MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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DECISION NO: 126/00/60D

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

IN THE MATTER of a charge laid by the Director of Proceedings pursuant to Section 102 of the Act against **NGAAMO RUSSELL THOMSON** medical practitioner of Te Kuiti

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mr G D Pearson (Chair)

Dr F E Bennett, Mrs J Courtney, Mr J C Cullen, Dr B D King (Members)

Ms G J Fraser (Secretary)

Ms H Gibbons and Ms P Dunn (Stenographers)

Hearing held at Hamilton on Monday 24 and Tuesday 25 July 2000

APPEARANCES: Ms B Klippel Counsel for the Director of Proceedings

Ms T W Davis, Director of Proceedings

Mr S R Clark Counsel for Dr N R Thomson.

1. THE CHARGE:

1.1 **THE** Director of Proceedings has brought a charge against Dr Ngaamo Thomson. The charge states that the Director of Proceedings has reason to believe that grounds exist entitling the Tribunal to exercise its powers under Section 109 of the Medical Practitioners Act 1995 ("the Act").

1.2 **THE** substance of the ground believed to exist, and the particulars of the charge against Dr Thomson, as notified to him are that:

> "On or about 3 September 1996 you acted in a way that amounted to professional misconduct in that you failed to appropriately assess and then manage the condition of your patient namely Ms Meretina Kura also known as Miriam Kura.
>
> **IN PARTICULAR YOU:**
>
> 1. Failed to recognise the seriousness of your patient's medical condition when you attended upon her;
>
> AND/OR
>
> 2. Failed to establish and follow an appropriate treatment plan consistent with the symptoms of your patient;

AND/OR

3. Failed to refer your patient immediately to hospital;

AND/OR

4. Inappropriately administered an oral preparation to your patient;

AND/OR

5. Failed to obtain your patient's informed consent to your proposed treatment plan;

OR

6. Failed to take reasonable steps to ascertain your patient's view on your proposed treatment plan, including taking into account the views of your patient's whanau as to what was in your patient's best interests;

AND/OR

7. Failed to keep a full and accurate clinical record of your attendance on your patient and your proposed treatment plan."

2. THE HEARING:

2.1 **DR** Thomson denied the charge, and the matter proceeded to hearing. The charge related to Dr Thomson's treatment of the late Ms Meretina Kura on 3 September 1996. Dr Thomson had attended Ms Kura at her home near Te Kuiti. As is now known, Ms Kura was then suffering from a subarachnoid haemorrhage (a leaking blood vessel bleeding into the membranes surrounding the brain,), and complications of that condition led to her death on 16 September 1996.

2.2 **THE** burden of proving the disputed facts is borne by the Director of Proceedings. It is well established that the standard of proof in disciplinary proceedings is the civil standard,

namely, the Tribunal must be satisfied on the balance of probabilities that the material facts are proved. It is equally well established that the standard of proof will vary according to the gravity of the allegations, and the level of the charge. The facts must be proved to a standard commensurate with the gravity of what is alleged: *Ongley v Medical Council of New Zealand* [1984] 4 NZAR 369 @ 375-376.

2.3 **THE** Director of Proceedings called 8 witnesses, namely:

- Ms Dianna Collison, who was a friend of Ms Kura. Ms Collision was present when the subarachnoid haemorrhage occurred, and for some of the time Dr Thomson was in attendance.
- Ms Patricia Roach, who was Ms Kura's sister-in-law, and a close friend. Ms Roach came to Ms Kura's home soon after Ms Kura became ill and was present some of the time Dr Thomson was in attendance.
- Ms Jenni Cox, who is an ambulance officer who was attending Ms Kura at the time Dr Thomson arrived at Ms Kura's home on 3 September 1996.
- Dr John Anthony Birch, who is a medical practitioner, engaged in general practice in the Hokianga area. Dr Birch gave evidence as to the appropriate course for a medical practitioner attending a person having the symptoms Ms Kura exhibited on 3 September 1996. Dr Birch has some 26 years experience practising in an isolated rural area, and he expressed his views in the context of a practitioner in such circumstances.
- Dr Keith Sands Buswell, who is a general practitioner practising at Te Kuiti. Dr Buswell was contacted by the ambulance officers, and later by someone else and

asked to attend Ms Kura. Dr Buswell arranged for Ms Kura to be admitted to hospital.

- Ms Martha Winikerei, who was Ms Kura's sister-in-law. Ms Martha Winikerei was at Ms Kura's home for some of the time that Dr Thomson was in attendance.
- Dr Shane Raymond Reti, who is a medical practitioner, with qualifications in general practice. Dr Reti was involved with the creation of the Pipiwai Health Clinic in 1990, which is the longest-running marae based health clinic in the upper North Island. He completed his family medicine training programme on rural attachments in Dargaville and Rawene. Dr Reti gave evidence regarding the proper course for a practitioner responding to a patient with the symptoms Ms Kura exhibited on 3 September 1996.
- Ms Joanne Ward, who was a second ambulance officer attending Ms Kura at the time Dr Thomson arrived at Ms Kura's home on 3 September 1996. Ms Cox was the senior ambulance officer in attendance. Ms Ward is an enrolled nurse, but she was not attending in that capacity.

2.4 **DR** Thomson gave evidence and called an additional 4 witnesses:

- Mr Panataua Benjamin Rangitaawa, who is an expert in the use of rongoa (Maori medicine), and the related spiritual and health issues.

