Medical Practitioners Disciplinary Tribunal

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All Correspondence should be addressed to The Secretary

NB: The nature of the surgery is not to be disclosed beyond the fact that it involved abdominal surgery

DECISION NO: 72/98/35D

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

IN THE MATTER of a charge laid by the Director of Proceedings of the Health & Disability Commissioner's office pursuant to Section 102 of the Act against **GORNOORI RAMA KRISHNAYYA** medical practitioner of Napier

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mrs W N Brandon (Chair)

Dr I D S Civil, Dr J C Cullen, Dr B J Trenwith, Mrs H White (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Napier on Tuesday 30 March 1999

APPEARANCES: Ms T Davis the Director of Proceedings.

Ms J Gibson for Mr G R Krishnayya.

1. THE CHARGE:

1.1 "**TAKE NOTICE** 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 in that between 12 December 1996 and 1 January 1997 Mr Krishnayya acted in a way that amounted to Professional Misconduct of a medical practitioner.

In particular Mr Krishnayya:

a) Failed to keep full, complete and appropriate medical records in relation to his patient, Christine Clarke.

AND/OR

b) Failed to communicate effectively with his patient and, more particularly, failed to listen to her.

AND/OR

c) Failed to appreciate the significance of leg pain experienced by his patient, Christine Clarke.

AND/OR

d) Failed to consider the significance of his patient's shortness of breath and examine her.

AND/OR

e) Being aware his patient had respiratory difficulty, he failed to examine and assess her condition."

1.2 AMENDMENTS TO PARTICULARS OF THE CHARGE:

IN closing submissions Ms Davis conceded that there was insufficient evidence to support Particulars (d) and (e) of the charge and withdrew those particulars. The matters raised in Particulars (d) and (e) were accordingly not the subject of deliberation by the Tribunal in coming to its decision on the charge presented.

2. BACKGROUND:

2.1 **THE** charge was brought to the Tribunal by the Director of Proceedings following an investigation by the Health & Disability Commissioner, the result of which the Commissioner formed an opinion that Mr Krishnayya breached the Health & Disability Commissioner (Code of Health and Disability Services Consumer's Rights) regulations 1996, commonly referred to as the "Code of Rights".

2.2 **THE** charge is laid pursuant to Section 102 of the Act.

2.3 **THE** charges arises out of Mr Krishnayya's care and treatment of the complainant, Ms Clarke following abdominal surgery performed by Mr Krishnayya at Parkside Hospital on 12 December 1996.

2.4 **THE** complaint against Mr Krishnayya distilled to two central allegations:

(a) That Mr Krishnayya's records were deficient; and

(b) That in his follow-up care, Mr Krishnayya was casual to the point of ignoring a complaint of leg pain, especially taking into account that the complaint was made in the context of post-operative care.

2.5 MS Clarke gave evidence that on 12 December 1996 she underwent abdominal surgery. One or two days after surgery she developed some difficulty with her breathing, however this was resolved on the removal of flowers from her room. Ms Clarke did suffer from hay fever at the time and was taking Rhinocort medication.

2.6 **MS** Clarke was discharged from hospital on 14 December 1996. On discharge, Mr Krishnayya gave Ms Clarke a small pot of chlorhexidine 1% in 1% hydrocortisone cream to rub onto the post operative wound. Ms Clarke described the wound as becoming very painful. Pus pockets appeared on the outside of the wound and the wound leaked some form of unpleasant substance. Mr Krishnayya prescribed Augmentin although the evidence from Mr Krishnayya was that this was a prophylactic prescription, rather than a prescription for wound infection. In any event, the Augmentin was given to Ms Clarke by Mr Krishnayya from supplies he had at his clinic, rather than by way of prescription for dispensing from a pharmacy. Mr Krishnayya did not record this prescription in Ms Clarke's medical record.

2.7 **MS** Clarke gave evidence that about Christmas time 1996 her leg began to ache. It was unfortunate, and a source of some confusion as the hearing progressed, that Ms Clarke’s statement of evidence failed to specify either which leg, or where on her leg, the ache was felt.

2.8 **MS** Clarke also alleged that Mr Krishnayya did not examine her leg at all; and that he told her not to worry about the pain and that it was just her body settling down from surgery. Ms Clarke also gave evidence that on the occasion when she mentioned the leg pain to Mr Krishnayya she was accompanied to the consultation by her then partner, Mr Peter Hunt. Mr Hunt also gave evidence which is referred to later in this Decision.

