MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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DECISION NO: 153/00/66D

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 and 109 of the Act against **O** medical practitioner of xx

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mrs W N Brandon (Chair)

Dr I D S Civil, Professor W Gillett, Dr L Henneveld,

Mr G Searancke (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Auckland on Friday 15 December 2000

APPEARANCES: Ms T W Davis the Director of Proceedings

Mr H Waalkens and Ms K Garvey for Dr O.

1. THE CHARGE:

1.1 **PURSUANT** to sections 102 and 109 of the Medical Practitioners Act 1995 ("the Act") the Director of Proceedings charged that, on or about 13 January 1997, 3 April 1997 and 27 April 1997, whilst treating Mr Brian Kennedy-Smith, Dr O was guilty of professional misconduct in that he failed to appropriately manage and treat Mr Kennedy-Smith, and he failed to keep adequate patient records.

1.2 **THE** Charge was particularised in several respects. In summary, it is alleged that Dr O administered Vitamin B12 injections which were of no clinical benefit and without obtaining Mr Kennedy-Smith's consent; that Dr O administered Solu Cortef for no clinically appropriate reason, without a treatment plan, and without obtaining Mr Kennedy-Smith's informed consent; that Dr O failed to develop an appropriate pain management plan; he failed to investigate Mr Kennedy-Smith's increasing and debilitating pain; and failed to keep adequate clinical records.

1.3 **ONE** Particular of the Charge, that Dr O failed to diagnose Mr Kennedy-Smith's cancer, was withdrawn at the conclusion of the Director's case against Dr O. Mr Kennedy-Smith died on 7 December 1997.

2. BACKGROUND TO THE CHARGE:

2.1 **THE** Charge arose out of Dr O's care and treatment of Mr Kennedy-Smith while he was a general practitioner in practice in xx with another GP, Dr xx. In December 1996, Mr Kennedy-Smith had recently returned to live in Auckland after residing in Palmerston North for 2 years. While he was living in Palmerston North Mr Kennedy-Smith had been treated for lower back pain. His symptoms of neck and back pain had persisted for several years and he had been diagnosed as suffering from osteoarthritis of the lower back and cervical spine.

2.2 **WHILE** he lived in Palmerston North Mr Kennedy-Smith had been under the care of his GP, Dr Linton. In May 1996 Mr Kennedy-Smith was referred to an orthopaedic surgeon, Mr Williams, at Mid-Central Health. Mr Williams reported that X-rays confirmed *"moderately severe osteoarthritic degenerative changes within the cervical spine with particular narrowing of the 3,4 and 5,6 disc spaces. There is some anterior syndesmophytes at both these levels and relative facet sclerosis and hypertrophy."*

2.3 **MR** Williams concluded that *"Really there is little from an orthopaedic surgical view point that I can offer this gentleman at the moment. Given his relatively widespread degenerative changes in the cervical spine a stabilisation procedure would be of little benefit to him. There is no indication currently to proceed to a decompressor procedure."*

2.4 **IT** was his recommendation that Mr Kennedy-Smith *"should be allowed to continue with conservative treatment modalities including intermittent physiotherapy and anti-inflammatory medication."*

2.5 **BETWEEN** May (the date of Mr Williams' report) and October 1997, Mr Kennedy-Smith continued to receive care and treatment for his osteoarthritis from Dr Linton. He then moved back to live in Auckland and, on 12 December 1997, he returned to Dr R Reeves, a general practitioner who had looked after him for several years prior to his move to Palmerston North. Dr Reeves examined him and recorded, amongst other things, that he was suffering from *"arthritis lower back, hip - Pain/headaches in neck…."*. Dr Reeves referred Mr Kennedy-Smith to Auckland Hospital Rheumatology Outpatients Department and for *"Bloods"*.

2.6 **IN** his referral letter to the Rheumatology Department Dr Reeves requested the Department Doctor *"to see this man to help with the management of his cervical degenerative arthritis. … Since his move to Palmerston North he seems to have become quite disabled because of his arthritis and to me shows an excess of physical disability compared with his clinical and x-ray findings. … I would appreciate your advice concerning this patient as I feel he should have an active rehabilitation programme and return to the workforce."* Mr Kennedy-Smith did not attend the Rheumatology Department for his assessment.

2.7 **INSTEAD**, on 13 December 1996, Mr Kennedy-Smith uplifted his notes from Dr Reeves, and, on 16 December 1996, Mr Kennedy-Smith attended at Dr xx's practice. Mr Kennedy-Smith delivered his records to Dr xx's practice, so that they were available to Dr xx and to Dr O.

2.8 **DR** xx's consultation notes for 16 December 1996 record: *"A1 long term back pain, neck, thoracic spine and lumbar spine. Orthopaedic specialist 'leave alone'. On invalid benefit. On Naprosyn 500mg, 1 bd, working well. No indigestion, Acupan PRN and Sandomigran 0.5mg, 3 at night. If standing too long left leg tingling and feeling hot. On examination very stiff and painful cervical and lumbar spine. Reduced sensation and power in the left hand, all fingers. BP 140/80. Prescription collar."*

2.9 **DR** O was in practice with Dr xx and it was customary for him to see Dr xx's patients if Dr xx was unavailable. It was in this context that Dr O first saw Mr Kennedy-Smith on 11 January 1997.

3.0 EVIDENCE FOR THE DIRECTOR OF PROCEEDINGS:

3.1 **MR** Kennedy-Smith's partner, Mrs Reihana-Ruka, Ms Deborah Meffin, an Investigator at the office of the Health and Disability Commissioner, and Dr Douglas Donald Baird, a general practitioner of Auckland, gave evidence on behalf the Director of Proceedings.

Mrs Reihana-Ruka

3.2 **MRS** Reihana-Ruka gave evidence regarding the significant amount of pain suffered by Mr Kennedy-Smith during 1997. It was her evidence that she usually accompanied Mr Kennedy-Smith on his visits to his doctor as he was unable to drive. It was her recollection that there was only one occasion when she did not attend when Mr Kennedy-Smith went to see either Dr xx or Dr O.