- Ms Ruby Winikerei, who is the sister-in-law of Martha Winikerei (who was called by the Director of Proceedings). Ms Kura was the aunt of Ms Ruby Winikerei's husband. Ms Ruby Winikerei and Ms Kura were both involved in the kohanga reo at Oparure, just north of Te Kuiti. Ms Kura was the kaiako (head teacher) at the

kohanga reo, and Ms Ruby Winikerei's children attended the kohanga reo. Ms Ruby Winikerei gave evidence about Ms Kura's knowledge and use of rongoa, and the values Ms Kura attached to it.

- Ms Tehuhuti Karamaene Huriwaka, who worked with Ms Kura at the kohanga reo, and was a close friend. Ms Huriwaka also gave evidence about Ms Kura's knowledge and use of rongoa, and the related wairua (Maori spiritual values).

- Ms Jeannie Bettina Nankivell, who is the Chief Executive of Te Rohe Potae o Rereahua Maniapoto Charitable Trust ("Te Rohe Potae"). Te Rohe Potae is an iwi provider. Te Rohe Potae has contracted with various government agencies to provide services to whanau, hapu, and iwi in respect of employment, social services, ACC, health, education and economic development and capacity building. Dr Thomson is employed by Te Rohe Potae to work within the Te Pou Ora Health Clinic based at Te Kuiti.

2.5 **IN** addition to the oral evidence an agreed bundle of documents was admitted by consent.

3. OVERVIEW OF THE EVENTS:

Preliminary:

3.1 **THERE** were elements of inconsistency in the evidence. The Tribunal is satisfied that the inconsistency was a result of all of the witnesses having been party to a very distressing event, and the passage of time since the events; not any deliberate manipulation of recall. In

the circumstances it was not to be expected that the witnesses could have had an exact recall of the series of events.

3.2 **FIRST** we outline our conclusions regarding the background events relating to the charge, and then we deal with some specific matters where the Tribunal has reached conclusions regarding the evidence.

Dr Thomson's practice:

3.3 **DR** Thomson has been a medical practitioner for some 35 years, most of the time in general practice at Te Kuiti, and earlier at Otorohanga. He was the visiting medical officer (anaesthetics) at Te Kuiti Hospital for 20 years. Dr Thomson as we have noted is employed by Te Rohe Potae to work within Te Pou Ora Health Clinic based at Te Kuiti. Te Rohe Potae provides a full range of primary health services within the Maniapoto Rohe. Dr Thomson works fulltime in Te Pou Ora Health Clinic, which also has a nurse, administration receptionist, and community health worker. Some 85% of the patient list are Maori. The Clinic took over Dr Thomson's practice in 1995, when there were some 500 patients in the practice, and there are now about 4,000 patients. Te Rohe Potae has advertised nationally and internationally in endeavours to engage another medical practitioner or practitioners, to ease what is clearly a very heavy workload faced by Dr Thomson. Those endeavours have not been successful. Dr Thomson clearly enjoys the respect and gratitude of his iwi, to which he has given many years of service.

3.4 **FOR** reasons that do not affect our consideration of the charge, there has been some tension between Te Pou Ora Health Clinic and: the Health Waikato Community Health Team, a medical centre based in the Te Kuiti Hospital, and the local ambulance service. The Te Kuiti general practitioners operate the Te Kuiti Hospital, but Dr Thomson does not participate in that arrangement.

Dr Thomson's relationship with Ms Kura:

3.5 **DR** Thomson had known Ms Kura for some 30 years, he knew her as a member of their iwi, and as a friend, but not as a close friend. There were some different perspectives on how well Ms Kura knew Dr Thomson, but we consider that Dr Thomson's evidence on this should be accepted.

3.6 **IN** 1996 Te Pou Ora Health Clinic was offering free health checks, including blood tests and blood pressure tests. Ms Kura was not a regular patient of Dr Thomson's (she usually saw a doctor at Otorohanga), but she took advantage of the free health check. Dr Thomson saw Ms Kura at her home, to take the blood sample, and blood pressure; and later to discuss the results of the blood test. Ms Kura had high cholesterol and mild elevation of her blood pressure. Dr Thomson advised Ms Kura that she should make some lifestyle changes as she was at risk of a stroke.

3.7 **DR** Thomson said that after telling her she was at risk of a stroke Ms Kura told him if she ever got into that condition she did not want to be left in hospital and would rather stay at home. Only Dr Thomson and Ms Kura were privy to this conversation, and we accept Dr

Thomson's description of the discussion. As Ms Kura had not suffered a stroke or other event the discussion can only have been on a general basis. Dr Thomson did not suggest that he had discussed Ms Kura's wishes given various degrees of impairment and potential prognoses; and it is difficult to see how it would be possible to do so in the absence of a specific condition being manifest.

Dr Thomson's first visit to Ms Kura's home on 3/9/96:

3.8 **THE** next material contact between Dr Thomson and Ms Kura was on 3 September 1996. In the early afternoon of 3 September 1996 Ms Kura was at her home with her friend Ms Collison. Shortly after 2-00 pm, or thereabouts, very suddenly, Ms Kura became seriously unwell. Ms Collison described the initial event in this way:

"Mere [Ms Kura] and I were sitting at the table talking normally. I put my head down to look for a cigarette in my pocket. When I looked at Mere, she was looking up at the ceiling and then I saw that her eyes started to roll back in her head. Ginger was in his bedroom. I went and knocked on his door and called out to him that there was something wrong with Mere. He came out and I told him to watch her while I rang the ambulance. I felt really panicky."

