District Health Board

Medical Officer, Dr B

A Report by the

Deputy Health and Disability Commissioner

(Case 19HDC01258)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This case highlights the importance of obtaining an adequate history from a consumer following an injury, including reading triage notes, and the importance of effective communication.

2. In 2018, a woman presented to a rural hospital emergency department following a fall that injured her thumb. Her wound was cleaned and sutured but no X-ray was taken. Around two weeks later she presented to another hospital, where she was treated for an infection. Subsequently she required surgery and developed arthritis in her thumb.

Findings

3. The Deputy Commissioner considered that the medical officer who treated the woman initially failed to provide services with reasonable care and skill because he did not obtain an adequate history in relation to her injury, and did not arrange for an X-ray. As such, the Deputy Commissioner found the doctor in breach of Right 4(1) of the Code.

4. The DHB was not found in breach of the Code.

Recommendations

5. The Deputy Commissioner recommended that the medical officer provide a written apology to the woman.

6. The Deputy Commissioner recommended that the DHB use an anonymised version of this report as a case study to encourage reflection and discussion within its orthopaedic service, confirm that all senior medical officers have attended a conference on the management of minor fractures, and facilitate a meeting with the woman to enable her to talk to the clinicians involved and discuss how the care provided has affected her.

Complaint and investigation

7. The Health and Disability Commissioner (HDC) received a complaint about the services provided by Dr B and a District Health Board (DHB) to Ms A. The following issues were identified for investigation:

- *Whether the District Health Board provided Ms A with an appropriate standard of care in November 2018.*
- *Whether Dr B provided Ms A with an appropriate standard of care on 3 November 2018.*

8. This report is the opinion of Deputy Commissioner Vanessa Caldwell, and is made in accordance with the power delegated to her by the Commissioner.

9. The parties directly involved in the investigation were:

Ms A	Complainant
Dr B	Provider/medical officer
DHB	Provider

10. Further information was received from:

Dr C	Consultant orthopaedic surgeon
Dr D	Orthopaedic registrar

11. Also mentioned in this report:

Dr E	Orthopaedic hand specialist

12. Independent expert advice was obtained from a specialist in rural hospital medicine, Dr Scott Wilson (Appendix A), and an orthopaedic surgeon, Dr John McKie (Appendix B).

Information gathered during investigation

Introduction

13. On 3 November 2018, Ms A fell over and injured her thumb. She received care for her injury at two hospitals — Hospital 1 and Hospital 2 — both of which are part of the DHB.

14. This report concerns the failure to X-ray Ms A's thumb at Hospital 1, and the subsequent care she received at Hospital 2. Since her injury, Ms A has had three operations and has scar tissue and a stiff and achy joint, and has developed arthritis that will require a further procedure in the future.

Hospital 1

15. In 2018, Hospital 1's Emergency Department (ED) comprised ten beds and provided emergency care for the region. X-ray services were available between 8am and 5pm, and on-call services were available after hours. The region had no after-hours GP services available at this point in time.

3 November 2018 — Hospital 1

16. Ms A presented to the ED at Hospital 1 at 6.21pm. The triage nurse documented "thumb swollen" and "bent back at time of injury".

17. Dr B, a medical officer, cleaned and sutured Ms A's wound with three sutures under local anaesthetic. Ms A told HDC that the administration of the local anaesthetic was painful. Ms A's thumb was not X-rayed.

18. Ms A's ED discharge letter stated:

> "Tripped and fell … isolated injury to left thumb … laceration volar[1] aspect mid thumb … flexor tendon[2] intact … [neurovascular] finger normal. Under [local anaesthetic] wound cleaned and sutured …
>
> [R]eturn to ED for worsening fever, pain, vomiting, difficulty breathing or swallowing, a new or concerning rash, worsening in your symptoms or condition or if you have any other concerns."

Ms A's and Dr B's recollection of events

19. On 10 December 2018, Ms A wrote to the DHB and stated that she recalled telling Dr B that she had "landed on the thumb, was reasonably certain that the thumb had gone backwards, and that the skin was split on the underside".

20. Dr B told HDC that he thought the injury was a laceration caused by a fall and, at the time, he was not aware of any excessive joint movement (ie, that the thumb had bent backwards)[3] having occurred during the fall. Dr B told HDC:

> "My recollection of [Ms A's] presentation was that there was pain, some slight swelling of her thumb (not severe), but there was no deformation and she could flex the joint."

21. In response to the provisional opinion, Ms A told HDC that she does not think that she would have been able to flex the joint much without considerable pain given the nature of the injury.

Decision not to X-ray Ms A's thumb

22. Dr B told HDC that his assessment of Ms A's injury was that it was a laceration only, and he was reassured that there was not deeper damage that required an X-ray. In particular, there appeared to be movement of the joint, a low degree of swelling, and a lack of deformity.

23. Dr B explained that his threshold for ordering imaging is low, and he did briefly consider ordering an X-ray. However, imaging services were not fully available after hours at Hospital 1 and, as Ms A was on holiday, he thought it would be inconvenient for her to obtain a follow-up X-ray the next day in an unfamiliar town.[4]

4–15 November 2018

24. Between 4 and 15 November, Ms A had her dressings changed by nurses. Ms A told HDC that the wound was not infected over this period.

[1] The palm of the hand.
[2] Tendons that enable the finger to bend.
[3] Hyperextension — excessive joint movement in which the angle formed by the bones of a particular joint is opened, or straightened, beyond its normal, healthy, range of motion.
[4] Ms A told HDC that she lives in the region and was on an overnight trip.

16 November 2018

25. On 16 November, Ms A had a follow-up appointment with her general practitioner (GP), who removed two of the three stitches and referred Ms A to have her thumb X-rayed. The GP documented:

> "[R]eports that she thought her thumb had hyperextension injury as well as laceration. She said she told the nurse at the time but the doctor didn't ask her more about it. No X-rays done at the time. Reports the repair of the laceration was quite painful despite local anaesthetics … no warmth/exudate."

26. After seeing the GP, Ms A had her thumb X-rayed at an urgent care clinic. The X-ray showed a fracture dislocation of the left thumb.[5] The urgent care clinic notes state: "Fell whilst [walking]? L thumb pushed backwards and split her skin open on inner side."

27. The urgent care clinic referred Ms A to the ED at Hospital 2, where she was assessed by Dr D, an orthopaedic registrar.

28. Dr D told HDC that Ms A's thumb was swollen, but the wound had healed and there were no signs of deep infection (no bacterial skin infection, redness,[6] inflammation,[7] fever, or discharge, and it was not warm to touch), her blood pressure and heart rate were within the normal limits, there was no pain over her joint, and the thumb had a good range of movement.