3.3 **MRS** Reihana-Ruka told the Tribunal that when Mr Kennedy-Smith went to see Dr Reeves he (Dr Reeves) told him that he would refer him to Auckland Hospital, and that he would have him back to work within three months. Mrs Reihana-Ruka did not accompany Mr Kennedy-Smith when he went to see Dr Reeves, but she said that both of them thought that the referral to Auckland Hospital meant that Dr Reeves intended for Mr Kennedy-Smith to have surgery. He decided to change doctors, and transferred his records to Dr xx. Both she and Mr Kennedy-Smith regarded Dr xx as Mr Kennedy-Smith's GP; they only went to see Dr O if Dr xx was unavailable. Both of them always asked for an appointment with Dr xx in the first instance.

3.4 **IT** was also Mrs Reihana-Ruka's recollection that Mr Kennedy-Smith saw Drs xx and O on more occasions than was recorded in his medical records. She recalled that Mr Kennedy-Smith saw Dr O *"about every week from about early January 1997 to September 1997."* She said that when Mr Kennedy-Smith saw Dr O, the records were in the room, but she did not see him writing in them. She thought that some visits might not have been recorded, particularly over the period between 29 May and 18 August 1997 during which no consultations were recorded by either of Dr xx or Dr O.

3.5 **DR** O's records recorded that the last time he saw Mr Kennedy-Smith was on 15 May 1997. Mrs Reihana-Ruka's evidence was that Mr Kennedy-Smith was at the doctors' *"week in and week out"*. She did not believe that there could have been any months when he did not go to one or other of the GPs.

3.6 **MRS** Reihana-Ruka gave evidence that Dr xx prescribed Naprosyn and Acupan for Mr Kennedy-Smith's pain, and that he had to keep going back to the doctors because of increasing pain. He seemed to get worse and worse. He was constantly in pain and it was increasing, to the point where he became virtually immobile. When he went to see Dr O he was walking very slowly, and obviously in pain.

3.7 **MRS** Reihana-Ruka told Dr O that Mr Kennedy-Smith's pain was getting worse, and that he could not mow lawns, or stand to cook. He also suffered bad headaches, *"four to five migraines a day"*, to the point where Mr Kennedy-Smith began to think that he might have a brain tumour.

3.8 **MRS** Reihana-Ruka asked Dr O if there was something else he could give Mr Kennedy-Smith for the pain, as the Naprosyn and Acupan did not seem to be working. She said that Dr O suggested Vitamin B12 injections *"would fix him up"*. She did not recall Dr O giving them any advice as to what Vitamin B12 injections were for, or if there were any side effects. There was no real discussion about Vitamin B12.

3.9 **MR** Kennedy-Smith told Mrs Reihana-Ruka that the Vitamin B12 injection 'sort of' made him feel better. But often he would say that visiting the doctor 'was a waste of time'. Mrs Kennedy-Smith did not recall any other medication, namely Solu-cortef, being mentioned, and until she received a copy of the medical records when she prepared her evidence, she was not aware that Solu-cortef had been administered to Mr Kennedy-Smith.

3.10 **AROUND** July or August 1997, Mr Kennedy-Smith's health worsened. It was Mrs Reihana-Ruka's evidence that:

"When Brian and I mentioned to Dr O the increasing pain and how Brian was finding it more and more debilitating, Dr O did not ask any more questions about the pain or how it affected Brian. He did not suggest sending Brian to anyone else for investigation nor did he talk to Brian about being concerned about the pain. I do not recall Dr O making any further investigations about the increasing pain that Brian was experiencing.

Brian became so debilitated that some days he could not walk at all. …Eventually on the 13th of September 1997 I said to Brian "I am not watching you crawl around any more. .. I rang Dr xx and Dr O but both were out. … On Monday 15 September 1997 I rang the ambulance …".

3.11 **MRS** Reihana-Ruka then told the Tribunal that after being administered morphine at the hospital Mr Kennedy-Smith obtained great relief from pain. He remained in hospital for a couple of weeks. On the Wednesday after he was admitted, Mr Kennedy-Smith telephoned Mrs Reihana-Ruka and asked her to go up to the hospital. At a meeting with one of the doctors treating him, Mr Kennedy-Smith was told that he had cancer. His records record that the clinical diagnosis was *"lung cancer with spread to bone, liver/mediastinum and supra-renal regions"*. He received palliative care from that point on and, 7 December 1997, Mr Kennedy-Smith passed away.

Ms Deborah Meffin

3.12 **MS** Meffin gave evidence regarding her investigation of Ms Reihana-Ruka's complaint about the care he had received from Dr xx and Dr O. Ms Meffin interviewed Mr Kennedy-Smith shortly prior to his death and presented a transcript of the interview. The transcript essentially confirms the evidence given by Mrs Reihana-Ruka. When asked if there was anything he wished to say, Mr Kennedy-Smith told Ms Meffin -

"Well, I find it strange that in a period of 12 months that there were never any x-rays and that nothing was looked at. I was not examined for anything else … in case

there was further ongoing developments happening inside me … In all the time I was with Dr xx I was in continuing pain … most of the time. It was like starting with a beautiful summer's day and gradually the wind and the rain coming. Some days it was just like winter with no respite at all. Dr xx made a mistake, it may have been inoperable 12 months ago. It may well have been incurable, but Dr xx could have found something to stop the pain. I have had 12 months of pain for no reason at all."

3.13 **IT** is clear from the transcript that Mr Kennedy-Smith felt that he had not been listened to by Dr xx. He thought it was strange that he had had no x-rays at all in Auckland. He said that he had told Dr xx that he could not stand upright, but his reaction was that there was nothing he could do, *"All Dr xx said was to use the drugs…"*. He was sure that Dr xx *"knew of the severity of the pain."* Dr O did not give him any pain relief beside the Acupan and Naproxin. He also told Ms Meffin that about two weeks after he had been diagnosed with cancer he had moved his medical records back to Dr Reeves.

