Dr A

Dr B

Accident and Medical Centre

District Health Board

A Report by the

Health and Disability Commissioner

(Case 02HDC04045)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mr C	Consumer
Accident and Medical Centre / Provider	
District Health Board / Provider	
Dr A	General Practitioner / Provider
Dr B	General Practitioner / Provider
Dr D	Registrar, the District Health Board

Complaint

On 27 March 2002 the Commissioner received a complaint from Mr C about the services he received at a Accident and Medical Clinic and a Public Hospital's Emergency Department (ED). The complaint was summarised as follows:

Dr A
On 7 January 2002, at the Accident and Medical Centre, Dr A did not provide services with reasonable care and skill and did not communicate appropriately with Mr C. In particular Dr A did not:
- *adequately assess the cause of pain in Mr C's thigh;*
- *adequately treat Mr C's pain;*
- *adequately explain the dosage of pain-killers that he had prescribed for Mr C.*

Dr B
On 22 January 2002, at the Accident and Medical Centre, Dr B did not provide services with reasonable care and skill to Mr C. In particular Dr B did not:
- *adequately investigate the cause of Mr C's pain;*
- *adequately treat Mr C's pain.*

The District Health Board
In early 2002 a doctor at the Public Hospital's Accident and Emergency Department did not provide services with reasonable care and skill to Mr C. In particular the doctor did not perform a thorough assessment to determine the cause of pain in Mr C's thigh.

An investigation was commenced on 23 July 2002, when the Accident and Medical Centre and the District Health Board were notified of the complaint. The investigation was suspended on 6 November 2002, pending the outcome of an ACC investigation.

On 1 May 2003, the investigation was recommenced and Dr A and Dr B were notified of the investigation. On the basis of the information provided by ACC, the Public Hospital doctor, Dr D, was not notified of the complaint, as there was no apparent breach of the Code of Health and Disability Services Consumers' Rights in respect of his actions.

Information reviewed

- Letter of complaint, dated 13 March 2002
- Further information provided by Mr C, dated 28 August and 6 October 2003
- Response from the District Health Board, dated 30 August 2002
- Further information provided by the District Health Board, dated 21 January 2003
- Response from the Accident and Medical Centre, received 9 September 2002
- Further response from the Accident and Medical Centre, dated 4 October 2002
- ACC Medical Misadventure file, received 21 March 2003
- Response from Dr A, dated 21 May 2003
- Response from Dr B, dated 13 June 2003
- Response form Mr C, dated 15 March 2004
- Response from the Accident and Medical Centre, dated 24 March 2004
- Response from the District Health Board, dated 2 April 2004

Independent expert advice was obtained from Dr Caroline Corkill, general practitioner.

Introduction

This report raises important issues about providers' obligations to consumers who cannot communicate effectively in English.

Under Right 5 of the Code of Health and Disability Services Consumers' Rights (the Code) all consumers have the right to effective communication in a "form, language and manner that enables the consumer to understand the information provided" and "where necessary and reasonably practicable, this includes the right to a competent interpreter".

In this case, Mr C, a Samoan, received care from three different doctors at two different institutions over a period of three weeks. At each of these consultations Mr C was accompanied by friends who acted as "interpreters", although it is accepted that they were not qualified to do so. At each consultation the providers involved did their best to communicate with Mr C. However, it is clear that they were not able to elicit a full history from Mr C, nor do they appear to have considered the dangers of relying on Mr C's friends as ad hoc interpreters. It is also evident that the providers' employers had not made them fully aware of the services available for accessing professional interpreting services, nor provided guidelines clarifying when such services should be accessed.

Regrettably, these issues were not raised as a central part of Mr C's complaint, which focused on the clinical care he received. Communication issues were therefore not part of my investigation. Mr C's lawyer has emphasised the apparent lack of effective communication and urged me to find the providers in breach of Right 5 of the Code. As these issues were not part of my investigation, I am unable to make such a finding, as to do so would be procedurally unfair to the providers. However, I have made extensive comment about these issues throughout this report.

Since Mr C's complaint, the Accident and Medical Centre and the District Health Board have taken steps to improve their services with regard to the issues raised by Mr C. I consider that Mr C's complaint has had a significant positive effect on the services provided by the Accident and Medical Centre and the District Health Board. I intend to disseminate this report widely, to raise awareness of this issue and prompt other providers to review their services, to ensure that they and their staff communicate effectively with consumers whose first language is not English.

