Medical Practitioners Disciplinary Tribunal

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DECISION NO: 73/98/37C

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

IN THE MATTER of a charge laid by Complaints Assessment Committee pursuant to Section 93(1)(b) of the Act against **KEVIN DAVID KARPIK** medical practitioner of Auckland

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mr P J Cartwright (Chair)

Ms S Cole, Dr J C Cullen, Dr M-J P Reid,

Associate Professor Dame N Restieaux (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Auckland on Monday 10 May 1999

APPEARANCES: Mr R Harrison QC for the Complaints Assessment Committee ("the CAC")

Mr I Thain for Mr K D Karpik.

1. THE CHARGE:

1.1 **ON** the application of Mr Harrison, which was made by agreement between counsel, the charge laid by the Complaints Assessment Committee (the CAC) pursuant to Section 94(4)(a) of the Medical Practitioners Act 1995 was amended to read:

"On 30 April 1996 and 3 September 1996 in the course of managing the treatment of a patient, Ms Ngaire Rowson, failed to:

(1) Examine and assess appropriately the nature and extent of an injury suffered by Ms Rowson to her right ankle on or about 1 April 1996 and on or about 23 May 1996 and

(2) To diagnose correctly that Ms Rowson was suffering from a ruptured Achilles tendon which injury later required reconstructive surgery:

being conduct unbecoming a medical practitioner which reflects adversely on the practitioner's fitness to practice medicine."

2. BACKGROUND:

2.1 **HAVING** injured her right ankle on 1 April 1996, Ms Rowson went to see her GP, Dr Johan Wilson, on 2 April 1996 and had an x-ray taken. This showed a possible avulsion fracture in relation to the insertion of the anterior talo-fibular ligament of the lateral ligament complex. She was put in a below the knee plaster and remained in it for four weeks. She saw Mr Karpik on 16 April 1996. Mr Karpik's note of the consultation on 16 April 1996 records:

"Summary: Diagnosis: Possible avulsion fracture in relation to the lateral border of the calcaneus.

This 25 year old woman presents following an inversion injury to her ankle done two weeks ago. X-rays at that time show possible avulsion fracture in relation to the insertion of the anterior talo-fibular ligament of the lateral ligament complex. She had been placed in a below knee POP on which she has been weight bearing with comfort. She is to remain in this plaster for a further two weeks. I will see her at that stage with a removal of plaster. No x-rays are required at that point. Of note she has longstanding problems with point of heel on the right side and also pain in the ankle region and this will need assessing once she comes out of plaster."

2.2 **AFTER** coming out of plaster Ms Rowson was referred back by Dr Wilson to Mr Karpik who saw her on 30 April 1996. Mr Karpik's notes of this second consultation record:

"Summary: Diagnosis: Right ankle sprain.

This young lady comes out of plaster today six weeks after her right ankle sprain I have instructed her today in range of movement exercises at the ankle and strengthening exercises for her peronei. I have not arranged a routine follow-up for her as I can find no objective sign of ankle instability. Presumably this is from a combination of peroneal tendon weakness and proprioceptive malfunction. I will see her only as required."

2.3 **MS** Rowson continued to have severe pain in her right ankle. She injured the same ankle again several weeks after coming out of plaster. Ms Rowson went back to Dr Wilson, who again did some x-rays and put her back in plaster. Dr Wilson again referred Ms Rowson to Mr Karpik.

His notes of the third consultation which took place on 3 September 1996 record:

"Summary: Diagnosis: Sprain lateral ligament right ankle

This young lady previously had an avulsion fracture of the tibia and distal fibula. She was placed in a below knee plaster. She had a repeat injury which has been treated here with a further plaster. Today I have seen her some two weeks after plaster removal. She has excellent movement of the ankle and a normal gait. I have advised her to work on her ankle motion. I have advised against any further plaster treatment, and to strap her ankle for activity. I have discharged Ngaire from this clinic but should be happy to see her back should this prove necessary."