3.9 **THE** ambulance arrived quite quickly. When the ambulance arrived Ms Kura was being supported in a chair. We have concluded the ambulance staff:

- Observed that Ms Kura was experiencing a fit or seizure,
- Put Ms Kura into a safe position (the recovery position - on her side on the floor),
- Established from persons present that she had not been unwell until the sudden collapse, she had no known history of epilepsy or seizures, and was not known to be taking medication or subject to allergies,
- Administered oxygen,

- Took Ms Kura's blood pressure (systolic only - by palpation), pulse, and ECG and blood sugar levels.

3.10 **WHILE** the ambulance staff were attending to her Ms Kura was incontinent, and vomited (the latter limiting the opportunity for administering oxygen). While the ambulance staff assisted her, Ms Kura began to regain consciousness, she immediately told them of pain in her head, and she held her head.

3.11 **IT** was at about this point in the sequence of events that Dr Thomson arrived at Ms Kura's home; he had received a telephone call asking him to come.

3.12 **IT** is an established protocol that when a medical practitioner is in attendance the ambulance staff will take instructions from the doctor; which is not to say that the ambulance staff cease to be involved in the care of the patient, or fail to express any concerns they may have.

3.13 **DR** Thomson was briefed by the ambulance officers, they told him Ms Kura's history, the result of the examination and tests they had undertaken, they also indicated that they considered the situation was serious, and Ms Kura should be transported to hospital. Dr Thomson instructed the ambulance officers to stop administering oxygen. In evidence the appropriateness of stopping the administration of oxygen was questioned, however, it was not a particular of the charge. By this time Ms Kura had regained consciousness and told Dr Thomson that she had a headache. We are satisfied that it must have been evident to

Dr Thomson that Ms Kura was complaining of extreme pain in her head. Dr Thomson carried out motor tests and Ms Kura was able to function normally. There was some conflict in the evidence regarding the motor tests, in that some witnesses who might have been expected to see the tests did not see them. We are satisfied that Dr Thomson's evidence of carrying out the tests is correct. An experienced practitioner could carry out such tests without attracting particular attention. Dr Thomson (or possibly the ambulance staff) also took a blood sample from Ms Kura.

3.14 **AFTER** Dr Thomson arrived Ms Kura said she wanted to go to the toilet. The ambulance officers did not consider that was appropriate as they thought Ms Kura was safest remaining on the floor. The ambulance officers had not allowed Ms Kura to go to the toilet as they thought it would be dangerous to move her in that way. We are satisfied that Ms Cox, one of the ambulance officers, said to Dr Thomson when the subject of going to the toilet was raised that Ms Kura could have some type of intracranial haemorrhage (there are different types of conditions where a broken blood vessel results in bleeding into the tissue of the brain or the surrounding membranes, "intracranial haemorrhage" is a general term covering all of them). We note that after leaving Ms Kura's home Ms Cox reported to the ambulance controller that she suspected that Ms Kura was having a subarachnoid haemorrhage, and that was recorded by the controller in the computer records.

3.15 **DR** Thomson made the decision that Ms Kura should be assisted to the toilet, and she was. While in the toilet Ms Kura had another collapse or fit, with lessened level of consciousness.

3.16 **MS** Kura regained consciousness after being assisted from the toilet. Dr Thomson conveyed to the ambulance staff that they should leave, as Ms Kura would not be transported to hospital.

3.17 **DURING** the course of these events Ms Kura asked to be given a Koromiko leaf infusion to drink. Ms Kura had the leaves to prepare the infusion. Dr Thomson asked one of the persons present to prepare the infusion. The infusion was prepared, it was not materially (if any) more viscous than water. Ms Kura drank a small quantity of the Koromiko infusion, and vomited.

3.18 **THE** ambulance staff left Ms Kura's home soon after 3.00 pm, we are satisfied that before they left they made it clear to Dr Thomson that they believed that Ms Kura's condition was serious, it might be an intracranial haemorrhage, and that they believed Ms Kura should be in hospital.

3.19 **FOR** completeness we observe that it was clear that Dr Thomson attended Ms Kura as a medical practitioner, despite being a friend. It did not appear that Dr Thomson took any significant issue with this point, but there was some evidence that could be pertinent to that issue. However, in view of the fact that Dr Thomson took charge, examined Ms Kura, directed that the ambulance staff cease administering oxygen, and decided that Ms Kura should stay at home (despite the ambulance officer's views), puts the matter beyond doubt. Dr Thomson attended Ms Kura as a medical practitioner on 3 September 1996.

3.20 **WHILE** he was at Ms Kura's home Dr Thomson arranged for Ms Kura to be put into her bed.

3.21 **VARIOUS** members of Ms Kura's whanau were present while Dr Thomson was in attendance, her husband was working, possibly difficult to contact, and expected to return home in the late afternoon.

3.22 **DR** Thomson then left Ms Kura's home and told the people at her home that if anything untoward should happen they were to ring him, and that in any case he would return later.

3.23 **DR** Thomson had other patients he wanted to attend to, and intended to return to the house later and discuss Ms Kura's condition with her husband. He would then have been able to reconsider whether Ms Kura should be admitted to Te Kuiti Hospital. There is no record that clearly identifies when Dr Thomson left Ms Kura's house, but it was sometime after the ambulance left. The ambulance left shortly after 3-00 pm.

