Dr B

A Report by the

Health and Disability Commissioner

(Case 01HDC01802)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Dr A	Complainant / Consultant paediatrician
Dr B	Provider / General practitioner
Miss C	Consumer
Mrs D	Consumer's mother
Miss E	Consumer's sister
Dr F	Specialist clinical microbiologist
Dr G	Clinical microbiologist at a medical laboratory
Dr H	Consultant paediatrician at a children's public hospital
Dr I	Infectious disease specialist at a sexual health service
Dr J	Clinical Director of a sexual health service
Mr K	Consumer's father
Dr L	Paediatric sexual abuse specialist

Miss C and her family have left New Zealand, and could not be contacted during the investigation.

Independent expert advice was obtained from Dr Tessa Turnbull, general practitioner.

Complaint

On 5 February 2001 the Commissioner received a complaint from Dr A, paediatrician, about Dr B, general practitioner. The complaint is that:

- *When seven-year-old Miss C presented to Dr B in May 2000 with vaginal gonorrhoea, Dr B did not take appropriate action. Dr B treated Miss C with intramuscular ceftriaxone, but did not consult with a paediatrician and made no referral to child protection agencies.*
- *On 10 August 2000 Dr B did not respond appropriately when he again diagnosed Miss C with vaginal gonorrhoea. Dr B compromised Miss C's diagnosis and management by treating her with intramuscular ceftriaxone before he referred her to the Child Protection Team at a children's public hospital.*

An investigation was commenced on 22 March 2001.

Information reviewed

- Relevant general practitioner records
- Relevant records from a children's public hospital and a public hospital

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

- Relevant laboratory results from a medical laboratory
- Relevant Police and Department of Child Youth and Family Services records

Information gathered during investigation

Mrs D and her daughters, seven-year-old Miss C and five-year-old Miss E, moved from Taiwan in New Zealand in September 1999. On 28 March 2000 Mrs D and her daughters enrolled with general practitioner Dr B. On this date Dr B examined Miss C as she had gastric problems.

On 17 April 2000 Mrs D took Miss C back to see Dr B. Dr B explained that Miss C had a rash on her body, which followed the outline of her togs, as well as a slight vaginal discharge. Dr B thought these symptoms were part of the same disease process, and from his history and examination concluded it was a sea lice reaction. Dr B treated Miss C with an antihistamine and also took a vaginal swab. Dr B's records of this consultation read:

> "rash is problem very inflamed skin area of swimming trunks, plaques, erythema, also labia discharge swab to lab plan antihistamines review mane".

Miss C returned to see Dr B on Tuesday, 18 April 2000 and he recorded the consultation as follows:

> "returns follow-up re skin rash oe dramatically better lesions no longer inflamed drying skin swab from lab nad".

Microbiologist Dr F advised me that he recalled Dr B contacting him to discuss this case on or around 17 or 18 April 2000. Dr F wrote:

> "My records indicate that I spoke to [Dr B] on either the 17 or 18th April 2000 regarding a seven year old girl who had N. gonorrhoea cultured from swabs that he had taken.
>
> [Dr B] told me that the patient had presented with a rash on her thighs.
>
> I asked him if he would take a second specimen so as to confirm our findings. We discussed the obvious legal implications and the importance of identifying and treating the source. I think that Dr B told me that the most likely source had come from, and had returned to, Asia.
>
> I do not believe that we discussed specific treatment because at the time I spoke to [Dr B] the antibiotic susceptibility tests had not been completed. I would have suggested that a swab be taken after treatment to ensure that the treatment had been effective. Laboratory records show that a further swab, presumably post treatment, was taken on 27th April. The result was negative, which indicated that the treatment had most likely been successful."

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

Dr F clarified the following:

> "'We discussed the obvious legal implications' relates to the significance of finding Gonococci in a child. A sexually transmitted infection in a child may result in the parents making an official complaint and I would have suggested to the Doctor that he should anticipate legal proceedings.
>
> I would have alerted him to ensure that the chain of evidence was secure: that the swab did indeed come from the child named on the request form, that there was no possibility of the specimen having the wrong name on the label, or having been contaminated with un-sterile instruments, and so on. That is why I would have suggested that the result should be confirmed by taking a second swab.
>
> 'The importance of identifying and treating the source' relates to the public health aspects of limiting the spread of sexually transmitted infections. The Health Department strongly recommends that not only should people infected with such organisms be treated, but also that their sexual contacts should be traced, tested and treated if found to be infected. I believe that the law allows for the public health authorities to force infected people to receive treatment. …"

Another vaginal swab was taken from Miss C on 19 April 2000. Dr B's records state:

> "problem is swab from lab grows gonorrhoea discussed with mother std screen amoxil 125/5 100mls".

On 20 April 2000 Dr B's records read:

> "22kg d/w [Dr G] test shows gonorrhoea sensitive to ceftriaxone 125mg I/m no family contact re std long discussion mother declines referral to spec".

Dr B advised me that when the vaginal swab returned it had grown gonorrhoea. He discussed this result with Dr G, clinical microbiologist at a medical laboratory. Dr B said Dr G advised him that the bacteria in question was sensitive to the antibiotic ceftriaxone. Dr G advised Dr B of the correct treatment for Miss C's gonorrhoea, and said that the resistance pattern of the bacteria showed it to be probably a South East Asian variant. Dr B explained that this implied that Miss C was infected either in Taiwan or by someone who had come to New Zealand from South East Asia.

Dr G advised that he was on leave from 17-19 April inclusive, and that Dr F covered for him during this time.

Dr G confirmed that he spoke with Dr B on 20 April 2000. Dr G recalled contacting Dr B on this day, although it was possible that Dr B telephoned him and he had to obtain laboratory information before returning Dr B's call. Dr G recalls Dr B telling him that a young patient had presented with a rash on her thighs, that he was concerned about the patient, and that comment was made about the home environment and people travelling between [New Zealand] and overseas. Dr G stated that he and Dr B then discussed

treatment. The usual recommended treatment for adults is a single dose of ciprofloxacin. However, this drug is relatively contraindicated in children and by 20 April the particular isolate from Miss C was known to be resistant to ciprofloxacin. Dr G recommended Dr B treat Miss C with ceftriaxone. Dr G' notes indicate that he recommended the paediatric dose as 25-50mg/kg, intravenous or intramuscular, up to a maximum of 125mg. Dr G explained that prescribing ceftriaxone usually requires a specialist endorsement, which is not usually carried by GPs. Dr G also discussed with Dr B the need to treat any concomitant chlamydia infection with 0.5-1gm of the drug azithromycin.

Dr G cannot explicitly recall discussing with Dr B the need to refer Miss C for further assessment, or that a follow-up culture be performed to check for cure following treatment, but this is what he would usually say when consulted about gonorrhoea. Dr G noted that a subsequent swab obtained from Miss C on 27 April did not recover *Neisseria gonorrhoeae*. He also confirmed that the gonorrhoea isolated in Miss C's case was resistant to ciprofloxacin, and that at that time most ciprofloxacin resistant strains being isolated were from people who had acquired their infection in South East Asia. Dr G recalls discussing this point with Dr B but does not know whether this was before or after Dr B's statement that there were people in the home who travelled between South East Asia and [New Zealand].