Information gathered during investigation

Background
Mr C is Samoan and has a limited command of the English language. At the time of the events under investigation he was 30 years old.

In March 2001 Mr C injured his right thigh in a rugby tackle. On 1 January 2002, Mr C appears to have aggravated this injury or suffered a new injury to the same area. In his letter of complaint Mr C stated that he still had pain from his original injury, which had never healed. However, this is not consistent with the history recorded by the general practitioners who saw Mr C in January. I have not been able to determine the exact cause of Mr C's injury, but do not consider it is necessary to do so in order to form my opinion on his complaint.

Consultation – Dr A
On 7 January 2002, Mr C went to the Accident and Medical Centre, where he saw Dr A. In his letter of complaint, Mr C stated that a friend accompanied him to this consultation. Mr C stated that he had trouble communicating in English because of "the language barrier". His friend told Dr A about a similar injury he himself had sustained, for which his GP had given him a triangle-shaped pill, and the friend suggested that this was what Mr C needed.

Dr A recorded that he was told that Mr C had injured his leg falling from a tree, with a history of a rugby injury in March 2001. Dr A's notes from the consultation record that he examined Mr C's leg and noted that he was walking with a slight limp, but was able to weight-bear and had a full range of movement. Dr A diagnosed a thigh sprain and prescribed Voltaren and tramadol to control any inflammation and provide pain relief. He referred Mr C to a physiotherapist.

In response to ACC's investigation, Dr A stated that he carried out a full examination of the leg and hip. He inspected and palpated Mr C's thigh and quadriceps muscles, and asked Mr C to walk to observe his gait, ability to weight-bear and degree of disability. He did not conduct a thigh measurement, as thighs are often asymmetrical and this would only suggest a soft tissue injury, which had already been established.

Dr A stated that, in the absence of any "sinister symptoms from the history", he conducted a reasonable assessment of what appeared to be a simple mechanical soft-tissue injury. Dr

A noted that at the time he examined Mr C, it is probable that there was only a soft tissue injury or haematoma.

Dr A advised that it is his usual practice to explain the dosage and frequency of all medicines he prescribes. He further stated that, as English is Mr C's second language and he was getting two medicines at the same time, he would certainly have explained that he should take the Voltaren only twice a day and the tramadol only every eight hours. I note that, at these doses, the Voltaren and tramadol should, at the least, have lasted 25 days and 10 days respectively.

Second visit to the Accident and Medical Centre
Mr C initially stated that he went back to the Accident and Medical Centre about a week later because he was still in pain and had run out of pain medication. He said that he paid for a consultation and prescriptions for more medication. However, Mr C subsequently provided me with his summary of the treatment he received for his injury, dated 27 June 2003, in which he does not refer to any consultation between 7 January and 22 January.

The Accident and Medical Centre has no record of a visit during this period and I have been unable to find any other record of it.

Given the lack of any records for this visit, I consider it probable that Mr C did not consult a doctor at the Accident and Medical Centre between 7 January and 22 January 2001.

Consultation – Dr B
On 22 January, Mr C returned to the Accident and Medical Centre because his health was deteriorating and he felt very sick. Again Mr C took a friend with him, although this friend had very little understanding of English. Mr C was initially seen by a practice nurse, who noted that Mr C had not been able to go to physiotherapy because he did not have any transport. Mr C was then seen by Dr B. Dr B examined Mr C's leg and agreed with Dr A's earlier diagnosis of a thigh sprain. She prescribed more Voltaren and tramadol and advised Mr C to go to physiotherapy.

In her response to my investigation, Dr B said that if Mr C had re-presented with deterioration having followed the treatment recommended by Dr A, she would have immediately recommended further investigations. However, when she examined Mr C she found nothing systemic. Therefore, she advised Mr C to attend physiotherapy and to return if there was no improvement. Dr B noted that in making that decision she was aware that the physiotherapist could refer Mr C on for further assessment if necessary.

Physiotherapy
Mr C attended physiotherapy on 25 January. The physiotherapist examined his leg and noted that it was only the hamstring that was painful. The physiotherapist treated the hamstring.

On 30 January Mr C again attended physiotherapy. The physiotherapist noted that the thigh was now very swollen and told Mr C to see a GP.

The Accident and Medical Centre
Mr C went back to the Accident and Medical Centre the same day, 30 January.

Mr C recalled:

> "I decided to return to the Accident and Medical Centre and seek more help but because I had no money the reception [sic] at the front desk had declined my visit and rights. Again I was not informed about filing for an ACC claim or informed that [the Accident and Medical Centre] for visitors was free."

