Medical Officer, Dr B

Nurse, Ms C

District Health Board

A Report by the

Health and Disability Commissioner

(Case 04HDC00463)

Parties involved

Master A	Consumer
Mrs A	Complainant/Consumer's mother
Mr A	Consumer's father
Dr B	Provider/Medical Officer
Ms C	Provider/Nurse
Mrs D	Provider/Hospital Manager
Ms E	Provider/ Nurse
Ms F	Provider/Nurse
Ms G	Provider/Nurse
Mr H	Provider/Ambulance Officer
Dr I	Urology Registrar
The Rural Hospital	Provider//Hospital
The City Hospital	City Hospital

Complaint

On 12 January 2004 the Commissioner received a complaint from Mrs A about the care her son, Master A, received at a rural hospital. The following issues were identified for investigation:

1. *Whether Ms C provided services of an appropriate standard to Master A on 5 May 2003. In particular:*
   - *whether Ms C's assessment of Master A on presentation to the Emergency Department was appropriate and adequate*
   - *whether, after her initial assessment of Master A, Ms C provided appropriate and adequate information to Dr B.*

2. *Whether Dr B provided services of an appropriate standard to Master A on 5 May 2003. In particular:*
   - *whether Dr B responded appropriately to the information provided to him by Ms C about Master A's condition, shortly after Master A's presentation to the rural hospital*
   - *whether Dr B's assessment, diagnosis and treatment of Master A during his stay at the rural hospital on 5 May 2003 were adequate and appropriate*
   - *whether the records made by Dr B about his assessment, diagnosis and treatment of Master A were adequate and appropriate.*

An investigation was commenced on 15 April 2004.

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

Information reviewed

Information was obtained from the following sources:

- Mrs A
- Master A
- Mr A
- Dr B
- Ms C
- Ms E
- Ms G
- Ms F
- Mr H
- An Ambulance Service
- Mrs D, Manager, the rural hospital
- Accident Compensation Corporation (ACC)
- Medical Council of New Zealand
- Master A's medical records from the District Health Board.

Independent expert advice was obtained from Ms Jane MacGeorge, registered nurse, and Dr Tony Birch, general practitioner.

Information gathered during investigation

Overview
This complaint concerns the failure to diagnose Master A with testicular torsion at a rural hospital. The delay in appropriate treatment led to the loss of Master A's right testicle. The investigation centres on the care that Ms C, nurse, and Dr B, medical officer, provided to Mr A.

Chronology
Between 11pm and midnight on 4 May 2003, 15-year-old Master A began experiencing chronic pain down the right side of his abdomen, radiating into his right testicle. He described the pain as "like being kicked in the balls". His mother gave him a Voltaren tablet and stayed up with him.

At 12.30am on 5 May 2003 Master A's symptoms worsened to the extent that his mother called the medical centre, and spoke to a staff member called […]. She suggested Mrs A call the rural hospital. When Mrs A called the hospital, she was connected to the hospital's answering service.

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At 12.40am Mrs A decided to call 111 and spoke to the operator from the Ambulance Service, who advised her to take Master A to a doctor immediately as she thought his condition sounded like testicular torsion.

The ambulance arrived at 1.01am. Master A was examined in the ambulance by the ambulance officer, Mr H, who Mrs A said confirmed Master A's testicle was swollen and possibly twisted. He advised Mr and Mrs A that Master A might need to be taken to the city hospital after being assessed at the rural hospital. Mr H advised me that when he examined Master A he was in pain (level 6 out of 10), showed guarding on the right lower quadrant of the abdomen, and was distressed and pale. Mr H also said that while Master A complained of pain there was no obvious discolouration or swelling of the testes.

The ambulance records state:

> "Pain right hand side abdomen radiating to right testicle. History, patient given one Voltaren by parent one hour ago, pain started 2300 hours, constant pain 6 out of 10 right hand side testicle and abdomen. On examination patient complained of pain in his right testicle and right upper and lower quads, abdomen, rebound pain on palpation, worse right lower quadrant, patient distressed, trembling, pain constant 6 to 7 out of 10, query appendicitis/testicular torsion, no medications, no allergies."

On arrival at the rural hospital at 1.25am, Mr H informed the Night Nurse Co-ordinator, Ms C, that his diagnosis was possible appendicitis/testicular torsion. Ms C assessed Master A with the assistance of nurses, Ms F and Ms E. When Ms C asked Master A his level of pain he reported 6 out of 10. Ms C said she examined his lower abdomen and reported no obvious guarding when she palpated his stomach. She also said that Master A did not complain of pain in his testicle, but there was some tenderness in his stomach.

Ms C informed me that the nurses were aware that Master A was uncomfortable and she decided not to examine Master A's groin, as she thought the doctor would examine him shortly anyway. Ms F and Ms E stated that Master A was reluctant to be examined and was uncooperative. Ms C noted that the ambulance officer had examined Master A's testicles and "had found no evidence of swelling, discolouration or pain even when the testes were moved". Ms C also said that Mrs A had examined Master A's testicles and found them to be normal.

Mrs A said that Ms C appeared to agree that it might be appendicitis, or a bowel condition; Ms C did not examine Master A's testes or his groin area. Master A and Mrs A denied that Master A was uncooperative or reluctant to be examined. Mrs A stated that she did not examine Master A's testicles at any stage.

Nurse C triaged Master A as level 4 (to be seen by a doctor within one hour). Ms C stated that she rang the medical officer, Dr B, who was sleeping on site, at approximately 1.50am and informed him of Master A's symptoms and condition. Ms C stated that she told Dr B:

> "A 15 year old boy had arrived by ambulance at 0120 hours with right iliac fossa pain. History of right lower abdominal pain with some radiation to right groin and testes

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> since approximately 2330 hours. Nil other previous history of note. Mother had given Voltaren ? dose at around 2330 hours. Ambulance staff had examined patient's testes and abdomen and their findings [were] that there was no evidence of testicular swelling, discolouration or discomfort/pain when the testes were examined. A provisional diagnosis of appendicitis with ? testicular torsion. [Dr B's] response was that 'it sounds more like appendix. They [I took to mean [city hospital] Emergency Staff] won't do anything until morning so we will leave it until then.' I replied 'do you realise this boy is a suspected torsion of the testes'. I told [Dr B] that I had not examined [Master A's] testes. [Dr B] repeated 'it sounds more like appendix and monitor until morning'.
>
> ...
>
> [Dr B] instructed me to give analgesia, take bloods and continue to monitor overnight. Keep on nil per mouth and notify him of any adverse changes in condition."

There is no note on the nursing triage form relating to testicular pain. At the bottom of the form the words "testes ok" have been recorded.

Dr B said that he received Ms C's call at approximately 1.30am.

> "At the time I received the call I was asleep, having worked over 60 hours with only a few hours sleep over the previous three days due to the shortage of doctors and no on-call general practitioner overnight at the hospital. This had been my third straight night on call.
>
> My recollection of the telephone conversation is vague, but I seem to recall being told by the nurse coordinator that [Master A] had a history of right lower quadrant abdominal pain for two to three hours but was settling down. The pain had started at approximately 10.30 that night and the family had tried Voltaren, which had given some relief, but the pain had recurred. There was no guarding and I recall the nurse informing me that [Master A's] recordings (temperature, pulse and blood pressure) were fine. I do recall asking, amongst other things, if there was any testicular pain or vomiting at this time. The nurse told me that this was fine as well. Had I been told there was testicular pain then I would definitely have attended [Master A]. However, I acknowledge that I might be confusing this recollection with what happened subsequently. I do not recall being told that [Master A] had arrived by ambulance."