29. Ms A told HDC that she told Dr D about the pain she had experienced at Hospital 1 (when the anaesthetic was applied) and he ignored her concern. Dr D told HDC that when he first met Ms A, he acknowledged that she was upset because her dislocation had been missed at Hospital 1, and he reassured her that they would help her as much as possible.

30. Ms A told HDC that she was nervous about local anaesthetic for the manipulation[8] of her thumb. Dr D told HDC that he discussed pain relief options for the manipulation (oral analgesia or a digital nerve block[9]), and Ms A chose oral analgesia. Dr D said that during the first attempt to manipulate the thumb, the wound split[10] and bled. He told HDC that Ms A found the first manipulation attempt painful, so they discussed the digital nerve block again. Ms A agreed to this, and a second manipulation was carried out.

31. Dr D said that he cleaned the area with alcohol swabs, performed the digital nerve block, checked that the digital nerve block was effective, and manipulated Ms A's joint again. Dr D noted that the ligaments were intact and there was no further bleeding from the wound.

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[5] Involving the base of the proximal phalanx of the right thumb and complete dorsal dislocation at the interphalangeal joint.
[6] Erythema.
[7] Cellulitis.
[8] External manipulation to put the bone back in its original place.
[9] A digital nerve block is used to anaesthetise a finger by injecting local anaesthetic to interrupt nerve signals travelling back from the digit.
[10] No more than approximately 5mm.

He applied a splint to keep the joint flexed. The subsequent X-ray of the thumb showed a reduced/relocated joint.

32. Ms A told HDC that she did not receive a prescription for pain relief to take home. Dr D said that owing to the passage of time, he cannot recall specifically whether he had a discussion with Ms A about pain relief, but that it was his usual practice to do so.

33. Dr D referred Ms A to Dr C, a consultant orthopaedic surgeon, for an appointment on 27 November 2018 for further management.

34. Dr D told HDC that he discussed Ms A's case with Dr C the following day (on 17 November 2018) as part of his usual discussion about patients seen on his shift, and showed him the X-rays. Dr D said that Dr C was satisfied with his management.

19 November 2018

35. On 19 November, Ms A's hand swelled and her thumb started to weep. She returned to the ED at Hospital 2 in the morning, but by 3pm had not been seen, so she left the ED and went to the urgent care clinic.

36. At the urgent care clinic, Ms A's thumb was swabbed, and she was prescribed oral antibiotics and told what to look out for if the infection worsened. The wound swab specimen showed heavy growth of bacteria[11] and signs of infection.[12]

20 November 2018 — first washout[13]

37. On 20 November, Ms A contacted the Orthopaedic Department at Hospital 2 with concerns about infection. Dr C arranged for Ms A to be admitted to Hospital 2 ED for acute admission under his care. Dr D told HDC that Dr C informed him that Ms A had developed an infection that required a washout in theatre.

38. At 10.45am, Dr D[14] reviewed Ms A and noted that she had a rash[15] around the whole thumb and pus-like discharge from the wound site but no signs of flexor sheath[16] infection. Swabs and blood tests were taken, and Ms A was commenced on antibiotics.

39. Ms A told HDC that prior to the washout, she asked if it would be done under local or general anaesthetic. Ms A recollected that Dr D told her that he could do either, but the anaesthetist would decide. Dr D told HDC that after a discussion between the anaesthetic registrar and Ms A, she agreed to have the washout performed under a digital nerve block and sedation. Ms A does not recall speaking to an anaesthetist before the washout. However, Dr D recalls Ms A speaking to a registrar anaesthetist prior to the washout.

[11] *Staphylococcus aureus*.
[12] Large numbers of white blood cells.
[13] Removal of all contaminated soft tissue.
[14] Dr D was the on-call orthopaedic registrar that day.
[15] Erythema.
[16] Flexor tendons are the tendons of the fingers; they run through a structure called the flexor sheath.

40. The theatre statistical record documented that the anaesthesia used for the washout was local infiltration.[17]

41. Dr D acknowledged that Ms A was understandably quite anxious and tearful prior to going to the operating theatre, so before the digital nerve block was performed, he ensured that there was sufficient time for sedation to be achieved before starting the operation.

42. Dr D told HDC that there were no complications with the washout.

20–27 November 2018

43. Between 20 and 27 November, Ms A remained in Hospital 2 and received intravenous and oral antibiotics.

23 and 26 November 2018 — second and third washout

44. On 23 November, it was noted that Ms A's infection was not settling and she had on-going pus discharge from her thumb. It was decided that a second washout was required. Dr D carried out the second washout, with a consultant orthopaedic surgeon present. Ms A's second washout was carried out under general anaesthesia,[18] and Ms A told HDC that she was able to speak to the anaesthetist before the second washout.

45. There is no typed theatre note for this washout. Dr D explained to HDC that there is a handwritten operation note for Ms A's washout, but it states only that the operation was performed and the postoperative plan. Dr D said that there was a technical error in that his dictation did not get transcribed, and he did not realise this until he was informed of the HDC complaint on 21 July 2020.

46. After the second washout, Dr C sought advice from Dr E, an orthopaedic hand specialist, to ensure that the management of Ms A's thumb was correct and to discuss future prognosis. Ms A recalls Dr D and Dr E visiting her, and remembers that Dr E advised her that a good outcome at that stage was to have half a thumb or "to retain the thumb as a post". There is no documentation relating to Dr D's and Dr E's discussion with Ms A.

47. Ms A remained in hospital after the washout. She told HDC that she did not have an X-ray after this washout.

48. On 26 November, two surgical registrars undertook a third washout and stabilised[19] Ms A's thumb joint under a general anaesthetic. Ms A told HDC that she was able to speak to the anaesthetist before the third washout.

Consent

49. Ms A told HDC that before either the first or second washout, Dr D told her that she "did not need to read the consent form for theatre, as it needed to happen any way". Dr D told HDC that he does not recall saying this to Ms A during any of their interactions. Ms A told HDC

[17] A technique that produces a loss of sensation restricted to a superficial, localised area in the body.
[18] A combination of medications used to induce a sleep-like state before surgery or other medical procedures.
[19] Using K-wiring.

that each time she went to theatre she felt distressed about the uncertainty regarding the type of anaesthetic she would be given.

Subsequent events

50. A targeted antibiotic was administered to Ms A intravenously, and a change to oral antibiotics took place on 28 November 2018. As Ms A's thumb had been stabilised with a transarticular K-wire,[20] there was no need for an external splint.

51. On 29 November, Ms A was discharged from hospital with a prescription for oral antibiotics and pain relief. The DHB told HDC that nursing staff gave Ms A advice about returning if there were any future signs of infection, and provided her with a Hand Trauma Information card.