Ms Kura being taken to Te Kuiti hospital:

3.24 **MS** Cox, one of the ambulance officers, soon after leaving Ms Kura's home, telephoned Dr Buswell. Dr Buswell was a Te Kuiti general practitioner, and he was the doctor who was on call for the Te Kuiti Hospital and Medical Centre on that day. Ms Cox said that she would not normally do that, as it was for Dr Thomson, the doctor in attendance, to make decisions concerning the patient. However, Ms Cox felt very strongly that Ms Kura

was in danger, and that Dr Thomson had not set up an appropriate management plan for Ms Kura in light of the symptoms she presented with.

3.25 **DR** Buswell was in a difficult position as he considered he could not go to Ms Kura's home and impose himself on another practitioner's patient, without an invitation from the patient or her family.

3.26 **IT** appears that Dr Buswell was briefed on Ms Kura's condition, and he told Ms Cox that he would need to be called by a member of the family before he could attend. In making that decision Dr Buswell was influenced by his belief that Ms Kura's life was probably not in immediate danger, having regard to the information he was given, particularly that Ms Kura had regained consciousness after the seizure or fit. Later, Dr Buswell estimates about 1½ hours later, Dr Buswell received a telephone call, apparently from Ms Martha Winikerei's daughter Marama requesting that he attend Ms Kura. Dr Buswell told the ambulance staff to get Ms Kura and bring her to the Te Kuiti hospital.

3.27 **THE** Te Kuiti hospital is a community hospital that cannot undertake advanced care or perform sophisticated investigations in the way that the Waikato Hospital can. The Te Kuiti Hospital has services provided by five general practitioners, they practise in Te Kuiti, and have a medical centre located in the hospital grounds (the medical centre operates independent of the Hospital). In addition a consultant physician and a consultant surgeon also provide services to the Te Kuiti Hospital. Dr Thomson is the only medical practitioner in Te Kuiti who does not provide services to the Hospital.

3.28 **TE KUITI** Hospital provides an environment in which patients can be closely monitored. If a decision is made to transport the patient to Waikato Hospital transportation will take an hour, to an hour and a half, by road. The air ambulance team can fly from Waikato. It may take in the order of an hour from calling the air ambulance (which comes from Hamilton) to transport the patient to Waikato Hospital; but there is the advantage that the specialist team can arrive by helicopter in as little as 20 minutes and immediately provide expert assistance.

3.29 **THE** ambulance brought Ms Kura to Te Kuiti Hospital at about 4:30 pm, and Dr Buswell saw her at the hospital. Dr Buswell was told of the history by the ambulance officers, exactly what was said is not clear. Dr Buswell undertook an examination of Ms Kura and made a provisional diagnosis of a cerebral haemorrhage (bleeding from the brain). Dr Buswell then contacted the air ambulance service, and asked that they come and transport Ms Kura to Waikato Hospital. At about 5:25 pm Ms Kura had another seizure and became deeply unconscious. The air ambulance arrived with an intensive care team about 5 minutes later, and took her to Waikato Hospital.

Dr Thomson's second visit to Ms Kura's home on 3/9/96:

3.30 **DR** Thomson, as he had said he would, returned to Ms Kura's home. The precise time is not clear, but it was after Ms Kura had been taken to hospital. Ms Kura was taken to hospital shortly after 4-00 pm. When he got to the house, Dr Thomson was told a second opinion had been obtained, and that Ms Kura had been admitted to hospital. Dr Thomson returned to his surgery and made notes relating to Ms Kura.

Dr Thomson's notes:

3.31 **DR** Thomson recorded his notes at 5:19 pm on 3 September 1996, and aside from recording Ms Kura's name, address, date of birth, age, and administrative details the notes stated:

"3/9/96 Called to house, ambulance present, 3pm, BP=140 Pulse 120, ECG - No Q waves, No ST changes, Blood> Lab, Headache Put to bed."

Ms Kura's death:

3.32 **THE** material produced by consent indicates that after Ms Kura was transferred to Waikato Hospital she had a CT scan, and it revealed an extensive subarachnoid haemorrhage, probably as a result of a right middle aneurysm (artery becoming weakened and distended, and in this case bursting). Ms Kura was medicated, and further CT scans were taken. Ms Kura did not regain consciousness. On 14 September 1996 a CT scan revealed total right cerebral hemisphere infarction (death of the tissue in the right side of the brain). Medical support was then withdrawn, and later ventilation discontinued. Ms Kura died shortly after 3:00 pm on 16 September 1996.

4. PARTICULAR FINDINGS:

Diagnosis:

4.1 **THERE** was conflicting evidence regarding Dr Thomson's diagnosis of Ms Kura's condition when he attended her on 3 September 1996. The prosecution contends that Dr Thomson did not appear to regard the condition as a serious one, or at least not as serious as the symptoms suggested. There was evidence from persons present to that effect. The prosecution also contended that Dr Thomson did not respond to Ms Kura's condition in a

way that was consistent with him considering that it was possible she had an intracranial haemorrhage. Those actions included permitting Ms Kura to go to the toilet, not sending her to the hospital, and letting her drink. In addition persons present heard Dr Thomson use the word "flu" or "influenza" when discussing what was wrong with Ms Kura. We are satisfied that he did so. Some witnesses also thought Dr Thomson was not taking the situation seriously.

4.2 **DR** Thomson however has given evidence that he did consider Ms Kura may have had an intracranial haemorrhage, that he did not diagnose that Ms Kura had the "flu", but he may have made a differential diagnosis of "influenzal encephalitis" (infection of brain tissues by an influenza virus). Dr Thomson gave evidence of an incident some years before where he had a series of patients who had what he believes was influenzal encephalitis, with some similarity to Ms Kura's symptoms.