In response to my provisional opinion, Dr B's lawyer confirmed that Dr B is clear that Ms C did not say to him that Master A had "suspected torsion of the testes", but rather that the testes "were ok". Dr B gave Ms C a verbal order for intravenous morphine and Maxolon, and asked to be contacted by nursing staff if there was any change in Master A's condition overnight. Ms C said she advised Mrs A of the outcome of the conversation with Dr B, and that Master A would be seen early in the morning.

Nursing staff gave Master A morphine at 1.48am and settled him in the treatment room. He remained relatively settled overnight.

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At approximately 7am Dr B saw Master A and asked him some questions. In an initial response provided to the investigation, on 11 May 2004, Dr B recalled:

> "The only entry regarding his testes were that they were okay. I do not recall the ambulance report being in the notes. I spoke with [Master A] and his mother. From the history I elicited, I gained the impression that he had possible early appendicitis or intestinal spasm of undetermined cause. I do not recall during the discussion with [Master A] or his mother any mention of his testes. I recall conducting a general examination of [Master A], including that of his chest, heart, lungs and abdomen, including the right side of the abdomen where the pain seemed to be originating from."

Dr B did not have the nursing or ambulance records before him at the time this explanation was given, as they were thought to have been lost. The records were subsequently located and provided to Dr B. He provided no further information regarding his initial assessment of Master A.

Dr B's notes at 7am record: "Abdominal pain — 1/7. Previously well (see notes). Awoke 2230H. Abdominal pain — right lower quadrant. Dull ache, intermittent. No radiation. No chest or back pain or syncope. Nausea. No vomiting or diarrhoea. No urinary symptoms. No trauma. No testicular pain or fever. Sore throat two weeks ago. Ambulant."

Mrs A said that Dr B did not examine Master A, and that he was still experiencing the symptoms later that morning, despite the morphine.

At approximately 8.20am blood samples were taken and, some time later, Master A had X-rays, an ECG (electrocardiograph) and a KUB (Kidney Ureter Bladder scan).

At 10.15am Dr B returned with the results of the blood tests, which were normal. Master A's pain had receded, and Dr B said that if he tolerated food, Master A could be discharged in the afternoon. Mrs A said Dr B examined Master A's right side at this time, but not his groin area.

Early in the afternoon, Master A had something to eat and Dr B said he could go home. Master A told his mother that he still felt pain in his right testicle. Mrs A expressed her concern to Nurse G who relayed this information to Dr B.

At 2.15pm Dr B re-examined Master A and noticed that his right testicle was swollen and tender. Dr B called the urologist at the city hospital. Dr B told the family that Master A needed to go to the Emergency Department at the city hospital urgently, and asked if they could drive there. Dr B informed me that in his experience ambulances have not always been the most reliable rapid form of transport to hospital, because of the need to assemble staff and the possibility of ambulances being out of town.

At 3pm the family left by car and arrived at the city hospital Emergency Department at approximately 5.00pm. A triage nurse examined Master A after 25 minutes. After another short wait he was examined by a urology registrar, Dr I, at 6pm. He said that Master A's

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testicle was swollen and possibly twisted, and that it could now be dead as a result of lack of circulation for more than six hours since the onset of symptoms.

Master A underwent a right orchidectomy (removal of the testicle) and a left orchidopexy (fixing of the left testicle in the scrotum). The operation note records that surgery commenced at 7.05pm.

The experience resulted in physical and emotional trauma for Master A and his family.

ACC

Mrs A made a claim for medical misadventure on behalf of Master A, arising from the delayed diagnosis of testicular torsion. The claim was accepted as a medical error on 24 December 2003. ACC received independent expert advice from a urologist, who had concerns regarding issues of competence in relation to Dr B's performance during this incident. ACC's advisor said that not only was Master A not examined on his admission to the public hospital, he was also not examined properly the following morning. The advisor said that it is imperative to exclude testicular torsion early as there is only a 6−8 hour window of opportunity in which to salvage a torted testis through surgery. He also questioned the use of the tests Dr B ordered later in the morning, which he said would have been unnecessary if Dr B had examined Master A. The advisor recommended that the case be referred to the Health and Disability Commissioner.

Medical Council

As a result of the referral from ACC, the Commissioner wrote to the Medical Council recommending that Dr B's competence be reviewed. The Medical Council informed me that Dr B underwent a performance assessment, following which the Competence Review Committee suggested that Dr B could benefit from a structured relationship with a mentor. The Council endorsed this suggestion, and Dr B agreed to implement it. The Council did not require Dr B to undergo an educational programme, having concluded that his practice met the required standard of competence.

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Independent advice to Commissioner

Nursing advice

The following expert advice was obtained from Ms MacGeorge, registered nurse:

"8 December 2004

Independent Advisor Report: Jane MacGeorge

Complaint: [Master A]

Reference: 04/00463/WS

Purpose:

To advise the Commissioner whether the services provided to [Master A] by [Ms C] at [a public hospital] were of an appropriate standard.

I have been asked to provide an opinion to the Commissioner on case number 04/00463/WS, and I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

Qualifications:

I qualified as a Registered General and Obstetric Nurse in 1980 at Cook Hospital, Gisborne. I hold a BA (Social Science) and MA (Applied) degrees. I have also completed a Certificate in Intensive Care Nursing. I have worked in a tertiary Emergency Service since 1992 in Educator and Nurse Consultant positions. I developed and coordinate the Postgraduate Certificate in Trauma and Emergency that is offered at VUW. I have held a Lecturer's position at Victoria University in Wellington since 2000, teaching in postgraduate education.

Expert Advice Required

To advise the Commissioner whether, in your professional opinion, the standard of care [Master A] received from [Ms C] was of an appropriate standard. In particular:

- What action should have been taken when [Master A] arrived at [the rural hospital]?
- Did [Ms C] undertake an appropriate examination/assessment of [Master A]?
- Did [Ms C] take an appropriate history of [Master A's] condition?
- Were [Ms C's] actions in calling [Dr B] reasonable?
- Was the information that [Ms C] gave to [Dr B] about [Master A's] condition sufficient?
- Should [Ms C] have insisted that [Dr B] examine [Master A] immediately?
- Was [Ms C's] action in administering intravenous morphine as

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instructed by [Dr B] without [Master A] being examined by a doctor appropriate?
- Was [Ms C's] record taking appropriate?
- If, in answering any questions, you believe that [Ms C] did not provide an appropriate standard of care, please indicate the severity of her departure from that standard. To assist you in this last point we note that some experts approach this question by considering whether the provider's peers would view the conduct with mild, moderate, or severe disapproval.
- Are there any aspects of the care provided by [Ms C] that you consider warrants additional comment?

Background

At midnight on 5 May 2003, 15 year old [Master A] began experiencing chronic pain down his right side, extending into his right testicle. He described the pain 'like being kicked in the balls'. His mother gave him a voltaren tablet and stayed up with him.

At 12.30pm his symptoms worsened to the extent that his mother called [the local medical centre] and spoke to a staff member called […]. She suggested [Mrs A] call [the public hospital]. [Mrs A] only got the Hospital's answering service when she called.

[Mrs A] called 111 and spoke to the operator from the Ambulance Service who advised her to take [Master A] to a doctor immediately as she thought his condition sounded like testicular torsion.

The ambulance arrived at approximately 1am. [Master A] was examined in the ambulance. The ambulance officer ([Mr H]) confirmed [Master A's] testicle was not swollen or discoloured. He advised that [Master A] may need to be taken to [the city hospital].

On arrival at [the rural hospital] [Mr H] handed over to [Ms C]. When [Ms C] asked [Master A] about his level of pain, he reported 6 out of 10. [Ms C] did not examine [Master A].

