

IN THE MEDICAL TRIBUNAL OF NEW SOUTH WALES
THE MEDICAL PRACTICE ACT 1992

DEPUTY CHAIRMAN: HIS HONOUR JUDGE J C McGUIRE
MEMBERS: DR D CHILD
DR E KERTESZ
MS J HOUEN

No. 40019/05 – DR Z

REASONS FOR DETERMINATION

26TH APRIL, 2006

The Health Care Complaints Commission complains that Dr Z (“the Practitioner”) being a medical practitioner registered under the Act, has been guilty of unsatisfactory professional conduct within the meaning of Sections 36 of the Act, in that the practitioner has demonstrated a lack of adequate knowledge, skill judgement or care in the practice of medicine and/or engaged in improper or unethical conduct related to the practice of medicine.

Particulars

In September, 2001 at the Villawood Detention Centre, Villawood (the detention centre) the Practitioner treated a female patient, Patient A, who was being detained at the centre. On 25 September, 2001

1. The practitioner failed to:

- a) Take a proper history including details of Patient A's recent illness, presenting symptoms, relevant past illnesses and relevant prior treatment/s;
 - b) Conduct a proper and complete physical examination of Patient A;
 - c) Formulate a proper treatment or management plan for Patient A;
 - d) Make any or any appropriate arrangements for follow up or review of Patient A.
2. The Practitioner inappropriately prescribed Patient A chlorpromazine hydrochloride (Largactil) in a dose which was excessive in all the circumstances.
 3. The Practitioner failed to direct nursing staff at the detention centre:
 - a) To monitor Patient A's fluid consumption and output;
 - b) To closely monitor Patient A after Largactil was administered.
 4. The Practitioner failed to make a proper record of her treatment of Patient A in accordance with requirements of the Medical Practice Regulation 1998 in that she failed to:
 - a) Document adequately the history of the presenting illness, including fluid intake and output;
 - b) Properly record the physical examination conducted;
 - c) Note her observations and signs and/or symptoms;
 - d) Record a management plan;
 - e) Detail appropriate directions to nursing staff at the detention centre relating to the ongoing monitoring and care of the patient;
 - f) Record any follow up or review arrangements.

At the outset of the proceedings before the Tribunal to consider the complaint, Counsel for the HCCC and Counsel for the Practitioner announced that as a result of negotiations, an Agreed Statement of Facts was to be placed before the Tribunal. That statement is in the following terms:

Agreed Facts

Patient A, a 24 year old woman, was detained by Immigration Officers at a brothel at Surry Hills on Sunday, 23 September 2001, and taken to Villawood Detention Centre (“VDC”). She was received at VDC at around 0730 hours and was assessed by a nurse who took a history of recent heroin use. Because she would be withdrawing from heroin whilst detained, Patient A was placed in an observation room, to be watched by Detention Officers, who reported to nurses from time to time about her condition. This was done in accordance with VDC policy.

The practitioner is a general practitioner. At the relevant time, she was contracted to provide medical services to VDC on a sessional basis for ten hours per week, and was on twenty-four hour call from Mondays to Saturdays. Another general practitioner, Dr Amin, also provided sessional services each week day morning. Nurses were on duty at VDC 24 hours a day, 7 days a week.

At around 1430 hours on 23 September 2001, a nurse contacted Dr Amin by telephone to request that he prescribe medication to relieve Patient A’s symptoms of withdrawal. Dr Amin prescribed Maxalon, Valium, Imodium and Buscopan. On 24 September 2001, Dr Amin saw Patient A

in the presence of a nurse in the observation room following the morning clinic session.

Dr Z first became aware of Patient A at around 1845 hours on 24 September 2001, when she was telephoned by a nurse seeking direction about treatment of hand spasm, a side effect of Maxalon. Dr Z prescribed Catapres and Cogentin.

On 25 September Dr Z saw Patient A in the VDC Clinic in the presence of a nurse for review of her withdrawal symptoms. She made notes in Patient A's medical record.