The Accident and Medical Centre recalled:

> "When Mr C returned to the Clinic after his second visit, he would have been informed by the receptionist that a sum of $15.00 was outstanding from his previous visit, but he would not have been turned away. It is quite probable, that, because of Mr C's limited knowledge of English, he misunderstood what had been said and a misunderstanding may have arisen between him and our receptionist. If there was such a misunderstanding we regret any consternation this may have caused Mr C, but we deny that he had been refused medical care because of a $15.00 debt."

The Accident and Medical Centre also provided me with a copy of a memorandum to its staff (undated), which sets out its policy that all patients should at least be assessed, regardless of outstanding debts.

Given the irreconcilable differences between the versions of events presented by Mr C and the Accident and Medical Centre, I am unable to determine whether the Accident and Medical Centre did in fact turn Mr C away or whether there was a misunderstanding on Mr C's part. However, it is clear that there was some confusion or dispute about the payment of Mr C's account and he left without being seen by a doctor.

Emergency Department – the Public Hospital
Mr C then went to the ED at a Public Hospital, where he was initially triaged. The triage note records that Mr C had injured his leg in a rugby tackle on 1 January 2002. It records that Mr C had been referred to a GP by the physiotherapist that day, but was "unable to afford GP". It notes that Mr C's thigh was swollen, hard and painful. Mr C's pulse was recorded as 60 and his temperature as 36.2°C. His blood pressure was normal.

Mr C was then seen by Dr D, the ED registrar. Dr D recorded that the leg swelling had increased since physiotherapy and that Mr C had mild pain but no fever. He carried out a neurological examination of Mr C's legs and assessed his vascular supply and gait, all of which were normal. Dr D diagnosed a right quadriceps haematoma (internal bruise or blood clot). He indicated that this may have been made worse by the physiotherapy, which was why Mr C's pain had increased. He advised Mr C not to have any more physiotherapy for a week and to return if he had any further concerns.

In his response to ACC, Dr D stated that he considered the possibility of infection, but there were no symptoms to substantiate that diagnosis.

Subsequent events
On 2 February Mr C decided to travel to another city, by bus, to be with his family. When he arrived at that city on 3 February 2002, he was very ill and his family was shocked at his appearance. Mr C's mother insisted on calling an ambulance and Mr C was taken to a Public Hospital.

At this Public Hospital, Mr C was assessed in the ED and admitted with a diagnosis of sepsis. He was admitted under the physicians and was reviewed by an orthopaedic registrar, who attempted to aspirate Mr C's thigh, with no result. Mr C was started on antibiotics. The next day, Mr C's temperature was still high and the orthopaedic surgeon suspected he had osteomyelitis with septicemia. An urgent MRI scan was carried out, which was reported as showing no abscess. However, over the next 24 hours, Mr C's clinical state strongly suggested an abscess. He was taken to theatre where an "extremely large" abscess was located and drained.

While in hospital, Mr C suffered acute liver and kidney failure. Mr C has since recovered but has not regained full function in his leg.

Communication
Mr C complained that there were significant communication problems during his consultations with Drs A, B and D.

At the first consultation Mr C was accompanied by a friend. Mr C had difficulty communicating with the doctor because of the language barrier and his friend told Dr A about "a similar injury he had sustained and that he was given a triangle shaped pill for his pain". Mr C's friend suggested that was possibly what Mr C needed. Dr A apparently agreed.

Dr A stated, in his response of 21 May 2003:

> "My consultation with Mr C took much longer than normal, in view of English being Mr C's second language. Mr C had brought with him a friend who spoke very good English and who was there to translate for Mr C. I was very conscious to ensure that there was adequate time both for discussion and translation. I felt therefore, that communication between us was perfectly adequate for clinical purposes. I remember taking time to establish a rapport and ensuring that he was satisfied as to the management plan."

Mr C stated that a friend accompanied him to his consultation with Dr B and that both he and his friend had a "very limited" understanding of the English language.

Dr B said, in her response of 13 June 2003:

> "I recall [Mr C] and the consultations [sic] I had with him well … I am dismayed that my notes do not reflect the time taken during the consultation or the thoroughness of the examination. I spent such a long time with [Mr C] and had to be much more than usually attentive to communicate because of language difficulties … I communicated

> through an interpreter, taking great care to speak slowly. I have no way of judging the interpreter's interpretation of what I said but carefully observed body language to try to gauge the effectiveness of communication. The clinic was very pressured with patients waiting. Despite this I consciously put those pressures out of my mind and slowed the consultation down, recognizing the challenges of communication."