[Ms C] called [Dr B] who was sleeping on site. He gave a verbal telephone order for IV analgesia, and advised that he would examine [Master A] in the morning. If there was any change overnight, the nurses were to call [Dr B].

Nursing staff gave [Master A] IV morphine and settled him in the treatment room for the night.

At 7am [Dr B] saw [Master A] and asked him some questions. He said some blood samples would be taken for testing. [Dr B] did not

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physically examine [Master A] at this time. [Master A] was still experiencing the symptoms despite the morphine.

At approximately 8.20am the blood samples were taken. Some time later [Master A] also had X-rays.

At 10.15am [Dr B] returned with the results of the blood tests, which were normal. [Master A's] pain had receded, and he said that if he tolerated food, he could be discharged in the afternoon. [Dr B] examined [Master A's] right side, but not his groin area.

At 3pm [the family] left for [a city] and arrived at [the city hospital] at 5pm. A triage nurse examined [Master A] after 20 minutes. After another short wait, he was examined by the urologist, [Dr I]. He said that [Master A's] testicle was swollen and possibly twisted. He said it could now be dead as a result of lack of circulation for more than six hours since the onset of symptoms.

At 6.45pm [Master A] underwent surgery for testicular torsion. The right testicle was removed because it had died.

Supporting Information

- Letter to the Commissioner from [Mrs A], dated 6 January 2004, and enclosures marked 'A' (numbered 1–100).
- Action note of telephone conversation with [Mrs A] on 22 March 2004, marked 'B' (numbered 101).
- Action note of telephone conversation with [Master A] on 31 March 2004, marked 'C' (numbered 102–103).
- Notification letter sent to [The District Health Board] dated 15 April 2004, marked 'D' (numbered 104–106).
- Notification letter sent to [Ms C] dated 15 April 2004, marked 'E' (numbered 107–109).
- Notification letter sent to [Dr B] dated 15 April 2004, marked 'F' (numbered 110–112).
- Letter from [The District Health Board] dated 3 May 2004, with enclosures, marked 'G' (numbered 113–200).
- Letter dated 11 May 2004 from [Dr B], marked 'H' (numbered 201–206).
- Information from [the ambulance service] received on 24 May 2004, marked 'I' (numbered 207–209).
- Action note of telephone conversation with [Master A] on 21 June 2004, marked 'J' (numbered 210).
- Letter dated 22 June 2004 from [Ms G], marked 'K' (numbered 211).
- Letter dated 25 June 2004 from [Dr B], marked 'L' (numbered 212).
- Transcript of interview with [Master A] on 6 September 2004, marked 'M' (numbered 213–222) including letter from [Mrs A]

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dated 9 November.

- Transcript of interview with [Mrs A] on 6 September 2004, marked 'N' (numbered 223–234).
- Transcript of interview with [Mr A] on 6 September 2004, marked 'O' (numbered 235–249).
- Transcript of interview with [Mr H] on 7 September 2004, marked 'P' (numbered 249–258).
- Transcript of interview with [Ms G] on 7 September 2004, marked 'Q' (numbered 259–269).
- Transcript of interview with [Ms E] on 7 September 2004, marked 'R' (numbered 270–278).
- Transcript of interview with [Ms C] on 7 September 2004, marked 'S' (numbered 279–300), including letter dated 6 October 2004 from C with enclosures.
- Transcript of interview with [Ms F] on 8 September 2004, marked 'T' (numbered 301–311).
- Letter from [Mrs D], Hospital Manager, dated 21 September 2004, marked 'U' (numbered 312–321).

Expert Advice Required

To advise the Commissioner whether the services provided to [Master A] by [Ms C] at [the public hospital] were of an appropriate standard, in particular:

Question:

What action should have been taken when [Master A] arrived at [the rural hospital]?

Answer:

[Master A] arrived at [the rural hospital] at 0125 as recorded both on the Ambulance Officer's report and 'Nursing Triage' Form. [Master A] was triaged immediately on arrival by [Ms C], assisted by two other nursing colleagues ([Ms F] & [Ms E]). The Emergency Department — nursing triage form records the triage time as 0125. The ambulance officer's interview transcript (249–258) states he handed over [Master A's] care to [Ms C] indicating a possible diagnosis of testicular torsion or appendicitis. The ambulance officer also stated verbally at handover that he had examined [Master A's] testes that appeared normal with no obvious swelling or discolouration.

[Master A] received an appropriate standard of care on arrival to [the rural hospital] by [Ms C]. The 'Hospital Admission Policy' and 'Triage Guidelines' were adhered to, and [Master A] was assessed by the Nursing Coordinator on duty and subsequently assigned a triage code. A triage code 4 allocated by [Ms C] on his presenting clinical findings was reasonable, even though a triage 3 would have taken into account the descriptor 'moderately severe pain'. However, [Master A] did receive pain relief promptly. It must be remembered that the triage nurse applies an Australasian Triage

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Scale (ATS) in response to the question "This patient should wait for medical assessment and treatment no longer than …" (ACEM, 2002).

[Master A] had vital signs taken which showed he was clinically stable and afebrile. Routine recording of a full set of vital signs is not standard practice across emergency departments nationally. Due to smaller patient volumes, triage and initial assessment appear to be combined at [the public hospital], providing good practice in this situation. [Master A] also received pain relief promptly at 0148, on the level of pain assessed by [Ms C].

All acute ambulance cases are required to be assessed by the duty hospital doctor (Medical Officer Special Scale [MOSS]) as to the patient's need for admission ([rural] Hospital Admissions Policy, 2002). [Ms C] notified [Dr B] of [Master A's] arrival within half an hour of his presentation. His triage code of 4 required that a Doctor see him within 60 minutes. It is acceptable practice that notification by a nurse, of a patient's arrival with an acute condition should be sufficient information to ensure a medical assessment within a triage time. In larger emergency departments external medical staff are notified of a patient's arrival, unless they are unstable there is very little information shared between the nurse and doctor. Referring general practitioners often call registrars but a nurse can take information to handover if the Registrar is in the operating theatre.

[Ms C] states in her transcript (279–300) 'that nurses are abused when they ring doctors in the middle of the night'. Unfortunately such occurrence does add to and influence decisions of nurses to pursue medical staff in an endeavour to get them to see patients within an acceptable timeframe. There appears to be increased responsibility carried by nurses working in rural emergency settings, where there are not always doctors present and readily available in the department. It is also noted that [Dr B] acted out of character this particular night that possibly impacted on how the nurses would otherwise have followed up with more calls to [Dr B]. There was a MOSS in the hospital responsible for seeing acute presentations.

Question:

Did [Ms C] undertake an appropriate examination/assessment of [Master A]?

Answer:

Yes, [Ms C] performed an appropriate assessment of [Master A] on presentation. The nursing triage form indicates he had a full set of vital signs. The transcripts of the nurses and ambulance officer (270–278/301–311/249–258) indicated that a handover and history was given to [Ms C]. The 'Nursing Triage' form documents that the testes were OK, and that [Master A] was 'tender on pressure to rebound RIF (right iliac fossa).' There is evidence in the transcripts; ambulance and nursing triage reports that there was consideration of testicular torsion as a differential diagnosis. The presentation of RIF pain with no complaints of testicular pain on arrival led the staff to believe a

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diagnosis of appendicitis to be more likely. However, testicular torsion should not have been discounted.

