procedures and observations are recorded with timed notes;
  - a patient's ED record includes his or her identifying information
- having a system for providing patients leaving the ED with written discharge instructions
- revising their protocol for dealing with patients with a painful scrotum.

The DHB has advised me that, since this incident, it has made the following improvements to the ED:

- improved overall staffing levels
- recruited permanent staff to fill the two casualty officer positions
- designated a senior clinical leader for the department
- allocated administrative time to its medical officers for improving ED practices and protocols and undertaking regular audits
- instituted a policy for casualty officers to review ED house surgeons' clinical notes
- initiated processes for case reviews and peer review.

Actions

The District Health Board
I recommend that the DHB review and improve the level of support available to its general surgeons, and continue to review its ED practices and policies in light of my report.

Dr B
I recommend that Dr B review her record keeping in light of my report.

Further actions

- A copy of this report will be sent to the Medical Council of New Zealand.
- A copy of this report will be sent to ACC's Medical Misadventure Unit.
- A copy of this report, with identifying details removed, will be sent to the Royal Australasian College of Surgeons and the Australasian College of Emergency Medicine, and to the Chief Medical Advisors of all District Health Boards, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.