Regarding his visit to the Public Hospital, Mr C states that he was "in excruciating pain and unable to express how I felt". Mr C had a friend with him. The friend suggested to Dr D that Mr C might be taking too many pills. Dr D apparently agreed that that was probably the cause of Mr C's "yellow" colour.

Dr D, in his brief response to ACC of 31 December 2002, did not mention any communication difficulties.

The triage form from the Public Hospital ED, completed by a triage nurse, noted "limited English".

ACC, during its investigation, asked the District Health Board to provide copies of Mr C's notes. The District Health Board initially advised ACC that there was no record of Mr C attending the ED in January 2002. However, having conducted a thorough search it was able to locate the records. The records incorrectly named Mr C.

In summary, both Dr A and Dr B state that they were very aware of the communication difficulties and took extra care and time to ensure that they communicated effectively with Mr C. However, despite their efforts, there was no consistent record of Mr C's injury. This led the doctors to consider different diagnoses. Dr A and Dr B thought that Mr C had fallen from a tree, which could have led to a thigh sprain. Dr D thought he had been injured in a recent rugby tackle and diagnosed a haematoma (a likely injury following a rugby tackle).

ACC's investigation

ACC received expert advice from Dr Andrew Swain, an emergency medicine specialist, about the care provided by Dr D. Dr Swain advised:

> "… From the information available [to Dr D], a haematoma (internal bruise) would be considered the most likely cause of swelling and tenderness in the thigh following a rugby tackle. It is extremely rare for a haematoma to become infected in the absence of an overlying wound, open fracture, or a susceptibility to infection …
>
> Despite the above, it is clear that Dr D did not dismiss the possibility of an underlying infection, he confirmed that Mr C had no fever or fast pulse (which would normally accompany an infection), and he advised the patient to seek further medical advice if he felt worse or a fever developed …
>
> Mr C was assessed by … Dr D in accordance with competent and reasonable practice … It appears that the patient's condition rapidly deteriorated over the next four days … Although it would have taken time for the osteomyelitis to develop, I see no evidence from the patient's presentation on 30th January that the condition should have been diagnosed then."

The Medical Misadventure Panel accepted Dr Swain's advice and concluded that Mr C's condition was "no[t] attributable to negligence on the part of the health professionals whom he consulted" (ie, not medical error), nor had he suffered a medical mishap. Mr C's claim was instead accepted by ACC on the basis that he had suffered personal injury by accident.

Independent advice to Commissioner

The following expert advice was obtained from Dr Caroline Corkill, a general practitioner:

"I note that English is the second language of the complainant Mr C.

In answer to your questions

Dr A

On 7 January 2002, did Dr A treat Mr C with reasonable care and skill? In particular, did Dr A:
- *adequately investigate the cause of Mr C's thigh pain?*
- *prescribe appropriate medication?*
- *appropriately refer Mr C to physiotherapy?*

On the basis of the information available, did Dr A take reasonable steps in the circumstances to enable Mr C to understand the information he was providing?

If Dr A did not provide adequate services please indicate:
- *what actions, if any, he could reasonably have been expected to take in the circumstances*
- *the severity of his departure from the required standard of care.*

On the basis of the information provided it is still difficult to tell whether the pain in Mr C's right thigh had been there all the time from March 2001 or whether there was some pain then and then a new pain on the first of January 2002. It is still not clear whether the new injury was from jumping from a tree as Dr A recorded or whether it was due to a rugby tackle as stated in the District Health Board record. The copy of the ACC form is not legible enough to be sure what it says or what dates it applies to. There are slight differences in all the histories taken by the doctors and nurses. It is hard to know if they were being told subtly different stories or understood differently. Inasmuch as the story was not clear it could be said that Dr A did not adequately investigate the cause of the pain, but the story of jumping out of a tree with some mention of a previous rugby injury on that side sounded reasonable, and it may be as good as the interpreter gave him. In retrospect, the accuracy of this history is of far more importance than it might have seemed at the time.

Dr A then examined Mr C's thigh and checked his knee and hip movement, found he was limping but able to weight bear. He did not check his temperature or systemic features but I would not expect him to if he thought he was checking a limb after a jump/fall onto the limb a week earlier. I think his diagnosis of thigh sprain is reasonable and his prescription of Voltaren and tramadol suitable for moderately severe pain relief. He did give what I consider quite a lot of pain relief for a sprain but not an unreasonable amount.