2.9 **IN** the early hours of 1 January 1997, Ms Clarke said she experienced a severe pain attack in her chest. The pain was so bad that she was only able to take shallow breaths and she thought that she may have been having an asthma attack, although previously she had only been suspected of suffering from asthma and still had the Ventolin inhaler prescribed for her in November 1994. She had in her possession a Ventolin inhaler which had been prescribed for her in November 1994. She had also indicated on her hospital admission form that she suffered from asthma because one doctor she had previously seen had diagnosed her as being a mild asthmatic.

2.10 **AT** the time she suffered the attack on 1 January 1997 Ms Clarke says she did not consider going to the Napier public hospital because at that time there was a lot of in-fighting between Hastings and Napier Hospitals and some terrible *"horror stories"* floating around in the community about the sort of treatment patients were getting. She also said she felt a loyalty to Mr Krishnayya and thought that he would know more than anyone about what was wrong with her because he had performed her surgery. She did not contact her GP at that time. Ms Clarke waited until later in the morning of 1 January 1997 and telephoned Mr Krishnayya both at home and at Parkside Hospital but was unable to contact him until about 10.30 that morning. It seems that initially Ms Clarke contacted Mrs Krishnayya at their home and that Ms Clarke then rang

Parkside Hospital and left a message for Mr Krishnayya who returned her call and waited at the hospital for her.

2.11 **MS** Clarke's evidence was that she got out of bed and dressed and then was driven immediately to Parkside Hospital. Mr Krishnayya examined her and arranged for her to go to Napier Public Hospital. Mr Krishnayya gave a referral letter to Ms Clarke and her admission to Napier Hospital is recorded in the Hospital Notes as occurring at 12.40 pm.

2.12 **IN** Napier Hospital Ms Clarke was diagnosed as having a deep vein thrombosis, although no diagnostic tests to confirm this diagnosis were carried out at the time, it being a public holiday and no staff or facilities were available.

2.13 **A** V/Q scan was carried out on 3 January 1997 with a normal result. There is no evidence of either a Venogram or a Doppler ultrasound being carried out at any time by Napier Hospital. The patient history taken from Ms Clarke on admission records, inter alia, *"Calf pain - started left calf then moved to right now resolved ... pleasant young lady no distress, no pallor, no cyanosis, no lymphodenopathy, hands NAD T = 36°, PR = 82, BP = 120/80 CVP not [elevated]. Apex not displaced. HS dual not added, no signs DVT no warmth, no swelling, PPP; RSP, RR = 12,* $Sa0^2$ *98% on air ... no wheeze ..."*. As to the surgical site wound, the admitting physician has recorded *"large healing incision looks fairly clean soft, mildly tender round wound"*. The ECG carried out on admission is recorded as *"sinus rhythm regular 75/min"*. The results of all investigations carried out on admission are recorded as being within the normal range.

2.14 **MS** Clarke remained in Napier hospital until 12 January 1997 and, notwithstanding the presumptive nature of the DVT diagnosis, was on Warfarin anticoagulant for three months.

3. EVIDENCE FOR THE DIRECTOR OF PROCEEDINGS:

Mr Hunt:

3.1 **MS** Clarke's former partner, Mr Peter Hunt, was called to give evidence regarding the post-operative consultation with Mr Krishnayya, which he attended with Ms Clarke. Unfortunately his recall of the events generally at issue was vague to the point of being unhelpful. His evidence also contradicted Ms Clarke's in some significant respects. For example, Ms Clarke's evidence was that when she mentioned her leg pain to Mr Krishnayya it was in her left leg; Mr Hunt's recollection was *"that it was her right leg that was in pain"*. Ms Clarke's complaint was that Mr Krishnayya did not respond to her complaint of leg pain and that he did not examine her leg. Mr Hunt gave evidence that he was *"certain that she did mention the leg pain and that Mr Krishnayya heard her ... and that when Christine told Mr Krishnayya about her sore leg Mr Krishnayya ran his hand over it. .... he ran his hand over the leg, he touched the leg."*

3.2 **MS** Clarke also gave evidence that she and Mr Hunt had together compiled her letter of complaint written to the Health & Disability Commissioner. She said that in preparing this letter she and Mr Hunt had relied upon notes which she had made to keep a record of what was happening in the context of Mr Krishnayya's care of her. She said that she had destroyed these notes once she and Mr Hunt had typed her letter of complaint.