52. Three months later, Ms A met with Dr C, and they discussed the results of an X-ray. Ms A told HDC that Dr C told her that approximately 10% of her cartilage was left in her thumb. Ms A is concerned about this statement, as she understands that X-rays do not show cartilage, and she would have needed an MRI scan to show the true state of her joint at that stage. Dr C explained to HDC that he told Ms A, in non-technical language, that owing to the progression of her arthritis, she had lost further cartilage in her joint.

53. Dr C told HDC that Ms A made a much better recovery than he had expected, but he had constantly reinforced the message that she had had a serious injury, and that she had recovered well considering how bad her injury had been.

Cause of infection

54. When Ms A wrote to the DHB, she asked whether the wound could have become infected following the manipulation (on 16 November 2018), and asked why it was not cleaned or dressed other than with strapping tape. Ms A reviewed her notes with her GP, and feels that there is no evidence of infection up to and including the time of manipulation, and that the infection developed one or one and a half to two days following the manipulation where the wound re-opened, was not cleaned, had no antiseptic applied, and was dressed only with a Zimmer splint and strapping tape.

55. Dr C stated to HDC that he told Ms A that it was unlikely that the infection was from the splint application on 16 November 2018. Dr C said that Ms A's cause of infection was discussed at his department's Morbidity and Mortality Audit meeting, and he had discussed it with an orthopaedic surgeon and everyone was in agreement that the severity of the infection reflects a process that had taken longer than four days (16 to 20 November 2018) to occur.

56. Dr C considers that the DHB's orthopaedic service should have had a lower threshold to admit Ms A and wash out her thumb on 16 November 2018, rather than discharge her. Dr C told HDC that he has sincerely apologised to Ms A for the error, on behalf of the department.

[20] Wires used to repair a fracture (broken bone).

57. The Head of Department for Orthopaedics at the DHB told HDC that an infective organism was most likely introduced at the injury, and was in a resting state until manipulation of the dislocation was performed.

Hospital 1

58. The DHB told HDC that it is unable to produce evidence of policies or protocols regarding after-hours imaging availability specific to this time period. It is therefore unclear what systems were in place at Hospital 1 for arranging urgent imaging after hours. However, the DHB provided HDC with a copy of its new policy dated 19 February 2021. The policy outlines that an on-call medical imaging technologist must be available throughout the entire period of call by pager or phone, and is to be at the hospital in 20 minutes from the time they are called.

Further information

Ms A

59. Ms A told HDC that the sequence of events may have tracked quite differently if an initial X-ray had been taken in Hospital 1.

60. Ms A said that as a patient, a lot of control is relinquished to medical staff, creating considerable vulnerability. She considers that when the relationship is not experienced as "safe", the experience is traumatic at a psychological and physical level. Ms A stated that she is now hyper-sensitive about her thumb and anyone touching it. She said that primarily this is linked with the experience with Dr B at Hospital 1, but was compounded by subsequent interactions with hospital staff.

Dr B

61. Dr B told HDC that he accepts his error of judgement in failing to get X-rays done, and explained that in hindsight he sees that the swelling alone should have been a reason to seek further imaging studies. Dr B said that in hindsight, he should have made a purely clinical decision without consideration of the other factors.

Dr D

62. Dr D told HDC that he is sorry that Ms A feels that at times he disregarded her feelings, and that this was certainly not his intention. Dr D said that he reviewed Ms A during her hospital admission several times to check her wound. He stated that he always made an effort to be professional and empathetic towards Ms A, as understandably she was upset about her original compound dislocation having been missed, and her extended hospital admission and need for multiple operations.

63. Dr D told HDC that he has the utmost regard for the concept of consent, including ensuring that patients have all the information they require to make fully informed decisions, and the need to communicate effectively and respectfully with patients to help them make the best decisions for themselves. Dr D said that he allows opportunity for questions after informing the patient of the risks and benefits associated with surgery, to fill in any gaps and ensure that patients are informed. Dr D stated that his discussions are usually far more detailed than what is written in the consent form.

64. Dr D told HDC that he has reflected on this case and acknowledges that he did not recognise the potential for a compound injury after hearing Ms A's account of her fall, which had occurred two weeks previously. Dr D conveyed his apologies to Ms A that he did not recognise it at the time, and said that in the future, he will have a higher index of suspicion based on the mechanism of the injury, and will ask for advice from a senior colleague.

Dr C

65. Dr C told HDC that he would like to express his sincere apology for the distress Ms A experienced. He stated: "I hope [Ms A] will accept that, at all times, I approached her care with the utmost good faith and sought to act in her best interests throughout."

Responses to provisional opinion

66. Ms A, the DHB, Dr B, Dr C, and Dr D were given the opportunity to respond to relevant sections of the provisional opinion.

67. Ms A said that she stands by her written account of events, which is her honest recollection of events. She stated that what she wanted was an appropriate acknowledgement of what had happened, and an appropriate apology and a sense of care around it. She said that if her initial complaint had been responded to appropriately, it is unlikely that she would have taken any further action.

68. Dr B, Dr C, and Dr D were given the opportunity to respond to the relevant sections of the provisional opinion and had no further comments.

69. The DHB stated that it had no further comments on the provisional opinion and is thankful for the feedback provided.

Opinion: Dr B — breach

History and assessment

70. On 3 November 2018, Ms A presented to Hospital 1 and saw Dr B. The nursing triage notes documented "thumb swollen" and "bent back at time of injury". Dr B documented: "[I]solated injury to left thumb … laceration volar aspect mid thumb … flexor tendon intact."

71. Whether Dr B was aware of the history of how Ms A injured her thumb (the mechanism of injury), including whether it was bent back (extended), is significant to assessing the standard of care. There are differing recollections of what Ms A told Dr B on 3 November 2018 in this regard. Ms A's evidence is that she told Dr B that she "landed on the thumb, was reasonably certain that the thumb had gone backwards, and that the skin was split on the underside". In contrast, Dr B told HDC that he thought that the injury was a laceration caused by a fall and, at the time, he was not aware of any excessive joint movement (that the thumb had bent backwards) having occurred during the fall. Dr B's recollection of Ms A's presentation is that there was pain, some slight swelling of her thumb (not severe), but

there was no deformation and she could flex the joint. Dr B told HDC that "flexor tendon intact" documented in his notes implies that he checked the joint movement.

72. I am satisfied that Dr B did not enquire fully into how Ms A injured her thumb, as, had he done so, I consider it likely that Ms A would have explained that her thumb had been bent backwards, as she told the triage nurse.