3.14 **IN** relation to his transferring his records from Dr Reeves to Dr xx, Mr Kennedy-Smith said that Dr Reeves had initially 'scared him off' with talk of the 'the knife'. When Dr Reeves first saw him he did not give him any pain relief, and he said that he was *"surprised at the state of you Brian because its only been about 2 or 3 years and you shouldn't have deteriorated to what you are now"*.

3.15 **MR** Kennedy-Smith told Ms Meffin - *"that should have been a clue to me too, or that something was not well, because he was the original one who saw me crunched over. I was on a walking [stick] then, when I came back from Palmerston North … it was just the talk of the knife" He said that he was with Dr xx for a total of 8-9 months, and was seeing him at least twice a month."*

3.16 **MS** Meffin also gave evidence that she had interviewed Mrs Reihana-Ruka at her home on 16 April 1998, and she interviewed Dr O on 29 June 1998. Ms Meffin did not record her interview with Dr O, but recorded her notes on her return to the office. She sent the notes to Dr O for comment, but he had not responded, and she did not pursue the matter, because *"he had not responded to many of my attempts to contact him in the past."*

3.17 **THE** Tribunal records that the Charge against Dr O is dated 28 September 2000.

Dr Baird

3.18 **DR** Baird is a Fellow of the Royal New Zealand College of General Practitioners. Dr Baird gave evidence relating to the use of Vitamin B12 injections for the treatment of pernicious anaemia, the usual indication for Vitamin B12 injections in New Zealand. Dr Baird told the Tribunal that:

"there is no other clinical indication for the use of intramuscular vitamin B12 although I remember it being used by a couple of elderly GPs when I was a medical student in the mid-70s as a pick-me-up for elderly people with non-specific malaise. It has a mild euphoric effect for a few days after administration".

3.19 **DR** Baird produced a copy of the New Ethicals Catalogue reference for Vitamin B12; there is no specific mention of it being indicated for pain relief, either for osteoarthritic pain, or pain relief generally. There is no evidence basis for the use of Vitamin B12 as pain relief.

3.20 **IT** was his opinion that a GP should advise his or her patient that Vitamin B12 injections were of no clinical benefit for osteoarthritis, but that a side effect of the injections may be a mild euphoric effect for a few days after administration. It is a well-tolerated medicine; potential side effects are rare, but major. If it was to be used as a placebo, that should be explained to the patient.

3.21 **SOLU**-cortef is an anti-inflammatory adrenocortical steroid compound, it is short-acting and used for severe or acute problems - it is completely excreted within 12 hours. In Mr Kennedy-Smith's case, although there was an indication for its use as an intravenous medication, there seems to have been no clear plan of action in its administration.

3.22 **IT** was Dr Baird's opinion that there may have been a case to administer Solu-cortef for acute exacerbation of pain, but not for ongoing severe pain.

3.23 **AS** in relation to Vitamin B12, Mr Kennedy-Smith should have been given information about potential side effects, and told that Solu-cortef only provides short term relief, before giving consent to its administration.

3.24 **DR** Baird's view was that an appropriate management plan for severe intractable pain should be based around finding the cause of the pain and reviewing the diagnosis if the pattern of pain does not conform to the diagnosis. Second opinions are mandatory for non-responsive patients. Initial refusal of referral *"should not be considered to be set in concrete and referrals should be canvassed in a deteriorating condition. Further refusal should be recorded in the notes."*

3.25 **THE** review process, examination and findings should all be recorded in the patient's notes.

4. EVIDENCE FOR THE RESPONDENT:

4.1 **IN** addition to Dr O, evidence for the respondent was given by Professor M W Tilyard.

Dr O

4.2 **DR** O gave evidence of his background and experience, both in New Zealand and xx. He has practised medicine in New Zealand for approximately eight years. In addition to his qualifications as a medical practitioner, he has obtained the qualification of Master of Clinical Pharmacology (Mpharm.). He has completed the accreditation process for Fellowship of the Royal New Zealand College of General Practitioners and expects to complete the practice component of the College's requirements for admission in the near future.

4.3 **HE** confirmed that Mr Kennedy-Smith was a regular patient of Dr xx's, and in early/mid-1997, he saw Mr Kennedy-Smith when Dr xx was unavailable. At each of those consultations he kept contemporaneous notes. Following a request made by the Tribunal, Mr Waalkens ascertained the existence of and arranged for the appointment book kept at the practice at that time to be brought in to the hearing and that was produced by Dr O. It confirmed that the records kept by himself and Dr xx were accurate insofar as they corresponded with appointments recorded for Mr Kennedy-Smith in that diary.

4.4 **DR** O told the Tribunal that during his 11 years in practice in xx, he and the doctors he worked with used both Vitamin B12 and Solu-cortef quite frequently, and always with good results. He had never had any complaints regarding their use. As in Mr Kennedy-Smith's case, they were used in combination with anti-inflammatories and pain-killers.

4.5 **PRIOR** to seeing Mr Kennedy-Smith for the first time in January 1997, he obtained his notes from Dr xx and read them. It was apparent that osteoarthritis had been diagnosed

several years earlier, and was the cause of the back and neck pain with which he presented when Dr O saw him. At the first consultation he performed a physical examination, took his blood pressure, and also performed a neurological examination which disclosed no abnormalities.

4.6 **THERE** was mild tenderness over the lumbar cervical spine, which he attributed to osteoarthritis. He prescribed Voltaren for back pain, for which Mr Kennedy-Smith was also taking Acupan and Naprosyn, and Sandomigran for his headaches. There were also two skin lesions which he considered suspicious. He removed these and sent them for histology. The lesion on his leg was diagnosed as solar lentigo; the leg lesion was seborrhoeic keratosis.

4.7 **HE** saw Mr Kennedy-Smith again for back and neck pain on 13 January 1997, and on this occasion, Mrs Reihana-Ruka asked if there were any other possible treatments for Mr Kennedy-Smith's pain, beyond what he was being prescribed. Given that he was already taking anti-inflammatories and pain-killers, Dr O suggested trying a Vitamin B12 injection.