2.4 **THEREAFTER** Ms Rowson's ankle remained swollen and she was in constant pain. For Ms Rowson this situation became impossible, as she found she could no longer participate in sport

and recreational activities that she had been enjoying, coupled with the affect her injured ankle had on her work with pre-school age children, an occupation which kept her on her feet most of the time.

2.5 **AFTER** several more months of pain Ms Rowson was referred to a second orthopaedic specialist, Mr A Hadlow. His diagnosis was a torn Achilles tendon, which needed reconstructive surgery straight away.

2.6 **BECAUSE** Ms Rowson was rather concerned that two orthopaedic specialists had made conflicting diagnoses, she requested a third opinion and was referred to a Mr Tomlinson at the Orthopaedic Centre at Mercy Hospital in Epsom. He made the same diagnosis as Mr Hadlow. Following Ms Rowson's visit to Mr Tomlinson on 23 March, she had surgery on 9 April which went well.

3. EVIDENCE FOR THE CAC

Ngaire Judith Rowson:

3.1 **MS** Rowson recalled suffering two injuries to her right ankle in 1996, one at the beginning of April 1996, the other late May 1996.

3.2 **AFTER** coming out of plaster on or about 30 April 1996 she noticed a big indent at the top of her right heel. When she compared it with her left ankle/heel, there was muscle on the left, but nothing on the right heel. She mentioned this to Dr Wilson whose referral of her to Mr Karpik followed on 30 April 1996. She mentioned the indent to him but he said he had not arranged a follow-up, as he could find no objective sign of ankle instability.

3.3 **AT** the third consultation on Mr Karpik on 3 September 1996 she again mentioned the indent to him, and the pain she had experienced in her right ankle. Mr Karpik made no comment except to say it would take a while to heel. On this occasion Mr Karpik examined her foot with the bandage still on, and he did not look at the indent.

3.4 **SHE** feels there was gross negligence on Mr Karpik's part. If the diagnosis was correct in the first place, and if he had examined her foot with the bandage off, a correct diagnosis could have been made, and she would have not have had to suffer for a year.

3.5 **WHEN** she had the first accident it was very painful, and she felt like a click or a bang, sudden pain as if someone had kicked her in the back of the leg.

3.6 **SHE** told Mr Karpik of the sensation immediately following the injury in the same way she had described it to Mr Hadlow and Mr Tomlinson. Describing the second accident, she said she was walking down the back steps at home, slipped and a similar thing happened, *"a banging sensation ..."*.

3.7 **SHE** recalled describing to Mr Karpik the sensation she felt following the second accident.

3.8 **UNDER** cross-examination Ms Rowson confirmed between the beginning of April, about the time when she had her first injury, and August of 1996, she made a large number of trips to the doctor's clinic, in all some 51 visits, most of which were because of her painful right ankle. And during that time she confirmed seeing a number of different doctors, between four or five different doctors, including the specialists. By reference to the notes made by the various doctors over

this period, including the visit to Dr Wilson on 30 April, and the notes made by Mr Karpik, Ms Rowson confirmed that none of those notes record any mention of any indent above her right ankle.

3.9 **MS** Rowson explained to Mr Thain that what drew her attention to the dent in her ankle was noticing it when she was shaving her legs when she first came out of plaster.

3.10 **MS** Rowson recalled she was *"pretty sure"* she remembered telling Mr Karpik about the dent when she saw him on the second occasion in April 1996. And to the best of her memory the dent had remained the same when she saw Mr Karpik for the third time in September 1996.

4. EVIDENCE FOR RESPONDENT:

Mr Karpik:

4.1 **HE** does not have a detailed recollection of his consultations with Ms Rowson, and was only able to recall general impressions in respect of her case. In describing how he dealt with her case he therefore relied upon his notes and where appropriate his usual practice in such a case.

4.2 **DESPITE** his request that all patients referred to him have a letter of referral, no letter of referral was available when he first saw Ms Rowson on 16 April 1996. Accordingly he had to take the details of her history from her.