73. My independent expert adviser, Dr Scott Wilson, a specialist in rural hospital medicine, advised that the obligation to obtain an adequate history falls to the treating healthcare professional, and that if Dr B failed to take an adequate history, this would be a moderate deviation from the standard of care. Dr Wilson said that the mechanism of injury is a key part of the assessment, and a hyperextension injury severe enough to tear the tissues on the volar surface of the thumb should have prompted greater consideration of bone or joint injury.

74. I agree with this advice. It was Dr B's responsibility to read the nursing triage notes and to obtain an adequate history of the fall and the mechanism of the injury from Ms A; therefore, I consider that Dr B failed to take an adequate history.

Decision not to X-ray and safety-netting advice

75. Ms A's thumb was not X-rayed on 3 November 2018, and Dr B told HDC that this was because the low degree of swelling, the movement of the joint, and the lack of deformation gave him some assurance that there was no deeper damage. Dr B said that his clinical assessment was that it was a laceration only, and he considered X-rays out of an abundance of caution rather than because he thought the presentation indicated deeper damage.

76. Dr B explained that his threshold for ordering imaging is low, and he did briefly consider ordering an X-ray. However, imaging services were not fully available after hours at Hospital 1 and, as Ms A was on holiday, he thought it would be inconvenient for her to obtain a follow-up X-ray the next day in an unfamiliar town.

77. Dr B told HDC that his recollection is that there was pain and some slight swelling of Ms A's thumb. The ED discharge summary stated:

> "[R]eturn to ED for worsening fever, pain, vomiting, difficulty breathing or swallowing, a new or concerning rash, worsening in your symptoms or condition or if you have any other concerns."

78. Dr Wilson advised that in traumatic hand injuries, if there is swelling, tenderness, or deformity, the standard of care is to X-ray to exclude joint injury or fracture, and Dr B's decision not to X-ray the thumb meant that his assessment was incomplete, hence he was unable to ascertain the full extent of the injury. Dr Wilson advised that fractured, dislocated, or subluxed joints[21] can still move through a limited and often painful range of motions, and that assessing joints involves more than simply ascertaining if the tendons are intact. Dr

[21] Where a connecting bone is partially out of the joint.

Wilson said that if an X-ray had been taken, whether at the time of injury or the following day, then appropriate referral could have been made to specialist services at Hospital 2.

79. Dr Wilson advised that if Dr B took a history and Ms A did not reveal that her thumb had bent backwards, the likelihood of damage to deeper structures was substantially lower. Dr Wilson said that with mild swelling and ongoing pain, an X-ray would still be indicated as a precaution, but the decision not to do so at the initial consultation would constitute only a mild deviation from the standard of care under these circumstances, given the planned follow-up and return advice that the patient had received.

80. Dr Wilson advised that it is common practice for low-risk patients who present out of hours[22] to rural hospitals to return the following day for X-rays, or to be referred to a provider in their home town if on holiday.

81. I agree with this advice. As explained above, I am satisfied that Dr B was unaware that Ms A's thumb had bent backward when she fell, and that this was a result of the inadequate history taken by Dr B. However, due to the pain and swelling present, it would have been prudent for Dr B to have arranged an X-ray of Ms A's thumb, or at the very least provided advice to Ms A to get her thumb X-rayed when she returned home.

Conclusion

82. In summary, I consider that Dr B failed to provide services to Ms A with reasonable care and skill because he did not obtain an adequate history in relation to her injury, and his assessment of Ms A's injury was incomplete owing to the lack of an X-ray. I acknowledge that imaging services were not fully available after hours at Hospital 1. However, I consider that it would have been appropriate for Dr B to advise Ms A to get an X-ray the following day. Had greater care been taken to enquire fully, and to assess and investigate Ms A's injury at its earliest presentation, her recovery may have been more favourable.

83. Accordingly, I find that Dr B breached Right 4(1)[23] of the Code of Health and Disability Services Consumers' Rights (the Code).

Local anaesthesia — other comment

84. I acknowledge that the administration of the local anaesthesia by Dr B was a very distressing experience for Ms A. Dr Wilson advised that Dr B's management of the wound was thorough, and he provided appropriate anaesthetic. Therefore, this report does not focus on this issue, as I consider that Dr B administered the local anaesthesia appropriately.

[22] In this case, at 6.21pm.

[23] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

Opinion: District Health Board — no breach

Hospital 1

85. Hospital 1 is a rural hospital, and in 2018 its ED comprised ten beds and provided emergency care for the region. X-ray services were available from 8am to 5pm, and on-call services were available after hours.

86. As a healthcare provider, the DHB is responsible for providing services in accordance with the Code. As set out above, I have found that Dr B breached Right 4(1) of the Code.

87. Dr B was an employee of the DHB at the time the breach occurred. In addition to any direct liability for a breach of the Code, section 72(2) of the Health and Disability Commissioner Act 1994 (the Act) states that an employing authority may be vicariously liable for any acts or omissions of its employees. A defence is available to the employing authority of an employee under section 72(5) if it can prove that it had taken such steps as were reasonably practicable to prevent the acts or omissions.

88. I am of the opinion that Dr B had an appropriate level of clinical experience and expertise, and that the DHB was entitled to rely on Dr B to provide appropriate medical care to Ms A, as outlined above. I also accept that from a resourcing perspective, it is not always possible to have 24/7 imaging availability in a small rural hospital. However, I would expect such a hospital to have had in place a system to ensure that important after-hours imaging was available when necessary — for example, by referring patients to Hospital 2 or ensuring that patients who required urgent imaging were prioritised the following day.

89. It is unfortunate that the DHB has been unable to produce evidence of the system that was in place at Hospital 1 for after-hours imaging at the time of these events. However, I accept that in Ms A's case, imaging was not urgent and could wait until the following day, and that it fell to Dr B to advise Ms A accordingly. In my view, the failure to do so lay with him on an individual level, and did not indicate broader systems or organisational issues at the DHB. Therefore, I consider that the DHB did not breach the Code, either directly or vicariously. It is positive that the DHB's new policy clearly sets out the availability of an on-call medical imaging technologist.

Hospital 2

90. In relation to the overall care provided at Hospital 2, Dr McKie advised:

> "While [Ms A], unfortunately, has had a poor outcome from a significant open injury, I do not believe there were any significant breaches of accepted care or practice at [Hospital 2]. As noted initially, the fundamental errors were as part of her initial assessment and then the delay in diagnosing the underlying fracture dislocation."

91. I agree with Dr McKie. While I acknowledge that there were minor oversights in relation to documentation and communication, as I have outlined below, overall I find that the DHB did not breach the Code.

Source of infection

92. As outlined above, Ms A's injury took place on 3 November 2018. Her thumb was manipulated on 16 November 2018, and an infection was identified on 19 November 2018. Ms A told HDC that her wound was cleaned and dressed inappropriately at this point, and she asked the DHB to consider whether her wound may have become infected following the manipulation.