4.8 **HE** said that he told them that Vitamin B12 was commonly used in xx and was a successful form of pain relief in such circumstances. It tends to provide a sense of *"well-being"*. He was not aware of any contra-indications, and he considered it worthwhile to try it and see if it helped.

4.9 **THE** next day he saw Mr Kennedy-Smith again. On this occasion he was seeking a repeat prescription for sandomigran. He did not complain of any neck or back pain, and

the Vitamin B12 appeared to have had a positive effect. Dr O said that he always checks to see if medication is working well, and he would not have repeated the Vitamin B12 injections if Mr Kennedy-Smith had given him a negative response.

4.10 **DR** O then went through the remainder of his consultations with Mr Kennedy-Smith. In brief these were as follows:

- 20/01/97, Mr Kennedy-Smith presented complaining of a sore neck. Dr O repeated the neurological tests and the results were normal. He thought mobility was a problem and suggested exercises Mr Kennedy-Smith could do. He gave him an ACC booklet which explained these exercises clearly;
- 1/04/97, Mr Kennedy-Smith presented with a sprained right knee and ankle suffered while lawn mowing. An ACC form was completed. He reported some neck pain; no back pain. He was still taking anti-inflammatories and pain-killers;
- 2/04/97, returned for a check of the sprained right knee and ankle; some neck pain, no back pain reported.
- 4/04/97, still experiencing pain in right ankle and knee. Dr O again Vitamin B12 as it seemed to alleviate symptoms previously. He also again recorded *"Neurovascular NAD"*.
- 6/04/97, still troubled by pain in right knee and ankle. Suggested Solu-cortef as this was also common practice in xx. Dr O explained that he expected it would give rapid, short-term relief for pain caused by osteoarthritis. He explained that it did have some potential side-effects but that these were associated with long term use. Dr O asked Mr Kennedy-Smith to return for evaluation during the next few weeks.

- 27/04/97, ankle, knee and cervical spine painful. Dr O administered second Solu-cortef injection, and Vitamin B12. He discussed these with Mr Kennedy-Smith and he was happy with both treatments.
- 15/05/97, none of his previous symptoms were raised. Mr Kennedy-Smith presented with an allergic rash of unknown origin only. He also saw Dr xx on the same date with the same complaint. This consultation was the last time Dr O saw Mr Kennedy-Smith.

4.11 **IN** relation to his management of Mr Kennedy-Smith's care, Dr O did not believe that Mr Kennedy-Smith mentioned any increase in pain to him. On a number of occasions, back and neck pain was not the presenting symptom. He was very sorry to hear that Mr Kennedy-Smith had died. He had ceased practice for a time between November 1997 and mid-1998 for personal reasons, and had returned to practice on a part-time basis only.

4.12 **IN** relation to his use of Solu-cortef, Dr O referred to a MedSafe web site which refers to the indications for Solu-cortef in New Zealand as including temporary treatment for a wide range of acute inflammatory and painful conditions, including osteoarthritis.

4.13 **DR** O also gave evidence of discussing Mr Kennedy-Smith's case with Dr xx, but said that he regarded Mr Kennedy-Smith as Dr xx's patient. While he did not offer that evidence as in any way excusing from him giving Mr Kennedy-Smith the best care that he could, he was aware that Mr Kennedy-Smith was not keen on surgery or any other referral at the time he saw him, and that Dr xx understood this also.

4.14 **HE** understood that both Vitamin B12 and Solu-cortef would give short-term relief only, and his plan of action would have been to have referred him on to a specialist for further treatment if necessary. However, shortly after he had tried the Solu-cortef and Vitamin B12 injections, he ceased seeing Mr Kennedy-Smith so the opportunity to follow-up with a referral did not present itself.

4.15 **HE** was also aware that short-term use of cortico-steroids is not likely to produce any side-effects, in fact they are almost non-existent. Even in hindsight, the other injuries suffered by Mr Kennedy-Smith complicated the picture, which, in Dr O's view, was not one of chronic, unresponsive pain. The clinical picture, in his view, was consistent with osteoarthritis.

4.16 **THE** only time that Dr O was aware that Mr Kennedy-Smith's pain was worse was when he suffered the injury to his knee and ankle, on top of the osteoarthritic pain, and then he seemed to get better, as would be expected as his injuries healed, and with the short-term additional pain relief administered by Dr O.

Professor Tilyard

4.17 **PROFESSOR** Tilyard is Professor of General Practice at the University of Otago School of Medicine. Professor Tilyard gave evidence regarding his extensive review of the published evidence pertaining to osteoarthritis, the use of Vitamin B12 and the use of steroid therapy.

4.18 **IN** relation to Vitamin B12, Professor Tilyard reported 144 references for the use of Vitamin B12 for pain relief, including the use of Vitamin B12 as an adjunct medication in

the treatment of osteoarthritis, specifically as an adjuvant medication in the conservative treatment of lumbar spinal stenosis. There does appear to be some improvement in neurogenic claudication in Vitamin B-treated patients.

4.19 **THERE** is also evidence of the beneficial effect of Vitamin B in chronic pain. Thus, there are a number of situations in which the use of Vitamin B12 is recognised; it is not limited to the treatment of pernicious anaemia. As Mr Kennedy-Smith was not responding to normal therapy, it was appropriate for Dr O to conduct an "N of 1 trial" (common in general practice) to see if the Vitamin B12 injections would provide any relief.

4.20 **IN** terms of providing information, Professor Tilyard accepted that the nature and extent of the information which should be provided to patients is contentious. It is not feasible to point out every potential risk/side effect. Current best practice is that general practitioners should inform their patients what investigations and/or treatments they are giving to their patients.

4.21 **A** competent GP should inform their patient about any common side effects, so that patients can take appropriate action should these occur. In the case of Vitamin B12, it has an excellent tolerability and no known toxicity.

4.22 **IF** Dr Baird's evidence was accepted, this would give rise to more onerous requirements on a doctor prescribing Vitamin B12 injections for no good reason. He did not agree with Dr Baird's evidence.