Patients are often subject to numerous assessments and questioning from a range of health professionals. [Ms C] assessed [Master A] to gather enough information to allocate an appropriate triage code 4 to hand over to the Doctor on duty. The nurses present during the initial assessment on [Master A] confirm [Ms C's] attempts to examine [Master A] and her questions related to testicular pain. She also appeared sensitive to [Master A's] privacy regarding the nature of his presentation. [Ms C] had indicated that she thought [Master A] would have had his testes examined on a medical assessment and the decision not to persevere with an examination was reasonable ... 'well instead of pulling his pants down, the doctor coming in and doing it half an hour later again'. Nurses do not routinely examine testicles as part of their practice. It is evident in the literature that scrotal pain carries diagnostic uncertainty even for medical staff (Pediatric Urology, Vol. 57, No. 4, 2002).

'Emergency Medicine Reports' (Vol. 23, No. 2, 2002) states that urologic emergencies present formidable challenges to diagnosis and management even to the emergency physician. In up to 90% of cases of acute scrotal pain, the diagnosis will be divided between testicular torsion, appendage torsion, and acute epididymitis. Testicle swelling with torsion occurs only after about 12 hours from onset. It may have been very difficult to find anything abnormal with [Master A's] testes at the time of his initial presentation, except for a complaint of pain. Emergency Medicine Reports the clinical diagnosis of testicular torsion is fraught with pitfalls, and diagnosis by history and examination alone is of limited value, as there is a wide variety of presentations and no pathognomonic signs. Physical exam alone is extremely unreliable, and the misdiagnosis rate can be as high as 50% when based solely on a physical exam. Had [Ms C] physically examined [Master A's] testes, it is highly unlikely that she would [have] found any abnormalities at this stage.

[Ms C] examined [Master A] sufficiently to establish an appropriate triage code, notify medical staff of [Master A's] arrival to the emergency department within a short timeframe of his arrival, and a request for pain relief that was administered within half an hour of his presentation to hospital. A presenting complaint of an acute abdomen should have been sufficient history to initiate a medical assessment within the triage time.

Question:

Did [Ms C] take an appropriate history of [Master A's] condition?

Answer:

Yes, [Ms C] took an appropriate history of [Master A's] condition. There is no documentation on the nursing triage form in the presenting problem section related to testicular pain, however the comment 'testes OK' is recorded at the bottom of the form. The transcripts acknowledge [Ms C] was aware of the concern regarding testicular

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torsion, from the handover from the ambulance officer. There are also statements from the nurses present at the initial assessment that [Ms C] tried to ascertain from [Master A] if he was still experiencing scrotal pain and she did try to examine him. His discomfort, thought to be abdominal pain, was enough for [Ms C] to get an order for pain relief early.

Anthony (www.mps.org.uk, 2002) reports abdominal pain is a fairly common symptom in cases of torsion of the testes, especially in younger patients who are possibly too embarrassed to draw attention to pain in their testes, or too young to communicate at all. He also reports 20–30% of patients complain of lower abdominal pain.

Question:

Were [Ms C's] actions in calling [Dr B] reasonable?

Answer:

Yes, [Ms C] notified [Dr B] regarding [Master A's] presentation at 0125 within half an hour of his arrival as pain relief was given at 0148. She also triaged [Master A] as a triage code 4 that required him to receive a medical assessment within 60 minutes.

Question:
Was the information that [Ms C] gave to [Dr B] about [Master A's] condition sufficient?

Answer:

[Ms C] notified [Dr B] soon after [Master A's] arrival. Even if scrotal pain was not clearly conveyed, [Master A] still had signs of an acute abdomen requiring medical assessment. [Master A's] pain was described sufficiently enough for an order of narcotics to be given.

Question:

Should [Ms C] have insisted that [Dr B] examine [Master A] immediately?

Answer:

The nurses' transcripts describe a reasonably lengthy conversation … between [Ms C] and [Dr B] when first notification was given of [Master A's] arrival to hospital. It is also acknowledged that [Ms C] was concerned when [Dr B] conveyed he was not coming to assess [Master A]. It is not unusual in any practice setting for nurses to have to persuade doctors to come and see patients. It is noted that it was unusual for [Dr B] not to come and see a patient straight away. The nursing transcripts indicate that they assumed [Dr B] would turn up during the night, which was his usual practice.

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[Master A's] haemodynamic stability and response to pain relief reassured the nurses that his condition was not worsening. This reassured and allowed them to [let] him sleep through the night and wait for a medical assessment in the morning. It is not acceptable in any emergency department setting for a patient presenting with an acute abdomen to wait 5 hours for a medical assessment. [[Ms C] should have called [Dr B] again when [Master A] went outside his triage time. It appears, considering the practice of holding patients overnight, that [Master A] was allowed to sleep without being disturbed.

Question:

Was [Ms C's] action in administering intravenous morphine as instructed by [Dr B] without [Master A] being examined by a doctor appropriate?

Answer:

Yes. [Ms C] followed good practice by ensuring [Master A] received appropriate assessment of his pain with subsequent pain relief early in his hospital stay. In recent years there has been considerable improvement in pain management prior to patients being seen by medical staff. Previously patients had to wait in pain, sometimes for hours, until they had a medical assessment, as it was feared that the pain relief would mask their symptoms.

The Employee Certification record shows that [Ms C] has been committed to keeping up her competencies and is certified to provide a range of advanced skills.

Question:

Was [Ms C's] record taking appropriate?

Answer:

Yes. [Ms C] completed the nursing triage form documenting [Master A's] presentation history assessment findings and a complete set of vital signs. Testicular pain was not documented however. Medication given was recorded on the 'Transfer from Inpatient Ward' form. Regular observations were also recorded overnight on the observation chart. There is also an entry at 0200 on the clinical notes and again at 0630 documenting [Master A's] progress.

Question:

If, in answering any questions, you believe that [Ms C] did not provide an appropriate standard of care, please indicate the severity of her departure from that standard. To assist you in this last point we note that some experts approach this question by considering whether the provider's peers would view the conduct with mild, moderate, or severe disapproval.

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Answer:

[Ms C] provided an appropriate standard of care to [Master A] on his arrival to [the public hospital]. The issues arise further into his hospital stay when he did not receive a medical assessment when first requested or within his triage time of an hour and not notifying [Dr B] again when he had not arrived. The fact that [Master A] settled and slept after pain relief probably clouded nursing judgement to persist in ensuring such an assessment occurred.

Question:

Are there any aspects of the care provided by [Ms C] that you consider warrants additional comment?

Answer:

From the hospital documentation and transcripts provided, [Ms C] provided an appropriate standard of care to [Master A]. The only criticism I have over RN [Ms C's] care is that she did not insist [Dr B] come and assess [Master A] earlier. There was a hospital policy stating that patients requiring admission had to be assessed by the designated duty hospital doctor (MOSS). There appears to be a culture of letting patients wait until morning to be assessed and treated if they were stable which needs to be reviewed as it clouds judgement when trying to make good clinical decisions.

References

1. ACEM. Policy Document: The Australasian Triage Scale. Retrieved 26/11/04: http://www.acem.org.au/open/documents/triage.

2. Anthony, S. (2002). Scrotal Confusion: Focus on diagnosis. Casebook 17. 5–11. www.mps.org.uk.

3. Emergency Medicine Reports. (2002). Diagnosis and emergency department management of Urologic Emergencies in the male Patient. 23 (2). 17–28."

Medical advice
The following expert advice was obtained from Dr Tony Birch, general practitioner:

"Medical/Professional Expert Advice — File 04/00463/WS [Dr B]

Thank you for your letter of 17th November requesting I provide an opinion to the Commissioner about the services provided by [Dr B] to [Master A], as detailed in the documents you supplied. I can confirm that I have no personal or professional conflict in this case. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors. I understand also that my report is subject to the Official Information Act and that my advice may be requested and disclosed under that Act and

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that the Commissioner's policy is to name his advisors where any advice is relied upon in making a decision.

