MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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PUBLICATION OF THE NAME OF THE PATIENT AND COMPLAINTANT IS PROHIBITED	**DECISION NO:**	250/03/101D
	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 **ANTON FRANCOIS HAUPTFLEISCH** Medical Practitioner of Levin

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL:

TRIBUNAL: Ms P Kapua (Chair)

Dr F E Bennett, Mrs J Courtney, Dr F McGrath, Dr A A Ruakere (members)

Ms G J Fraser (Secretary),

Mrs H M Hoffman (Stenographer)

Mrs J Kennedy (Scopist)

HEARING Held at Wellington on Monday 28 and Tuesday 29 July 2003

APPEARANCES: Ms T Baker and Mr J Tamm for the Director of Proceedings

Mr H Waalkens and Ms G Phipps for Dr A F Hauptfleisch

Introduction

1. Dr Hauptfleisch is a registered medical practitioner. He practices as a general practitioner in Levin and appears to have been in that practice since 1996. At the time of the events giving rise to the charge before this Tribunal Dr Hauptfleisch was a general practitioner based in Levin.

The Charge

2. On 2 April 2003 the Director of Proceedings charged Dr Hauptfleisch with professional misconduct in respect of his care and management of Mrs A between 26 April and 27 April 2001.

3. The particulars of the charge allege:

> *"1. On or about 26 April 2001 you failed to consult with, or refer Mrs A, to a specialist or other medical practitioner in a timely manner for the purposes of excluding or confirming a diagnosis of intracranial haemorrhage or other abnormality in the brain.*
>
> *AND/OR*
>
> *2. On or about 27 April 2001, having been advised by your patient's husband Mr A that there was no improvement in your patient's condition you:*
>
> *(a) refused to consult with a specialist when asked to by Mr A; and/or*
> *(b) failed to refer your patient, or assist referral of your patient, to a specialist in a timely manner.*

4. The charge alleges that the particulars either separately or cumulatively amount to professional misconduct. At the commencement of the hearing Ms Baker withdrew particular (2)(a) of the charge.

5. In a decision dated 25 July 2003 the Tribunal granted applications for a permanent order prohibiting publication of the name and identifying details of the patient involved and the name and identifying details of the complainant.

6. In a decision issued contemporaneously with this decision the Tribunal has set out the reasons for declining Dr Hauptfleisch's application for interim name suppression on 22 July 2003.

Factual Background

7. There was general agreement between the parties as to the facts of what had occurred on 26 and 27 April 2001.

8. Mrs A is 47 years of age and has had epilepsy since she was 11 years old. Although she did experience some migraine headaches at the onset of puberty she had not experienced many headaches and had gone for about 18 years, from 1973 until 1990, without a fit.

9. In November 1992 she was employed at xx and experienced pain in her head while at work. She described it thus:

> *"I felt as though there was a band right around my head. It was very sudden. I remembered that I was in so much pain that I couldn't answer the phone."*[1]

She remained unwell for a number of days and after having two grand mal seizures she was taken to Palmerston North Hospital where she was discharged after two days. A subsequent CT scan revealed that she had an arteriovenous malformation ("AVM"). There was some suspicion that her experience in 1992 was a brain haemorrhage but because of the time between the event and the scan it could not be confirmed. She was advised that her AVM could be operated on but because of her epilepsy and because she did not have a history of brain haemorrhages she opted for radiotherapy.

Following that incident Mrs A has continued to be monitored by Dr Bala Krishnan of the Neurosurgery Department at Wellington Hospital. In May 2000 she had an MRI and was told that everything was fine. Between 1993 and 2001 she has had about three or four fits. Prior to the events of April 2001 she had last had a fit in November 2000.

10. On the 26 April 2001 Mrs A was at work having returned from a month's holiday in the South Island. Mrs A described herself as feeling very relaxed and not feeling particularly stressed.

11. In the year prior to that she had been through a stressful time with her daughter and her son. At the time of a fit in November 2000 she had mentioned this stress to Dr Hauptfleisch and he had recorded it in her notes as *"stress + + +"*[2]. However at the time that she and her husband went away on holiday Mrs A was feeling happy and rested and had been in contact with her daughter prior to the holiday.