93. Dr D told HDC that when Ms A's thumb was manipulated on 16 November 2018, a small part of the wound bled, and the split in her skin was less than 5mm and superficial. Dr C is of the view that it is unlikely that the infection resulted from the treatment on 16 November 2018. He explained that the severity of Ms A's infection reflected a process that had taken longer than four days.

94. Dr McKie advised that initially Ms A's infection would have been contracted through her initial open fracture dislocation, although the physical trauma of late manipulation in an inflamed area would no doubt have had an influence on the activation of what was apparently a latent infection.

95. I defer to the clinical opinions of Dr C and Dr McKie on this issue. I note that it is not the role of this Office to comment on issues relating to causation. Based on Dr McKie's advice, I am reassured that the clinicians at Hospital 2 provided services with reasonable care and skill, and I understand that whilst not desirable, infections can arise as a complication of an injury.

Opinion: Dr D — educative comment

96. On 16, 20, and 23 November 2018, Dr D treated Ms A's thumb injury.

Communication

97. In Ms A's complaint, she highlighted a number of instances where she did not feel that communication with Dr D built trust or was collaborative.

98. First, she recollected attempting to explain her experience at Hospital 1 to Dr D to provide him with context about why she was sensitive to the type of anaesthetic being applied, but she felt ignored. Dr D recollects this, but feels that he tried to reassure Ms A as best he could.

99. Secondly, Ms A told HDC that before one of the washouts, Dr D told her that she did not need to read the consent form for theatre, as the washout needed to happen anyway. Dr D has no recollection of this.

100. Thirdly, Ms A recounted that her first washout was distressing, particularly around the administration of the anaesthesia (sedation and nerve block). She also recollected asking about the type of anaesthetic that would be used, and being told by Dr D that it would be for the anaesthetist to decide. Dr D recalls that Ms A was tearful and anxious, but told HDC

that after the discussion with the anaesthetic registrar, Ms A did agree to the anaesthetic used.

101. I empathise with Ms A and agree that consumers should be at the centre of the care being provided to them. Although it is difficult for me to reconcile the somewhat differing recollections above, I trust that Dr D will reflect on Ms A's experience and the importance of effective communication.

No pain relief prescription provided

102. Ms A told HDC that she did not receive a prescription for pain relief to take home on 16 November 2018, and she had to go to another healthcare provider for pain relief the following morning. Dr D said that owing to the passage of time, he cannot recall specifically if he discussed pain relief options with Ms A, but that this would be his usual practice.

103. There is no contemporaneous documentation that indicates that Dr D discussed pain relief with Ms A, and Ms A told HDC that she had to go to another provider the following morning for pain relief. This suggests that if pain relief was discussed with Ms A, she would have agreed to a prescription. I therefore consider it more likely than not that pain relief was not discussed on 16 November 2018.

104. Dr McKie advised that the failure to enquire about or provide analgesia would constitute a minor departure from the expected standard of care. I accept Dr McKie's advice, and I remind Dr D of the importance of enquiring whether a patient requires pain relief on discharge.

Decision not to wash out on 16 November 2018

105. Dr C told HDC that there should have been a lower threshold to carry out a washout on 16 November 2018.

106. Dr McKie advised that given that the wound had apparently healed at this stage and sutures had been removed, the decision not to carry out further wound irrigation and washout seems appropriate. Dr McKie further advised that reopening Ms A's wound for further washing and debridement may have lessened the subsequent events, but this would have been an unusual practice in a wound that had apparently healed.

107. I agree with this advice. I accept that in hindsight it may have assisted Ms A to have had a washout on 16 November 2018. However, as there were no signs of the infection at this point, I accept that Dr D's management of Ms A's thumb on 16 November 2018 was appropriate.

Documentation

108. On 23 November 2018, Dr D carried out a further washout with a consultant orthopaedic surgeon present, and there is no typed theatre note for the washout on this date.

109. Dr McKie advised that it is regrettable that for whatever reason (be it that dictation was either not made or lost in the system), there was no typed operative note from Dr D for the

second washout on 23 November 2018. There is, however, a clear contemporaneous handwritten annotation of the surgical procedure in the notes, as would be expected.

110. I agree that it is unfortunate that a typed operation note was not generated on this occasion, but consider that there was a suitable record of the procedure in the clinical notes.

Opinion: Dr C — no breach

Documentation — educative comment

111. Ms A has raised a concern that when Dr E and Dr D visited her after the second washout, Dr E advised that "a good outcome at this point was to have half a thumb or to retain the thumb as a post", and that this conversation was not recorded in her notes. The DHB confirmed that there is no documentation in Ms A's clinical documents in regard to the ward round by Dr D and Dr E following the second washout.

112. Dr McKie advised that it would be ideal for this conversation to have been recorded in the notes, but that if the consultation was just to confirm that appropriate care was being delivered and not to change the plan of care, then reasonably there may not have been any significant recording of this, as opposed to a request to formally transfer the care to another colleague.

113. I agree with this advice and I remind Dr C of the importance of thorough documentation.

After care — other comment

114. Ms A told HDC that she met with Dr C three months after her injury and they discussed the results of an X-ray, and Dr C told her that she had approximately 10% of her cartilage left in her thumb. Ms A is concerned that X-rays do not show cartilage. Dr C explained to HDC that he told Ms A, in non-technical language, that owing to the progression of her arthritis, she had lost further cartilage in her joint.

115. As I understand it, Dr C attempted to explain to Ms A that as a result of septic arthritis, she had lost cartilage in her thumb. Dr C has explained that he used non-technical language to convey this information, but possibly this led to confusion. The misunderstanding that appears to have resulted is unfortunate, and while I acknowledge Dr C's attempt to explain matters in plain language, I remind him of the value of checking to ensure that patients have fully understood what has been explained to them.

Changes and actions since events

Dr B

116. Dr B has reflected on his clinical practice since this complaint was brought to his attention, and he now uses investigations in a very detailed manner to obtain a more complete assessment of presentations. He explained that in cases of injury, he continues to have a very low threshold for imaging studies.

117. Dr B told HDC that he is extremely remorseful for the prolonged pain and suffering caused to Ms A, and for his oversight, and he apologised for the deficiencies in his management of her case. He said that he has learnt significant lessons from his reflection on events. Dr B acknowledged that his treatment was part of a chain of events that led Ms A to have a very negative experience of the medical profession. He acknowledged that he is not able to undo this, but said that he would be happy to meet with Ms A should she want to discuss any concerns or talk generally about what happened to her.