4.23 **AS** to the administration of Solu-cortef, Professor Tilyard's evidence was that there is excellent international medical evidence that inflammation plays a key role in the treatment of osteoarthritis. The use of steroid therapy may modulate inflammation and the pain pathway in osteoarthritis. *"The issue"*, said Professor Tilyard, *"is whether steroids can be used to modulate the inflammatory response; and if so, in what manner they should be administered."*

4.24 **PROFESSOR** Tilyard produced a summary of the evidence and references he had reviewed, and advised that *"there is a strong body of medical evidence endorsing the use of steroid therapy in osteoarthritis. ... it is therefore common practice in a patient with acute inflammatory exacerbation of their osteoarthritis to be given intramuscular steroids. This would normally be a long-acting, depo preparation. General practitioners are advised in the most recent update of "Practical General Medicine" that steroid injections are of value in acute exacerbation of osteoarthritis, and that commonly two injections will be required before any benefit is apparent."*

4.25 **IT** was Professor Tilyard's opinion that *"short term use"* of a medication is to ascertain therapeutic benefit. The choice of medicines is very much determined by what a practitioner is taught, by the choices and preferences of his or her teachers, and by his or her own experience, or the experience of his or her peers, or the medical environment within which they work. In xx, where Dr O received his medical education and where he worked for several years, Vitamin B12 was commonly used, and to good effect.

4.26 **PROFESSOR** Tilyard was aware that in xx oral B12 is available and it is used in ways that are foreign to NZ practitioners, but it is widely accepted in xx. The key issue is that it does no harm.

4.27 **IF** in xx, Dr O's experience was to use Solu-cortef, then Professor Tilyard would expect that to continue in New Zealand. Dr O administered the injections intra-muscularly, a procedure which should be within the competence of any New Zealand general practitioner. He did not administer any joint injections into the neck, hip or lower spin which would require more specialised expertise.

4.28 **IN** Professor Tilyard's view there was no doubt that Mr Kennedy-Smith had severe spinal osteoarthritis as documented in the x-rays taken in Palmerston North, and the referral letters written by Dr Linton and Dr Reeves. The significant question was when did the pain of his secondary cancer deposits begin to exceed the pain of his known osteoarthritis. This would have been impossible to determine, and Professor Tilyard *"was not surprised that Dr O did not pick this up"*.

4.29 **ON** the basis of the information he had reviewed, he could not see any strong clinical indications that Mr Kennedy-Smith had a second severe disease while being treated for his osteoarthritis. He did not agree with the inference in Dr Baird's evidence that *"Dr Reeves recognised that the patient needed further investigation immediately on seeing him"*. Dr Reeves' referral letter specifically asks for assistance with management of cervical degenerative arthritis. In particular, he was looking for a rehabilitative programme to enable Mr Kennedy-Smith to get back to work. At no stage did Dr Reeves indicate any concern that there might have been some underlying pathology which he wanted investigated.

4.30 **FINALLY**, in relation to the suggestion that morphine might have been administered to Mr Kennedy-Smith for pain relief, Professor Tilyard's evidence was that he would *"strongly advise"* against the use of narcotics for pain relief in relatively young people, (in 1997 Mr Kennedy-Smith was 54) but at some stage pain from the osteoarthritis was overtaken by pain from the developing cancer. If that had been known, then there would have been good reason to give morphine, but in the context of Mr Kennedy-Smith's known history of osteoarthritis, he had many years left, therefore there would have been good reason to avoid the use of narcotics.

4.31 **IT** was not until 18 August 1997 that Dr xx recorded that Mr Kennedy-Smith's neck was *"still painful"*, and that he had a *"dry cough one week, chest tick"*. This was verified in the clinical summary and note prepared at Auckland Hospital stating that Mr Kennedy-Smith had a *"dry cough two weeks"*. He was admitted to Auckland Hospital on 15 September 1997.

4.32 **IN** relation to Dr O's records made of Mr Kennedy-Smith's consultations, Professor Tilyard considered that they were sufficient to give any other practitioner seeing Mr Kennedy-Smith a reasonable, basic understanding of his condition and care by reviewing his clinical record. He was not aware of any general practitioner in New Zealand (although he was sure there were some) who would, for every presentation, record the history of the presenting condition in the context of a chronic ongoing disorder.

4.33 **IT** was Professor Tilyard's conclusion that Dr O's conduct was *"reasonable in the circumstances"*. He agreed with Dr Baird that it was not uncommon for patients such as

Mr Kennedy-Smith to be best managed within the GP environment. If questions had been raised regarding a new diagnosis, then that would have been a different matter. The clinical evidence was that Mr Kennedy-Smith's pain was chronic, sometimes acute, and sometimes severe, consistent with the diagnosis.

4.34 **IT** is also relevant that the events at issue occurred over a relatively short period of time (4-5 months). If they had occurred over a period of years, that also would have been a different matter. It is appropriate to review a diagnosis from time to time, because it is easy to become 'trapped' and to miss signs of other disease occurring. The time frame in the context of this complaint is too short for this to have been a factor in Mr Kennedy-Smith's case.

5. THE DECISION:

5.1 **HAVING** carefully considered all of the evidence provided to it, and submissions made by both counsel, the Tribunal is satisfied that none of the Particulars of the Charge are established and that Dr O is accordingly **not guilty** of the Charge of professional misconduct in terms of section 109 of the Act.

6. REASONS FOR DECISION:

The Standard of Proof -

6.1 **IT** is well-established that the standard of proof in disciplinary proceedings is the civil standard, the balance of probabilities. 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.

6.2 **THE** standard of proof may vary within a single case. All elements of the charge must be proved to a standard commensurate with the gravity of the facts to be proved: *Ongley v Medical Council of New Zealand* [1984] 4 NZAR 369, 375 - 376.

6.3 **IN** relation to a charge of professional misconduct, the middle of the hierarchy of offences which the Tribunal may be satisfied is proven, the Tribunal must be satisfied, on the balance of probabilities, that the practitioner has "*so behaved in a professional capacity that the established acts under scrutiny would be reasonably regarded by his colleagues as constituting professional misconduct"*; *Ongley*, (supra, p375).