In the progress notes she wrote:

*25/9/01 Vomiting continues - was dystonic yesterday
Not eating
O/E – very emaciated
Dry mouth, lips
Will need to have Sustagen + multivitamins end of week
For Largactil
Catapres
Cogentin
Buscopan

(signed) Z*

Dr Z made other observations of Patient A, carried out other examinations and arranged for other tests to be carried out but did not make a record of any of these matters contrary to the requirements in the Medical Practice Regulation 1998.

In the medication chart she wrote up orders for Largactil, Maxalon, Buscopan, Cogentin and Catapres. Largactil and Catapres are both drugs

known to lower blood pressure. When she wrote up the order for Catapres she directed nursing staff to check Patient A's blood pressure before each administration. However, no records of blood pressure readings can be located. Dr Z's instructions were that the Largactil be administered orally in doses of 25 mg morning and 50 mg at night. However, at 2415 hours on 25 September a nurse gave Patient A 50 mg of Largactil intramuscularly.

In the early hours of the next morning Patient A died. An inquest was held into her death and Dr Z gave evidence. The coroner found that the direct cause of Patient A's death was narcotic withdrawal and the antecedent causes were malnutrition and early acute pneumonia.

Dr Z admits that she failed to make a proper record of her treatment of Patient A, in accordance with requirements of the Medical Practice Regulation 1998 in that she failed to record:

- Patient A's history of drug use, and the symptoms associated with her previous withdrawals from narcotics;
- That Patient A presented as 'uptight' and agitated;
- That Patient A reported that Valium was not giving relief for agitation and that she had had trouble sleeping;
- That Patient A reported that she had used Largactil for relief of symptoms of withdrawal in the past;
- That Patient A reported that she had passed urine that morning, did not have diarrhoea and that she was "feeling better" in relation to the vomiting;

- That Patient A was alert and oriented, that her activity level had increased since the day before, and that skin turgor was okay;
- That a chest examination was performed;
- That urinalysis was to be performed when a urine sample was available;
- That a request for liver function test and blood count was made for pathology;
- That she told nursing staff to monitor Patient A's fluid intake and output.

Dr Z admits Particular 4 (a), (b), (c), (d) and (e) of the Amended Complaint, and admits that her conduct amounts to unsatisfactory professional conduct. The Health Care Complaints Commission does not press particulars 1, 2, 3 and sub-particular (f) of Particular 4 of the Amended Complaint.

It will be seen that the HCCC does not press particulars 1, 2, 3 and sub-particular (f) of Particular 4.

Section 36 of the Act provides that unsatisfactory professional conduct includes any contravention by the Practitioner (whether by act or omission) of a provision of this Act or Regulations.

It is conceded that the deficiencies in the Practitioner's note taking constituted such a contravention.

It is to be noted that the HCCC makes no complaint that the Practitioner's level of treatment or that her conduct in any way impacted upon the death of the patient.

The HCCC submitted that it would be appropriate in the circumstances for the Tribunal to find that the Practitioner is guilty of unsatisfactory professional conduct and to make orders reprimanding her and to provide for her submission to an audit of her medical records at such intervals as the Medical Board considered appropriate.

The Tribunal is comfortably satisfied that the Practitioner's conduct constituted unsatisfactory professional conduct.

It has considered the impressive body of references and testimonials attesting to the Practitioner's competence and the high regard in which she is held both as a doctor and as a person. Comments include the observation of her consistently high standard of practice.

The conduct complained of occurred in 2001. The Practitioner has been in practice since 1981 and there is no suggestion that there was any irregularity or deficiency in her completing consultation notes and records either before or after the single incident in September, 2001.

Indeed, subsequent random audits have demonstrated appropriate records.

Accordingly, the Tribunal declines to make the suggested order with regard to audits of the Practitioner's records.

In all the circumstances, the Tribunal considers that in the interests of the community and the medical profession, the following orders are appropriate.

1. The Practitioner is reprimanded.
2. The Tribunal directs pursuant to Clause 6 of Schedule 2 of the Medical Practice Act that the name of the patient not be published.
3. The Tribunal directs pursuant to Clause 6 of Schedule 2 of the Medical Practice Act that Dr Z's name not be published.

HIS HONOUR JUDGE J C McGUIRE

DR D CHILD

DR EMERY KERTESZ

MS J HOUEN