3.3 **MR** Hunt however was unable to remember any of the details as to how the letter of complaint was prepared and had no recollection as to whether or not there were any notes or other records available to them at the time.

3.4 **IN** closing, Ms Gibson has referred to the evidence of Ms Clarke and Mr Hunt as *"inherently contradictory"*. The Tribunal considers that a fair assessment and, inevitably, the contradictions between the two accounts diminishes the credibility of both.

Professor John Albert Windsor:

3.5 **PROFESSOR** Windsor is a consultant surgeon at Auckland Hospital and an Associate Professor of Surgery at the University of Auckland. He provided the Health & Disability Commissioner with an expert opinion in relation to Ms Clarke's complaint against Mr Krishnayya. At the hearing Mr Windsor's original statement of evidence which was circulated prior to the hearing was presented to the Tribunal in a substantially amended form. As a result, Mr Windsor's evidence was partly orally, partly written, and much of his evidence addressed particulars (d) and (e), which were subsequently withdrawn. Of relevance to the remaining particulars, Mr Windsor's evidence was:

(1) That if Ms Clarke did report calf pain and that was ignored by Mr Krishnayya, then Mr Krishnayya did not act appropriately;

(2) If there had been a complaint of leg pain, or particularly calf pain, then it would be appropriate for the complaint to be recorded, the leg examined for tenderness, swelling and heat, as well as pain on dorsi-flexion of the foot and the findings positive/negative recorded;

(3) That the prescription of antibiotics ought to have been recorded in Ms Clarke's medical record maintained by Mr Krishnayya

(4) If Mr Krishnayya's usual practice in relation to patients who present with leg pain, or more particularly calf pain, is to check the patient's physical signs of deep vein thrombosis and refer them to a physician or for radiological investigations as necessary, then that is appropriate practice;

(5) That if Ms Clarke's account of Mr Krishnayya's care and treatment of her is accepted as accurate then there are clear deficiencies in the clinical records kept by him and the standard of his record keeping falls below what could be expected of his reasonable peers;

(6) Eight post-operative consultations is a large number of consultations for an elective procedure;

(7) That before subjecting a young woman to three months of anti-coagulation therapy in the face of a negative VQ scan he would have looked for evidence of a deep vein thrombosis by either of the two usual means and a Venogram or a Doppler ultrasound would have been appropriate;

(8) That Mr Krishnayya's attendance on Ms Clarke on New Year's Day when he was not on call was evidence of a caring doctor.

4. THE RESPONDENT'S EVIDENCE:

Mr Michael Anthony Sexton:

4.1 **MR** Sexton practices as a general surgeon at Grey Hospital and is a fellow of the Royal Australasian College of Surgeons (1984). In relation to the complaint regarding Mr Krishnayya's records, Mr Sexton noted that Mr Krishnayya had kept records of every consultation with Ms Clarke and the dates thereof. Private consultation records are essentially an aide memoir for each individual practitioner and, whilst there are no rules as to what must and must not be included, a patient's record should be accurate and appropriate to the circumstances. In Mr

Sexton's view, the only blemish on the part of Mr Krishnayya was his failure to record the prescription of Augmentin, which prescription appeared to have been given as a result of Ms Clarke's concern that there might be an infection rather than because of any concern on his part that an infection had developed in Ms Clarke's operation wound. Mr Sexton's evidence was that *"most active practitioners have prescribed prophylactic antibiotics at some time or other"*. Mr Sexton's opinion was that the picture one gets from Mr Krishnayya's records is of an untoward post-operative course until the emergency consultation on 1 January 1997.

4.2 **IN** relation to Particular (b) Mr Sexton noted the conflict between Ms Clarke and Mr Hunt and Mr Krishnayya. But Mr Sexton confirmed that any complaint of leg pain should have been recorded, the leg examined for tenderness, swelling and heat as well as pain on dorsiflexion of the foot, and the findings, both positive and negative recorded. Whether or not further investigation is required depends on the level of suspicion of the formation of a deep vein thrombosis.

4.3 **MR** Sexton commented that he regarded the diagnosis of DVT made at Napier Hospital as being dubious on clinical grounds both from the history and the clinical findings. He also noted that no investigations were carried out to confirm the presumptive diagnosis.