I consider the referral to physiotherapy appropriate but would not be worried if the patient chose not to go, because sprained muscles usually settle with rest and time.

From the information provided it is hard to say whether Dr A took reasonable steps to enable Mr C to understand the information he was providing. If he thought it was a thigh sprain and gave him pain relief, then all he would have to do was tell Mr C this and how to take the medication and to come back if things changed. Both doctor and patient seem to agree on this in that Dr A says this is what he did, and it is what Mr C actually did.

My conclusion is that in his one contact with Mr C, Dr A probably did provide adequate services.

Dr B

On 22 January 2002, did Dr B treat Mr C with reasonable care and skill? In particular, did Dr B:

- *adequately investigate the cause of Mr C's thigh pain?*
- *prescribe appropriate medication?*

Was it appropriate for Dr B to refer Mr C back to physiotherapy?

On the basis of the information available, did Dr B take reasonable steps in the circumstances to enable Mr C to understand the information she was providing?

If Dr B did not provide adequate services please indicate:

- *what actions, if any, she could reasonably have been expected to take in the circumstances*
- *the severity of her departure from the required standard of care.*

On the basis of the given information it is very hard to say whether Dr B adequately investigated the cause of Mr C's thigh pain. She had a reasonable history of muscle sprain from the visit on January 7 and I think made the mistake of accepting that history and line of reasoning (and another doctor's opinion) rather than making her own diagnosis and trying to rule out other possible causes. This is an unfortunate but common mistake, and probably justifiable in the circumstances because there was no indication of fever or systemic illness.

It appears from her notes she examined the knee thoroughly, checking the range of movement, various ligaments and the kneecap. She found tenderness in the back of the

knee. It is a pity she has no record of the pulse she took, his temperature, or the diameter of his thigh, but I think many doctors in this situation would have done as she did and not recorded things that seemed normal. As Mr C was now three weeks post injury, two weeks post initial investigation, it is a shame she did not question the diagnosis more, but muscle sprains can take longer than three weeks to heal and the physiotherapist would be a good person to monitor the progress of the muscle sprain.

The medication prescribed was appropriate.

I think it was appropriate to refer Mr C back to physiotherapy. I think his going to the physiotherapist was more important this time because it enabled another health professional to monitor the progress of an injury which was starting to seem a bit slow to heal.

It is very hard to comment on the quality of communication between Mr C and Dr B but she wanted him to take more pain relieving medication and go to physio and he did both so she must have provided basically adequate information.

In conclusion I think Dr B seemed to have provided adequate services even though she missed an opportunity to diagnose osteomyelitis. It can be an easy diagnosis to miss, and from the apparent lack of systemic symptoms at this stage it is not surprising that it was missed.

The other aspects of care I feel warrant consideration include the fact that communication was obviously difficult though it appears both doctors and patient tried to overcome this. This contributed to inaccuracies in the history, which made the diagnosis hard to suspect.

The diagnosis of osteomyelitis was missed by the two doctors. This missed diagnosis had a chance of being detected when the physiotherapist referred Mr C back to the doctor, but the system at [the Accident and Medical Clinic] discouraged follow up of the problem by having different doctors see him each time and by not encouraging review of the problem because of a minor debt issue. The seriousness of the illness was compounded by the doctor at [the Public] Hospital also missing the diagnosis – even though these hospital notes do record his temperature which was normal. Presumably the osteomyelitis was at a more advanced stage then and was still missed so this suggests the [Accident and Medical Centre] doctors were not 'missing the obvious' in their diagnoses.

This case is a reminder of the importance of accurately recording significant normal findings like pulse and temperature, and of not narrowing the possible diagnoses too early."

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

1) Every consumer has the right to have services provided with reasonable care and skill.

…

5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

RIGHT 5
Right to Effective Communication

1) Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter.

RIGHT 6
Right to be Fully Informed

1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –

…

b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; …

No further action: Dr D and the District Health Board

I have decided to take no further action regarding the services Mr C received at the Public Hospital as, on the basis of Dr Swain's advice to ACC, I am satisfied that Dr D exercised reasonable care and skill in examining and treating Mr C's leg injury.

I note that Dr Swain advised ACC that on the basis of the information available to Dr D – that Mr C had suffered his injury in a rugby tackle – a haematoma would be considered the most likely cause of the swelling and tenderness in his thigh. Furthermore, the complication that Mr C suffered to his haematoma, an infection, was an extremely rare complication given that there was no overlying wound, open fracture, or susceptibility to infection.