4.3 **THERE** is a conflict in the evidence, Ms Cox says she told Dr Thomson that Ms Kura had a subdural haemorrhage (a bleed in the membranes surrounding the brain, but nearer the surface than the membranes involved in a subarachnoid haemorrhage), and she said that Dr Thomson responded by saying *"no, she's got the flu, who's the doctor?"* Dr Thomson says he "*indicated to the ambulance officers that she could have a bleed from the blood vessels in the brain. I did not diagnose that Ms Kura had the flu, however I may have made a differential diagnosis of influenzal encephalitis.*" It is clear that there was a degree of tension between Ms Cox and Dr Thomson, apparently relating to an incident that took place sometime before. We are satisfied that Dr Thomson

did use the word “flu” or “influenza”. However, it appears that Dr Thomson may have been less than frank with Ms Cox as to his assessment of Ms Kura’s condition.

4.4 **IT** is clear that it was not possible to make a definitive diagnosis of Ms Kura’s condition without undertaking assessments that could only be undertaken in hospital. However, we are satisfied Dr Thomson knew it was very likely that Ms Kura had an intracranial haemorrhage. We have had careful regard to Dr Thomson’s evidence, including his evidence that he was concerned that Ms Kura could die at any moment. In addition we have considered factors that make Dr Thomson’s evidence that he thought that an intracranial haemorrhage was a likely cause of Ms Kura’s condition inherently believable. First, is the fact that Ms Kura’s symptoms pointed very clearly indeed to a possible intracranial haemorrhage, and Dr Thomson is an experienced doctor of many years standing. Second the ambulance officers specifically told him that they believed that was the cause of Ms Kura’s condition. Third, Dr Thomson did regard Ms Kura’s situation as serious enough to warrant him returning later in the afternoon. Finally, in the light of the inadequate treatment plan for Ms Kura’s condition, which we discuss below, it is a frank admission on Dr Thomson’s part to acknowledge that he appreciated how serious Ms Kura’s condition could be.

4.5 **DR** Thomson had a particular reason for considering that influenza was a possible causal factor (though it should have been seen as unlikely given the sudden onset of the condition), and he may well have chosen to find a reason not to simply accept what Ms

Cox said. Accordingly, the fact that Dr Thomson mentioned the flu or influenza does not show that he was not cognisant of the possibility of an intracranial haemorrhage.

4.6 **WE** note that Dr Thomson's notes do not refer to any intracranial event as a potential diagnosis, but the notes do not refer to any diagnosis at all.

Acceptability of treatment plan:

4.7 **DR** Thomson's treatment plan had two elements, first that Ms Kura should rest in bed, and second that the situation would be re-evaluated.

4.8 **WE** are satisfied that Dr Thomson's treatment plan was seriously inappropriate. He had identified:

- That Ms Kura had a potential intracranial haemorrhage,
- That Ms Kura had been experiencing some form of seizure, and varying levels of consciousness (with no history of epilepsy or other condition that would predispose her),
- That Ms Kura was experiencing severe pain,
- That Ms Kura was incontinent, and vomiting.

4.9 **WE** are satisfied that unless there were special factors requiring a different approach a person exhibiting such symptoms should have been taken to a hospital, and the circumstances demanded urgency. The only special factor raised was a claim by Dr

Thomson that Ms Kura had instructed him that she should not be admitted to hospital in the circumstance she was found on 3 September 1996. We consider that issue below.

4.10 **GIVEN** the symptoms, the manifest need for hospitalisation could not have been altered by re-evaluation after waiting for a period of time. Faced with the symptoms identified we are satisfied that it is not possible to obtain a definitive and specific diagnosis without admission to a hospital. In hospital there is the opportunity for further medical treatment, and possibly surgical treatment. That factor is, in itself, sufficient to demand that the patient be transferred to a hospital as soon as possible. In addition the medical treatment would potentially include sedation, which would make the patient more comfortable (Ms Kura was in intense pain), as well as other potential interventions that could improve the patient's condition. There are also obvious hazards in leaving a patient who is experiencing seizures, varying levels of consciousness, and vomiting, without medical supervision to ensure that the patient's airway is kept clear. While the ambulance staff were in attendance they were protecting Ms Kura in that way.

Consent to treatment plan:

4.11 **HAVING** determined that deciding not to send Ms Kura to hospital immediately was not an acceptable treatment plan, it is necessary to consider the reason advanced in justification of that course of action. Dr Thomson gave evidence that the course of action he took was influenced by what Ms Kura told him when he discussed the results of her blood test and blood pressure reading, sometime 6 months earlier.

4.12 **IT** is of course open to a patient, who is adequately informed of the consequences, and who has the capacity to decide, to refuse medical treatment, or some form of medical treatment. It is also appropriate for whanau to express wishes that will be respected concerning treatment options, and withholding treatment in the context of end of life decisions.

4.13 **DR** Thomson's evidence regarding his discussions with Ms Kura was this:

"After receiving the blood test results … I recall warning Mrs Kura that she was a candidate for a stroke. She said that if she ever got into that condition, that she did not want to be left in hospital and would rather stay at home.

The clinic did not retain notes … however I certainly recall having those discussions with Mrs Kura."