4.4 **IN** terms of customary practice, and in relation to medical record keeping generally, it was Mr Sexton's evidence that most surgeons, particularly in their private practice, are accustomed to using a form of shorthand that they are comfortable with, and which gives them the information they feel is appropriate from each consultation. Anything untoward should obviously be recorded

but if there was no untoward event or complaint then Mr Krishnayya's simply recording *"checked"* would be sufficient.

Dr Gerald Richard John Barclay Lewis:

4.5 **DR** Lewis practices as a cardiologist in Wellington. He is a member and a fellow of the Royal College of Physicians, and of the Royal Australasian College of Physicians.

4.6 **DR** Lewis also commented on the number of post-operative consultations, and that at least one of these consultations had occurred on a weekend. Dr Lewis' view *"this frequent post-operative follow-up certainly does not suggest to me an uncaring surgeon"*. Dr Lewis went on to say that he considered it would be quite unfair to expect a surgeon to make voluminous notes when a patient is seen every couple of days, particularly when his major interest was to look at the abdominal wound. Dr Lewis gave evidence that Mr Krishnayya had previously consulted him as a specialist physician when Dr Lewis was working as a cardiologist in the Hawkes Bay area. His clinical experience with Mr Krishnayya was that he was very sensitive to the development of deep vein thrombosis and if he suspects DVT he always calls a physician immediately.

4.7 **IN** relation to the leg pain reported by Ms Clarke, it was Dr Lewis' evidence that deep vein thrombosis does not move between the legs. It is very unusual to have deep vein thrombosis in both legs and he noted that the Napier Hospital notes do not record that there were any clinical signs to be seen in the legs. Dr Lewis also referred to Ms Clarke's evidence that the Napier Hospital doctors told her that *"leg pain after stomach surgery is a number one warning for blood clots"*. *"It is certainly possible"*, said Dr Lewis, *"that this has drawn Ms Clarke's*

attention to the relevance of calf pain". The movement of pain from one calf to the other, certainly did not, in Dr Lewis' view suggest deep venous thrombosis and he wondered about the true diagnosis of DVT made by Napier Hospital. It was unfortunate that Ms Clarke did not have venography, ultrasound or any other investigations to confirm the presence of a DVT.

4.8 **FURTHER**, if Ms Clarke had a DVT post-operatively, evidence of that should have been present when she was admitted to hospital. In Dr Lewis' view there would still have been signs of a DVT in the leg, such as swelling, warmth, veins distended, dusky appearance, tenderness on flexion. The Napier Hospital admission notes expressly record that none of these symptoms were present.

4.9 **IN** relation to Mr Krishnayya's record keeping, Dr Lewis expressed his belief that Mr Krishnayya's hospital and post-operative notes should be compared with those of other physicians and clinicians around the country, particularly in private hospitals and he submitted that they were as good as any he had seen. In summary, in Dr Lewis' experience, the clinical notes and the number of times he saw Ms Clarke were at least of a standard achieved by most of his colleagues.

Mr Krishnayya:

4.10 **MR** Krishnayya gave evidence of the abdominal surgery and explained that abdominal surgery is *"a very big operation"* and that the site wound *"was very big, and they can be very painful"*. He explained that he was solely responsible for the surgery and follow-up care and that it is his policy when he discharges patients to give a supply of whatever is needed for them to take home, that he encourages patients to telephone him, and he sometimes telephoned them

to check on their post-operative progress. *"We keep a close eye on the patient",* he said. In relation to the number of post-operative visits Mr Krishnayya said that they were not done to create extra income because he did not charge the patients for their post-operative visits. His practice was to give a composite figure for the surgery and the follow-up care.

4.11 SOMETIMES Mr Krishnayya visits patients at their home to give post-operative care however it is more convenient to do the treatment in the hospital and it was his policy to do all of the dressings and removal of stitches himself. His nurses only performed these post-operative cares if he was present. Mrs Clarke's post-operative course after discharge was uneventful. She had slight wound ooze but given the extent of the surgery and the size of the wound these wounds do take some time to heal. It is apparently not unusual for the wound to ooze, and there may be some inflammation as a reaction to surgery not necessarily indicating infection.

4.12 IT was Mr Krishnayya's evidence that there was nothing unusual in Ms Clarke's case and that her wound healed as expected within a couple of weeks. He had prescribed her antibiotics because the wound was continuing to discharge and Ms Clarke and Mr Hunt were both clearly convinced that it was infected.