Dr B advised me that on 20 April at 2.45pm he telephoned the consultant paediatric advice line at a children's public hospital. He discussed Miss C's case with a paediatrician, whose name he could not recall. The call lasted two minutes and 21 seconds. Dr B supplied the number of the cellphone he called. He stated that he advised the children's public hospital paediatrician that Miss C had a gonorrhoea infection of the vagina, and that "at no stage was it suggested that I refer Miss C to any child protection agency".

In response to my provisional opinion Dr B advised that the reception during this conversation was "notoriously poor", that the paediatrician had a strong accent, and that misunderstanding was likely. A paediatric sexual abuse service was not discussed.

My staff spoke to Dr H during the investigation and noted that her accent is that of an average New Zealander. Dr H did not recall poor reception during her discussion with Dr B.

Paediatrician Dr H was on call at the hospital on 20 April 2000 and in that capacity held the cellphone number provided by Dr B. Dr H recalled that Dr B introduced himself and asked whether she could supply some intravenous ceftriaxone for one of his patients. He wanted the patient to come to the hospital to have the medication administered.

Dr H explained to Dr B that she could not give out medication without seeing and assessing the patient herself. She then asked Dr B what the antibiotic was for. Dr H recalled that Dr B was very reluctant to have his patient assessed at the hospital and he told Dr H that the patient had Neisseria.

Dr H explained to my staff that there are two sorts of Neisseria: *Neisseria meningitidis* and *Neisseria gonorrhoeae*. Dr H assumed that Dr B meant that the child had *Neisseria meningitidis* and started to tell Dr B that the patient needed to come into hospital for other tests such as a lumbar puncture. Dr B then told Dr H that the patient actually had gonorrhoea, not meningitis.

Dr H stated that she then began advising Dr B that in this case the patient needed to be assessed by a paediatric sexual abuse specialist at the hospital. Dr H said that Dr B did not listen to her advice to refer the patient to a paediatric sexual abuse service, and that he got "a bit cross" at this point, although he did not actually shout at her. Dr B said something along the lines of "I can see that you're not going to help me", and ended the phone call.

Dr H said that this was the most unusual phone call she had ever received on the advice line cellphone. In August or September 2000, after having seen Miss C in August, Dr A, Clinical Director of a paediatric sexual abuse service, mentioned to Dr H that he had seen a child with gonorrhoea who had been treated with ceftriaxone by a general practitioner. Dr H recalled her conversation with Dr B and recounted it to Dr A, as she had found the call to be so unusual.

A private hospital pharmacy confirmed that it filled a prescription for ceftriaxone from Dr B for Miss C on 20 April 2000. The prescription was for a 500mg injection of ceftriaxone and the instructions were for half the ampoule to be administered. It cost approximately $31.20. It was explained that ceftriaxone is generally found only in hospital pharmacies and a specialist referral is required to obtain a government subsidy for it, although any doctor can prescribe it. The pharmacy is affiliated with a private hospital and supplies ceftriaxone on prescription.

Dr B treated Miss C's gonorrhoea infection with a ceftriaxone injection on 20 April 2001. He also took vaginal swabs from Miss E and Mrs D, which returned negative results.

Dr B explained his decision to treat and not refer Miss C by saying that Miss C did not live with any men and had no contact with any males except for her classmates. He considered Mrs D, Miss C's mother, to be caring and competent and stated that she fully understood the implications of Miss C's gonorrhoea infection. Mrs D declined a paediatric referral. Dr B felt that at that point he had done all he reasonably could in the circumstances.

Dr B's records show that on Thursday, 27 April 2000 Miss C returned for a follow-up visit concerning her gonorrhoea infection. On examination nothing abnormal was detected; her hymen was intact and another swab was sent to the lab. No vaginal discharge was present. Dr B considered Miss C was cured. Although Dr B advised Mrs D that gonorrhoea is a sexually transmitted disease and she should seek paediatric advice, Mrs D declined any specialist referral. Dr B's records read:

> "returns followup re gonorrhoea oe nad [on examination no abnormality detected] hymen intact swab to lab no discharge dx [diagnosis] recovered".

On 30 May Miss C again saw Dr B for a bacterial throat infection. He recorded:

> "problem is sore throat cough fever oe [on examination] ent [ears, nose and throat] ok chest ok febrile dx bacterial throat infection rx [treatment] cotrimox [co-trimoxazole, an antibacterial] 480*10 [480mg for 10 days]".

On 7 August 2000 Mrs D took Miss C back to see Dr B as Miss C had developed another vaginal discharge. Dr B explained that as Mrs D immediately suspected another gonorrhoea infection, she brought Miss C directly to see him. His records of this visit are as follows:

> "problem is pv [per vagina] discharge see previous entries swab to lab [Mrs D's email address] ceftriaxone".

Mrs D and Miss C returned to see Dr B on the evening of Thursday, 10 August 2000. Dr B's records of the consultation read as follows:

> "problem is recurrence of gono see results d/w [discuss with] [Dr I].
>
> d/w [Dr I] has to be sexual contact plan d/w [Dr J] given I/m [intramuscular] ceftriaxone 250mg".

Dr B advised me that the swab results again showed that Miss C had gonorrhoea but with a slightly different sensitivity pattern to previous swabs. He stated that he immediately contacted Dr I, the on-call microbiologist and the clinical director of a sexual health service, who advised Dr B that ceftriaxone was the appropriate antibiotic to use, and that he should call Dr J, a sexual health specialist. Dr B advised me that Dr J suggested he contact the Child Protection Agency at the children's public hospital, to discuss Miss C's case further. Dr B stated that unfortunately the children's public hospital consultant advice line is only available during the day and it was therefore too late to discuss Miss C's case that day. As Mrs D understandably wanted her daughter treated immediately, Dr B administered intramuscular ceftriaxone that evening.

Dr A explained that the children's public hospital consultant advice line was available to general practitioners to call in for paediatric advice, and at that time was available from 8.30am to 5pm, but that after hours a GP could telephone the general public hospital number to speak to the consultant on call. A paediatric consultant and a paediatric sexual abuse consultant are on call 24 hours.

The private hospital pharmacy confirmed that on 10 August 2000 a prescription from Dr B for Miss C was presented for a 250mg ceftriaxone injection, with instructions to administer half the ampoule.

Dr F advised me that he spoke to Dr B on 9 August 2000 and faxed him a copy of a laboratory report showing that a gonococcus sample had been obtained from Miss C. Dr F and Dr B discussed the implications of this finding – that it could indicate a failure of Miss C's initial treatment in April, a new infection from another source, or a new infection from the original source. Dr F explained that this particular strain of gonococcus was resistant to

the antibiotic Ciproxin, and that at that time less than 5% of strains of gonococci were resistant to that antibiotic. Thus if this was a new infection it was likely to have come from the same or a closely related source.

Dr I also recalled Dr B telephoning him for advice on or around 7 August 2000. Dr I stated that his recollection of the call is quite poor but he does recall a "murky tale" about a child with a sexually transmitted disease, and his advice would have been for Dr B to "get out", ie to get expert advice from sexual health experts.