4.14 **DR** Thomson said he did not discuss the option of going to hospital with Ms Kura on 3 September 1996, the evidence indicates that such a discussion would not have been possible having regard to the intense pain Ms Kura was suffering, and her varying levels of consciousness. Dr Thomson did however elaborate on the earlier discussion, he said:

- Ms Kura, when discussing the risk of a stroke, had said she was not frightened of dying, and was adamant that she did not want to live as an invalid.
- Dr Thomson asked what he was to do *"when it comes to that time"*, and Ms Kura *"just told [Dr Thomson that he] would know what to do"*. He said *"Oh, well, what I can do, Mere, is keep you at home"*, and she said *"Yep, I'm quite happy with that."*
- Dr Thomson and Ms Kura had discussed wairua, and that she was quite happy for her wairua to travel on.

- The discussion had taken place some 6 months before the events of 3 September 1996.
- Ms Kura had been very strong and forceful when she expressed her wishes to Dr Thomson.

4.15 **WE** accept Dr Thomson's evidence of the discussion he had with Ms Kura some 6 months before she became ill. However, we do not consider that it can be taken as a justification for delaying Ms Kura's admission to hospital. It is clear from the evidence that Ms Kura had a discussion regarding not wanting to be left incapacitated, or have treatment that may prolong a period of permanent incapacitation. That discussion, which took place in the absence of any specific condition affecting her could not justify failing to seek the best response to the symptoms Ms Kura presented with on 3 September 1996. We have reached that conclusion as:

- It was not possible to provide a definitive diagnosis when Dr Thomson attended Ms Kura. Dr Thomson was not in a position to conclude the cause of Ms Kura's illness was something from which full recovery would not be possible; or that medical or surgical intervention would not make full recovery possible or more likely,
- Ms Kura was in intense pain, there was nothing in the discussion that Dr Thomson had that absolved him from responsibility to see that Ms Kura had the opportunity of medical intervention to make her as comfortable as possible,
- The discussion never addressed the issue of leaving Ms Kura in a vulnerable state without a health professional in attendance to ensure she did not suffer harm from losing consciousness and having her airway obstructed,

- Ms Kura, or her whanau if she was not in a position to decide for herself, had to have a competent differential diagnosis, and competent description of the prognosis based on that differential diagnosis before making any decisions regarding having less than the treatment and care demanded by the symptoms which she presented. The discussion Dr Thomson had with Ms Kura was not directed to the symptoms she presented with, and she could not be taken to have expressed an informed consent relating to the situation Dr Thomson faced on 3 September 1996.

Use of rongoa:

4.16 **WE** are satisfied that Ms Kura asked Dr Thomson for an infusion of Koromiko leaves, in the expectation that it might reduce her nausea and vomiting. Ms Kura had the Koromiko leaves available. The Director of Proceedings did not suggest that the Koromiko leaves could have been harmful or inappropriate, except in the sense that taking any liquid by mouth could have been harmful.

4.17 **THE** evidence indicates that a conservative response from a general practitioner would be to avoid any intake of food or liquid pending evaluation at a hospital. However, we accept Dr Thomson's evidence that he acted appropriately. First Ms Kura wanted to take the Koromiko leaves, that involves issues of wairua, as well as the medicinal properties of the Koromiko leaf infusion. We accept Dr Thomson's evidence that it was reasonable to believe that Ms Kura's wishes should be respected, and that consuming a small drink with the viscosity of water did not constitute a significant hazard in the circumstances. The patient did not have an empty stomach at the time and was already vomiting, accordingly

the risk of aspiration (material being sucked into her respiratory tract/lungs) was not significantly affected - and Dr Thomson made a judgment that taking the Koromiko leaf infusion could relieve the vomiting. It there was to be any surgical intervention, it would not be immediate and the small amount of liquid would not greatly change the situation the patient was already in, in relation to being prepared for surgery.

Previous disciplinary process irrelevant:

4.18 **THERE** was evidence that Dr Thomson had previously been the subject of a professional disciplinary charge, and that charge had been established. It appears that Dr Thomson had failed to respond adequately to a patient in a hypoglycaemic coma. Counsel for the Director of Proceedings contended this was similar fact evidence.

4.19 **WE** do not consider that the previous disciplinary proceedings add in anyway to the evidence in support of the charge. The so-called "similar fact evidence" amounts to no more than, that on a previous occasion Dr Thomson made a serious error of judgment responding to a patient who was unconscious. It would be wrong to infer that because a practitioner made an error of judgment on one occasion they were more likely to have made an error of judgment on another occasion.

4.20 **THIS** was not a case where a patient gives evidence of improper behaviour, and the practitioner denies having engaged in such behaviour; and the prosecution seeks to adduce evidence of similar behaviour on a past occasion. There are occasions when such evidence is sufficiently probative to be admitted. In this case there is no dispute as to whether events

occurred, or did not occur, in respect of which the events of the previous occasion can be in anyway probative.

4.21 **THE** only issue in respect of which the previous incident could be relevant was as to whether Dr Thomson's judgement was appropriate or acceptable - not to determine what actually happened. However, that would amount to no more than asserting that because Dr Thomson had made a mistake responding to a patient on one occasion he had a propensity to make mistakes, so we should more readily conclude he had made a mistake on this occasion. How Dr Thomson responded to another patient with a different condition, and a different set of symptoms, cannot possibly assist in determining what events occurred on this present occasion; or whether his judgment was deficient or otherwise.

4.22 **ACCORDINGLY** we have not taken this evidence into account.