4.13 THE prescription of Augmentin was not recorded in the notes because it was given to Ms Clarke at the appointment desk while she was making another appointment. The antibiotic was given solely to comfort her and Mr Krishnayya did not have her notes with him at the time.

4.14 IN relation to the leg pain Mr Krishnayya was adamant that Ms Clarke had not mentioned leg pain and that DVT can happen rarely after abdominal surgery. Indications of deep vein thrombosis requires investigation by means of a Venogram or Doppler ultrasound.

4.15 IT was Mr Krishnayya's evidence that if Ms Clarke or her partner had advised him of calf pain he would have checked first for physical signs of DVT and referred her to a physician and/or for radiology investigations if he had thought that was necessary.

4.16 UP until the morning of 1 January 1997 he was of the view that Ms Clarke's post-operative course was normal and her wound was healing well. On New Year's Day his wife had received a telephone call from Ms Clarke at approximately 9.30 am at his home. He was already at the hospital and he contacted Ms Clarke straight away. Ms Clarke told him that she had chest pain during the night and although he was not her GP he asked her to come in straight away. However Ms Clarke did not arrive at Parkside Hospital for two or more hours. When she did not arrive he telephoned her back and she told him that she had no transport and had to wait for her partner to bring her in to see him. She came in at around 12.30 pm or so. Mr Krishnayya checked her and thought that she had a myocardial infarction. He did not think that it was appropriate to delay matters and he telephoned the admitting house surgeon at Napier Hospital, wrote a letter of referral, which included the information that he had prescribed antibiotics, and he sent her to the hospital. Mr Krishnayya also gave evidence of events following 1 January 1997, however as none of these events relate to any of the particulars of the complaint they have not been taken into account in the Tribunal's deliberations.

5. DECISION:

Particular (a):

"Mr Krishnayya failed to keep full, complete and appropriate medical records in relation to his patient, Christine Clarke."

5.1 **THE** complaint in relation to Mr Krishnayya's record keeping focused on two matters:

(1) His recording simply *"checked"* in relation to Ms Clarke's post-operative visits; and

(2) His failure to record the prescription for antibiotics.

5.2 **IN** relation to the first, the Tribunal considers that the most important points to bear in mind are, first, that the records were made in the context of what Mr Krishnayya considered to be routine post-operative care; secondly, that they were Mr Krishnayya's own notes kept as an aide memoir for his own future reference; and thirdly, that the antibiotic was prescribed prophylactically, for Ms Clarke's own peace of mind, rather than for any clinical reason.

5.3 **PROFESSOR** Windsor was critical of Mr Krishnayya's records because, in his view, the word *"checked"* does not convey any useful information. It does not specify what was checked or whether the findings were correct or not. However, in the Tribunal's view the record *"checked"* whilst brief, made by an experienced specialist practitioner in the context of his usual practice giving routine post-operative care conveys all of the information he might need for future reference.

5.4 **THE** record does record the fact that Ms Clarke was seen by Mr Krishnayya, the date of the consultation and, if only by omission, that there was nothing untoward or out of the ordinary noticed or necessary.

5.5 **IN** recording *"checked"*, Mr Krishnayya relied upon his customary practice in checking his patients and carrying out his *"routine"* post-operative care. The record is his reminder there was nothing unusual about the course of care he carried out. *"It is usual surgery, usual post-operative recovery, usual patient, usual post-operative care, so there is nothing to be remembered"*, he said in evidence. Having had the opportunity to observe Mr Krishnayya giving evidence, both in reading and expanding upon his statement of evidence and during a prolonged and frequently repetitive cross-examination, the Tribunal found him to be a credible witness and formed the impression that he is a diligent, experienced surgeon.

5.6 **HOWEVER**, Mr Krishnayya also clearly holds the view that the only purpose of the record kept by a practitioner ought to be to enable him to deliver appropriate care to his patients. In the course of his evidence Mr Krishnayya explained *"The other thing you have to appreciate, you write these notes if you think your patient is your enemy. People who come to see you as a surgeon trust in you, and this kind of defensive medical practice I'm not sure I am very comfortable with"*.