Dr J, Clinical Director of a sexual health service, recalled Dr B contacting him on or around 7 August 2000 to discuss a diagnosis of gonorrhoea. Dr J stated that Dr B briefly explained the details of the case of a young girl who had gonorrhoea that was apparently antibiotic resistant. Dr B also explained that he had previously treated this girl for a similar infection, and asked Dr J's advice as to what to do given that this was an unusual presentation and pattern of resistance. Dr J told Dr B that he was concerned with both the diagnosis of this infection in a young girl and that she needed treatment and appropriate follow-up from an agency such as [a paediatric sexual abuse service]. Dr J stated that he suggested Dr B telephone Dr A, Clinical Director of a paediatric sexual abuse service, and the conversation then ended.

Dr B's notes on 11 August 2000 read as follows:

> "problem is recurrence of gono see results d/w [Dr A] referred to [a children's public hospital].
>
> second cons visit to home with social welfare child to [a children's public hospital]".

Dr B advised me that on the morning of 11 August he contacted Dr A at a paediatric sexual abuse service to advise him of Miss C's disease. Dr B went to Miss C's home in the afternoon to explain the situation to Mrs D. The child protection team (from the Department of Child Youth and Family Services (CYFS)) was already present. Dr B said that Mrs D was very frightened. He explained to Mrs D and Mr K (Miss C's father) what was happening. Mr K told Dr B that he was already being treated for a long-term sexually transmitted disease. Dr B is unsure what this disease was, but said that it could not have been gonorrhoea, which is easily treated with short-term antibiotics.

Dr A recorded the time of the phone call with Dr B as midday on 11 August 2000. Dr A noted that Miss C had been diagnosed with vaginitis in May and the culture was positive for gonorrhoea; Miss C had currently had another case of vaginitis and the culture was positive for gonorrhoea; and she had been treated the previous evening. Dr B advised Dr A that as Miss C's mother did not arrive home from work until 4.00pm, and the child was at school, it would be appropriate to contact them after 4.00pm that day. Paediatric sexual abuse service staff advised CYFS and the Police of the referral and the suspicion of sexual abuse.

CYFS's social workers visited the family that evening and a social worker took Mrs D and Miss C to a children's public hospital for assessment at about 8.30pm. Another social

worker stayed with Mr K as he had been asked to find alternative accommodation for the weekend and to have no contact with his daughters.

A paediatric sexual abuse specialist, Dr L, assessed Miss C at the children's public hospital that evening. Dr L examined Miss C and took samples and swabs for testing; gonorrhoea was not grown from the swabs. A follow-up appointment was made for the following week, and an appointment was also made for Miss E to be examined by the paediatric sexual abuse service team.

In Miss C's notes Dr L noted a phone call to Dr B at 7.15pm on 11 August 2000. During this call Dr L advised Dr B that they had been unable to contact Mrs D and it was important to do so as soon as possible, as Miss C had already been treated and there were concerns for her safety. Dr B advised Dr L that he had seen Mrs D that afternoon and informed her of the significance of the sexually transmitted infection, and to expect to be contacted by the children's public hospital for examination. Dr L recorded a later call from Dr B during which he advised that he was at Miss C's home and that Mrs D and Miss C were coming into the children's public hospital accompanied by a CYFS social worker. Dr L explained to me that she had had no previous contact with Dr B about Miss C, but had received information from Dr A, who had taken the referral from Dr B earlier that day.

Dr B said that after his home visit, at approximately 8.30pm, he telephoned Dr L and warned her that he thought Mrs D was very frightened and it was likely that the family would leave New Zealand.

Dr B has supplied copies of emails between himself and Mrs D over the weekend of 12 and 13 August. These emails discuss gonorrhoea infection and transmission, how it can occur, Mrs D's belief that her husband was innocent and had not sexually abused her daughter, and the legal implications of Miss C's diagnosis.

Over the weekend Mr K stayed in a motel and Mrs D and the girls stayed in the family home. CYFS had initially wanted the children to live with an alternative caregiver over the weekend but compromised as Mrs D had been so distressed at the thought of having the children taken from her. Over the weekend the Police and CYFS staff visited both Mrs D and Mr K.

Customs records show that Mr K left New Zealand for Hong Kong and Mrs D and the girls left for Taipei on Monday, 14 August. This was discovered after Miss E missed her appointment at the children's public hospital on Tuesday, 15 August for her examination and screening. (Customs records show that Mrs D and her children arrived in New Zealand on 13 September 1999, left for Hong Kong on 25 June 2000 and returned on 13 July 2000. Customs records also show that Miss C's father, Mr K, arrived in New Zealand from Hong Kong on 6 May 2000 and left again on 31 May 2000. He returned to New Zealand on 13 July 2000.)

Dr L explained her concerns about Dr B's management of Miss C as follows:

> "I have concern about [Dr B]'s management of [Miss C]. [Dr B] had diagnosed [Miss C] as having an acute genital infection with Neisseria gonorrhoea. In this age group this is extremely likely to be a sexually transmitted infection. To our knowledge no other route of infective transmission has been definitely described in children of this age. Therefore the safety of [Miss C] becomes of paramount concern requiring involvement of paediatrics, Child, Youth and Family Service and Police. My major concern is that I understand from [Dr A] that [Miss C] had had a previous episode of vaginal gonorrhoea diagnosed and treated with antibiotic by [Dr B] with no paediatric consultation or referral to a child protection agency. I recognise that [Dr B] referred [Miss C] to [a paediatric sexual abuse service] on the second occasion.
>
> Before referring [Miss C] to [a paediatric sexual abuse service], [Dr B] had the evening before treated the genital infection which is extremely sensitive to appropriate antibiotics. I explained to [Dr B] over the phone (1915 phone call as above) my concern that this meant we may no longer be able to isolate the infection. I explained that the swabs he had taken were not handled according to chain of evidence, therefore could not be used as evidence in a criminal prosecution, in contradistinction to our procedures in [a paediatric sexual abuse service], at the children's public hospital where strict chain of evidence is maintained. At [the paediatric sexual abuse service], a full health screen for sexually transmitted infections that may coexist is usually also undertaken. I reiterated the urgency of our assessment and safety concerns. [Dr B] then responded by visiting the family (as above)."

The children's public hospital records note that Dr B was contacted on or around 29 August 2000 by a CYFS social worker. Dr B had declined a meeting with the social worker but told her to send him relevant information on the management of gonorrhoea.

An interagency meeting was held on 8 September 2000 at the children's public hospital. The intention to hold such a meeting was stated in a letter from Dr L to CYFS dated 24 August 2000, which was copied to Dr B. Present were representatives from the children's public hospital and CYFS. The Police apologised for their absence. Miss C's case, and possible changes to the way in which children with gonorrhoea would be managed in future, were discussed.

Dr A initially wrote to Dr B with his concerns about Miss C's management on 18 January 2001. In this letter Dr A explained why he was concerned that Miss C was not referred to a paediatric sexual abuse service in May when the first diagnosis of gonorrhoea was made, and that she had already been treated with ceftriaxone prior to the referral to a paediatric sexual abuse service in August. Dr A asked for an explanation why Dr B chose to manage Miss C's case as he did.