Dr Thomson's treatment did not affect the outcome for Ms Kura:

4.23 **IT** is not necessary for us to determine whether the delay in transferring Ms Kura to Waikato Hospital caused her death, or detrimentally affected her prospects of recovery. The charge must fail, or be made out, on the basis of whether Dr Thomson responded properly to the circumstances in which he found himself - not the fortunate or unfortunate consequences of any error of judgment. However, during the course of the hearing comments were made to the effect that *"we will never know whether the delay caused Ms Kura's death"*. Accordingly, in case it is contended to be an issue relevant to penalty,

and having regard to the feelings of Ms Kura's whanau, and Dr Thomson, it is appropriate that the Tribunal express its conclusions regarding this issue.

4.24 **WE** are satisfied there is no doubt that Dr Thomson's failure to transport Ms Kura to hospital immediately made no difference to the outcome. The Tribunal has considered the records from the Waikato Hospital, which were produced by consent. When Ms Kura arrived at the Hospital she received medical treatment, including sedation, and her condition was evaluated and monitored. Surgical intervention was not appropriate. In the majority of cases where there is a severe subarachnoid haemorrhage the patient will not recover, and there is nothing that can be done to prevent that outcome. Ms Kura was unfortunately such a case, and nothing could have changed that.

5. DECISION:

Legal principles:

5.1 **THE** test for professional misconduct is well established, see for example *Ongley v Medical Council of New Zealand* (1984) 369 @ 375:

> *"Has the practitioner so behaved in a professional capacity that the established acts under scrutiny would reasonably be regarded by his colleagues as constituting professional misconduct? With proper diffidence it is suggested that the test is objective and seeks to gauge the given conduct by measurement against the judgment of professional brethren of acknowledged good repute and competency, bearing in mind the composition of the tribunals which examine the conduct. …"*

5.2 **IN** accordance with the decision of the Court of Appeal in *Duncan v MPDC* [1986] 1 NZLR 513, the Tribunal, dealing with a comprehensive charge, considered each of the particulars supporting the charge separately. Having made findings on each of the

particulars, we then determined the overall gravity of the conduct that fell short of adequate standards.

The charge:

5.3 **WE** are satisfied the charge is established, Dr Thomson acted in a way that amounted to professional misconduct, in that he failed to appropriately assess (in the sense that hospitalisation would have resulted in further investigation and diagnosis), and manage the condition of his patient Ms Meretina Kura. We have however not concluded that all of the particulars have been established. We record our conclusion in respect of each of the particulars, and identify the extent to which proven particulars establish the charge.

5.4 The first particular was that:

Dr Thomson failed to recognise the seriousness of his patient's medical condition when he attended upon her.

We have concluded that particular was not established. For the reasons we have identified, we are satisfied that Dr Thomson knew that Ms Kura's condition was serious, and that it was very likely to be an intracranial haemorrhage.

5.5 **THE** second and third particulars were that:

Dr Thomson failed to establish and follow an appropriate treatment plan consistent with the symptoms of his patient.

And/or

Failed to refer his patient immediately to hospital.

For the reasons identified we are satisfied that these particulars are both established. We have determined that these particulars are in themselves sufficient to establish the charge of professional misconduct. This error of judgment was serious enough to compel us to conclude that the charge was established at the level of professional misconduct. In reaching these conclusions we have had regard to the fact that:

- Urgent definitive diagnosis was demanded by the symptoms Ms Kura presented when examined by Dr Thomson. That could have led to important medical or surgical intervention, though as it transpired in Ms Kura's case nothing that could alter the outcome was possible - but Dr Thomson could not know that when he examined Ms Kura.
- Ms Kura was in extreme pain, and she was likely to be able to be made more comfortable in hospital.
- It was not safe to leave Ms Kura with no medical professional in attendance when she was vomiting and experiencing varying levels of consciousness.
- The inappropriateness of failing to urgently transfer Ms Kura to a hospital, and leaving her unattended is all the more grave due to the fact that Dr Thomson dismissed an ambulance and the attending staff. The ambulance staff were preparing to transfer Ms Kura to hospital, and they specifically drew Dr Thomson's attention to the seriousness of the situation. This was not a case were Dr Thomson was simply tardy in taking appropriate action, he actively intervened to stop the appropriate, necessary and conventional response to Ms Kura's circumstances.

5.6 **THE** fourth particular was that:

Dr Thomson inappropriately administered an oral preparation to his patient.

For the reasons we have identified, we do not consider that this particular is established. We do not find Dr Thomson's actions inappropriate in that regard.

5.7 **THE** fifth and sixth particulars were alternatives:

Dr Thomson failed to obtain his patient's informed consent to his proposed treatment plan.

Or

Failed to take reasonable steps to ascertain his patient's view on his proposed treatment plan, including taking into account the views of his patient's whanau as to what was in his patient's best interests.

The issue of informed consent has two dimensions in the present case. It is a particular of the charge, which needed to be proved by the Director of Proceedings if it was to be established. In addition, Dr Thomson raised informed consent as a defence to the charge that he failed to respond adequately to Ms Kura's condition.

In terms of being a particular of the charge, the significance of informed consent is affected by our findings in respect of other particulars. Had we found that Dr Thomson's diagnosis, treatment plan, and treatment (including not immediately transferring Ms Kura to hospital) were appropriate then informed consent would have stood as a determinative ground in support of the charge. Having found that Dr Thomson's treatment plan was seriously inappropriate, lack of informed consent could amount to an aggravating feature. Though in any event, it is not likely that a patient would give informed consent to a treatment plan they knew was seriously inappropriate. However, if a patient did give truly informed consent,

and insist on, what would otherwise be a deficient treatment plan, the practitioner may be obliged to act in accordance with the patients wishes.