5.7 **UNFORTUNATELY**, in the environment of modern medical practice, especially in the context of a private commercial practice such as Mr Krishnayya's which offers specialist care for specific and discrete procedures, the traditional notion of a doctor/patient relationship is changing and is increasingly characterised in commercial terms, with all of the attendant business risks, and

benefits. Like it or not, the adequacy of medical records will increasingly be defined in terms of their effectiveness in managing risk, which includes the risk of complaint.

5.8 **THE** importance of keeping adequate medical records is (at least) twofold - to maintain a high standard of patient care, and to provide a clear contemporaneous record so that, if the care and treatment of a patient is ever called into question, the doctor is able to give evidence refreshed and corroborated by his written record.

5.9 **AGAINST** that, and in considering Particular (a) on the basis of the totality of the relevant evidence, the Tribunal is satisfied that Mr Krishnayya's record of Ms Clarke's course of care is not out of keeping with the norm, particularly in the context of a busy, private specialist practice carried on by an experienced practitioner. That finding is not intended to express any approval or otherwise to adjudge the content and adequacy of medical record keeping by New Zealand's medical practitioners. Nor should it be interpreted as having any wider application than this present case; it is no more than a finding made on the basis of the evidence before the Tribunal on this occasion.

5.10 **THE** adequacy of Mr Krishnayya's record kept in relation to this patient must be judged against the standard of a reasonable, experienced specialist practitioner, in private practice, providing post-operative care. He is not required to lead the way, or to demonstrate the highest standards of medical record keeping such as would provide a benchmark for his colleagues. Nor may he fall below the standard of his peers.

5.11 **THE** Tribunal accepts Mr Krishnayya's concession that the prescription of antibiotics should have been recorded but it does not find this omission to be a culpable oversight, particularly taking into account the fact that this information was properly included in the letter of referral to Napier Hospital *"when it mattered"*. That is, when Ms Clarke went to someone else's care.

5.12 **IN** relation to Particular (a), the Tribunal also records that the Director of Proceedings annexed to her closing submissions extraneous materials regarding medical records. These materials had not previously been referred to or presented to the Tribunal as part of the Director's case, either as part of the agreed bundle of documents or produced through a witness at the hearing. In making its decision, the Tribunal has disregarded this material, and all references to, and evidence given in relation to, other material including correspondence and investigations undertaken by the Health & Disability Commissioner, not formally produced at the hearing.

5.13 **ACCORDINGLY** the decision of the Tribunal is that Particular (a) is not established.

Particular (b):

"That Mr Krishnayya failed to communicate effectively with Ms Clarke and, more particularly, failed to listen to her."

5.14 **MS** Clarke was concerned that Mr Krishnayya did not listen to her, especially when she complained of an infection in her wound and leg pain.

5.15 **IN** response to a question from the Tribunal, Mr Krishnayya stated that in 36 years of medical practice in Britain and New Zealand he was not aware of any misunderstandings arising between him and his patients. However he fairly conceded that sometimes patients may have a difficulty

with his accent and mode of expression and, having had the opportunity to observe both of them at the hearing, and to listen to their evidence, the Tribunal is of the view that the possibility of miscommunication or of Mr Krishnayya and Ms Clarke talking 'past each other' may lie at the heart of this complaint.

5.16 **HOWEVER**, whilst miscommunication, or a deterioration in the doctor/patient relationship might be the source of complaint, it is by no means the case that a complaint of this general nature in the absence of something more specific in the nature of misconduct or incompetence should necessarily attract the censure of professional disciplinary proceedings.

5.17 **IT** also appears to the Tribunal that it is most relevant in relation to Particular (b) that Mr Krishnayya arranged and attended eight post-operative consultations with Ms Clarke and that he personally attended to the dressing of her wound. Viewed overall, this care of Ms Clarke can hardly be characterised as *"casual"* or even *"Ho hum"* as was alleged. Putting to one side the mere possibility of miscommunication at a non-clinical level, the Tribunal finds no evidence to support a finding of professional misconduct in relation to the allegation contained in Particular (b).

Particular (c):

"That Mr Krishnayya failed to appreciate the significance of leg pain experienced by Ms Clarke."

5.18 **ALL** of the expert evidence, and Mr Krishnayya's own evidence on this point was consistent. If Ms Clarke complained of leg pain this should have been followed up by Mr Krishnayya and the proper investigations carried out.