4.3 **SHE** presented to him 2 ½ weeks after the initial injury. She presented wearing a below knee plaster. X-rays were available to him from the time of the injury. Ms Rowson advised him that

she had injured her ankle by rolling over on it. The x-rays showed small bits of bone which was consistent with an injury to the lateral ligament of the ankle arising from an inversion injury.

4.4 **BECAUSE** all of the material available to him in relation to the injury was consistent with an injury to the lateral ligament, he did not consider it necessary to remove the plaster to examine her. It is not unusual treatment for a ligament injury to be treated in plaster, so he left the plaster on.

4.5 **CONFIRMING** that the notes of his first meeting with Ms Rowson were an accurate record of his consultation with her, however he said he did not have an opportunity to check them or any subsequent notes, because they were kept only on the computer and he was unable to access them. His request that all notes would be made available to him in hard copy was not met. Obviously this was an unsatisfactory state of affairs, and was ultimately one of the reasons why he ended his association with the practice in December 1996.

4.6 **IF** Ms Rowson had described the sensation she experienced at the time of the injury, either as a "*sudden pain and bang*", or as if she had been kicked, he would have immediately considered the possibility that she had ruptured her Achilles tendon. He would have removed the plaster and examined her ankle.

4.7 **ALTHOUGH** noting that Ms Rowson said that she mentioned an "*indent*" to him at the consultation on or about 30 April 1996, he is confident that she did not. If she had it would have been his invariable practice to record this in his notes of the consultation because it would be strong evidence of a ruptured Achilles tendon. He did not note it.

4.8 **ALTHOUGH** he examined the ankle in these circumstances a ruptured Achilles tendon would be very difficult to diagnose. After four weeks in plaster a dent would be difficult to see because healing would have likely concealed the gap. This difficulty is compounded where the patient has well built legs, as did Ms Rowson (in contrast to someone with skinny legs) as the depth of muscle and flesh surrounding the site of the injury has a further concealing effect.

4.9 **REFERRING** to the notes made by Dr Wilson on 23 May 1996 when he saw Ms Rowson after further injuring her ankle, he noted she presented with severe pain and swelling and a *"palpable lump over lateral aspect of Achilles tendon ... partial rupture of tendon ..."*, Dr Wilson injected a steroid into the tendon and commenced Ms Rowson on a course of electro-acupuncture which continued to some months. At the same time he placed her in a below-knee plaster. Mr Karpik expressed his belief that the treatment provided by Dr Wilson at that time was inappropriate. Mr Karpik said *"At this stage she should have been referred urgently to an orthopaedic surgeon as it appears from Dr Wilson's notes that a diagnosis of a rupture to the Achilles tendon was a distinct possibility. At that stage if the tendon was ruptured, surgery would have been indicated"*.

4.10 **DR** Wilson did not contact him regarding this further injury until Ms Rowson was referred to him on 3 September 1996, over three months after the injury. Again she came without a referral letter. Although his clinic was held in Dr Wilson's rooms, he did not have access to his computerised notes.

4.11 **BY** reference to the 3 September 1996 consultation, Mr Karpik noted mention in Ms Rowson's letter to the Medical Council that her ankle was bandaged when he examined her and that he did not remove the bandage. He does not recall whether she was wearing a bandage. However he had noted that she had excellent movement of the ankle and a normal gait. If he did not see any swelling or evidence of pain, which he would have noted if these had been present, in all of these circumstances he had no reason to suspect damage to the Achilles tendon, and therefore did not remove the bandage to examine the ankle (if it was bandaged). An ability to walk with a normal gait is regarded as strong evidence against a diagnosis of a ruptured Achilles tendon.

4.12 **THE** fact that Ms Rowson had been in a plaster for some time before she came to see him meant that a diagnosis of a ruptured Achilles tendon would have been very difficult.

4.13 **WITH** the benefit of hindsight it is possible that when Ms Rowson presented to him in September it was following a rupture to her Achilles tendon in May. However, her normal gait means that it was a very atypical presentation. Given that she had been in a plaster for some time after the injury, he believes that it would have been a difficult diagnosis to make.