We are satisfied that in the present instance lack of informed consent was not made out as an element of the charge, so it does not affect our finding regarding the deficient treatment plan. On 3 September 1996 Ms Kura was not in a position to give informed consent to a treatment plan. She was in too much pain, and her capacity for sound decision making severely compromised by her condition. Furthermore, while members of Ms Kura's whanau were present we are not satisfied they were in a position to make a decision that Ms Kura should have less than optimum treatment. Ms Kura's husband had to at least have the opportunity of contributing to such a decision. Arguably, Dr Thomson could have taken positive steps to locate Ms Kura's husband sooner, that is however less than clear, and certainly not enough to establish a disciplinary offence in this case.

Accordingly, Dr Thomson was dealing with a patient from whom informed consent could not be obtained in the circumstances, and full consultation with her whanau was not immediately possible. Dr Thomson's obligation was therefore to provide the most appropriate care unless and until Ms Kura and/or her whanau were in a position to give informed consent to do otherwise.

Dr Thomson raised informed consent (in a discussion some six months earlier) as a justification for not providing Ms Kura with the optimum or most appropriate care. We have concluded, for the reasons stated, that claim must fail on the facts. The discussion Dr

Thomson and Ms Kura had some six months earlier could not, and did not, amount to informed consent that excused Dr Thomson from having Ms Kura transported to hospital urgently. The discussion did not direct Ms Kura's mind adequately to the issues raised by the symptoms she had on 3 September 1996; and she did not give instructions directed, other than in the most general sense, to the issues raised by those symptoms.

Accordingly, the absence of informed consent has not been proved as an element of the charge, and this particular fails. Dr Thomson raised a positive defence of informed consent, and that has not been established as a defence to the charge.

5.8 **THE** seventh and final particular is that:

Dr Thomson failed to keep a full and accurate clinical record of his attendance on his patient and his proposed treatment plan.

We find on the facts that this particular is established. It is a professional obligation to keep adequate clinical records. Clinical notes enable a practitioner to pass on accurate information to other health professionals who may be treating the patient, and ensure that the patient can obtain information regarding treatment at a later point in time should they need it. The notes were inadequate, there is no diagnosis (differential or otherwise), and the treatment plan extended only as far as saying Ms Kura had been "put to bed". Dr Thomson knew Ms Kura was likely to be suffering a very serious condition, and he had made a most unusual response. He has said that his response was in part based on an earlier discussion, which was not itself recorded at the time. The notes are inadequate to convey:

- The condition Dr Thomson found Ms Kura in,
- What he was going to do about it (other than bed rest), and
- Why he did not take the appropriate and usual step of permitting the ambulance staff transport Ms Kura to hospital as they were intending to do.

In the circumstances the notes should have at least recorded that information in a comprehensible form.

We do not conclude that the inadequate notes would in themselves be sufficient to establish the charge at the level of professional misconduct, they were however an element of the management of Ms Kura's condition that was deficient. Whether the notes would be sufficient to establish the charge at a lower level is not a matter we are required to determine. However, the inadequate notes were part of the overall conduct that was sufficient to establish the charge at the level of professional misconduct, and amounts to an aggravating feature.

5.9 **ACCORDINGLY** our conclusion is that Dr Thomson acted in a way that amounted to professional misconduct, in that he failed to appropriately assess, and then manage the condition of his patient Ms Meretina Kura, as he:

- Failed to establish and follow an appropriate treatment plan consistent with the symptoms of his patient, and failed to refer his patient immediately to hospital (which was a necessary part of an appropriate treatment plan - that would have led to obtaining a definitive diagnosis); and

- Dr Thomson's failure to manage properly the condition of his patient included a failure to keep a full and accurate clinical record of his attendance on his patient and his proposed treatment plan, which affects the overall gravity of the conduct (but was not professional misconduct in itself).

6. SUBMISSIONS ON PENALTY:

6.1 **WE** invite counsel for both parties to make written submissions on penalty in accordance with the following timetable:

- The Director of Proceedings to file submissions with the Secretary, and serve it on the solicitors for Dr Thomson not later than 14 days from the receipt of this decision,
- Dr Thomson to file submissions with the Secretary, and serve it on the Director of Proceedings not later than 14 days from the receipt of the Director of Proceeding's submissions

6.2 **COSTS** are reserved.

6.3 **IN** the course of evidence it emerged that Dr Thomson had previously had some condition imposed on his practice arising out of a disciplinary process, and may have been subject to a competence review. Dr Thomson in evidence was unsure of the detail of what had occurred.

6.4 **IT** appears that these matters are recent, and they may well affect the orders the Tribunal should make. For example, if a competence review has been undertaken recently, and it dealt with issues raised by this charge, on the face of it there will be little point in having another review.

6.5 **ACCORDINGLY**, the Tribunal records that it would be helpful to know what has taken place recently in respect of supervision, competence review, or other similar matters. We also record that a competence review involves issues of confidentiality and privacy, and the Tribunal does not wish to intrude unnecessarily or inappropriately. Nonetheless, if Dr Thomson has been subject to a competence review process he may wish to consent to disclosure of the scope of the review, whether it progressed to a conclusion, and if so what it was.

6.6 **LEAVE** is reserved to the parties to apply for orders or directions in respect of information relating to any earlier supervision or review.

DATED at Wellington this 21st day of August 2000

.....

G D Pearson

Deputy Chair

Medical Practitioners Disciplinary Tribunal