Dr B responded promptly to Dr A's letter, advising that it was unfortunate Dr A had chosen to wait six months before discussing the case as his memory of the details had "faded somewhat". Dr B stated that his warning that the parents were likely to leave New Zealand with the children had been ignored and they had been allowed to return to parental care,

subsequently leaving the country. Dr B asked Dr A for an explanation why this had occurred.

In Dr A's response to Dr B he explained that it took six months to raise his concerns as he believed Dr L was going to follow up the matter. Dr A also summarised the events following Dr B's referral to the children's public hospital and prior to the family leaving the country. Dr A stated that he would be happy to provide more information if Dr B required it, and he reiterated his initial questions: why did Dr B not refer Miss C for assessment when he first diagnosed gonorrhoea, and why did he treat her for the gonorrhoea before referring her for assessment in August?

Dr B again responded promptly and stated:

> "If there was a wish for my input as to what went wrong with the management of this case I should have been invited to comment several months ago. I am unable to help you further at present."

Dr A brought his concerns about Dr B's management of Miss C to the Commissioner's attention, after his unsuccessful attempts to discuss them with Dr B directly. Dr A wrote:

> "… On August 11 2000, [Dr B] referred to my team a seven year old Taiwanese girl with vaginal gonorrhoea. The consensus of medical opinion in the Western world is that genital gonorrhoea in a seven year old girl is a sexually transmitted disease until proven otherwise. [Dr B] had already compromised her diagnosis and management by the fact that he had treated her with intra-muscular ceftriaxone the day before. The effect of this was to make prosecution impossible, because by the time we saw her the ceftriaxone had already rendered her cultures negative. The usual swabs taken in general practice are not taken according to chain of evidence, and cannot therefore be used as evidence in a criminal prosecution.
>
> [Dr B] then astonished me by acknowledging that the girl had previously presented to him in May 2000 with vaginal gonorrhoea. [Dr B] had treated this at the time with IM ceftriaxone (which is the correct antibiotic, but which is not a medication usually available or used in general practice), had not consulted with a paediatrician and had made no referral to child protection agencies.
>
> The referral to us was dealt with urgently on the afternoon and evening of Friday August 11. We notified the department of Child Youth and Family Services and the Police. The details of what happened then are provided in the attached correspondence. Essentially, the father skipped the country with his wife and children. …
>
> I have tried to correspond with [Dr B] expressing my concerns about his management of this case, and asking for an explanation. [Dr B] has rebuffed my inquiries, and essentially refuses to offer an explanation for his management decisions. These decisions were well outside the bounds of standard medical practice in the year 2000,

and I have met with nothing but astonishment from colleagues when I have sought their opinion on this case.

I am concerned that [Dr B]'s management of this child's case was unsafe. He has said nothing to me to give me any confidence that he would manage another such case differently in the future. For the safety of other abused children who may be his patients in the future, I am unable merely to ignore this case. …"

Independent advice to Commissioner

The following expert advice was obtained from an independent general practitioner, Dr Tessa Turnbull:

"Background:

[Dr B] was [Miss C] and her family's GP – the family had emigrated from Taiwan, registering with [Dr B] in March 2000. [Miss C]'s father commuted on two occasions to [New Zealand] in late March and August 2000 but continued to work in Taiwan.

On 17/4/00 [Miss C] consulted [Dr B] with her mother for a rash and vaginal discharge. To [Dr B]'s surprise, gonorrhoea was diagnosed from the swab. [Dr B] consulted with [Dr F], a […] microbiologist, about appropriate antibiotic treatment on 17th or 18th April 2000. [Dr F] spoke to [Dr B] in general terms about possible legal implications of the diagnosis and the chain of evidence. This was in general terms, and did not specify the higher standard practised at [the paediatric sexual abuse service].

[Dr G] of […] spoke to [Dr B] on 20/4/00 about appropriate antibiotic treatment recommending IM or IV ceftriaxone. [Dr B] phoned the on call paediatrician [at the children's public hospital], [Dr H], on 20/4/00 and discussed with her some details of the case. He asked whether it was possible for [Miss C] to come into hospital and have IV ceftriaxone for gonorrhoea. [Dr H] indicated that [Miss C] should have an assessment by [the paediatric sexual abuse service] staff, which [Dr B] declined. [Dr B] disputes this and says no mention was made of referral to the Child Protection Unit. [Dr H] says she shortly afterwards discussed the telephone discussion with [Dr A].

[Dr B] treated [Miss C] with IM ceftriaxone on 20/4/01 obtained through a prescription from [the private hospital pharmacy]. He tested [Miss C]'s mother and sister for sexually transmitted diseases, both testing negative. [Dr B] talked with [Miss C]'s mother about the case. He told her that paediatric referral would be a good idea but she declined this advice and [Dr B] accepted this.

On 7/8/00, [Miss C] saw [Dr B] again with the same symptoms. Again gonorrhoea was diagnosed with slightly different antibiotic sensitivities. [Dr B] contacted [Dr I], the on

call microbiologist, who suggested an appropriate antibiotic and also suggested calling [Dr J], a sexual health expert. [Dr B] did this and [Dr J] suggested he also refer [Miss C] to the Child Protection Unit at the children's public hospital. The consultant advice line is available during daytime only so [Dr B] treated [Miss C] with ceftriaxone on the evening of 10/8/01. [Dr B] contacted [Dr A] about midday on 11/8/00, and the Unit social worker notified CYFS and the police of the situation. [Dr B] made a house call to [Miss C]'s home speaking to both [Miss C]'s parents that afternoon in the presence of the CYFS social worker. [Dr B] said that he indicated his concern to [Dr L] that [Miss C]'s mother was fearful of the investigation and the family may leave NZ.

[Dr L] assessed [Miss C] with her mother at the children's public hospital on the evening of 11/8/00. [Miss C]'s father moved into a local motel at CYFS request. [Dr B] had email communication with [Miss C]'s mother on 12/8/00 and expressed concern for [Miss C]'s safety. [Miss C] and her family left New Zealand on 14/8/00 before the investigation could be completed.

On 18/1/01 [Dr A] wrote to [Dr B] expressing his concern that [Miss C] was not referred to his unit at the time of the first diagnosis of gonorrhoea. His main intention appears educational ie to let [Dr B] know that denial by the perpetrator and other adults is common in cases of child sexual abuse and he mentions the medicolegal implications of specimen collection. He wished to understand [Dr B]'s reasons for treating [Miss C]'s sexually transmitted disease without further referral to the appropriate authorities.

On 25/1/01 [Dr B] replied to [Dr A] expressing concern at the time delay in communicating with him and concern that [Miss C] and her family had left the country despite his notification to [Dr L] that this might happen.

On 25/1/01 [Dr A] wrote to [Dr B] recounting the events of the case, providing further information and asking again for further information.

On 27/12/00, [Dr B] wrote to [Dr A] stating that he was unwilling to discuss the case further.

On 31/1/00, [Dr A] wrote to [Dr B] stating he was making a complaint to the Medical Council. This was then passed on to the Health and Disability Commissioner for action.