12. On the 26 April 2001 Mrs A suddenly felt dreadful at about 4.30 p.m.. She describes it thus:

> *"I got an instant headache, starting in the back of my head and spreading around my head. I felt as though I had a tight band around my head. I felt really awful."*[3]

Mrs A sought help from the office manager and asked them to ring her husband but he was still on his way back to Levin from Masterton. He suggested that they ring Mrs A's sister who came to pick her up. Someone from work had also rung ahead to the doctor's surgery. On the way to the doctor's surgery Mrs A vomited and on arrival at the surgery she was placed in the nurse's room. She could not walk without aid and was holding her head because of the pain.

13. When Dr Hauptfleisch came to see her she told him that she had had this before. He examined her including feeling the back of her neck and advised her that he considered that she had had a muscle spasm in her neck. The doctor's notes on that date states:

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[1] Evidence of PM A, para 4
[2] Bundle of Documents, p9

"Tight band around back of head unable to hold head properly BP l(arm) 100/80 r (120/70) vomited x 1, Voltaren inj im 75/3 mls L(im)."[4]

14. Dr Hauptfleisch's practice nurse, Ms Berquist, had written the note and she records Mrs A's arrival as:

"Mrs A appeared to be in pain, had her eyes closed and was holding her head. I found it very difficult to get a good history from her and her sister often answered for her. She told me that she had a headache like a tight band around the back of her neck and it was exactly like that she had with an aneurysm several years ago."[5]

15. It is not clear whether the advice given to Dr Hauptfleisch about the earlier incident was taken into account by Dr Hauptfleisch and the Tribunal has not had the benefit of hearing directly from Dr Hauptfleisch.

16. On Dr Hauptfleisch's instructions, Ms Berquist gave Mrs A a Voltaren injection and was asked to monitor her. Ms Berquist told the Tribunal that that observation involved:

"I just, sort of, kept coming in and asking if she was okay and then, sort of, going out and seeing to the other patients and then kept coming back in. I didn't actually record that as such."[6]

17. There do not appear to be any further recordings following the Voltaren injection. There is a recording in Dr Hauptfleisch's handwriting that may have been made on the 26 April which states:

"Neuro obs intact"[7]

18. Somewhere between 15 and 30 minutes after the Voltaren injection Dr Hauptfleisch came and asked Mrs A how she was feeling. Both Mrs A and her sister, who was with her, gave evidence that she had responded that the pain was alright as long as she didn't move her head. Ms Berquist gave evidence that Mrs A's response was that her pain was less severe. What is clear is that Mrs A still required assistance to leave the surgery and to get into her sister's car. Mrs A's sister is clear that there were no

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[3] Evidence of PM A, para 15
[4] Bundle of Documents, p10
[5] Evidence of JA Berquist, para 5
[6] Transcript of Proceedings, p130, lines 11-14
[7] Bundle of Documents, p10

instructions given to her in the event that her sister's condition deteriorated. Ms Berquist however was of the view that Dr Hauptfleisch had told Mrs A to call an ambulance in the night or return in the morning if she was still concerned. Ms Berquist recalled that she had also stressed that to Mrs A although Mrs A's sister believed that Ms Berquist had left by the time she and her sister had left the surgery. During cross-examination Ms Berquist did state that:

"…people that we are concerned about, we usually always say that, it's common practice that Dr Hauptfleisch and I say, and especially, like, considering the amount of time that she'd been in the room and we'd done lots of observations, I am positive that we said that because we wouldn't just, like, get them to go and not follow it up by saying, if they need any further assistance or are too concerned, then to call for help."[8]

19. The Tribunal however notes that there are no entries on the record that indicate any suggested treatment and Ms Berquist did state in her oral evidence that she job shares and that if there were a patient that she was concerned about she would leave a note or give the nurse a ring in the morning. In this particular instance Ms Berquist did neither of those things.[9]

20. Mrs A left the doctor's surgery with her sister who stopped to fill the prescription on the way home. Mrs A's sister gave evidence that she discussed her sister's health with the chemist who advised her to call the ambulance during the night or in the morning if she didn't improve. This information was passed on to Mr A. Mrs A's condition did not improve overnight and according to her husband she vomited a few times during the night. In the morning she was still in a great deal of pain and Mr A waited for the surgery to open at 8 a.m. as he wanted to talk to Dr Hauptfleisch. Mr A insisted on being put through to Dr Hauptfleisch and relayed what had happened during the night and asked him to come and see his wife. Dr Hauptfleisch said that he could not visit as he had a surgery full of patients and asked for no further information.