Dr Swain noted that, despite the rarity of an infection, Dr D was alert to this possibility, as he confirmed that Mr C had no fever or fast pulse and advised Mr C to seek further medical advice if he felt worse or if he developed a fever.

Dr Swain considered the fact that four days after his consultation with Dr D, Mr C was admitted to the Public Hospital with serious complications and that the infection in Mr C's leg would have taken some time to develop. However, Dr Swain was satisfied that there was no evidence available on 30 January, when Dr D examined Mr C, that should have led him to diagnose the infection at that time.

I also note that when Mr C was admitted to the Public Hospital in the other city, while he was obviously unwell, it took several days to establish the exact cause of his condition.

I am satisfied, in light of Dr Swain's report, that there is no evidence that the District Health Board or Dr D did not exercise reasonable care and skill in examining and treating Mr C's leg injury. Accordingly, I do not intend to take any further action on this aspect of Mr C's complaint.

Opinion: No breach – Dr A

Treatment
I accept Dr Corkill's comments that, given the history taken by Dr A (falling out of a tree), he adequately assessed Mr C's leg injury, made a reasonable diagnosis and instituted appropriate treatment.

Dr Corkill considered that Dr A's examination was appropriate and, while he did not check Mr C's temperature or systemic features, this would not be expected given that Dr A was checking a limb after a jump or fall onto a limb a week earlier. Dr Corkill also considered that Dr A's prescription of Voltaren and tramadol was reasonable and the referral to physiotherapy appropriate.

In all the circumstances, I am satisfied that Dr A's assessment, diagnosis and treatment plan were reasonable and that he provided Mr C with services with reasonable care and skill. Accordingly, Dr A did not breach Right 4(1) of the Code.

Communication
Dr Corkill advised me that if Dr A thought Mr C had suffered a thigh strain, and therefore prescribed pain relief, he was obliged to inform Mr C about his diagnosis, how to take the medication, and to return to the Accident and Medical Centre if things changed.

Dr A stated that it is his usual practice to explain the dosage and frequency of all medicines he prescribes, and that as English is Mr C's second language and he was getting two medicines at the same time, he would certainly have explained the medication instructions to Mr C carefully – that Mr C should take the Voltaren twice a day and the tramadol every eight hours.

I am satisfied that these instructions were uncomplicated and that Dr A believed he had communicated this information to Mr C in a way that he could understand. However, despite Dr A's efforts, Mr C did not understand the instructions.

I consider that Dr A was placed in a difficult situation, as the Accident and Medical Centre appears not to have provided the support necessary to overcome the communication problems. I comment on this issue later in my report. With the benefit of hindsight, it is apparent that Dr A should have arranged an interpreter for Mr C. Nonetheless, I accept that Dr A took reasonable steps in difficult circumstances to explain his instructions to Mr C and his friend. In these circumstances, Dr A did not breach Right 6(1)(b) of the Code.

Opinion: No breach – Dr B

Investigation of Mr C's pain

I accept my expert advice that Dr B provided adequate services to Mr C, despite missing an opportunity to diagnose osteomyelitis. I note my expert's comments that this can be an easy diagnosis to miss and, given the lack of systemic symptoms, it was not surprising it was missed.

Dr Corkill advised me that, following from Dr A's consultation on 7 January, Dr B appears to have been presented with a reasonable history of muscle sprain and probably made the mistake of accepting that history and line of reasoning, rather than making her own diagnosis. I note Dr Corkill's comments that this was an "unfortunate but common mistake", which was probably justifiable in the circumstances, given that Mr C had no indication of fever or systemic illness. I also note Dr Corkill's advice that, given the length of time since the injury and assessment by Dr A, it was "a shame" that Dr B did not question the diagnosis more, although muscle sprains can take longer than three weeks to heal.

I accept that Dr B thoroughly examined Mr C's knee, checking the range of movement, various ligaments and the kneecap, although she did not record Mr C's pulse, temperature, or the diameter of his thigh (see "Record-keeping" below).

I note Dr Corkill's advice that, on the basis of the information available, she found it "very hard to say" whether Dr B adequately investigated the cause of Mr C's thigh pain, although I also note her following comments:

> "Presumably the osteomyelitis was at a more advanced stage [when Mr C was seen at the Public Hospital] and was still missed so this suggests [the Accident and Medical Centre] doctors were not 'missing the obvious' in their diagnoses."