5.19 **THE** factual evidence given by Ms Clarke and Mr Krishnayya respectively is unequivocal; Ms Clarke alleging she told Mr Krishnayya she was suffering from pain in her leg and that he ignored her, Mr Krishnayya in turn equally adamant that Ms Clarke did not tell him that she had leg pain. To further muddy the waters, we have Mr Hunt's evidence which corroborates both Ms Clarke by confirming her evidence that she did mention leg pain to Mr Krishnayya and Mr Krishnayya's evidence that, if Ms Clarke did mention leg pain to him he would have examined her leg for symptoms of a DVT (Mr Hunt saying that when Ms Clarke mentioned her leg pain Mr Krishnayya ran his hands over her leg and told her that there was nothing wrong).

5.20 **IN** the absence of any dispute as to what a reasonable practitioner ought to do if a patient reports leg pain post-operatively and in the face of the conflicting accounts given by Ms Clarke and Mr Krishnayya, the Tribunal's finding must turn on its assessment of the credibility of them both.

5.21 **IN** assessing the credibility of Ms Clarke, the Tribunal records her comment that

"[She] wasn't really aware that there were any problems until I was admitted to the Napier Public Hospital and the doctors that saw me there after I had the ECG were quite horrified that the leg pain hadn't been followed up on so that gave me warning bells that I hadn't had the treatment I should have. I started to take notes - I'm that type of person - to keep a record of what was happening. I was unaware that there was anything like the Tribunal until I went to my own doctor to get a repeat prescription of the Warfarin then I was given your [HDC] pamphlet. When I prepared my submissions to send to your office I had previously taken down notes which I could refer to."

5.22 **THE** Tribunal also records the confusion between Ms Clarke and Mr Hunt as to which leg the subject of the complaint of leg pain allegedly made to Mr Krishnayya, and Ms Clarke's report of her *"leg pain"* becoming *"calf pain - started left calf then moved to right now resolved"* made on admission to Napier Hospital on 1 January 1997. It is also relevant to record that Ms Clarke was not admitted to Napier Hospital on the basis of leg pain or suspicion of DVT on the

part of Mr Krishnayya, but for an ECG because he suspected she had a myocardial infarction, although none of the examinations carried out on admission revealed any symptoms either of infarction or DVT and Ms Clarke was admitted to Napier Hospital on the basis of a presumptive diagnosis only.

5.23 **IN** assessing the respective credibility of Ms Clarke and Mr Krishnayya, the Tribunal puts to one side the evidence given by Mr Hunt. It was clear that Mr Hunt had no real recollection of the events and his evidence was so vague and his memory so poor that his evidence must be discounted as unreliable.

6. DECISION:

6.1 **MR** Krishnayya has been charged at the level of professional misconduct. On the scale of charges, professional misconduct is in the mid range of charges. The Tribunal accepts Ms Gibson's submission that it is a serious charge and the Tribunal should require a degree of probability measured on a sliding scale and consistent with the gravity of the allegation. It is the Director of Proceedings who bears the onus of proof and before the Tribunal can make a finding in relation to the charge it must be satisfied that the Director has discharged this onus.

6.2 **THE** onus of proving the charge must be met to the appropriate standard, and the credibility of the complainant is critical. The Tribunal is not satisfied, on the balance of probabilities and at the level of professional misconduct, that the particulars supporting the charge have been proven.

6.3 **THE** Tribunal has considered the submissions made by the Director that, if the Tribunal determines that the charge is not established at the level of professional misconduct, then it is

within the Tribunal's power to amend the charge if it is considered appropriate, and Ms Gibson's submission that, pursuant to Clause 14 of the First Schedule to the Act, the Tribunal may only amend the charge in the course of the hearing and with notice to the doctor.

6.4 **IN** the event, and without determining the issue, the Tribunal did go on to consider, in the course of its deliberations, whether or not it would have found the charge established at a level of conduct unbecoming that would reflect adversely on Mr Krishnayya's fitness to practise medicine (we did not understand the Director to be suggesting that the charge be amended upwards), had it been laid at that level. It is satisfied that Mr Krishnayya is not guilty of the charge at either level.

6.5 **ACCORDINGLY** the Tribunal is satisfied that Mr Krishnayya is not guilty of the charge, as particularised in Particulars (a), (b) or (c).

6.6 **THERE** are no issues as to costs.

DATED at Auckland this 25th day of May 1999

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W N Brandon

Deputy Chair

Medical Practitioners Disciplinary Tribunal