6.4 **THE** test is objective; that is, the conduct under review is measured against the judgment of the practitioner's professional peers of acknowledged good repute and competency, *"bearing in mind the composition of the tribunals which examine the conduct"; Ongley v Medical Council* (supra).

6.5 **THUS,** while the evidence of what other doctors would have done or as to how they would assess Dr O's management and conduct of Mr Kennedy-Smith's care or of acceptable practice generally in the circumstances which presented in this case, is a useful guide, perhaps even the best guide, it is never more than that; all of the evidence given to the Tribunal is weighed against the judgment of the trial judge, or in this case, a specialist tribunal comprising both medical practitioners and lay members.

6.6 **SIMILARLY**, the issue as to whether or not the outcome might have been different had the practitioner's management of the patient's care been different, will not determine

whether or not a charge is proven. The central issue for the Tribunal's inquiry is to ascertain whether or not the practitioner's conduct and management of the case at the relevant time constituted an acceptable discharge of his or her professional and clinical obligations. Only if the Tribunal identifies any such shortcomings or errors may it go on to determine if those shortcomings or errors are culpable, and warrant the sanction of a finding against the practitioner.

6.7 **THEREFORE**, a practitioner may be found guilty of a professional disciplinary charge notwithstanding that any actions, failures or omissions on his or her part did not affect the outcome for the patient.

Burden of Proof -

6.8 **THE** burden of proof is borne by the Director of Proceedings.

Informed Consent -

6.9 **IN** relation to the issue of informed consent, the Director of Proceedings referred to the decision of the Australian High Court in *Rogers v Whitaker* (1992) 175 CLR 479, as 'the leading case' in this area. In that case, the Court determined that the issue as to whether or not the patient has received sufficient information to allow him or her to make a reasoned choice whether or not to consent to treatment 'is not a question the answer to which depends on medical standards or practice,' that is a matter for the Court to determine.

6.10 **IN** a passage that is relevant in the context of this present Charge, the Court stated that:

"… a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it."

6.11 **IT** is also relevant in the present context that the wording of Right 6(2) of the Code, with its focus on what a 'reasonable consumer, in that consumer's circumstances' needs to make an informed choice, follows closely the approach taken by the Court in *Rogers v Whitaker.*

6.12 **MS** Davis also referred to a Decision of this Tribunal (Decision No.138/00/58D) in which the Tribunal concluded that:

"Nevertheless, the fundamental principle is that of self-determination, and the right of the individual to decide what happens to their body; a person has a right to know what treatment entails in order to be able to make a reasoned choice and thus, to give valid consent. What the law requires of doctors is that they provide the patient with sufficient information to make a considered decision. It does not require, nor has it been suggested, that the doctor is required to pass on to the patient everything there is to know about a condition or proposed treatment."

6.13 **THE** Tribunal therefore assessed the issue as to whether or not Dr O was guilty of Particulars 2 and 5 (which alleged that he had not obtained informed consent to administer Vitamin B12 and Solu-cortef to Mr Kennedy-Smith) within the context of this legal framework described above, and the Code of Health and Disability Services Consumers Rights. With regard to the latter, it must also be borne in mind that a breach of the Code does not necessarily constitute a professional disciplinary offence.

7. FINDINGS IN RELATION TO PARTICULARS OF CHARGE:

Particulars 1 to 7 of the Charge

7.1 **THESE** Particulars involve the allegations that Dr O administered Vitamin B12 and Solu-cortef to Mr Kennedy-Smith, which injections were of no clinical benefit, or for no clinically appropriate reason in the circumstances, in the absence of a treatment plan or any appropriate plan to manage his pain, and without obtaining his informed consent.

7.2 **THE** Tribunal has set out the factual background to the Charge and the evidence given by all of the witnesses at some length because it is important that the Charge, and the allegations upon which the charge is based, are considered in their context. Viewed in context, Dr O impressed the Tribunal as a caring and competent practitioner who was concerned to do his best for Mr Kennedy-Smith, notwithstanding that he saw him only on an intermittent basis, and over a relatively short period of time.

7.3 **THE** Tribunal is satisfied that Dr O regarded Mr Kennedy-Smith as Dr xx's patient, and while that by no means absolves him of any obligation or duty to provide Mr Kennedy-Smith with an appropriate standard of care, it was clear that Dr O regarded himself as the 'junior partner' in the practice, and that he deferred to Dr xx. The Tribunal believes that he would have been reluctant to 'interfere' in Dr xx's management of his patients.

7.4 **MR** Kennedy-Smith was also seen by Dr O against the background of a long term diagnosis and treatment including a relatively recent review by an orthopaedic surgeon, which confirmed that diagnosis and treatment. Dr O said that he had read Mr Kennedy-Smith's records before he saw him for the first time. He was aware of all of this

background, including the fact that the orthopaedic surgeon, Mr Williams, and recommended conservative treatment, and that Mr Kennedy-Smith had transferred across to Dr xx's practice because he did not want any new assessment or treatment, particularly if that involved any surgical intervention.

7.5 **IT** is also significant that Dr O did not see Mr Kennedy-Smith for the same reason each time that he attended for a consultation. Of a total of 11 consultations, only three related directly to his osteoarthritis; one visit related to Mr Kennedy-Smith's suffering bad headaches; five related to the strained back, right knee and ankle Mr Kennedy-Smith suffered while mowing the lawn (for which an ACC claim was made), and the last visit was for the allergic rash, which was apparently so severe that he also saw Dr xx on the same day for the same reason.

7.6 **IN** relation to the administration of Vitamin B12 and Solu-cortef, the Tribunal is satisfied that Mrs Reihana-Ruka was so concerned for Mr Kennedy-Smith and the pain he was suffering that she asked Dr O if there was anything else that could be tried to give him some relief. The Tribunal is satisfied that Dr O's experience and expertise, both as a medical practitioner in xx and as a practitioner with an additional, highly specialised, qualification in pharmacology, was such that he was aware that both of these medicines could, and often were, used in the treatment of osteoarthritis or for chronic pain, and with good, albeit short-term, results.