4.14 **IT** is likely that Messrs Hadlow and Tomlinson had the benefit of a letter of referral from Dr Wilson when they saw Ms Rowson. The information as to the circumstances of the injury, and the appearance of a dent in the tendon at that time, would have made diagnosis straight forward.

Donald Harley Gray:

4.15 **CURRENTLY** employed as Chief Medical Officer at Middlemore Hospital, he was Professor of Orthopaedic Surgery at the University of Auckland from 1975 until 1993. Currently he is also

Senior Examiner for Orthopaedic Surgery for the Royal Australasian College of Surgeons in New Zealand.

4.16 **WHEN** Mr Karpik saw the patient on 30 April the ankle almost certainly had some swelling as a result of having the plaster removed three days previously. If an indentation had been present at this time, it would have been very difficult to see. Similarly, the patient's gait would not have fully recovered from the period of a plaster immobilisation. It would therefore have been very difficult to detect a rupture of the Achilles tendon at this time if there had been no specific history or indication that rupture had occurred. The history of a rolled ankle is not consistent with a rupture of the Achilles tendon.

4.17 **ON** the balance of the evidence before him, it is unlikely that the tendon was ruptured during this first injury.

4.18 **IT** is not clear when Ms Rowson sustained a rupture of her Achilles tendon. The balance of the evidence suggests that this probably did not occur in March, but most likely occurred in May. It is likely the tendon was injured at the time, but as a lump was present initially, it is unclear whether the full separation occurred then or at a later date. It is noteworthy that the case notes show that the gap in the tendon was first detected in February 1997 despite many visits and examinations by general practitioners. There is no history of any further injury after May.

4.19 **ON** the evidence available the treatment of it by Mr Karpik was reasonable and consistent with modern standards given the information available to him during March and April. The lack of a

letter of referral, and particularly the history of an injury on a kerb, would have made the diagnosis of a ruptured Achilles tendon more difficult to sustain.

4.20 **ON** the balance of probabilities, the rupture occurred in May or shortly thereafter.

4.21 **IN** the absence of a clear indication of the mechanism of injury, it would be possible for a practitioner to miss this diagnosis, although such an omission is not desirable.

5. DISCUSSION AND FINDING:

5.1 **MR** Harrison explained his overview of the principle issues was:

(1) Whether or not Ms Rowson was suffering from her ruptured Achilles tendon when she first presented to Mr Karpik in April 1996;

(2) If so, whether Mr Karpik should have identified the nature and extent of her injury at that time;

(3) Alternatively, whether Ms Rowson was suffering from a ruptured Achilles tendon when presenting to Mr Karpik for consultation in September 1996;

(4) Whether he should have diagnosed the nature and extent of her injury on that occasion.

5.2 **THE** burden of proof is on the CAC to establish that Mr Karpik is guilty of the charge, and to produce the evidence that proves the facts upon which the charge is based. It is well established in professional disciplinary cases that the civil, rather than the criminal standard of proof is required, namely proof to the satisfaction of the Tribunal, in this case the Medical Practitioners Disciplinary Tribunal on the balance of probabilities. At the same time, however, the cases

recognise that the degree of satisfaction which is called for will vary according to the gravity of the allegations.

5.3 **IN** *Brake v Preliminary Proceedings Committee* (Full Court, Auckland, HC 169/95, 8 August 1996) the full Court put it this way (pa):

"The standard of proof is not the criminal standard. The Preliminary Proceedings Committee is required to prove the charge to the civil onus, that is, proof on the balance of probabilities. But the authorities have recognised that the degree of satisfaction for which the civil standard of proof calls, will vary according to the gravity of the facts to be proved: ***Ongley v Medical Council of New Zealand*** *[1984] 4 NZAR 369, 375-6. The charges against the appellant were grave. The elements of the charge must therefore be proved to a standard commensurate with that gravity."*

5.4 **IN** his letter of 26 February 1997 to Dr Wilson it was stated by Mr Hadlow that Ms Rowson had an old rupture of the right Achilles tendon *"which obviously happened back in March last year [1996]"*. And although Mr Tomlinson was equally unequivocal as to diagnosis, he did not proffer an actual or likely date of injury event.