21. Mr A wanted Dr Hauptfleisch to ring Dr Bala Krishnan and Dr Hauptfleisch agreed to do so but said he could make no promises as to whether it would be that day or the following day. Mr A was somewhat frustrated and asked for Dr Bala Krishnan's

[8] Transcript of Proceedings, p126, lines 4-13
[9] Transcript of Proceedings, p134, lines 27-31

telephone number. He was told to ring the surgery again and speak to the receptionist and get the number from her, which he did. On ringing Wellington Hospital he was told that Dr Bala Krishnan was on leave. When Mr A rang Dr Hauptfleisch again he was told to bring Mrs A in to see him and because he could not move her Mr A suggested that he brought her in by ambulance. The ambulance arrived and Dr Hauptfleisch came out to see Mrs A in the ambulance. Dr Hauptfleisch then stated that she would have to be admitted to hospital and he wrote the referral letter to Palmerston North Hospital.

22. On arrival at Palmerston North Hospital a CT scan was performed and it confirmed that Mrs A had had a brain haemorrhage. She was then transferred to Wellington Hospital by helicopter. During the helicopter flight she had a seizure.

23. In Wellington Hospital Mrs A and her husband discussed treatment options and opted for stereotactic treatment. Mrs A remained in Wellington Hospital for approximately two weeks, was transferred to Palmerston North for one night and then discharged. She underwent stereotactic surgery in Dunedin in June 2001.

24. It appears that following these events there was no contact at all between Dr Hauptfleisch and Mr and Mrs A until the hearing before the Tribunal.

Case for the Director of Proceedings

25. The Director of Proceedings called five witnesses, Mr and Mrs A, Mrs A's sister, Dr Venkatraman Bala Krishnan and Dr Tessa Turnbull.

26. There is very little in dispute in relation to the facts but it is the Director of Proceeding's position that it is Dr Hauptfleisch's response to the situation when Mrs A presented to him on 26 April 2001 and the events that occurred on the following day that give rise to a charge of professional misconduct. The Director of Proceedings acknowledges that cases of a missed diagnosis are not necessarily the subject of disciplinary proceedings. The Director of Proceedings however considers that Mrs A's presentation and her history that was known to Dr Hauptfleisch as well as the comments made by her at the time that she presented would have raised the suspicion of a brain haemorrhage. In failing to exclude brain haemorrhage as a diagnosis, the

Director of Proceedings contends that Dr Hauptfleisch is guilty of professional misconduct.

27. This position was, according to the Director of Proceedings, exacerbated by Dr Hauptfleisch's actions the following day in his apparent lack of concern for Mrs A's lack of improvement and action taken by him only following aggressive and insistent behaviour on the part of Mr A.

28. Dr Bala Krishnan had seen Mrs A since 1993 at his Palmerston North neurosurgery outpatient clinic on a regular basis. Dr Bala Krishnan acknowledged that a general practitioner may find it difficult to diagnose a haemorrhage of the brain. What Dr Bala Krishnan did however say was that in circumstances where the existence of an AVM is known to the doctor then a scan is the only way in which a proper diagnosis could be achieved. In terms of the Doctor's notes that were before the Tribunal, Dr Bala Krishnan expressed the view that with the symptoms described by Dr Hauptfleisch in the letter of referral to the hospital, namely;

"previous occipital lobe AVM. Treated by radio-therapy. Now presenting with headache, photophobia and vomiting, no focal neuro signs"[10]

there were only two diagnoses with that history, either a cerebral bleed or a migraine. Dr Bala Krishnan stated that the only way to differentiate those two diagnoses would be to do a CT scan.[11] That option may well have occurred to Dr Hauptfleisch but according to both Mrs A and her sister he had stated that they did not need to be bothered by scans, etc.

29. In cross-examination Dr Bala Krishnan again stated that *"brain haemorrhage should come first in the picture for exclusion."*[12]

30. Dr Turnbull gave evidence that, in her opinion, the characteristics of the headache that Mrs A had when she presented to Dr Hauptfleisch would have suggested something other than a tension headache/muscle spasm, particularly given the information that was available. Dr Turnbull accepts that it was appropriate for Dr Hauptfleisch to make

[10] Bundle of Documents p.40
[11] Transcript of Proceedings, page 82, lines 13-14
[12] Transcript of Proceedings, page 87, lines 33-34

a diagnosis, albeit incorrectly in this instance, but considers that on the information before him his diagnosis should have been different but that in any event there should have been a follow-up plan in place in response to his diagnosis. Dr Turnbull was questioned intensely over the reliance by a general practitioner on clinical assessment and history and she was not prepared to express an opinion as to what percentage each part made up.