OPINION:

To advise the Commissioner whether [Dr B] exercised reasonable care and skill in treating [Miss C]. Did those services comply with professional, ethical and other relevant standards?

Did [Dr B] take appropriate action when he first diagnosed [Miss C] with gonorrhoea in April 2000?

Yes, I believe he did. It is clear that [Dr B] was surprised by the diagnosis of gonorrhoea and puzzled by its origin in a young child living in a household without

males. It is not clear whether [Dr B] had any previous experience of treating child sexual abuse but it is very likely that this was a unique case for him. It is not a common event for any GP and particularly one practising in an affluent suburb.

It seems to me that lack of experience meant that he was not aware of the points made by [Dr A] to him by letter in January 2001 ie that denial by the perpetrator and other adults is common in cases of child sexual abuse and there are specialised medicolegal implications to specimen collection.

To gain expert advice [Dr B] consulted two […] pathologists about the appropriate treatment and consulted the on call paediatrician [at the children's public hospital]. There is dispute between the two about whether referral to the Child Protection Unit was suggested. In any case [Dr H] talked to [Dr A] about the discussion and there was no further follow up to [Dr B] at that time.

Was [Dr B]'s clinical management of Miss C's condition on this occasion in accordance with professional standards?

[Dr B] treated [Miss C] with IM ceftriaxone as suggested by [Dr G]. This was available to him throughout legitimate sources, paid for by [Miss C]'s family. [Dr B] did a follow-up swab and also tested [Miss C]'s mother and younger sister for sexually transmitted diseases.

[Dr B] should have referred [Miss C] to [a paediatric sexual abuse service] at this time. It seems he did not do so because he did not realise this specialised facility was available or that he was compromising [Miss C]'s health and safety by not making the referral. He was unduly persuaded by [Miss C]'s mother that the infection was picked up 'incidentally' and was not sexually transmitted. He suggested referral to a paediatrician but the advice was declined.

In her emails to [Dr B], [Miss C]'s mother appears equally torn between love and concern for her child and loyalty and concern for her husband. She did not believe that her husband sexually abused her daughter whether through naivete or otherwise and undoubtedly conveyed this feeling to [Dr B] through all her communications with him.

Many GPs would have acted in a very similar manner to [Dr B] under the same circumstances ie in a way that put [Miss C]'s medical treatment first. Many GPs, like [Dr B], would not understand the full implications and consequences of the diagnosis and the risk to [Miss C] of remaining in the home situation without fuller investigation.

Almost universally GPs believe that swabs taken in their surgeries and processed in the usual way would stand up as legal evidence. Only those with DSAC [Doctors for Sexual Abuse Care] or other specialised training would understand the [paediatric sexual abuse service] level of the chain of evidence.

Would it have been appropriate for [Dr B] to refer [Miss C] for specialist care once this diagnosis had been made? If so, to whom? When?

[Dr B] did suggest referral to a paediatrician to [Miss C]'s mother but the advice was not taken up. He did not recognise the threat to [Miss C]'s health and safety at this time and seemed to believe the infection was 'one off' and not sexually related.

Referral to a paediatrician with specialised knowledge of child abuse, to CYFS or to the police will start the ball rolling where GPs suspect child abuse or neglect. Different GPs will do this in different ways according to their local contacts and the nature of the abuse. The recently published guidelines for referral for suspected child abuse and neglect (enclosed) [dated December 2000] state that management is complex and there are a variety of sources of guidance and expert advice available to GPs.

[Dr B] stated that [Miss C]'s mother declined specialist referral on this occasion. Would it have been appropriate for [Dr B] to alert the sexual abuse team in spite of [Miss C]'s mother's alleged wishes?

Yes, it would have been appropriate but did not happen on this occasion. [Dr B] followed the correct procedure on the second occasion and this was on the specific advice of [Dr J].

Did [Dr B] take appropriate action when he diagnosed [Miss C] with gonorrhoea again in August 2000?

Yes, he again sought expert advice and got the correct information.

He did, however, once again put the medical treatment of [Miss C] first and did not recognise the exacting nature of the collection of specimens in a way that would fully satisfy a court of law.

He elected to treat [Miss C] before the referral could be actioned because immediate out of hours referral to the Unit appeared impossible and he was anxious to treat [Miss C] as soon as possible. There was probably equal concern and pressure from [Miss C]'s mother to treat the child immediately.

Was his clinical management of [Miss C]'s condition on this occasion in accordance with professional standards?

[Dr B] 'got it right' the second time. Referral to [a paediatric sexual abuse service] was delayed until the following day because it was 'out of hours' when the lab results came through and he had talked to [Miss C] and her family. [Dr B] co-operated with [the paediatric sexual abuse service], CYPS and the police and he acted as an important advocate or intermediary between the family and the authorities stressing the need for investigation and follow-up of all the family. He communicated this further to [Miss C]'s mother by email on 12/8/00.

Was it appropriate and in accordance with professional standards for [Dr B] to treat [Miss C] before referring her to [a paediatric sexual abuse service]?

As mentioned above, I think [Dr B] was treating [Miss C] the patient first, not [Miss C] a child who had been sexually abused. The treatment was provided with good intention and not in an attempt to collude with the family against authorities and [Miss C]'s best interests.

What was the professional standard at that time for the management of sexually transmitted diseases diagnosed in children? Where was this standard found?

GPs develop knowledge in the area of child abuse over time. Child sexual abuse is seen less often and publicity and training is relatively recent and goes hand in hand with public and police recognition of the nature and extent of the problem in the community.

DSAC has run courses for many years but this is mainly to provide training for GPs with a special interest in this area and those who work with the police and/or CYFS directly.

The 'standard' was published in February 2001 and distributed to GPs some time later. It was launched with some publicity but like any guideline needs to be accompanied by further education so that the recommendations can be implemented. Like many other guidelines published over recent years there will be patchy education and uptake and the guideline will be studied and utilised by GPs in different ways.

Did [Dr B] comply with this standard when treating [Miss C]?

Yes he did in general terms in August 2000.

Are [Dr B]'s records of [Miss C]'s treatment of an acceptable standard?

Yes, I think that they are. They are a standard computerised record, which act as an aide memoir to GPs in their management of patients. Some GP medical records will be fuller according to time constraints, computer literacy and knowledge of the importance of the medical record as a medico-legal document in today's practising environment.

Are there any other issues raised by the supporting documentation?

I believe [Dr A]'s desire initially was to educate [Dr B] in better management of child sexual abuse. He did this by letter some months after the events. There was an opportunity to take this up much earlier with [Dr B] after the discussion between [Dr A] and [Dr H]. This would have been a positive move along the lines of quality improvement, to help networking between colleagues and assist education and prevent a similar event occurring in the future.

…"

Response to Provisional Opinion

Dr B responded to my provisional opinion as follows:

"1. I referred [Miss C] to the Medical Officer of Health on 22 April 2000. Gonorrhoea is a notifiable disease; therefore referral is a legal requirement. It is my practice to refer all notifiable disease to the Medical Officer of Health. At that time I considered her infection was most likely an STD, although [Mrs D] suggested it had been passed through a contaminated towel.