In all the circumstances, I am satisfied that Dr B took reasonable steps to investigate Mr C's symptoms and form a diagnosis. While it is clear that Dr B could have been more proactive in questioning Dr A's initial diagnosis and considering other possible causes for Mr C's ongoing problems, the diagnosis of a thigh sprain remained a reasonable

conclusion, especially in the absence of any other systemic symptoms. In my opinion, Dr B did not fall below the standard of care required, and therefore did not breach Right 4(1) of the Code.

Treatment
I accept Dr Corkill's advice that, given her diagnosis, Dr B prescribed appropriate medication and appropriately referred Mr C back to physiotherapy, where Mr C's progress could be monitored. In my opinion, Dr B provided services with reasonable care and skill in respect of this matter, and did not breach Right 4(1) of the Code.

Record-keeping
I note that Dr B did not record some matters she checked – in particular Mr C's pulse, temperature, and the diameter of his thigh – because she considered them normal. In this respect her practice was not ideal. I endorse Dr Corkill's comments that this case is a reminder of the importance of accurately recording significant normal findings such as pulse and temperature.

I remind Dr B of her professional obligations, as set out in "Good Medical Practice: A Guide for Doctors" (Medical Council of New Zealand, 2000):

> *"3. In providing care you must:*
> *...*
>
> keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed."

Other comments

Systems for enabling continuity of care

Dr Corkill commented that the diagnosis of osteomyelitis could have been detected when the physiotherapist referred Mr C back to the Accident and Medical Centre, on 30 January, but the system at the Accident and Medical Centre discouraged follow-up of the problem by having different doctors see Mr C each time, and by not encouraging review of the problem because of a minor debt issue.

I also note that the District Health Board failed to ensure that Mr C's name was correctly recorded in its ED records. This error could have had very serious consequences if the records were needed for future treatment.

Under Right 4(5) of the Code, patients have the right to co-operation among providers to ensure quality and continuity of services. Patients will inevitably see different doctors and nurses when attending Accident and Medical Centres and Emergency Departments. It is therefore especially important that accurate records are kept to help ensure patients receive continuity of care.

The District Health Board
In response to my provisional opinion, the District Health Board advised me that its staff have been given training to ensure that names are correctly recorded, and have been instructed to call an interpreter if there is any doubt about a communication problem. The District Health Board also provided me with a copy of its Interpreter Service Policy, which clearly outlines the professional interpretation services available to staff.

The Accident and Medical Centre
The Accident and Medical Centre has provided me with a copy of its policy on Refusal to See Patients, which states that all patients must (at the least) be triaged, regardless of any debt issues. If repeat bad debtors do not have a life-threatening or serious illness requiring urgent treatment, they may be refused treatment and directed to the nearest publicly funded facility. I recommend that the Accident and Medical Centre ensure that its policy is adhered to and that in practice debt issues do not unreasonably hinder patients' access to care.

Communication issues

I have not formed an opinion on the communication between Mr C and the providers involved in his care (with the exception of Dr A's instructions about medication) as these issues were not raised in Mr C's initial complaint and were therefore outside the scope of my investigation. However, it is evident that there were significant communication problems during all of these interactions.

Right 5(1) of the Code gives consumers the right to have effective communication in a form, language and manner that enables them to understand the information provided. This includes, "where necessary and reasonably practicable", the right to a competent interpreter. In my view, it is the individual provider's responsibility to assess whether effective communication is occurring in any given situation and to consider what further measures are reasonably available to enable the consumer to understand the information provided. It is the responsibility of the provider's employer to ensure that the necessary support (such as access to interpreter services) is available.

The Accident and Medical Centre
During the course of my investigation I asked the Accident and Medical Centre to provide me with its policies for dealing with patients who may have difficulty communicating in English. The Accident and Medical Centre provided a copy of its policy on informed consent. This policy outlines the legal obligations for informed consent. It also includes an "Example of a possible consent process with respect to a common examination procedure" (a pelvic examination). The first paragraph of this example states:

"Communication	Language difficulty
➢ adequacy	?English 1st language
➢ comprehension	?Need an interpreter
	?Understanding (Age, education level)"

The Accident and Medical Centre also stated that its staff can access an interpreter service, via the other Hospital, if necessary. The Accident and Medical Centre did not provide any

information about how to assess whether an interpreter is needed or how staff access the interpreting service.