I qualified MB, ChB in 1968 from Victoria University of Manchester, UK. I also hold a Diploma in Obstetrics from the Royal College of Obstetricians (1970) and a Diploma in Health Administration from Massey University (1985). I have been a Member — now Fellow of the Royal New Zealand College of General Practitioners since 1980. Prior to working in New Zealand I worked in an isolated area of Fiji for three years. For the past 30 years I have worked as a rural general practitioner in Rawene, Hokianga. This practice involves on call work and the care of patients in a small rural hospital.

I have read the extensive **supporting information** supplied by the Commissioner, viz:

- Letter to the Commissioner from [Mrs A], dated 6 January 2004, and enclosures marked 'A' (numbered 1–100).
- Action note of telephone conversation with [Mrs A] on 22 March 2004, marked 'B' (numbered 101).
- Action note of telephone conversation with [Master A] on 31 March 2004, marked 'C' (numbered 102–103).
- Notification letter sent to [the District Health Board] dated 15 April 2004, marked 'D' (numbered 104–106).
- Notification letter sent to [Ms C] dated 15 April 2004, marked 'E' (numbered 107–109).
- Notification letter sent to [Dr B] dated 15 April 2004, marked 'F' (numbered 110–112).
- Letter from [the District Health Board] dated 3 May 2004, with enclosures, marked 'G' (numbered 113–200).
- Letter dated 11 May 2004 from [Dr B], marked 'H' (numbered 201–206).
- Information from [the ambulance service] received on 24 May 2004, marked 'I' (numbered 207–209).
- Action note of telephone conversation with [Master A] on 21 June 2004, marked 'J' (numbered 210).
- Letter dated 22 June 2004 from [Ms G], marked 'K' (numbered 211).
- Letter dated 25 June 2004 from [Dr B], marked 'L' (numbered 212).
- Transcript of interview with [Master A] on 6 September 2004, marked 'M' (numbered 213–222) including letter from [Mrs A] dated 9 November.
- Transcript of interview with [Mrs A] on 6 September 2004, marked 'N' (numbered 223–234).
- Transcript of interview with [Mr A] on 6 September 2004, marked 'O' (numbered 235–249).
- Transcript of interview with [Mr H] on 7 September 2004, marked 'P' (numbered 249–258).
- Transcript of interview with [Ms G] on 7 September 2004, marked 'Q' (numbered 259–269).
- Transcript of interview with [Ms E] on 7 September 2004, marked 'R' (numbered

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270–278).

- Transcript of interview with [Ms C] on 7 September 2004, marked 'S' (numbered 279–300), including letter dated 6 October 2004 from [Ms C] with enclosures.
- Transcript of interview with [Ms F] on 8 September 2004, marked 'T' (numbered 301–311).
- Letter from [Mrs D], Hospital Manager, dated 21 September 2004, marked 'U' (numbered 312–321).

Brief Factual Summary

At midnight on 5 May 2003, 15 year old [Master A] began experiencing chronic pain down his right side, extending into his right testicle. He described the pain 'like being kicked in the balls'. His mother gave him a voltaren tablet and stayed up with him.

At 12.30pm his symptoms worsened to the extent that his mother called [the local medical centre] and spoke to a staff member called […]. She suggested [Mrs A] call [the public hospital]. [Mrs A] only got the Hospital's answering service when she called.

Mrs A called 111 and spoke to the operator from the Ambulance Service who advised her to take [Master A] to a doctor immediately as she thought his condition sounded like testicular torsion.

The ambulance arrived at approximately 1am. *The ambulance officer ([Mr H]) examined [Master A] — including his testes — in the ambulance. He did not note any swelling of the right testis. He noted a differential diagnosis between acute appendicitis and torsion of the testis. The provisional diagnosis he put on the top of the form was 'Acute Appendicitis'. (This may have been because of a mistaken belief that there should have been changes in the testis.)* He advised that [Master A] may need to be taken to [the city hospital].

On arrival at [the rural hospital] [Mr H] handed over to [Ms C]. When [Ms C] asked [Master A] about his level of pain, he reported 6 out of 10. [Ms C] did not examine [Master A]. *This is a disputed statement. The only thing that is certain from all the statements is that [Ms C] did not examine [Master A's] scrotum and testes.*

[Ms C] called [Dr B] who was sleeping on site. It should be added that there is a difference of opinion about what information was relayed over the telephone. [Dr B] has no recollection of the possibility of torsion being mentioned. He gave a verbal telephone order for IV analgesia, and advised that he would examine [Master A] in the morning. If there was any change overnight, the nurses were to call [Dr B].

Nursing staff gave [Master A] IV morphine and settled him in the treatment room for the night. His mother remained with him in the room.

At 7am [Dr B] saw [Master A] and asked him some questions. He said some blood samples would be taken for testing. [Dr B] did not physically examine [Master A] at

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this time. (This again is a statement which may be disputed. [Dr B's] 'notes' show a physical examination report under a time of '0700'. The only agreed fact is that [Dr B] did not examine [Master A's] testes.) [Master A] was still experiencing the symptoms despite the morphine.

At approximately 8.20am the blood samples were taken. [Master A] was in too much pain to walk to the laboratory so the technician came to him. Some time later [Master A] also had X-rays.

At 10.15am [Dr B] returned with the results of the blood tests, which were normal. [Master A's] pain had receded, and he said that if he tolerated food, he could be discharged in the afternoon. [Dr B] examined [Master A's] right side, but not his groin area. Although much of the evidence points to this being the time that [Master A] was examined, see above.

Early in the afternoon, [Master A] had something to eat and [Dr B] said he could go home. [Master A] told his mother that he still felt pain in his right testicle. [Mrs A] expressed her concern to the nurse, [Ms G], who relayed this information to [Dr B].

At 2.15pm (the time on the note is '1330H') [Dr B] examined [Master A] and noticed the right testicle was swollen. [Dr B] called the urologist at [the city hospital]. [Dr B] told [Mrs A] that [Master A] needed to go to [the city hospital] and asked if she could drive him there as it would be quicker than the ambulance.

At 3pm [the family] left for [a city] and arrived at [the city hospital] at 5pm. A triage nurse examined Master A after 20 minutes. After another short wait, he was examined by the urologist, [Dr I]. He said that [Master A's] testicle was swollen and possibly twisted. He said it could now be dead as a result of lack of circulation for more than six hours since the onset of symptoms.

At 6.45pm [Master A] underwent surgery for testicular torsion. The right testicle was removed because it had died.

Report

1. *Should [Dr B] have examined [Master A] when he first arrived at [the rural hospital?*

   This question is difficult to answer because of conflicting reports. On the face of it, a young patient arriving in the early hours by ambulance with a history of feeling like he had been 'kicked in the balls' has a diagnosis of torsion of the testis until proved otherwise. Unfortunately the report given by [Ms C] and the recollection of [Dr B] are at total variance. She says she gave 'torsion' as a possibility and he says that 'abdominal pain' was all that was reported to him.

   In retrospect, it is obvious that, if [Dr B] had examined [Mr A's] scrotum when he first arrived at the hospital, he would have found the testis to be in an abnormal

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position, made the proper diagnosis and referred him on to [the city hospital] immediately. The testis would then have been saved.

The diagnosis of torsion is not an easy one. The history is really important and the examination can be difficult. It requires a recognition that the testis is not in the right alignment in the scrotum. This is not a finding that a nurse — even an experienced one — could be expected to be certain about.

