

DCC053 JLS-D

MEDICAL TRIBUNAL OF NEW SOUTH WALES

CHAIRPERSON: BLANCH CJ OF DC

MEMBERS: DR D CHILD
MS A GRAY
MS M WROTH

TUESDAY 14 FEBRUARY 2006

IN RE DR NAVIN PATANJALI AND THE MEDICAL PRACTICE ACT**CLOSED COURT FOR CROSS-EXAMINATION OF NURSES 1 AND 2****SUPPRESSION ORDERS FOR PATIENT AND DRs A, B AND C****JUDGMENT**

CHAIRPERSON: This matter comes before the Tribunal as a complaint brought by the Health Care Complaints Commission in accordance with s 51.1 of the Medical Practice Act 1992. The complaint is that Dr Patanjali has been guilty of unsatisfactory professional conduct within the meaning of s 36 of the Act and/or professional misconduct within the meaning of s 37 of the Act in that he has demonstrated that the knowledge, skill or judgement possessed or care exercised by him in the practice of medicine is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience and/or has engaged in improper or unethical conduct relating to the practice of medicine.

The particulars are that at or about 23.50 on 9 February 2002 the practitioner on duty as a locum at Camden Hospital was called and attended to review Mrs X, an 84 year old patient, who reportedly had a decreased level of consciousness following a fall.

In the course of attending the patient the practitioner

(1) failed to examine the patient when he attended on her at about 23.50 and failed to ascertain whether she was suffering any injury following a nurse's report that the patient had suffered a fall and had a reduced level of consciousness.

(2) falsified his entry in the patient's clinical notes for 23.50 by asserting the results of a series of investigations and observations of the patient when no such investigations or observations had been undertaken by the practitioner.

(3) failed to make entries in the patient's medical record which were accurate contrary to clause 13 and schedule 2 of the Medical Practice Regulation 1998.

As asserted in the complaint, the incident in question occurred at Camden Hospital on 9 February 2002 just before midnight. The doctor at that stage was the only doctor in the hospital and he was attached to the emergency section of the hospital and when the patient fell he was summoned to the ward. When he got there he made a note of an examination he conducted and that note indicates that he carried out six investigations.

The first entry indicates that he observed and measured the Glasgow Coma Scale of the patient which he recorded as being at 15, which is the normal reading for an alert person. Secondly he made an entry that the pupils were equal and reacting to light. Thirdly he said there were no focal nervous system signs. Four, he noted that the cardiovascular system had no abnormality to detect, which indicated that he had listened to the chest

of the patient. Fifthly, he noted no abnormality in the gastrointestinal tract and sixthly he noted no abnormality detected in the hips and pelvis area. Those entries would indicate that the doctor had carried out an examination of the patient which would have taken some little time.

An assertion was made shortly after this by Nurse 1 that no such examination had occurred. She made a note to that effect on the patient's record sheet at 5 am and her statement has been tendered to the Court and she has given evidence and been cross-examined. Her evidence is that the doctor came into the room, she told him that the patient had fallen and hit her head and had been incontinent of urine and faeces. She said she may have informed the doctor that her eyes were open, she was conscious when found, but had a reduced level of consciousness, and she may have told the doctor "she's okay now".

She says that the doctor was in the room for one to two minutes only and that during that time he did not speak to the patient and did not touch her. He did not shine a torch in her eyes and he did not inspect her chest with a stethoscope, nor did he check her reflexes, nor did he palpate her abdomen and he did not check her hips or pelvis. She said he stood near the end of the bed and did nothing. She said before he left the room he said to her "get an X-ray in the morning and do neuro obs for four hours".

She said that during that period Nurse B was also in the room. She drew a diagram of herself standing on the

right hand side of the bed and Nurse B standing on the left hand side of the bed with the doctor standing at the bottom of the bed. She indicated in her statement that Nurse B was there during this whole process. She gave evidence in her statement that after the examination at some stage she spoke to Nurse B and said "Look at this [Nurse B]. This is a load of shit. He didn't do this did he?". She said "No he didn't".

The doctor has given evidence that, although he cannot remember the particular incident, he has never written out the results of an examination without doing the examination. He said he would regard doing that as quite inappropriate.

The question then for this Tribunal is very much a question of whether the evidence of Nurse 1 can be accepted as both honest and accurate. It is said to be supported by some other material in the case and all of that needs to be examined on the basis that in a Tribunal such as this we are dealing with the necessity for the complaint to be proved at the level required by the decision in **Briginshaw v Briginshaw** 1938 60 CLR 336. It has been said that although there are only two tests known to the law as to the burden of proof, namely the balance of probabilities and beyond reasonable doubt, that in some cases when dealing with the balance of probabilities test the degree of satisfaction for which that civil standard of proof calls may vary according to the gravity of the fact to be proved and it is well recognised of course that in Medical Tribunal matters the gravity is high. Of

course, as the cases indicate, that does not mean that the case has to be proved beyond a reasonable doubt.