7.7 **FURTHER**, Dr O was aware that both medications were well-tolerated, safe, and 'would do no harm'. The Tribunal is also satisfied that there is sufficient evidence to

establish to its satisfaction that Dr O probably did tell Mr Kennedy-Smith that the injections *"might help"* and that, in the circumstances and on the basis of his evidence (which the Tribunal accepts), he did provide sufficient information to enable Mr Kennedy-Smith to give his informed consent. In any event, the Tribunal is not satisfied that the Director was able to establish, to the requisite standard of proof, that there was any failure or omission in this regard by Dr O.

7.8 **SIMILARLY**, the Tribunal is satisfied that, in the circumstances, it was appropriate for Dr O to administer the injections of Vitamin B12 and Solu-cortef for the short-term relief of inflammatory pain. At the time the injections were administered (between January and April 1997) Mr Kennedy-Smith had been diagnosed with osteoarthritis, and he also suffered the strain injury which could have exacerbated his osteoarthritis. On that basis, the Tribunal accepts Professor Tilyard's evidence that it would not have been appropriate to administer narcotics, such as morphine, given Mr Kennedy-Smith's age, and the known diagnosis.

7.9 **DR** O was also conscious of the fact that conservative treatment had been recommended by a specialist orthopaedic surgeon, and that Mr Kennedy-Smith had relatively recently rejected a referral to the Rheumatology Clinic. In all the circumstances, the Tribunal considers that it was clinically appropriate for Dr O to try a short-term, low level, therapeutic treatment intervention which he knew was likely to provide some relief and would do no harm.

7.10 **THE** Tribunal accepts Dr O's evidence that he did discuss Mr Kennedy-Smith's case with Dr xx, and that if the injections proved beneficial, and he had continued to see Mr Kennedy-Smith, particularly on a less ad hoc basis, and he had been aware of the level of chronic pain, he would have referred him to a pain clinic or to a specialist such as a rheumatologist.

Particular 7: That Dr O failed to investigate Mr Kennedy-Smith's increasing and debilitating pain

7.11 **MOST** significantly, in relation to Particular 7, it was Dr O's evidence that Mr Kennedy-Smith did not mention any increase in pain to him, and the interview transcript (and Mrs Reihana-Ruka's evidence regarding the July/August timing of this) seems to suggest that it was to Dr xx that Mr Kennedy-Smith directed his complaints of increasing pain, rather than to Dr O. Certainly, there is no reference in the clinical notes, that Mr Kennedy-Smith was complaining of *"increasing"* pain; specifically in the period January to May 1997.

7.12 **TO** the extent that any increase in pain should have been obvious to Dr O between January and May 1997, it is understandable in the circumstances that Dr O might have ascribed this to the injury which Mr Kennedy-Smith suffered at the beginning of April, rather than being caused by his osteoarthritis, or any underlying, undiagnosed, pathology.

7.13 **ANY** misunderstanding in this regard would also have been reinforced by the fact that, once the worst of the strain had healed (and Mr Kennedy-Smith had been given injections of Vitamin B12 and Solu-cortef), the only other occasion on which Dr O saw him was

nearly three weeks later and for the allergic rash. There is simply no evidence of a clinical 'picture' of increasing pain presented to Dr O.

7.14 **MRS** Reihana-Ruka was quite sure that Mr Kennedy-Smith's health worsened in July and August 1997, and this would accord with the likely progress of the subsequently diagnosed underlying disease. She said that both she and Mr Kennedy-Smith mentioned this to Dr O. However, that timing in relation to Dr O is inconsistent with the available documentary evidence. Mrs Reihana-Ruka also impressed the Tribunal as a truthful witness, and it is entirely understandable that her recollection of dates and timing might be confused in relation to events which occurred over three years ago, and she has also had to cope with Mr Kennedy-Smith's death in the meantime.

7.15 **THE** Tribunal is satisfied that, to the extent that Dr O did decide to offer a short-term trial of Vitamin B12 and Solu-cortef to see if these would help, and in an attempt to provide greater pain relief than Mr Kennedy-Smith's usual medicines were giving, Dr O did develop a treatment plan, and an appropriate plan to manage Mr Kennedy-Smith's pain, at an appropriate time and at least in a very preliminary way. When he saw Mr Kennedy-Smith on subsequent visits, Dr O was satisfied that the injections had given him some relief. But he always regarded Mr Kennedy-Smith as Dr xx's patient and any such plan would have been developed, and most likely managed, by or in consultation with Dr xx.

7.16 **IN** any event, the Director did not present sufficient evidence as to what would have been an *"appropriate plan"*, or what it is alleged Dr O should have done. It is understandable that, having witnessed the relief Mr Kennedy-Smith obtained from the injection of

morphine he was given when he was admitted to Auckland Hospital that he and Mrs Reihana-Ruka would have wished he had been given such relief sooner.

7.17 **HOWEVER**, the Tribunal must proceed cautiously, keeping in mind that it reviews a practitioner's conduct with the benefit of hindsight. It is the Tribunal's task always to determine whether or not the practitioner's conduct and management of the case **at the relevant time** constituted an acceptable discharge of his or her professional and clinical obligations. A central question for the Tribunal is always, *"what did this doctor know, or should have known, at the time the events under scrutiny occurred"?*

7.18 **IN** relation to the events at issue in relation to this charge, the Tribunal is not satisfied that the Director has established any shortcoming on Dr O's part.

7.19 **FOR** example**,** the Tribunal is not satisfied that any failure to develop a long-term plan for the management of Mr Kennedy-Smith's pain is a criticism that should be directed at Dr O. As Mr Waalkens noted in his submissions to the Tribunal, Mr Kennedy-Smith regarded Dr xx as his doctor. He saw Dr xx throughout the year, and the emphasis of Mr Kennedy-Smith's complaint about the care he had received, particularly the failure to diagnose his cancer, was on Dr xx's management of his care and treatment. There is very little reference in the interview transcript to Dr O. The crux of Mr Kennedy-Smith's complaint is directed at Dr xx.