118. Dr B stated that he has made the following changes to his practice:

a) He has started to ask for much more detail regarding the mechanism of falls, to form a more complete mental picture of how injuries occurred and what that may tell him about the injuries.

b) He has improved his listening.

c) He carefully notes everything that patients have said about their experience of the injury (including pain and sensations) and what this may tell him about an injury.

d) He attempts to provide very clear instructions on how to manage injuries and when to re-present to the ED or GP for review if the injury is not improving as expected.

119. Dr B has provided HDC with a written apology to Ms A.

DHB

120. The DHB told HDC that the majority of Hospital 1 senior medical officers (including Dr B) have attended the CASTED [24] conference, which involves the management of minor fractures, and the remainder will attend at the earliest opportunity.

121. The DHB advised that a case study will be presented using Ms A's experience to encourage reflection and discussion within the orthopaedic service.

[24] Provider of orthopaedic courses.

Recommendations

Dr B

122. I acknowledge the changes made by Dr B to improve the service he provides, and consider that no recommendations regarding his clinical care are necessary. However, I recommend that Dr B provide a formal written apology to Ms A for the breach of the Code identified in this report. The apology should be sent to HDC, for forwarding to Ms A, within three weeks of the date of this report.

DHB

123. I recommend that the DHB:

a) Use an anonymised version of this report as a case study, to encourage reflection and discussion within its orthopaedic service, within six months of the date of this report.

b) Confirm that all Hospital 1 senior medical officers have attended the CASTED conference, within six months of the date of this report.

c) Facilitate a meeting with Ms A to enable her to talk to the clinicians involved and discuss how the care provided has affected her, within three months of the date of this report.

Follow-up actions

124. A copy of this report with details identifying the parties removed, except the experts who advised on this case, will be sent to the New Zealand Medical Council, and it will be advised of Dr B's name in covering correspondence.

125. A copy of this report with details identifying the parties removed, except the experts who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to the Commissioner

The following expert advice was obtained from Dr Scott Wilson:

"**Date: 3 April 2020**

Ref: C19HDC01258

I have been asked to provide an opinion to the Commissioner on case number C19HDC01258. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

My name is Dr Scott Wilson. I have been vocationally registered as a specialist in Rural Hospital Medicine with the Medical Council of New Zealand since 2011, registration number 33017. I have also completed a Postgraduate Diploma in Rural and Provincial Hospital Practice with distinction. I have worked at SMO level in Rural Hospital Medicine in New Zealand for the past 15 years, predominantly in Level 3 rural hospitals. I am currently working as a full time Rural Hospital Specialist in Ashburton Hospital.

I was the Clinical Director of Ashburton and Rural Hospitals for Canterbury District Health Board from 2012 to 2015, and Clinical Leader for Dargaville Hospital from 2016 until 2018. I have been an elected member of the Council for the New Zealand College of General Practice, Division of Rural Hospital Medicine since 2014.

The expert advice requested by the Commissioner is as follows:

To review the documents provided and advise on whether I consider the care provided to [Ms A] at [Hospital 1] was reasonable in the circumstances, and why.

In particular I have been asked to comment on:

1. The adequacy of [Ms A's] care at [Hospital 1], including safety netting advice/follow-up.
2. Whether all appropriate investigations and imaging were undertaken.
3. Any other matters in this case that I consider amount to a departure from accepted practice.

Documents considered in compiling this report were:

- Letter of complaint dated 9 July 2019
- [The DHB's] response dated 6 September 2019 and [Dr C's] undated response
- Clinical records from [the DHB] covering the period from 3 November 2018 to 28 March 2019
- Clinical notes from [the urgent care clinic] and GP clinic
- Clinical notes and specialist reports from [the] Medical Centre.

Background (direct copy of summary taken from HDC letter dated 6 March 2020)

[Ms A] sustained a serious injury to her left thumb after falling whilst walking … on 3 November 2018. She was initially treated at [Hospital 1] where her thumb was cleaned and stitched under local anaesthetic. A follow-up appointment with her general practitioner (GP) and an X-ray determined that the thumb was dislocated and fractured.

On 16 November 2018, she presented to the Emergency Department at [Hospital 2] where the joint was subsequently relocated and a Zimmer splint applied. [Ms A] was re-admitted on 20 November 2018 with a wound infection and underwent left thumb debridement and washout. Two further washouts were completed on 23 November 2018 and 26 November 2018.

My opinion

This case involves a number of presentations and interactions with medical teams in both [Hospital 1] and [Hospital 2]. My opinion will focus on the care provided by the staff at [Hospital 1].

[Ms A] states in her letter that she fell while walking on Saturday, November 3rd 2018. The clinical records document that she presented to [Hospital 1] at 6.21pm, and was triaged 1 minute later at 6.22pm. She explained she had landed on her thumb with considerable force and that she believed the thumb had gone backwards resulting in a tear to the skin at the base of the thumb on the palmar side. [Dr B's] notes document an isolated injury to the left thumb. He documents the laceration, indicates that the flexor tendons are intact, and that the thumb has good blood flow and normal sensation. No comment is made regarding swelling, deformity, or the joints.

[Dr B] documents the wound was cleaned then closed with 3 sutures under local anaesthetic. It was then dressed and he documented a recommendation that the sutures be removed at 10 days. [Ms A] was discharged at 9pm.

1. The adequacy of [Ms A's] care at [Hospital 1], including safety-netting advice/follow up.

[Ms A] presented to a Rural Hospital Emergency Department on a Saturday evening, the timeliness of her triage, assessment, treatment, and discharge was reasonable and consistent with what is provided in other centres of this size.

The history given suggests considerable force from the fall, and the possibility of a significant hyperextension injury to the thumb. Both of these should raise suspicion of damage to deeper structures, including fractures. The nursing triage notes indicate the thumb was swollen on presentation.

[Dr B's] documentation is brief, thus it is difficult to draw conclusions on the exact appearance of the thumb, and examination findings when [Ms A] first presented. The history and examination findings help determine the probability of damage to any deeper structures, thus the need for any imaging, referral, and specific treatment.

In traumatic hand injuries the standard of care is to X-ray if swelling, tenderness, or deformity is present to exclude joint injury or fracture. This is especially important if there is an associated wound, as compound fractures and open dislocations require immediate referral at the time of injury to the appropriate specialist service.

[Dr B's] decision not to X-ray the thumb meant that his assessment was incomplete, hence he was unable to ascertain the full extent of the injury. Given the history of injury, and the documented swelling, this decision constitutes a severe deviation from the standard of care.