2. *Was it appropriate for [Dr B] to give [Ms C] a verbal telephone order to give [Master A] intravenous morphine without examining [Master A]?*
   I have been in the same situation as [Dr B] on many occasions: having worked all day and expecting to work the next and wondering whether the problem would wait until morning without any deterioration. Abdominal pain is always one of the most difficult problems to know what the right thing to do is. If all the vital signs are normal, this can be even more difficult. I know that I have ordered pain relief for the patient and then seen them first thing the next morning. I would never, however, order intra-venous morphine.

3. *Were [Dr B's] actions the next morning when he did examine [Master A] appropriate?*
   This, it seems to me, is the next in a line of missed opportunities. I can find no evidence in the whole sheaf of notes supplied that proves that [Dr B] actually examined [Master A] at around 7:00AM when he saw him. The verbal evidence is that [Dr B] took a cursory history and ordered some tests. It is unclear, but seems unlikely that [Dr B] put a hand on [Master A's] abdomen, and he certainly did not examine his genitals. Had he done so, he almost certainly would have found swelling and tenderness and made the correct diagnosis.

   Whilst I can understand, if not agree with, [Dr B's] failure to see and examine Master A in the early hours, his failure to adequately examine [Master A] when he saw him around 7 o'clock is conduct that I view with moderate to severe disapproval. In situations of uncertainty, when I have made a decision NOT to go in to see a patient, I have always felt uncomfortable until I have actually seen and thoroughly examined him or her.

   As an aside, the failure of [Dr B] to see [Master A] urgently seems, from all the accounts, to be totally out of character for him and remains unexplained in all the documents supplied.

4. *Were the tests [Dr B] ordered appropriate?*
   I have no dispute over the nature and appropriateness of the tests ordered by [Dr B]. If a diagnosis of acute appendicitis is held, they were reasonable. But even here the most important factors are the history and the examination.

5. *Was [Dr B's] assessment and diagnosis of [Master A's] condition appropriate?*
   [Master A's] story gives an absolutely typical history and natural progression of torsion of the testis. It is notably difficult to get a good history out of a boy of 15,

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but his mother seems to have been quite forthcoming. Even the enrolled nurse on duty was told that his symptoms had started by [Master A] feeling like he had been 'kicked in the balls'. She, however, cannot be expected to have been aware of the importance of this.

It seems that the ambulance officer made the correct diagnosis but again was unaware of the true clinical picture; there is usually no swelling or signs of inflammation of the testis until hours have passed with no blood supply to it.

6. *Was [Dr B's] record taking appropriate?*
   This is hard to answer because it appears that the originals of the records have still never been found. From the copies I have seen, it appears that [Dr B] took a full history and performed a physical examination on [Master A] at 7:00AM on 5th May 2003. These notes, however, are on a form which, for the most part, simply require ticks or abbreviations; there is no narrative. Although the time at the top of the form is written as '0700', there is a note about the testes at '1330H'. The nature of the form and the fact that it is only a copy leaves questions unanswered. On the basis of the information I have, I cannot comment on [Dr B's] note taking.

7. *Please indicate severity of departure from standard.*
   As I have indicated earlier, it would seem that this incident was an aberration in the context of generally exemplary conduct in an intolerable situation. It seems that [Dr B], by not attending at the time of [Master A's] arrival, fell short of reasonable standards of care. Unfortunately he did not take steps when he saw [Master A] in the morning to rectify the situation. The outcome for [Master A] has been severe and permanent, and I believe that [Dr B] is aware of this and is genuinely sorry. Whilst his actions fall short of reasonable standards, I do not believe that his behaviour was reprehensible. I also believe that he understands his errors and has learned from his mistake. I do not believe that disciplinary action would serve any purpose.

   In this situation it also appears that [Dr B's] desire to serve his community has been part of his undoing. It appears that he had been on duty for the previous three nights in the context of a general shortage of medical staff and unreasonable commitments of his own time and efforts. Though it might be said that he should just have refused, in a rural area one is part of the community as well as being the doctor. In my opinion, the administrators of the health system in the area must accept a good deal of the blame for the outcome in this case.

8. *Are there any aspects of the care provided by [Dr B] that you consider warrant additional comment?*
   When [Dr B] finally made the diagnosis of torsion of the testis, I wonder why he did not get him to surgery immediately. There was a gap of 5 hours between the diagnosis and the surgery. This probably would have made no difference to the outcome for the testis, but it may have; sometimes there is some blood supply which allows the testis to survive for longer than would seem possible in theory.

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This delay, while [Master A's] mother was ignorant of the importance of the time factor, had left her feeling like she contributed to the final outcome. On top of the loss itself, she has the guilt that, by her inaction – not being assertive enough about getting the testes examined; not rushing off immediately to [the city hospital] – she partly was to blame for the outcome.

I do not understand [Dr B's] actions here. If he thought there was a chance of saving the testis, he should have packed the boy off right away. If not, he should have explained fully to [Master A's] mother that the testis would be lost anyway and been honest about his part in that outcome. I believe that, had this latter been done, the matter would have been dealt with there and then without recourse to the Commissioner and without all the heart searching and the mountains of paper. In my experience, people — particularly your neighbours in a rural community — accept that you are human and make mistakes now and then. I know this from experience and know that it is always best to be honest and authentic. Maybe this was an area of knowledge that [Dr B] was weak in.

In the light of day and with the benefit of hindsight, this would appear to be a simple case of missing what should be a straightforward diagnosis. There are, however, many unanswered questions: When it was [Dr B's] usual practice to get up to assess patients in the middle of the night, why did he not come to see this teenager when the question of torsion of the testis had been mentioned? If 'torsion of the testis' had been mentioned and was in the notes, why did this normally thorough doctor not examine the testes at 7:00AM when he first met him? Where are the original notes and why have they remained 'missing' in this case?

I trust that this report is of assistance to the Commissioner in reaching his judgment. Please do not hesitate to contact me if any further clarification is required."

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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.

…

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

Relevant standards

District Health Board Admissions Policy (January 1998)

"**Ambulance cases**

All patients brought to hospital by ambulance will be assessed by the Duty Hospital Doctor [MOSS] as to the patient's need for admission."

District Health Board Medicines Management Policy (January 2001)

"**9.4.1 Verbal orders procedure**

A verbal order must:

- where the verbal order is given over the phone, be **accepted** by two persons legally able to administer, or one person legally able to prescribe;
- where the verbal order involves IV or Epidural therapy, be **accepted** by a registered nurse, registered midwife or enrolled nurse with a basic IV certificate;
- be **read back** to the authorised prescriber for confirmation;
- be **recorded and identified** as a verbal order by the acceptor on the prescription sheet (the name of the prescriber must be recorded);

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- be **dated, timed and signed** on the prescription sheet by the acceptor and, for a phone order, by the second person; and

- be **countersigned by the authorised prescriber within 12 hours** of giving the verbal order.

A verbal order becomes invalid after 12 hours if it has not been countersigned by the authorised prescriber. Do not administer from a verbal order after 12 hours has elapsed, if the order remains uncountersigned."

National Triage Scale

"CODE 4

BLUE DOTS
SEMI-URGENT

Definitive Medical Care initiated within 60 minutes
Action: Patient is sent to waiting room via reception
Reassessed every 30 minutes for safety and comfort
Examples may include:

- Localised Cellulitis with systemic signs
- Controlled epistaxis
- Head injuries with LOC < 5 minutes
- CVA's
- Abdominal pain with no systemic signs
- Stable fracture"

Opinion: Breach — Ms C

Follow-up
Under Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code), patients are entitled to have services provided with reasonable care and skill. Under Right 4(2) of the Code consumers have the right to services that comply with legal, professional, ethical and other relevant standards.