You have a copy of that referral letter on page 2 of my clinical notes.

2. I declined to discuss [Miss C]'s case with [Dr A] when he wrote to me in January 2001 for the following reasons. He was not the paediatrician involved in her case. He waited for nearly a year before he wrote to me regarding [Miss C]'s illness and some months after she left the country. I was not notified of the interagency meeting regarding [Miss C]'s case, which would have been the appropriate forum to discuss it. I do not consider that I have been uncooperative; rather I am somewhat frustrated that [Dr A] has been critical of my actions now, yet did not contact me when he had every opportunity to do so in April, or August 2000.

3. I do not recall [Dr F] telling me that I should anticipate legal proceedings. He did not tell me to ensure that the chain of evidence was secure; certainly if I had been advised to ensure tests be carried out in a particular way I would have done so. [Dr F] did not discuss the public health aspects of the disease, although I did actually do all the things he recommends. The tenor of the conversations that I had with [Dr F] and [Dr G] were of a clinical nature. There was no emphasis on the legal implications of diagnosing the infection in a child.

4. In your report you note that my recollection of the conversation that I had with [Dr H] differs […]. You have chosen to accept [Dr H]'s version. The conversation was over a cellphone with notoriously poor reception and [Dr H] has a strong accent. It is very possible that we misunderstood each other, however it does not follow that my recollection of the conversation was inaccurate and I completely reject your conclusion. Further, [a paediatric sexual abuse service] was not mentioned to me during that conversation and the first I knew of the service was when it was mentioned by [Dr J].

As I have already said, [Mrs D] refused my advice that she consult a paediatrician in spite of a long discussion with her in that regard. My concern at that time was that [Miss C] needed to be treated for Gonorrhoea and I needed to obtain Ceftriaxone. My primary reason for telephoning [the children's public hospital] advice line was to obtain this medicine. I explained to [Dr H] that [Miss C] had a Gonorrhoeal infection of the vagina sensitive to Ceftriaxone. [Dr H] refused to supply me the medicine, advising me that it could only be used in [the children's public hospital]. Because [Mrs D] refused a referral, she would not allow [Miss C]

to go to [the children's public hospital] and I believe she would have remained untreated. [Mrs D] then obtained the Ceftriaxone from [the private hospital].

As I have stated above, I did not ignore [Dr H]'s advice to refer [Miss C] to [a paediatric sexual abuse service] in April 2000, as she did not give me this advice. If she had, I would have asked her to explain further, as at that stage I had not heard of [the paediatric sexual abuse service].

[Dr H] had my name and telephone number. [Dr H] states that [he/she] discussed [Miss C]'s disease with [Dr A] immediately after speaking with me. Both [Dr H] and [Dr A] have said they had concerns regarding my treatment of [Miss C] at this time, yet they did not telephone me back to raise these with me or follow it up in any other way.

5. The provisional report states that paediatric advice is available 24 hours a day. That is not entirely correct. At the time of [Miss C]'s infection, paediatric registrars, not paediatricians, managed the after hours paediatric advice service. This service was patchy and not easy to access.

6. My referral in August was as fast as the system at that time allowed. I telephoned a succession of medical specialists, some of who are difficult to contact, and it was not until [Dr J] advised me of [a paediatric sexual abuse service] that I knew it existed. I had no knowledge of the document 'Breaking the Cycle …' which you have included in your report, as it was not published until February 2001, and distributed to general practitioners after that.

7. I reviewed my practice with the aid of the Medical Council of New Zealand competence committee in December 2001. They rated me as very competent.

   I acknowledge that I could have managed [Miss C]'s case differently but I believe my clinical management was reasonable in the circumstances of this case. This is the general conclusion that your own expert draws. I am now more fully aware of the procedures for dealing with sexual abuse cases and will act accordingly in future if I am presented with a child I suspect is the subject of such abuse.

8. There is understandably a lot of anger that a young girl has left the country in the care of a child molester (although to my knowledge no steps have been taken to pursue [Mr K]). I believe that the enormity of this outcome has coloured your report. That [Miss C] was allowed to leave was not my fault, and as you are aware, that occurred after referral to [a paediatric sexual abuse service] and CYFS and the police. I was concerned that the family would leave, in particular because [Mrs D] was very frightened, and warned the paediatrician at [the children's public hospital], [Dr L], of this concern.

I do not accept that I have acted in breach of Right 4 of the Code."

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

…

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.

Other Relevant Standards

Children Young Persons and Their Families Act 1989

Section 6

"… [The] welfare and interests of the child or young person shall be the first and paramount consideration."

Section 15

"Any person who believes that any child or young person has been, or is likely to be, harmed (whether physically, emotionally, or sexually) ill-treated, abused, neglected, or deprived may report the matter to a Social Worker or a member of the Police."

Section 16

"No civil, criminal, or disciplinary proceedings shall lie against any person in respect of the disclosure or supply, or the manner of the disclosure or supply, by that person pursuant to section 15 of this Act of information concerning a child or young person (whether or not that information also concerns any other person), unless the information was disclosed or supplied in bad faith."

Good Medical Practice: A Guide for Doctors (Medical Council of New Zealand, February 2000)

"…

2. Good clinical care must include

- An adequate assessment of the patient's condition, based on the history and clinical signs and, if necessary, an appropriate examination;
- Providing or arranging investigations or treatment where necessary;
- Taking suitable and prompt action when necessary;
- Referring the patient to another practitioner, when indicated.

3. In providing care you must

- Recognise and work within the limits of your competence; know when you do not know or cannot do capably;
- Be willing to consult colleagues; …"

Breaking the Cycle: Interagency Protocols for Child Abuse Management (New Zealand Children and Young Persons Service, 1996)

Guidelines and Procedures for the management of child sexual abuse in general practice – supplied by Doctors for Sexual Abuse Care (DSAC)

"Introduction

The role of the GP in management of sexual abuse is crucial. This role can be considered in the following stages:

Awareness:

- Be aware of the clinical indicators of child sexual abuse.

Consultation:

- Seek advice. Help is available from several sources.

Referral:

- Take effective action.

Follow-up:

- Maintain family contact and provide support.

Prevention:

- Play a part in prevention within your practice and within the community.

Always consider the safety of the child

…

Provide crisis support for the child, family/whanau

…

Follow-up

Provide continuing medical care and follow-up to ensure that:

- the child remains safe:

  — further abuse can occur when an offender rejoins the family or when the family loyalties change

  — prompt re-referral to the NZCYPS is essential if this is suspected

- injuries heal:

  — STDs have been recognised and treated appropriately

  — Possibility of pregnancy is recognised and assistance provided

- the child and other family members receive therapy:

  — at times of future crisis or as the child develops

  — further referrals for therapy may be needed

Referral

Most presentations of child sexual abuse are not urgent. However 5% of cases present acutely and require an urgent response.

Take effective action

The following require an urgent response with immediate referral for specialist medical assessment:

- recent sexual assault, rape or last incident of abuse having occurred within seven days
- obvious physical trauma/known or suspected internal trauma
- systemic signs or symptoms of illness/local signs and symptoms especially significant genital discharge or bleeding/ano-genital pain.