5.5 **IN** cross-examination Mr Karpik said he accepted Mr Hadlow's diagnosis, but not his timing of the injury event. Mr Karpik explained, an explanation which we accept, that because Mr Hadlow had only first seen Ms Rowson in February 1997, a specialist would reasonably be able to construct a timeframe by reference to the previous three or four weeks, but to pinpoint a specific month 12 months ago was, in Mr Karpik's words, *"impossible"*. We agree.

5.6 **MR** Karpik's opinion is supported by the evidence of Professor Gray. He was of the view, on the balance of the evidence before him, of it being *"unlikely that the tendon was ruptured during this first injury"*. The presence of a palpable lump over the lateral aspect of the Achilles

tendon at the time of the second injury sustained on 22 May 1996 indicated to Professor Gray that there was no rupture in the earlier incident in March.

5.7 **AND** neither was it clear to Professor Gray whether the tendon was fully ruptured at the time of the May injury or ruptured later. Professor Gray explained the steroid injection, while reasonable treatment, may well have contributed to a subsequent rupture of the tendon.

5.8 **ON** the basis of the evidence of Mr Karpik and Professor Gray, which we accept, we find that Ms Rowson was not suffering from her ruptured Achilles tendon when she first presented to Mr Karpik in April 1996. Accordingly it becomes unnecessary for us to examine any further the nature and extent of Mr Karpik's management of the injury suffered by Ms Rowson to her right ankle on or about 1 April 1996.

5.9 **MS** Rowson next presented to Mr Karpik on 3 September 1996. At that time she was seen after having sustained a further injury to her right ankle. From Ms Rowson's medical notes it appeared to Mr Karpik that she had been in plaster in the intervening period for a six week timeframe.

5.10 **EARLIER** in this Decision there were accounts of the evidence of Ms Rowson to the effect that there was an indent at the top of her right heel. It was Ms Rowson's evidence that she mentioned an indent to Mr Karpik at the consultation on 30 April 1996. However given our finding that Ms Rowson was not suffering from her ruptured Achilles tendon in April 1996, we consider we do not need to take the question of whether there was an indent on 30 April 1996 any further.

5.11 **IT** was Ms Rowson's further evidence that at her third consultation on Mr Karpik, on 3 September 1996, that she again mentioned the indent to him, but that he made no comment except that the injury would take a while to heal.

5.12 **ON** the other hand, under cross-examination, it was Mr Karpik's evidence that he had no recollection, by reference to his notes or otherwise, of ever being told by Ms Rowson that she had a dent in her ankle.

5.13 **MR** Harrison is correct in submitting that the Tribunal is required to make a credibility finding, because Dr Karpik testified that the existence of a dent would be telling evidence of a rupture of the Achilles tendon.

5.14 **IT** is not possible to make such a credibility finding simply by reference to which of the two witnesses the Tribunal feels gave the more believable evidence. Both witnesses appeared to be entirely truthful, genuine and sincere in the evidence which they gave before the Tribunal. Therefore extrinsic aids may assist the Tribunal on the point.

5.15 **CROSS**-examination of Ms Rowson by Mr Thain elicited that following the consultation between specialist and patient on 30 April 1996, that the latter saw a number of different doctors at her GP's clinic up until the time of her second accident on 23 May 1996. Ms Rowson confirmed to Mr Thain that none of the several notes made covering the period 30 April - 23 May record any mention of any indent above her ankle. Although at a GP consultation on 23 May 1996 note was made of *"palpable lump over lateral aspect of Achilles tendon"* suggestive of *"... a ? partial rupture of tendon ..."*, under cross-examination Ms Rowson conceded it was not until

examination of her ankle by Dr Wilson on 10 February 1997 that he first noticed the indent. Ms Rowson also conceded it was just after Dr Wilson first noticed the indent that he referred her on, at her request, for a second opinion from Mr Hadlow.