31. In terms of the following morning it was Dr Turnbull's view that while the referral to hospital was untidy and slightly unsatisfactory it *"did achieve its rightful end."*[13]

Case for Dr Hauptfleisch

32. It was the case for Dr Hauptfleisch that the Director of Proceedings had not proved the charge and particularly not in respect of the manner in which the particulars are expressed.

33. Dr Hauptfleisch chose not to give evidence himself but called Ms Berquist, his practice nurse. There was very little difference in respect of the evidence between Ms Berquist and that called on behalf of the Director of Proceedings except in relation to whether Mrs A had improved following the Voltaren injection and whether or not she was given advice in relation to calling a duty doctor or an ambulance if her condition deteriorated.

34. In respect of the matter of Mrs A's condition following the Voltaren injection, it may have been Ms Berquist's assumption that there had been some improvement but if she were present when Mrs A left the surgery as she states, she would have been aware that Mrs A was still unable to walk unassisted and was holding her head and needed help to get into the car. As to the advice in respect of the ambulance or duty doctor it may be that it was normal practice but it is not clear whether in fact it was done, or that Ms Berquist assumed that was done because it was the normal practice. It may also be relevant that Ms Berquist did not consider Mrs A's condition serious enough to warrant advising the nurse that would be on duty the following morning.

[13] Transcript of Proceedings, page 112, lines 12-18

Standard of Proof

35. The onus of proof is on the Director of Proceedings to establish the charge in this case and that requires the charge to be proved on the balance of probabilities.

36. The requisite standard of proof in medical disciplinary cases was considered by Jeffries J in *Ongley v Medical Council of New Zealand*[14] where the High Court adopted the following passage from the judgment in *re Evatt: ex parte New South Wales Bar Association*[15]:

> *"The onus of proof is upon the Association but is according to the civil onus. Hence proof in these proceedings of misconduct has only to be made upon a balance of probabilities; Rejfek v McElroy*[16]*. Reference in the authorities to the clarity of the proof required where so serious a matter as the misconduct (as here alleged) of a member of the Bar is to be found is in acknowledgement that the degree of satisfaction for which the civil standard of proof calls may vary according to the gravity of the fact to be proved."*

37. That position has been followed in *Gurusinghe v Medical Council of New Zealand*[17]*; M v Medical Council of New Zealand (No. 2)*[18]*; and Cullen v Medical Council of New Zealand*[19].

Professional Misconduct

38. Jeffries J in *Ongley v Medical Council of New Zealand*[20] formulated a test for defining professional misconduct as:

> *"Has the practitioner so behaved in a professional capacity that the established acts under scrutiny would be reasonably regarded by his colleagues as constituting professional misconduct?... 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 position of the Tribunal which examines the conduct."*

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[14] (1984) 4 NZAR 369
[15] (1967) 1 NSWLR 609
[16] [1966] ALR 270
[17] [1989] 1 NZLR 139 at 163
[18] Unreported HC Wellington M239/87 11 October 1990
[19] Unreported HC Auckland 68/95 20 March 1996
[20] supra 13

39. In *B v The Medical Council*[21] (in the context of a charge of conduct unbecoming), Elias J (as she then was) stated:

> *"In the case of diagnosis or treatment, conduct which falls short of the mark will be assessed substantially by reference to usual practice of comparable practitioners…those standards to be met are, as already indicated, a question of degree; … I accept that the burden of proof is on the balance of probability. Assessment of the probabilities rightly takes into account the significance of imposition of disciplinary sanctions. I accept that the Court must be satisfied on the balance of probabilities that the conduct of the practitioner is deserving of discipline."*

40. The applicable principles to be taken from these statements are:

(a) A finding of professional misconduct (or indeed conduct unbecoming) is not required in every case where a mistake is made or an error proven.

(b) The question is not whether an error was made, but whether the practitioner's conduct was an acceptable discharge of his or her professional obligations (in all the circumstances of the particular case).

(c) The departure from acceptable standards and/or the failure to fulfil professional obligations must be significant enough to attract sanction for the purposes of protecting the public.