In response to my provisional opinion, the Accident and Medical Centre informed me that, at the time of Mr C's complaint, some of the Accident and Medical Centre's policies were in the developmental stage. However, since 2003, the Accident and Medical Centre has attained ACC accreditation and successfully passed an independent audit process. Risk management and quality assurance policies have been implemented, and regular meetings are now held to identify risks and improve patient care. The Accident and Medical Centre has systems to effect and monitor changes made as a result of these meetings.

The Accident and Medical Centre also provided copies of a number of its policies, although they did not include a policy related to the use of interpreters.

In this case, Dr A and Dr B were both aware of the potential problems with communication and attempted to adjust their approach accordingly. I note Dr Corkill's comments that, despite the efforts of Drs A and B and Mr C to overcome the communication problems, difficulties remained and they appear to have contributed to inaccuracies in the history, which in turn made the diagnosis of Mr C's injury more difficult.

I am concerned that the Accident and Medical Centre does not appear to have provided its staff with sufficient guidance to ensure that they were able to communicate effectively with a patient such as Mr C. Although the Accident and Medical Centre has brought the issue of effective communication to the attention of staff, via its policy on informed consent, it has not provided adequate guidance on a number of issues that are critical to determining whether it is "necessary and reasonably practicable" to use a competent interpreter in any given situation. These issues include how to assess whether an interpreter is required, whether it is appropriate to allow a support person, friend or family member to act as an interpreter, and how to access "competent" interpreting services.

I note that the Office of Ethnic Affairs has prepared comprehensive guidelines entitled: *Let's Talk: Guidelines for Government Agencies Hiring Interpreters* (see Appendix 1). While intended for government agencies, the guidelines may be helpful to providers considering their obligations under Right 5(1) of the Code.

In this case Mr C was accompanied to each of his consultations by a friend or support person, who was able to provide some basic form of "interpretation". However, it is clear that there were ongoing communication difficulties that the support persons were unable to overcome. I note, in particular, that Mr C's friend at the first consultation told Dr A about his own leg injury. The involvement of a friend acting as an "interpreter" may have given the doctors a false assurance that Mr C could understand what they were telling him. Dr B referred to Mr C's friend as an "interpreter", yet Mr C stated that his friend had only limited English.

Both Dr A and Dr B stated that they were aware of the communication problems and were careful to ensure that they were communicating effectively with Mr C. However, had the Accident and Medical Centre provided them with further instructions and support for

dealing with such situations, they may well have decided to seek professional interpreting services, rather than rely on Mr C's friends to act as "interpreters".

The District Health Board
Mr C stated that when he went to the Public Hospital he was "in excruciating pain and unable to express how I felt". Mr C had a friend with him who apparently "interpreted" for Mr C. Dr D did not advise me of any communication difficulties, but Mr C clearly felt that there were some communication problems. I am satisfied that there were indeed communication difficulties that Dr D failed to recognise or adequately respond to.

As noted above, the District Health Board has provided staff with training and information about when and how to access interpreting services.

Use of general practice advisor

In response to my provisional opinion, the Accident and Medical Centre questioned my use of Dr Corkill as an expert advisor. It submitted that the standard of care expected of a GP working in an Accident and Medical Centre may be different from that expected of a GP working in general practice.

In this case I do not consider that seeking advice from an Accident and Medical practitioner would have altered my opinion. I note that Dr Corkill advised me that Dr B provided adequate services and, while she did not diagnosis osteomyelitis, it can be an easy diagnosis to miss. I also note that the diagnosis was subsequently missed by Dr D at the Public Hospital, and was not evident on an MRI scan done at the Public Hospital in the other city several days later. The abscess was not conclusively identified until Mr C underwent surgery at the Public Hospital in the other city. In the circumstances I am satisfied that Dr B adequately investigated and treated the cause of Mr C's pain, and that it was appropriate to rely on Dr Corkill's advice to that effect.

I also note that ACC also sought advice from a general practitioner and that neither Dr A nor Dr B is vocationally registered as an Accident and Medical practitioner.

Recommendation

- I bring my comments regarding providers' obligations under Right 4(5) and Right 5 of the Code to the attention of the Accident and Medical Centre and the District Health Board. I recommend that both providers consider what changes they can make to their services to improve communication with, and continuity of care for, patients whose first language is not English.

Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand.
- A copy of this report, with details identifying the parties removed, will be sent to the Royal New Zealand College of General Practitioners, the Australasian College of Emergency Medicine (New Zealand Faculty), the Royal Australasian College of Physicians, the Chief Medical Advisors of all District Health Boards, and Quality Health New Zealand, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.