5.16 **IN** re-examination by Mr Harrison Ms Rowson said she was *"pretty sure"* she first noticed the dent when she came out of plaster. Her attention to the dent in her ankle was drawn when she was shaving her legs when she first came out of plaster. Asked again by Mr Harrison if the indent, as she had first described it, was still present as a symptom when she saw Mr Karpik in September 1996, Ms Rowson replied *"... I'm pretty sure I did, yes"*.

5.17 **WE** have detected slight uncertainties in Ms Rowson's recollection on the subject of the indent. However Mr Karpik was certain that she never mentioned it to him. These two factors coupled with the fact that the indent received no mention in any of several medical notes, lead us to conclude, and we so find, that Ms Rowson is unlikely to have mentioned the matter to Mr Karpik at the consultation on 3 September 1996. This finding, however, should not be allowed to detract from Ms Rowson's genuinely held belief that she did tell Mr Karpik about the dent in her ankle at one time or another.

5.18 **ON** the basis of that finding, the Tribunal's inquiry will now be directed to establishing whether Mr Karpik should have diagnosed the nature and extent of Ms Rowson's injury at or following the consultation on 3 September 1996.

5.19 **IT** was Mr Harrison's primary submission, with the exercise of reasonable care and skill, on the evidence as it stands, that Mr Karpik could have discovered the condition of ruptured Achilles tendon in September 1996. In support of that submissions Mr Harrison emphasised two points:

5.20 **FIRST** there was no procedure in place for a proper referral from the GP, Dr Wilson, to the orthopaedic surgeon. It was an extremely informal arrangement which, in Mr Harrison's submission, the patient was placed at serious risk. Self evidently, Mr Harrison explained, the risk was that the specialist would not be fully and properly informed of the nature and extent of the diagnosis conducted by the GP, and also, about the full extent of the symptoms as presented by the patient.

5.21 **SECONDLY** Mr Harrison argued that the records from 23 and 24 May 1996 consultations provide compelling evidence of the unsatisfactory nature of the informal arrangement whereby a specialist, when seeing a patient on informal referral, did not have access to patient records from the GP.

5.22 **REFERENCE** back to the evidence given in cross-examination is necessary to appreciate the thrust of these two submissions.

5.23 **MR** Harrison asked Mr Karpik if he placed any weight on whether or not Ms Rowson had suffered a sensation like being kicked in the back of the ankle. Mr Karpik replied that he would have placed huge weight on such information but that unfortunately this was not something he had been told by Ms Rowson.

5.24 **TO** the suggestion that his notes did not record anything of this nature because he had not asked about the injury sensation, Mr Karpik replied *"We don't ask leading questions"*, that the patient recounts what happens which is then documented by the specialist. To the Chair Mr Karpik explained what he meant by leading questions, is the need to give the patient the chance to account for what happened, rather than jumping to conclusions about what happened.

5.25 **MR** Karpik's best recollection, which was his formal evidence, was that when Ms Rowson first visited the surgery on 30 March 1996, she said that she had *"felt a click"*, a sensation which is not consistent with the rupture of an Achilles tendon. Subsequently, however, Mr Karpik noted that Ms Rowson seemed to have described the sensation differently to both Mr Tomlinson (*"a sudden pain and bang"*) and to Mr Hadlow (*"as though someone had kicked her in the back of the ankle"*). We accept Mr Karpik's explanation , that if Ms Rowson had described the sensation she experienced at the time of the injury as she had recounted it to the other two specialists, he would have immediately considered the possibility that she had ruptured her Achilles tendon, and removed the plaster to examine her ankle. We agree with Mr Karpik it is likely that Messrs Hadlow and Tomlinson had the benefit of a letter of referral from Dr Wilson when they saw Ms Rowson. The information as to the circumstances of the injury and the appearance of a dent in the tendon at that time would have made diagnosis much more straight forward.

5.26 **PROFESSOR** Gray confirmed, because the gap in the tendon was first detected clinically in February of the next year, that at this time the diagnosis would have been relatively easy to make because of the presence of a gap, and prolonged period out of plaster.