41. The issue is essentially whether the conduct of Dr Hauptfleisch is culpable, that is, whether it is conduct deserving of discipline.

The Decision

42. In reaching its decision, the Tribunal has given careful consideration to all of the evidence presented to it and the helpful submissions made by both counsel. While there are some aspects in respect of the evidence that may be different between the parties, those differences can perhaps be explained by the different interpretations of the circumstances. For the purpose of completeness the Tribunal acknowledges that Ms Berquist may have interpreted Mrs A's response that she felt better if she did not

[21] Unreported HC Auckland HC11/96 8 July 1996

move her head as indicative of an improvement but considers that that would not have been confirmed by Mrs A's demeanour following that response.

43. In relation to the information given to Mrs A and her sister it is not clear on the evidence whether information was given on this occasion and certainly there is nothing recorded to show that.

44. The charges are dealt with in respect of each particular.

45. The first particular states that Dr Hauptfleisch was guilty of professional misconduct in respect of his care and management of Mrs A, namely:

> **1. On or about 26 April 2001 he failed to consult with, or refer Mrs A to, a specialist or other medical practitioner in a timely manner for the purposes of excluding or confirming a diagnosis of intracranial haemorrhage or other abnormality in the brain.**

46. The Tribunal is satisfied that there were serious deficiencies in Dr Hauptfleisch's management of Mrs A regarding this particular.

47. While Mr Waalkens' submitted that the charge was too specific in stating reference to a specialist or other medical practitioner rather than a hospital it is the Tribunal's view that this particular of the charge relates to Dr Hauptfleisch's omission to refer Mrs A to hospital for a CT scan when she presented to him on 26 April 2001. The CT scan would be carried out by a "specialist or other medical practitioner" and to that end falls within the particular.

48. The Tribunal is of the view that Dr Hauptfleisch had before him Mrs A's notes, he was familiar with her, and she and her sister had both clearly made the point that this was similar to what had occurred in 1992. Dr Hauptfleisch, for reasons not before the Tribunal, chose to put that information to one side and diagnosed muscle spasm or tension headache.

49. The overwhelming evidence from Dr Bala Krishnan and Dr Tessa Turnbull was that where a patient was presenting with a headache that had begun from the back of the head and was accompanied by vomiting, there was a need for some diagnostic

assistance, particularly a CT scan. It is clear that that possibility was discussed with Dr Hauptfleisch but that it was dismissed by him.

50. In any other circumstance when a doctor may be presented with these symptoms the possibility of misdiagnosis would be heightened by a lack of information, which was not the case here.

51. The Tribunal has heard no evidence as to why Dr Hauptfleisch did not take that action and there is nothing in the notes to indicate any reason for the omission.

52. On that particular alone the Tribunal finds Dr Hauptfleisch guilty of professional misconduct.

2(b) On 27 April 2001 he failed to refer Mrs A or assist referral of Mrs A to a specialist in a timely manner.

53. The Tribunal is of the view that Dr Hauptfliesch assisted in the referral of Mrs A at the insistence of her husband. It is of some concern to the Tribunal that without Mr A's insistence and, in his own words, *"aggressive behaviour"* Mrs A's referral to hospital might have been deferred for a longer period of time.

54. The Tribunal however does accept that on 27 April 2001 Dr Hauptfleisch, on assessing Mrs A in the back of the ambulance, did move in a timely manner to assist with her referral to Palmerston North Hospital. There was some confusion in respect of the ambulance times but in relation to the specific charge against Dr Hauptfleisch, very little turns on that.

55. The Tribunal considers that Dr Hauptfleisch could certainly have done more to assist the referral and to that end, the Tribunal considers this particular of the charge has been made out and it amounts to professional misconduct.

56. Cumulatively the two established particulars amount to professional misconduct.

57. The Tribunal therefore finds that Dr Anton Francois Hauptfleisch, medical practitioner of Levin is guilty of professional misconduct in respect of his treatment of Mrs A.

58. The Tribunal invites counsel for the Director of Proceedings to file written submissions as to appropriate penalty. These submissions are to be filed two weeks from the date of this decision. Submissions will be served on counsel for Dr Hauptfleisch and he will be given a further two weeks to make any submissions he wishes to make in reply.

DATED at Auckland this 15th day of October 2003.

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Prue Kapua

Deputy Chair

Medical Practitioners Disciplinary Tribunal