Recent acute sexual assault requirements

In these situations the role of the GP is to:

- treat only life-threatening medical conditions, taking care to preserve the evidence required for a forensic examination
- note verbatim the child's words as these may be admissible in court as evidence
- refer urgently for multidisciplinary assessment, involving police and NZCYPS, particularly if the child is at risk of further abuse. The investigative and forensic process will proceed as for the adult.

It is important that the child has a caregiver accompany her/him at this time.

Urgent medical response

In an acute crisis the child is at greater risk of:

- re-abuse, including physical abuse, by the alleged perpetrator for disclosing the abuse
- retraction of claim due to physical and psychological pressure by the perpetrator, family/whanau
- revenge from other family/whanau members.

NZCYPS and the police have the power of statutory intervention under CYP&F Act 1989 to protect a child at risk. It cannot be the role of the GP.

Always consider the safety of the child

Refer appropriately

If there is a reasonable suspicion that child sexual abuse has occurred and child is at risk of further abuse, refer promptly to NZCYPS or the police.

Take effective action

The diagnosis and management of child sexual abuse is complex and requires multi-disciplinary expertise associated with family and whanau to ensure that:

- the health, welfare and protection of the child take precedence over other considerations
- competent evaluation takes place, including evidential history and careful expert medical assessment with the collection of objective forensic evidence
- trauma to the child caused by multiple questioning or examination is minimised
- the appropriate decisions are made concerning judicial procedures
- assessment of psychological needs is made
- provisions of therapy and follow-up treatments are provided
- the best possible relationship between the child and the non-abusing parent is maintained

The NZCYPS and the police have joint policies for investigating child abuse complaints based on a multi-disciplinary system that involves:

- police
- NZCYPS social workers
- medical practitioners
- therapists and counsellors. (Sexual Abuse Teams)

Doctors have a moral responsibility and a professional duty of care to report child abuse.

Section 16 of the CYP&F Act 1989 protects a doctor who reports a suspicion of child abuse to NZCYPS or the police, provided the report is made in good faith.

Never attempt to manage suspected child sexual abuse alone.

Unless the abuse is reported and protective services can intervene it is unlikely that the abuse will stop.

Consultation

Act within the limitations of your experience to clarify possible abuse.

It is never the role of the GP to examine a child to prove or disprove that sexual abuse has occurred but to develop a reasonable suspicion that sexual abuse may have occurred.

Seek advice

If in doubt about the basis of your concern, or how you should proceed in response to your suspicions of child sexual abuse, use your network to consult with a colleague who has more experience in this area than you.

Help is available from several sources

Such colleagues may include:

- a more experienced GP
- a paediatrician experienced in sexual abuse
- a forensic medical examiner/police surgeon
- NZCYPS social worker (local SA team)
- a worker in a sexual assault service, for example, HELP Foundation.

Refer

If there are non-specific physical indicators of abuse or minor behavioural abnormalities, consider a referral on non-specific grounds mentioning concerns about the possibility of child's sexual abuse, for example abdominal pain, vaginal discharge, minor behavioural problems to:

- a specialist paediatrician experienced in sexual abuse for a general paediatric assessment and/or
- a child therapist experienced in sexual abuse for a psychological assessment
- informally discuss the child's problems with the NZCYPS sexual abuse team worker. They may already have other reported concerns about the child or the alleged offender.

If an assessment does not reveal sexual abuse, the child may still have the problems that caused the initial concern and referral for relevant therapy is still a helpful outcome for the child.

Your advocacy and action on behalf of the child is essential. It may be the only chance an abused child receives.

…

The role of the GP in management of child sexual abuse

…

Do not manage a case of child sexual abuse alone

…

Multi-disciplinary teamwork

A medical history and examination will often disclose new information which contributes significantly to the investigation.

In addition, doctors may be in a position to contribute constructively to the management of an investigation.

In such cases it is important that we do not act in isolation, but as part of the team and thus have an opportunity to share information, opinions and advice.

In order for this to happen those officers who have statutory powers to investigate and protect children must understand more fully the role that can be played by doctors skilled in the area of child sexual assault.

Conversely the doctors themselves must understand both the extent and the limitations of their role."

Opinion: Breach – Dr B

Right 4(2)

Miss C had the right to receive medical services from Dr B that complied with professional standards.

On both occasions that Dr B diagnosed Miss C with gonorrhoea he treated her with the antibiotic ceftriaxone, after consultation with experts in the field to determine the appropriate treatment for the particular strain. It has not been disputed that this was the correct clinical treatment for Miss C's gonorrhoea infection.

However, the Interagency Protocols for Child Abuse Management clearly state in several places that a GP should not attempt to manage a case of suspected sexual abuse alone. Advice and assistance is available from several sources, including Doctors for Sexual Abuse Care (DSAC), Child, Youth and Family Services (CYFS), the Police and the public hospital system (via [a paediatric sexual abuse service]). It is important that the correct clinical treatment is received, but it is clearly equally important that the correct referrals are made so that a child suspected to be the victim of sexual abuse remains safe and is not exposed to the risk of further abuse. When signs or symptoms indicate that sexual abuse has occurred, the need for immediate specialist referral becomes urgent. This is so even when the parents or caregivers oppose referral – the child's best interests must remain paramount. The

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diagnosis and management of sexual abuse is complex and requires multi-disciplinary expertise to deal with it appropriately and promptly.

Expert consensus is that an infection such as gonorrhoea in a child can be acquired only through sexual contact. Sexual contact with a child is sexual abuse. Seven-year-old Miss C had vaginal gonorrhoea on two occasions and this could only have been acquired through sexual abuse.

In response to my provisional opinion Dr B confirmed that in April 2000 he considered that Miss C had most likely been infected through sexual contact, although Mrs D suggested that it had been passed through a contaminated towel.

A child with a sexually transmitted disease requires not only clinical treatment, but also protection from the perpetrator, psychological assistance, a forensic evaluation, and often ongoing therapy and treatment. This cannot be undertaken by a GP in isolation. A GP's role when confronted with a child who may have been sexually abused is to act within the limitations of his or her experience, to treat life-threatening medical conditions, and to refer the child to expert assistance. The Medical Council of New Zealand's guidelines, 'Good Medical Practice', also state that doctors should act only within the limits of their competence, be willing to consult colleagues, and refer to another practitioner when necessary.

The child's safety and welfare should be the paramount concern, as clearly stated in the Children Young Persons and their Families Act 1989. The DSAC Guidelines and Procedures for the management of child sexual abuse in general practice state that doctors have a moral responsibility and a professional duty of care to report suspected child abuse. I agree. Section 16 of the Children Young Persons and Their Families Act 1989 protects doctors who disclose in good faith information about suspected child abuse.

My advisor pointed out that although it would have been appropriate for Dr B to have referred Miss C to [a paediatric sexual abuse service] when gonorrhoea was first diagnosed in April, dealing with sexual abuse of a child is not a common occurrence for most GPs, and that many GPs are therefore not aware of the specialised procedures and resources available. Nor would most GPs be aware that swabs taken in their surgeries are not admissible as evidence in legal proceedings, or understand the full implications and consequences of the diagnosis and the risk to a child remaining in the home situation without thorough investigation.