5.27 **UNDER** cross-examination Mr Karpik agreed with Mr Harrison that not having access to the hard copy of Dr Wilson's notes was not good practice because it makes the information available much more restrictive.

5.28 **MR** Harrison asked Mr Karpik if it was his responsibility, before he completed his diagnosis of Ms Rowson, to ensure he had obtained from Dr Wilson hard copies of all previous notes made by him and other doctors relating to Ms Rowson's injury. Mr Karpik answered, if he were at all uncertain of the finding or the problem, *"Yes"*. Mr Karpik amplified it is not unusual to have a patient who has left their referral information behind, and consequently the history is taken directly by the specialist from the patient.

5.29 **THAT** explanation is accepted by the Tribunal, particularly because we agree with Mr Karpik better words than *"good practice"* to describe the practice protocol of GP documented referral would be *"ideal practice"*.

5.30 **MR** Karpik acknowledged ideal practice was to have GP notes, but that not to have them did not impair his ability to take his own history, conduct his own examination and reach a specialist conclusion. This explanation is accepted by the Tribunal, particularly that available GP notes *"are an adjunctive measure to [his] own assessment"*.

5.31 **THE** GP notes of 23 and 24 May 1996 were considered by Mr Harrison to be of considerable relevance to Mr Karpik's inquiry. The note of 23 May referred to *"palpable lump over lateral aspect of Achilles tendon ... ? partial rupture of tendon ..."*. The note of 24 May referred to *"... the Achilles tendon is not well displayed but there does seem to be a lucency in the*

tendon about 20 mm above the top of the calcaneum. Better information about this tendon can be obtained by small parts ultrasound ...".

5.32 **MR** Karpik explained that the 24 May note more than likely was an x-ray report, that is, a radiologists report. He said the Achilles tendon described as *"not well displayed"* was not necessarily indicative of injury, because he said it is not possible to judge the status of soft tissues by plain x-rays. Mr Harrison asked Mr Karpik to accept that if he had seen in particular the notes of 23 and 24 May, that he might have given very careful consideration as to whether or not Ms Rowson had suffered a rupture of the Achilles tendon when he saw her on 3 September 1996. Mr Karpik conceded there was no doubt that that information would have been helpful and furthermore it was certainly possible it might have led to a different diagnosis.

5.33 **IT** is noted that Dr Karpik did not have easy access to the general practitioner's file as this was computer based and inaccessible to the consulting specialist. This lack of communication between the referring doctor and specialist did compromise the patient's management in that concerns raised by the general practitioners were not brought to the attention of Dr Karpik.

5.34 **FINALLY** there is the issue of a normal gait which Mr Karpik noted Ms Rowson had on 3 September 1996, in conjunction with what he described as excellent movement of the ankle. Although Professor Gray did say there was debate on the issue, his evidence was not as to an even debate about whether or not a ruptured Achilles tendon affects gait. The debate he referred to was whether or not, in all cases, the effect on the patient's gait would always be detectable outside of the laboratory. In summary the thrust of Professor Gray's evidence seemed to be that a normal gait is a strong indication that there is no ruptured Achilles tendon.

6. IN CONCLUSION:

6.1 **WE** agree with Professor Gray the matter at issue is whether Mr Karpik's practice fell below the required standard in September 1996. Further we agree with Professor Gray that the tendon was almost certainly ruptured at this time. The issue is whether the history and physical findings would have made the diagnosis evident. In dismissing the charge we accept Professor Gray's assessment that the evidence of rupture must have been difficult to detect. Assuming no dent was apparent and gait was normal, then the treatment of it was reasonable and appropriate in the circumstances.

6.2 **HAVING** found in Mr Karpik's favour, it is not necessary for us to consider whether his conduct reflects adversely on fitness to practise medicine.

6.3 **THE** charge is dismissed.

DATED at Auckland this 4th day of June 1999

.....

P J Cartwright

Chair

Medical Practitioners Disciplinary Tribunal