The evidence of Nurse 1 needs to be examined by comparison with all of the other evidence in the case. The first thing to be observed about Nurse 1's evidence is that it was apparent in the way she gave evidence that she had very strong opinions about what had been happening in the South West Sydney Area Health Service and very strong opinions about the failure to do anything about it in times past. Evidence was received by the Tribunal that she had made complaints to the Independent Commission Against Corruption and in speaking to the Independent Commission Against Corruption she made various allegations against various people, including a Minister of the Crown and various people who worked in the hospital system where she worked, including doctors and nurses.

Once again what can be drawn from that about Nurse 1 is simply the fact that she was very determined to do what she could to overcome the problems that she perceived in the Health Service. Of course one interpretation of that may be that she is a very genuine, well-intentioned person attempting to do her best to achieve reforms. Another interpretation might be that she is so strong-willed in her own interpretation of events that she is determined to have her view of the system and what occurred in it accepted. In either event she appeared to bear that character in the witness box, and that is borne out by the complaints she made to the Independent Commission Against Corruption and it is a circumstance that must alert any

tribunal of fact to consider her evidence carefully and ensure that it is accurate and honest.

A number of criticisms of her evidence have been made. Perhaps the most striking criticism of her evidence is the fact that her account of what occurred on the night differs in some significant respects from the evidence of Nurse B.

The first such discrepancy is the fact that Nurse A said that after the patient fell Nurse B went to the patient and then Nurse B came and got her and took her to the patient. Nurse B's account of that is that the two nurses were together, they heard the fall and together they went to the room where the patient had fallen.

The second discrepancy between their accounts is the fact that Nurse B said she was not on the left hand side of the bed at all, she was on the right hand side of the bed and she was not standing near the windows. The third discrepancy is that Nurse B said she left the bedside of the patient who had fallen and went to attend to another patient in the next bed who had called out for assistance in getting a drink of water. In leaving the bedside of the patient who had fallen she went to the other side of a curtain and she had her back to where the doctor and the patient were.

The next discrepancy between their accounts relates to who raised concerns about the doctor's notes? I have already quoted the statement of Nurse A that she was the person who said the notes were wrong, and that Nurse B agreed. Nurse B in her statement says that she first said

that the doctor had not examined the patient and then Nurse A agreed.

I should observe in respect of these variations that because Nurse B said she left the area where the patient who fell was, and was out of sight of the patient and the doctor with her back turned, and on the other side of a screen, she is not a person who is in a position to give a continuous account of what occurred between the doctor and the patient. Moreover she said at one stage that when she left the patient who fell the patient and the doctor were there alone.

There was another aspect of the evidence given by Nurse A in her statement to ICAC where, in the record of interview which was tendered, she said that the other nurse had signed the complaint form that she, Nurse A, had filled in at the end of the investigation. Objectively that is not correct, that is only signed by her and it was not suggested that Nurse B had in fact signed it.

There is a further matter in respect of Nurse A's complaint, that is in significant contrast to the evidence contained in another statement. Nurse B was in a supervisory role at the hospital. Nurse A went to Nurse B and in her statement she said "I met with Lisa B and Nola Fraser a few days later after submitting the problem report. At this meeting Lisa B told me that she had already spoken with Dr Patanjali and he had admitted to her that he did not examine Mrs X. Lisa B said that this was a quality issue. I disagreed with her casual attitude to Dr Patanjali's actions."

A statement was obtained from Ms B and it has been tendered in evidence. She says that she had a conversation with Dr Patanjali about a report by a nurse that he had not carried out an examination of a patient but documented that he had. She said the conversation included words to the following effect:

"He said, 'Well you know if you want me to do a full examination on every patient at 3 o'clock in the morning then I will'. I said, 'That's not the point, the point is the accuracy of the records. The concern is not how comprehensive your examination was but that your documentation doesn't accurately reflect what you did or didn't do. Documentation should be accurate, truthful and contemporaneous'. He said, 'Well in future I'll do a complete physical assessment on every patient'. I said, 'I am not questioning your medical management of the patient but the accuracy of your documentation'."

She was, at that stage, the nursing unit manager and there is nothing in that statement to indicate that Dr Patanjali had said to her that he had not carried out the examination. There is a vast difference between an argument as to whether or not the examination was adequate and an argument about whether there had been any examination at all. There is therefore a real problem between the evidence of Nurse A and the evidence given by Nurse B.

It has been submitted on behalf of the Health Care Complaints Commission that there are aspects of the doctor's explanation which are less than satisfactory and which could lead to the conclusion that he simply did not carry out the investigation he said he did on the night the patient fell. It is firstly submitted that his

account that he returned at 7.30 the next morning to visit the patient is only explicable on the grounds that he had discovered there was a complaint about his notes and he sought to rectify the situation. What he did at 7.30 in the morning was go back to the see the patient who complained of pain and the doctor then organised for her to have an x-ray which revealed a fracture of the pelvis.