[Dr B's] management of the wound was thorough, he provided appropriate anaesthetic, cleaned the wound well, gave a tetanus booster, and closed with 3 sutures. The wound was dressed prior to discharge. This management of the wound was reasonable and aligned with the standard of care for a simple superficial laceration. [Ms A] writes that the local anaesthetic was injected into the thumb. This is common practice and can sometimes be painful, especially if there is significant swelling, however this is an effective way of providing anaesthesia and does constitute the standard of care for treatment of digital injuries.

The advice on the discharge letter provided by [Dr B] states 'ROS (removal of sutures) in 10 days time, and urgent review if concerns of thumb movements or altered sensations/wound infection'. Given [Dr B's] assessment that this was a simple superficial wound then this advice was reasonable and is the standard provided in other rural hospitals.

I note that [Ms A] had the wound dressed regularly by a nurse over the next 2 weeks, and there was no concern raised around thumb movements, altered sensation, or wound infection. Swelling did persist, as documented on November 16th by both the GP and [Dr D] at [Hospital 2], however both also documented the wound to be well healed, with no signs of infection.

Overall, the care provided to [Ms A] at [Hospital 1] was not adequate due to the incomplete assessment of the injury. If an X-ray had been taken in line with the standard of care, either at the time of injury, or the following day, then appropriate referral could have been made to specialist services at [Hospital 2].

[Dr B] has reflected on this decision and has unreservedly apologised for this error in judgement. He has acknowledged that he believed that [Ms A's] injury was a simple superficial wound, which he managed very appropriately as such.

2. Whether all appropriate investigations and imaging were undertaken.

As previously I will only be commenting on the investigations and imaging relevant to the care provided at [Hospital 1] on November 3rd 2018.

[Dr B] did not take suitable action to identify the extent of the injury and misdiagnosed it as a simple laceration when the subsequent investigations showed it was much more

significant. Fingers can often be very swollen and tender, masking underlying bony injury and rendering parts of the examination unreliable. For this reason the standard of care in traumatic hand injuries with associated swelling, tenderness, or deformity includes an X-ray as part of the assessment, this was not done.

If [Dr B] felt that a dislocation or fracture was not likely following his assessment, examination, and exploration of the wound, then deferring the X-ray to the following day would not be unreasonable given the fact that it was a weekend evening and in many rural hospitals the staff that take X-rays (radiographers) are on call for emergencies only. Standard practice in these circumstances is to provide splinting and arrange for the patient to represent the following day for X-rays.

Failing to X-ray the thumb at all however would constitute a severe deviation from the standard of care.

Apart from an X-ray, no other investigations are indicated in this case when first assessed in the Emergency Department at [Hospital 1].

3. Any other matters in this case that I consider amount to a departure from accepted practice.

I do not believe there are any other matters pertaining to the care provided at [Hospital 1] that deviate from accepted practice.

My opinion and comments are based solely on the clinical information I have received. I am happy to be contacted should you require anything further, or wish to discuss in more detail.

Yours Sincerely,

Dr Scott Wilson, FDRHMNZ
Rural Hospital Specialist"

The following further advice was received from Dr Wilson:

"**Date: 6 October 2020**

Ref: C19HDC01258

I have been asked to provide further advice to the Commissioner on case number C19HDC01258. My initial report was provided on 3 April 2020.

The further advice requested by the Commissioner is as follows: To review the documents provided and advise

1. Whether it causes me to amend my conclusions drawn in my initial advice, or make any additional comments.
2. Any further comment about the care provided by [Dr B].

3. Any comment about systemic issues at [the DHB]. If there are systemic issues, to elaborate on these with respect to how other rural hospitals operate in those respects.
4. Any other matters in this case that I consider warrant comment.

Documents considered in compiling this report were:

- [Dr B's] letter dated 5 August 2020;
- [The DHB's] letter dated 26 August 2020 and its attachments;
- [Ms A's] email dated 9 September 2020

My opinion

1. Whether it causes me to amend my conclusions drawn in my initial advice, or make any additional comments.

The conclusions reached in my report from 3 April 2020 were based entirely on the documents I had received at the time. [Ms A] had provided details from her letter of 10 December 2018, and I received the comprehensive clinical notes from [the DHB]. [Dr B's] letter of 5 August 2020 has provided new information. Considerable details in the letter were not included in his consultation notes, and so not considered at the time of my initial report. I have reviewed all of the previous documents again in light of this new information.

In my initial report I advised that the history of considerable force and hyperextension mechanism should have raised suspicion of damage to deeper structures. Furthermore that the standard of care is to X-ray if swelling, tenderness, or deformity is present to exclude joint injury or fracture.

[Dr B] states in his letter that after assessing [Ms A] he understood the injury was a laceration due to a fall. The mechanism of injury is a key element in the clinical assessment of patients in the emergency setting. There are inconsistencies in the documents provided regarding what was discussed, and what was documented. [Ms A] indicated she discussed the hyperextension mechanism with [Dr B], and hyperextension (bending the thumb back) is documented in the nursing triage notes. [Dr B] indicates he was unaware of this mechanism at the time, documenting only that [Ms A] had tripped and fallen. [Dr B] agrees this history of hyperextension, if known to him at the time, would raise the possibility of damage to deeper structures that would warrant further investigation.

With regards to the physical examination. [Dr B] states in his letter of 5th August that he recalls [Ms A] was in pain, some slight swelling of thumb (not severe), no deformity, and she could flex the joint. [Dr B's] clinical notes at the time of the original consultation do not make any comment regarding the presence or absence of these findings. The nursing notes indicate simply that the thumb was swollen.

My original advice was based on the information documented at the time of the consultation. A history of a hyperextension injury was detailed by [Ms A] and the triage

nurse, there was considerable pain, swelling, and an open wound. If these details are accurate then I stand by my initial conclusion that failure to X-ray was a severe deviation from the standard of care.

If however [Dr B] took a history from [Ms A] and was advised it was a simple laceration not a hyperextension injury, and if the swelling was mild, there was no deformity, and [Ms A] could flex the joints then I agree that the likelihood of damage to deeper structures was substantially lower. With mild swelling and ongoing pain an X-ray would still be indicated as a precaution, however the decision not to do so at the initial consultation would only constitute a mild deviation from the standard of care under these circumstances given the planned follow up and return advice that the patient had received.

2. Any further comment about the care provided by [Dr B].

Obtaining an accurate history of the mechanism of injury is a key part of the clinical assessment and the standard of care. It is unclear from the documents provided exactly how detailed [Dr B] was in this regard as he simply advises his understanding was that it was a laceration due to a fall. [Ms A] states she discussed the mechanism with the doctor, and it is recorded in the nurses triage note. [Dr B] states he was unaware. If [Dr B] did not obtain a satisfactory history of the injury then this would constitute a moderate deviation from the standard of care.