7.20 **THE** Tribunal is satisfied that this evidence suggests that Mr Kennedy-Smith's pain increased from approximately mid-August 1997, well after the last time Dr O saw him (in

May 1997). It is also the case that Mr Kennedy-Smith did not visit either doctor between the end of May (when he saw Dr O) and 18 August 1997, from which time on he was seen by Dr xx, and his cancer was diagnosed in mid-September 1997.

7.21 **ON** that basis, the Tribunal is not satisfied that the allegations contained in Particulars 1 to 7 were proven on the basis of the evidence given to the Tribunal. It was appropriate that Particular 8 of the Charge, that Dr O failed to diagnose Mr Kennedy-Smith's cancer, was withdrawn.

Particular 9

7.22 **PARTICULAR** 9 alleges that Dr O failed to keep adequate clinical records in that the records did not include a note of the presenting complaint, history of condition, the examination findings nor an adequate record of treatment.

7.23 **AS** in relation to the other Particulars of the Charge already discussed, the allegations contained in this Particular must be considered in the context of all of the relevant facts and circumstances. On that basis, the Tribunal is satisfied that it has not been established that Dr O is guilty of any misconduct warranting an adverse finding of a professional disciplinary offence.

7.24 **THERE** were two aspects to this Particular in terms of the Director's case presented to the Tribunal. The first of these was that the records did not accurately record all of Mr Kennedy-Smith's consultations with Dr O. As stated above, the Tribunal asked the whereabouts of the practice's appointment book for 1997, and it was delivered in to the

hearing. On examination it was clear that all of the records kept by both of Dr O and Dr xx corresponded exactly with appointments recorded in the practice diary/appointments book.

7.25 **SECONDLY,** Particular 9 alleged that the clinical records were inadequate in terms of content. In relation to this aspect of the charge, the Tribunal is satisfied that the records kept by Dr O in relation to his consultations with Mr Kennedy-Smith are adequate. They are not the most complete or fulsome notes that could have been made but they are by no means the worst, nor can they be said to be seriously deficient, or falling below an acceptable standard, in terms of their clinical context.

7.26 **IN** this case, Dr O saw Mr Kennedy-Smith against the background of a known diagnosis, and an accidental injury he suffered while lawn mowing, and an allergic rash. Dr O was not Mr Kennedy-Smith's primary general practitioner; the appropriate 'test' in terms of the adequacy of his notes is, 'are they sufficient to enable Dr xx, or any other general practitioner or locum, to ascertain what was the presenting symptom on the occasions when he was seen by Dr O, and what care and treatment was given to Mr Kennedy-Smith by Dr O'?

7.27 **PROFESSOR** Tilyard was satisfied that, against that sort of test, Dr O's records provided sufficient information. The Tribunal accepts that assessment. In any event, Dr Baird's evidence was not critical of Dr O, but rather was confined to his giving his view as to what a general practitioner's clinical records ought, ideally, to include.

7.28 **TO** the extent that Dr O's records do not refer to any *"presenting history … investigations arranged"*, the presenting history in relation to Mr Kennedy-Smith's osteoarthritis was well-documented in his clinical record. The injury/strain he suffered was the subject of an ACC claim (recorded in the notes), and explained in the notes as a *"strain"*, a description which is relatively self-explanatory, and Dr O did not arrange any *"investigations"*.

7.29 **FOR** the reasons set out above, Dr O was not aware that Mr Kennedy-Smith suffered from *"chronic non-responsive and possibly sinister conditions"* which required *"a clearly enunciated plan of action"*, and this is not a fact for which the Tribunal finds any culpability on his part.

7.30 **ON** this basis, Dr O's notes are not inadequate in terms of Dr Baird's criteria for adequacy. As the Tribunal has stated on previous occasions, any practitioner who fails to keep adequate clinical records will be at risk of an adverse finding. At a minimum, the clinical record should record the date of the visit, the presenting symptoms, a record of examinations made, the practitioner's findings, any medication given or prescribed, any advice given, and any investigations or follow-up visits or tests ordered.

7.31 **IN** a 'shared care' situation, the notes must provide any other member of the clinical team, or locum, with sufficient information to enable them to ascertain the patient's clinical history, current or chronic conditions and any medication that the patient is taking, or has recently received. On the basis of these criteria, the Tribunal has concluded that Dr O's clinical records are adequate, and if the Tribunal would have preferred them to be more

complete, it is not to the extent that it considers any adverse finding is warranted, either at the level of professional misconduct, or conduct unbecoming that reflects adversely on a practitioner's fitness to practice.

7.32 **IN** the present context, the Tribunal considers that it is also relevant that Dr O's notes are certainly no worse, in terms of their content and quality, to those made by Dr xx (which were also produced) which are not the subject of any complaint, or any professional disciplinary charge.

7.33 **FOR** all of these reasons therefore, the Tribunal is satisfied that Particular 9 is not established.

8. ORDERS:

8.1 **HAVING** determined that none of the Particulars of the Charge have been established, the Tribunal orders that the Charge of professional conduct laid against Dr O is dismissed.

8.2 **THE** Tribunal's decision is unanimous.

Orders Suppressing Publication

8.3 **THERE** are currently in place Orders suppressing publication of Dr O's name and any identifying details, pending the determination of the Charge, or further order of the Tribunal.

8.4 **FOR** the following reasons the Tribunal is satisfied that it is appropriate in the circumstances that its Orders that his name is not to be published should be made permanent:

8.4.1 **IT** is in the interests of innocent third parties that his name not be published;

8.4.2 **THERE** is no public interest in publication of his name or any identifying details.

8.5 **IN** order to ensure that Dr O is not identified, the Tribunal also orders that Dr xx's name is not to be published.

8.6 **AS** a result of the Tribunal's decision, there are no issues as to penalty or costs.

DATED at Auckland this 20th day of February 2001

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W N Brandon

Chair

Medical Practitioners Disciplinary Tribunal