The rural hospital Admissions Policy (2002) states that all acute ambulance cases are to be assessed by the duty hospital doctor (Medical Officer Special Scale (MOSS)) as to the patient's need for admission.

Ms C was told by the ambulance officer that Master A had pain radiating to his right testicle, and that his diagnosis was possible appendicitis/testicular torsion. Ms C examined

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Master A's lower abdomen but not his testes or groin area. She and the other nurses present recall that Master A was reluctant to be examined (although this is denied by Master A and his mother). Ms C triaged Master A as triage code 4. According to the Triage Guidelines this meant that Master A should wait for no longer than one hour for medical assessment and treatment. Ms C contacted Dr B within half an hour of Master A's presentation, but Dr B did not come to examine Master A. Ms MacGeorge advised me that when Dr B did not come to examine Master A within the one-hour triage time, Ms C should have called Dr B again. Ms MacGeorge commented: "It is not unusual in any practice setting for nurses to have to persuade doctors to come and see patients."

When Dr B did not examine Master A within the hour, Ms C should have telephoned him again and strongly advised him that Master A needed an examination by a doctor.

Ms MacGeorge advised:

> "[Master A's] haemodynamic stability and response to pain relief reassured the nurses that his condition was not worsening. It is not acceptable in any emergency department setting for a patient presenting with an acute abdomen to wait 5 hours for a medical assessment."
>
> …
>
> "The fact that [Master A] settled and slept after pain relief probably clouded nursing judgement to persist in ensuring such an assessment occurred."

Ms MacGeorge also commented:

> "There appears to be a culture of letting patients wait until morning to be assessed and treated, if they are stable, which needs to be reviewed as it clouds judgement when trying to make timely clinical decisions."

Ms C had a professional responsibility to ensure that Master A was examined by a doctor within the triage time. Ms C should also have been alert to the possibility of the analgesia masking Master A's symptoms, so the fact that he had settled with analgesia did not mean he did not need to be assessed. In my view, Ms C's failure to call Dr B again to request assessment of Master A within the triage time is a breach of Right 4(1) of the Code.

Analgesia

Dr B gave verbal instructions to Ms C to give Master A analgesia, take bloods and monitor him overnight. Dr B also said to keep Master A nil by mouth and asked to be notified of any adverse change. At 1.40am Ms C gave Master A IV morphine 3mg and at 1.48am gave a further mg of morphine. Master A slept through the night.

Ms MacGeorge advised me that she did not have any concerns about the intravenous morphine that was administered, and commented:

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"In recent years there has been considerable improvement in pain management prior to patients being seen by medical staff. Previously patients had to wait in pain, sometimes for hours, until they had a medical assessment, as it was feared that the pain relief would mask their symptoms."

She noted that Ms C was certified to provide a range of advanced treatment, including IV narcotics administration. Ms MacGeorge also commented on the quick time in which the nurses administered analgesia as per Dr B's instructions.

The hospital policy for verbal telephone orders that was relevant in May 2003 states:

"A verbal order must:

- where the verbal order is given over the phone, be **accepted** by two persons legally able to administer, or one person legally able to prescribe;
- where the verbal order involves IV or Epidural therapy, be **accepted** by a registered nurse, registered midwife or enrolled nurse with a basic IV certificate;
- be **read back** to the authorised prescriber for confirmation;
- be **recorded and identified** as a verbal order by the acceptor on the prescription sheet (the name of the prescriber must be recorded);
- be **dated, timed and signed** on the prescription sheet by the acceptor and, for a phone order, by the second person; and
- be **countersigned by the authorised prescriber within 12 hours** of giving the verbal order."

There were specific hospital policies for the acceptance of verbal orders and the administration of medication. In this case, the order was accepted by Ms C, who had a current IV certificate, but there is no evidence that the order was accepted by a second appropriate person. The records do not state that the order was a verbal telephone order, when the order was given, who gave the order, or whether it was witnessed. In failing to follow the hospital policies, Ms C breached Right 4(2) of the Code.

Record-keeping
Ms MacGeorge commented that Ms C's record-keeping in relation to presenting history, assessment findings and vital signs was appropriate. However, Ms C did not note testicular pain in the records. In fact the triage notes record "testes ok". This is despite the ambulance officer's record that Master A's pain was radiating through to the right testicle, and he had pain in that area. Ms C said that when she assessed Master A, she asked him whether he had any pain radiating to the groin and loin, and Master A appeared reluctant for her to examine the area. However, Ms C did not record Master A's reluctance in the notes, or that she did not examine the area.

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Given that Ms C did not examine Master A's groin, and that a possible diagnosis of testicular torsion had been raised, it was important for the notes to accurately record this. This takes on particular importance as Dr B stated that he does not recall Ms C informing him of possible testicular pain during the telephone conversation in the early hours of the morning, when relating Master A's condition. A detailed record of this conversation would have assisted in accurately assessing what information was given to Dr B.

I also note the lack of information recorded in relation to the verbal order for analgesia, as discussed above.

In my opinion, Ms C's record-keeping was inadequate and did not record important information, amounting to a breach of Right 4(2) of the Code.

Opinion: Ms C — No Breach

Examination

My independent nurse advisor, Ms MacGeorge, commented that Ms C performed an appropriate assessment of Master A when he arrived at the hospital. She noted that a full set of vital signs had been documented, and that a handover from the ambulance officer had taken place.

Ms MacGeorge stated that it was appropriate for Ms C not to examine Master A's testicles on his arrival at the rural hospital. Even if Ms C had examined his testicles at that point, she may not have noticed anything out of the ordinary. It is not usual for nurses to examine the scrotal area.

My medical advisor, Dr Birch, commented:

> "The diagnosis of torsion is not an easy one. The history is really important and the examination can be difficult. It requires a recognition that the testis is not in the right alignment in the scrotum. This is not a finding that a nurse — even an experienced one — could be expected to be certain about."

Given the triage code of 4, which meant that a doctor is to see the patient within one hour of arrival, and taking into account Master A's sensitivity, Ms C's actions in not examining him were reasonable. It was not unreasonable for Ms C to think that the doctor would examine him within an hour.

I note that there is a discrepancy between the information provided to me by the family, and by Ms C and the other nurses present, about what questions were asked and what was said during the assessment, particularly in relation to whether Master A had pain in his groin area. I have been unable to resolve this discrepancy and, as noted above, the medical records do not assist in clarifying this issue.

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Consequently, while I am concerned about the discrepancy in the information provided, I accept my experts' advice, and am satisfied that Ms C's initial assessment of Master A was appropriate in the circumstances. In my view, it was reasonable for Ms C not to persist in investigating Master A's condition and examining him, and therefore she did not breach the Code in this regard.

Telephone call to Dr B

There is a discrepancy in the information provided to me by Ms C and Dr B about what was said about Master A's condition and history, during their telephone call at approximately 1.40am. In particular, it is unclear whether Ms C informed Dr B that Master A had arrived at the Emergency Department by ambulance, or that the ambulance officer had noted pain radiating to the right testicle, and recorded his impression of possible testicular torsion. The medical records do not assist in clarifying this. I am unable to reconcile this point and do not consider that continued investigation would elicit any further information. It remains an unanswered question whether Dr B would have acted differently had he been informed about possible testicular torsion.