Dr B explained that, having given Miss C appropriate medical treatment and having suggested paediatric referral to Mrs D (which she refused), he believed he had done all he reasonably could for Miss C. Miss C had no contact with men, and he considered Mrs D to be a caring and competent mother who fully understood the implications of Miss C's gonorrhoea infection.

I do not agree that Dr B's decision not to refer Miss C to child protection authorities when he first diagnosed her with gonorrhoea in April 2000 was reasonable in the circumstances or

in accordance with professional standards. The fact that Miss C, a child, had contracted a sexually transmitted infection should have clearly indicated to Dr B that she was not safe in her current environment.

The professional standard is to consult and refer when a sexually transmitted disease such as gonorrhoea is diagnosed in a child. Dr B did not refer Miss C to child protection as required, but chose to treat her himself.

Dr B stated that his main concern was to treat Miss C's gonorrhoea infection. Mrs D had refused a paediatric referral, and Dr H refused to supply the medication required to treat Miss C outside of the hospital setting. Dr B feared that if he insisted on referring Miss C to the hospital for treatment, Mrs D might have refused to go, and Miss C would have remained untreated.

Mrs D was understandably upset and reluctant to acknowledge that her daughter had been sexually abused. However, [a paediatric sexual abuse service] is a specialist unit, with greater expertise and resources than are available to a general practitioner. Dr B's responsibility was to make the referral. Miss C's subsequent care and follow-up would then have been the responsibility of the experts.

Dr B consulted several experts in the field of microbiology and sexual health to determine the appropriate treatment for Miss C. Dr F stated that he would have discussed with Dr B the diagnosis and its legal implications, including the possibility of legal proceedings and the need to ensure the chain of evidence was secure. Dr B does not recall Dr F mentioning these points. Dr G discussed the diagnosis and treatment with Dr B. Dr G' normal practice at this point would have been to discuss the need to refer Miss C to specialist assessment.

Dr B then discussed Miss C's case with paediatrician Dr H, on the paediatric advice line at [the children's public hospital]. Dr B stated that at no stage did Dr H suggest that he refer Miss C to a child protection agency. Dr H, however, clearly recalled telling Dr B that Miss C should be sent to [a paediatric sexual abuse service] for assessment by sexual abuse specialists, at which point Dr B terminated the call. Dr H's account of the information given to Dr B during their conversation is consistent with standard practice for a paediatrician contacted by a GP in relation to a case of suspected child sexual abuse. I accept that Dr H did recommend referral to [the paediatric sexual abuse service].

Dr B explained that Dr H had a strong accent, the cellphone reception was poor, and that it was likely they misunderstood each other. Dr H does not recall the reception being poor, and [his/her] accent is that of a typical New Zealander.

Even if Dr B had initially been unaware of the interagency protocols and the need to refer Miss C for assessment by paediatric sexual health experts, following his discussions with Dr F, Dr G and Dr H, he should have been well aware of his professional obligations. I do not accept Dr B's statement that he did not follow advice to refer Miss C to specialist care as he never received such advice. More than one other practitioner has independently stated that they either did or would have told Dr B to refer.

In response to my provisional opinion Dr B stated that he notified the Medical Officer of Health, as gonorrhoea was a notifiable disease. The purpose of such a notification is for contact tracing rather than to manage suspected sexual abuse cases. Dr B also had a responsibility to refer Miss C to specialist care.

Dr F advised Dr B of the second gonorrhoea infection on 9 August. Dr B consulted Dr I and Dr J, who both advised consulting a specialist agency such as [a paediatric sexual abuse service]. Dr B treated Miss C on 10 August but did not refer her to [a paediatric sexual abuse service] until midday on 11 August.

A prompt referral to a paediatric sexual abuse service in April would probably have protected Miss C from further assault and infection, and minimised potential future harm. When Miss C was re-diagnosed in August, Dr B should have been well aware of the need for prompt referral to ensure her ongoing health and safety. Instead, he delayed referral for two days.

Dr B submitted that the emotive aspects of this case – a young girl left in the care of the alleged perpetrator – have coloured my opinion, and that it was not his fault that Miss C was able to leave New Zealand.

This investigation has focused on Dr B's management of a case of suspected sexual abuse of a child. I have no jurisdiction over the other matters (including the identity of the perpetrator, or how and why Miss C was able to leave the country) and have made no finding or comment in relation to them. They have been included in this opinion only where necessary to explain the relevant background.

In failing to refer Miss C appropriately in April 2000 and August 2000, Dr B failed to comply with professional standards and therefore breached Right 4(2) of the Code.

Right 4(5)

Under Right 4(5) of the Code, Miss C had the right to co-operation among all providers involved in her care to ensure she received quality and continuity of care.

In my opinion Dr B did not co-operate appropriately with other providers who needed to be involved in Miss C's care, and this resulted in Miss C not receiving appropriate management in a timely fashion.

Gonorrhoea is transmitted through sexual contact. Sexual contact with a child is sexual abuse. A diagnosis of gonorrhoea in a child should therefore alert a practitioner to the possibility of sexual abuse. As discussed earlier, when sexual abuse of a child is suspected prompt referral to specialist care, and co-operation with other agencies, is essential to ensure the child's protection.

Several people told Dr B of the need to refer Miss C to specialist care, yet he did not do this in April, nor in a timely manner in August. He ignored Dr H's explicit advice to refer Miss C to a paediatric sexual abuse service in April, and in August he delayed calling Dr A until

after he had treated Miss C. Dr B's statement that he could access paediatric advice from a hospital only during normal working hours was also incorrect. Although the consultant advice line was available only during normal working hours, paediatric advice was available 24 hours a day.

I consider Dr B's subsequent refusal to discuss Miss C's case with Dr A to be further evidence of his unco-operative attitude. I do not accept that Dr B's frustration at not being consulted earlier justified his refusal to discuss this case with Dr A.

In failing to co-operate with other providers who needed to be involved in Miss C's care, Dr B breached Right 4(5) of the Code.

Actions

I recommend that Dr B take the following actions:

- Review his practice in light of this report.
- Attend DSAC training on how to deal with cases of suspected child sexual abuse.

Further actions

- Copies of this opinion will be sent to the complainant, Dr A, the Director-General of Health, the Medical Council of New Zealand, and the President of the Royal New Zealand College of General Practitioners.
- A further copy of this opinion, with identifying features removed, will be sent to the Royal New Zealand College of General Practitioners, the New Zealand Medical Association, the New Zealand Venereological Society, the New Zealand Charter of the Australasian College of Sexual Health Physicians, Doctors for Sexual Abuse Care and the Commissioner for Children, and will be placed on the Health and Disability Commissioner's website, www.hdc.org.nz, for educational purposes.
- In accordance with section 45(f) of the Health and Disability Commissioner Act 1994, I will refer this matter to the Director of Proceedings to determine whether any further action should be taken.

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

Addendum

The Director of Proceedings considered this matter and decided not to issue proceedings before the Medical Practitioners Disciplinary Tribunal or the Human Rights Review Tribunal.