There is no evidence that there was any news of the complaint being conveyed to the doctor during the course of the night. The most that can be said is that it might have happened if one of the nurses in the emergency section received a call from Nurse A. The doctor explains his trip to the patient in the morning at 7.30 as being his usual practice. He was cross-examined about that but his evidence simply was that, if he had time to do it, it was his usual practice to visit any patient that he had seen during the course of his shift and he did have the opportunity on this occasion. He went back and received an immediate complaint from the patient of pain so he arranged for an x-ray.

There is a further criticism of his account in that he said when he went back he did not read the notes. If he had read the notes he would have read a note put there at 5 o'clock in the morning by Nurse A about the fact that there had been no examination. He said he did not read those notes and did not see that entry and the question is raised as to why he would not read the notes as to what had been happening to this patient between the time he left the patient and 7.30 in the morning. That is a

question which, in these proceedings, has not received a satisfactory answer, unless it is the answer that he simply did not read the notes.

It has been pointed out that in doing the examination that he did do there is no note that he made of an examination of a head injury, and yet a head injury was what might have been expected from the description that he was given of the patient falling from a commode chair into a wall, and he accepted that he should have noted a head injury. There was no note that he had examined the patient's neck and he agreed that that was one of the factors that he should have attended to. It was submitted from these deficiencies that they indicate he did not conduct any examination at all.

It was also submitted that he had information, or should have had information, and should have made observations which would have led to him not recording the Glasgow Coma Scale as being 15, which is the reading one would expect of a normal healthy patient. There was, on the evidence, some material provided to him. Certainly Nurse A says she told him the patient had hit her head and was somewhat confused, and may have told him that she was all right now. Dr Bezzina, the peer reviewer, thought of the information that was available in the records that it might not indicate a Glasgow Coma Scale of 15. Those criticisms can be made but otherwise the evidence was that this patient was 84 years of age and was suffering from a degree of dementia and confusion and undoubtedly those are factors that might also have affected that assessment.

A significant criticism was made of the doctor because he said he could not remember a conversation Dr A said he had with him. Some time in February, that is the same month as the incident occurred, Dr A said that he telephoned the doctor and their conversation included words to the effect "he said 'well I may not have done a real detailed exam'". I said "did you do a complete exam?" he said "no, probably I didn't". I said "what you say in the chart has to be consistent with the examination you undertook, this is highly inappropriate, I'll be looking into this".

Dr A indicated that he had significant difficulty in remembering the precise conversation and he was also interviewed at ICAC. He said his impression now was the conversation with the doctor was whether he had done an adequate examination, but he had difficulty recollecting the precise conversation. He said "I wouldn't want to try to recall him verbatim because I frankly don't remember".

In so far as the criticism that he cannot remember speaking to Dr A that criticism is that Dr A was a senior person ringing up about a significant criticism and it is something that ought to have stuck in his mind. The doctor, however, was asked to recall this conversation some more than two and a half years after the conversation had occurred. In my view it would be totally unrealistic to expect him to remember the conversation. It may not be so unrealistic to expect him to remember that a conversation had occurred. He says it did not, as far as he can remember, and it may be that if the conversation

did occur it did not appear to the doctor that the criticism was as serious as the allegation that is made here before this Tribunal.

It was also submitted that the failure of the doctor to notice a bruise on the left thigh was another indicator of the fact that he had not carried out an examination and some little time was spent in attempting to assess the period that the doctor was at the patient's side. As I have already indicated Nurse A said it was no longer than one or two minutes. Nurse B said that it might have been, at the most, five minutes and Nurse B also said that she was only absent for a minute or two from the bedside of the patient who had fallen and when she came back the doctor had gone.

The doctor himself estimates that the time it would take him to do the examination that he has recorded would be about 10 minutes. Dr A says that such an examination would take about 5 minutes and Dr Bezzina, the peer reviewer, said, when you take into account the various times he gave, that it would take between 13 and 18 minutes. Obviously all the time estimates are different. It is a fact that people can be very mistaken in estimating periods of time and for my part I see nothing in the evidence that has been given about the time to prove affirmatively that the doctor was with the patient only for one or two minutes, or for a period insufficient to carry out the examination he did.

All of those matters need to be taken into account but, as I said at the beginning, the case really comes

down to an assessment of whether the evidence of Nurse A, supported to the extent that it is by Nurse B, can prove this complaint to the comfortable satisfaction of this Tribunal. In my view, bearing in mind the various criticisms and disparities in the evidence, I do not believe that it can and accordingly I would dismiss the complaint. That then will be the decision of the Tribunal.