Opinion: Breach — Dr B

Examinations

Ms C informed me that she advised Dr B by telephone that Master A had arrived by ambulance, but Dr B does not recall being given this information. It was Dr B's responsibility to check what the triage code was and whether Master A had arrived by ambulance. Dr B also stated that the ambulance report was not on the file when he reviewed it at 7.00am, later that morning. However, the triage documentation recorded that Master A had arrived by ambulance. In my view, if Dr B could not find the ambulance record on the file, he should have searched for it to check what Master A's symptoms were when the ambulance arrived at his home. I also note that it is usual practice for the ambulance report to form part of the Emergency Department file.

Dr B recalls asking Ms C if there was any testicular pain or vomiting, and was told there was none. In contrast, Ms C stated that she informed Dr B that Master A might have testicular torsion or appendicitis, and that he had yet to be examined. Dr B told her that it sounded more like appendicitis and that she should give analgesia and monitor him overnight.

It is unclear exactly what the nature of Dr B's examination of Master A was on the morning of 5 May 2003. Mrs A stated that Dr B did not examine Master A at all at the 7.00am attendance, although he did ask lots of questions and ordered tests. Mrs A said that Dr B examined Master A's abdomen on the right side at approximately 10.15am when he returned with the results of the blood tests. Dr B stated that he examined the abdomen as well as the chest, heart and lungs at some stage during the morning. It is clear from Dr B's

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comments that he did not perform an examination of the groin area until the early afternoon, after Master A had told his mother he was still experiencing pain in his testes.

Dr Birch commented that Dr B's failure to examine Master A on his admission to hospital in the early hours of the morning could be understood in light of his excessive workload but that by not attending Master A at the time of his arrival, Dr B's care fell short of reasonable standards. Dr Birch also stated: "Abdominal pain is always one of the most difficult problems to know what the right thing to do is. If all the vital signs are normal, this can be even more difficult. I know that I have ordered pain relief for the patient and then seen them first thing the next morning. I would never, however, order [by telephone] intra-venous morphine."

Regardless of whether Dr B should have given a verbal telephone order for intravenous morphine, if he considered Master A's reported abdominal pain sufficiently serious to make such an order, it raises the question why he did not examine Master A.

I note that ACC's medical advisor stated that the failure to examine Master A on his admission to the rural hospital was below the standard of care to be expected, as was the failure to fully examine him the following morning at 7am. Dr Birch stated: "[Dr B's] failure … to adequately examine [Master A] when he saw him around 7 o'clock is conduct that I view with moderate to severe disapproval."

Dr B should have examined Master A on his arrival at the hospital, particularly if he considered his pain severe enough to justify intravenous morphine. Certainly Dr B should have undertaken a thorough examination (including Master A's genitals and groin area) when he attended at 7am. In my opinion, Dr B did not provide services to Master A with appropriate care and skill, and breached Right 4(1) of the Code.

Opinion: Breach — The District Health Board

Employers are responsible under section 72(2) of the Health and Disability Commissioner Act 1994 for ensuring that employees comply with the Code. 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 breaching the Code.

As discussed earlier, my nurse advisor Ms MacGeorge noted that there seemed to be a culture at the rural hospital of patients waiting until morning before being assessed and treated. The nurses who were interviewed during the investigation indicated that some doctors were reluctant to come and see patients when requested by nursing staff. However, Dr B does not appear to have been one of these doctors. In fact, the nurses said how conscientious Dr B was, and that on the evening in question they expected him to show up to check on the patients as he usually did.

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Dr B raised the issue of three nights on call and working 60 hours consecutively as a factor in not coming to see Master A in the early hours of 5 May. My medical advisor, Dr Birch, stated that under these circumstances "the administrators of the health system in the area must accept a good deal of the blame for the outcome in this case".

The DHB provided further information to show that steps had been put in place at the time to ensure that doctors were not overworked; MOSSs were responsible for developing their own roster, and Dr B had chosen to work elsewhere in his time off from the rural hospital.

Notwithstanding the corporate responses, it appears that the rural hospital allowed the culture of patients waiting to be assessed by a doctor to develop and continue. While assessment and triage policies were in place, they do not appear to have been enforced by hospital management. I note that improvements have been instituted by the hospital to prevent similar occurrences in the future.

On balance, I consider that the District Health Board is vicariously liable for the actions of Dr B and Ms C in failing to comply with hospital assessment and triage policies.

Other comment

Referral to the city hospital

Dr Birch commented, in relation to Dr B referring Master A to the city hospital, that the delay between diagnosis and the surgery at the city hospital is concerning, as there may have been a chance of saving the testicle. Dr B has indicated that his preference, for speed and efficiency, was for Master A to be taken to the city hospital by car by his mother rather than in an ambulance. In these circumstances, it was important for Dr B to make Master A and his family aware that time was of the essence if there was to be any chance of saving the testis. Mrs A and Master A should have been told that they needed to go directly to the city hospital, and request urgent triage and admission. In addition, Dr B should have told the city hospital that when Master A arrived, he needed to be seen immediately. The delay in Master A being triaged and admitted to theatre at the city hospital indicate that this did not occur. I draw these matters to Dr B's attention.

Communication

Dr Birch also informed me that Dr B should have explained to Mrs A and Master A, at the time when he made the referral, that the delay in examining the testicle may have affected its survival. The failure to provide this information has meant that Master A's mother, who was unaware of the time factor for treating testicular torsion, feels partly to blame for the outcome. This has caused the family additional stress.

Record-keeping

While I note that Dr Birch said he could not make an assessment of Dr B's record-keeping, I am concerned that the records were inadequate. It is not clear exactly when Dr B

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examined Master A on 5 May or what examinations took place. In this case there is significant discrepancy between the recollections of Master A and his mother, and those of hospital staff, and even between Dr B's recollections and Ms C's. Accurate record-keeping would probably have resolved these discrepancies. I draw this issue to Dr B's attention.

Action taken

Ms C
Ms C provided a written apology to Master A and his family, in which she stated:

> "I unreservedly accept the findings in the Commissioner's provisional report of 19 April 2005.
>
> Accordingly, I sincerely apologise for breaching Rights 4(1) and 4(2) of the Code of Health and Disability Services Consumers' Rights.
>
> I sincerely apologise for any distress that you and your family experienced as a result of my omission to ask a second time for the doctor to come and assess you on 5 May 2003.
>
> I confirm that I have reviewed my practice in light of the Commissioner's report.
>
> In April 2004 I resigned from the acute practice setting and now work in the community as a public health nurse."

The rural hospital
Mrs D confirmed in a letter dated 28 April 2005, that the rural hospital's systems have been reviewed in light of my report.

Dr B
Dr B has confirmed that as a result of this case he has changed his practice by:

- attending promptly after all calls, irrespective of the information conveyed or extracted;
- refusing to work during the day before or after a night on duty;
- being more assertive in resisting requests to provide cover at the hospital and other practices;
- utilising sick leave when ill; and
- reducing the hours he works.

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Dr B also provided a written apology to Master A and his family, stating:

> "As you know, I apologised to you by letter after your treatment at [the rural hospital]. I wish to apologise again to you.
>
> Since the day I learned of the outcome from your mother, I have had a deep sense of remorse and regret about what happened. A day has not passed without several thoughts about that day, dwelling on those events and wishing I had done things differently.
>
> Despite remaining remorseful and distraught, I have learned a lot from the event and I hope others will also learn from it as well.
>
> Again, I am sorry for not coming to the emergency department to examine you when you arrived.
>
> Now I attend all patients immediately when called, and treat with more caution information provided by nursing staff.
>
> I acknowledge the comment made by the Commissioner that I should have advised you and your mother that the delay in examining the testicle could have affected its survival."

Follow-up actions

- A copy of this report will be sent to ACC, the Medical Council of New Zealand, and the Nursing Council of New Zealand.
- A copy of this report, with details identifying the parties removed, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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