The clinical notes constitute the contemporaneous record of any consultation and treatment. These need to be accurate and as detailed as necessary, with relevant positive and negative findings, to support the conclusions reached and treatment provided. The notes in this case are brief, and [Dr B] did not comment on swelling, deformity, or joint movement at the time of the consultation in these clinical records. These are extremely important findings as without comment it is difficult to draw firm conclusions on how the thumb appeared and functioned on the evening of 3 November 2018, even with the additional information provided in later correspondence.

As stated in my initial report, I believe [Dr B] provided thorough care of the laceration to [Ms A's] thumb.

3. Any comment about systemic issues at [the DHB]. If there are systemic issues, to elaborate on these with respect to how other rural hospitals operate in those respects.

[Dr B] advises that he briefly considered ordering an X-ray for [Ms A], however imaging services were not fully available out of hours and [Ms A] was on holiday. These are common challenges encountered in rural hospitals in New Zealand, with limited radiography staff operating an out of hours roster for emergencies only. Medical staff must balance the clinical urgency for imaging with pragmatism, as if staff are called in out of hours for non-emergency work it may impact on daytime services and staff retention. It is common practice for low risk patients presenting out of hours to rural

hospitals to return the following day for X-rays, or to be referred to a provider in their home town if on holiday.

4. Any other matters in this case that I consider warrant comment.

I have no further comment regarding the care provided by the staff at [Hospital 1].

Yours Sincerely,

Dr Scott Wilson, FDRHMNZ
Rural Hospital Specialist"

The following further advice was received from Dr Wilson:

"**Date: 28 December 2020**

Ref: C19HDC01258

I have been asked to provide further advice to the Commissioner on case number C19HDC01258. My initial report was provided on 3 April 2020, and subsequent advice on 6 October 2020.

The further advice requested by the Commissioner is as follows:

To review the documents provided and advise

1. Whether it causes me to amend my conclusions drawn in my initial advice, or make any additional comments.
2. Any further comment about the care provided by [Dr B].
3. Any other matters in this case that I consider warrant comment.

Documents considered in compiling this report were:

- Letter from [the DHB] dated 19 November 2020 and its attachment
- Further information from [Dr B]

My opinion

1. Whether it causes me to amend my conclusions drawn in my initial advice, or make any additional comments.

The conclusions reached in my initial advice from 3 April 2020 were based on the documents available at the time. [Dr B] provided additional information following this report which resulted in 2 potential scenarios, detailed in my subsequent advice of 6 October 2020.

[Dr B] has provided further correspondence to my report of 6 October 2020. This additional information does not cause me to amend my previous conclusions, however does provide for 3 potential scenarios.

In scenario A, [Ms A] discussed the hyperextension mechanism with [Dr B] (as in her initial correspondence) and the triage nurse (as documented in triage nurses notes). A brief examination followed in which the thumb was noted to be swollen and painful. [Dr B] failed to appreciate the significance of the mechanism and examination findings, did not take an X-ray, and incorrectly concluded the injury was a simple laceration. He provided thorough wound care and closure and discharged [Ms A] with return advice. If this scenario is accurate then both the history and physical examination findings would generate concern for damage to deeper structures and the care provided would constitute a severe deviation from the standard of care provided in other Rural Hospital emergency departments. This was the conclusion reached in my initial advice of April 3rd.

In scenario B, [Dr B] was unaware of the hyperextension mechanism and believed the injury was a simple laceration (as detailed in his subsequent correspondence). This may have come about through either an inadequate or no history being taken by [Dr B], or a misunderstanding of the information provided by [Ms A]. In [Dr B's] letter he writes that the thumb was only mildly swollen, all joints moved freely, there were no deformities and only minimal tenderness. If this scenario is accurate then the examination findings are reassuring, however the mechanism of injury is a key part of the assessment and a hyperextension injury severe enough to tear the tissues on the volar surface of the thumb should have prompted greater consideration of bone or joint injury. [Dr B] agreed that if he was aware of the mechanism at the time it would have warranted further investigation. The obligation to obtain an adequate history falls to the treating healthcare professional, if [Dr B] failed to take an adequate history this would be a moderate deviation from the standard of care. I documented this conclusion in my second report from 6 October 2020.

In scenario C, [Dr B] did take a history of the injury and was informed by [Ms A] that it was a simple laceration, not a hyperextension injury. [Dr B] was reassured by his examination findings and concluded it was a simple laceration, provided thorough wound care and discharged [Ms A] with appropriate follow up advice. If this scenario is accurate then [Dr B's] management was reasonable, and as documented in my previous reports while many rural doctors would consider ongoing pain a reason to X-ray, the decision not to do so would at most constitute a mild deviation from the standard of care. This scenario and conclusion were also documented in my report of 6 October 2020.

2. Any further comment about the care provided by [Dr B].

The clinical notes written at the time of the initial consultation at [Hospital 1] are brief, with significant further information being provided by [Dr B] in his later correspondence of 5 August 2020. [Dr B] documented in the clinical record a laceration to the volar aspect mid thumb, flexor tendon intact, and n/v finger normal. In [Dr B's] most recent correspondence (undated) he states that the documentation 'flexor tendon intact' means that joint movement was checked and documented. I accept that there must have been some movement in the thumb joints in order to conclude that the flexor

tendons were intact. I however would also point out that fractured, dislocated, or subluxed joints can still often move through a limited and often painful range of motion. Assessing joints involves more than simply ascertaining if the tendons are intact.

I stand by my initial statements that [Dr B] did not comment on the presence or absence of swelling or deformity. The nurses indicate in their correspondence that the thumb was swollen. It is unclear the extent to which the joint movements were assessed, however I accept that some degree of flexion at the IP joint must have been present to conclude that the flexor tendon was intact.

3. Any other matters in this case that I consider warrant comment.

I have no further comment regarding the care provided by the staff at [Hospital 1].

I am happy to be contacted should you require anything further, or wish to discuss in more detail.

Yours Sincerely,

Dr Scott Wilson, FDRHMNZ
Rural Hospital Specialist
Ashburton Hospital"

Appendix B: Independent clinical advice to the Commissioner

The following expert advice was obtained from Dr John McKie, a consultant orthopaedic surgeon:

"**Complaint: [DHB]**

19HDC01258

6 October 2020

Thank you for asking me to review the clinical records and answer specific questions regarding the experience of [Ms A] at [the DHB] in November 2008. As well as reviewing all the information you have sent me, I have taken the liberty of accessing the relevant radiographs that were taken during the time of her presentation.

As you are aware, my name is John Mckie. I am a Consultant Orthopaedic Surgeon in both public and private practice in Christchurch, New Zealand. I am a vocationally registered Orthopaedic Surgeon currently employed by the Canterbury District Health Board and previously the Clinical Director of the Department of Orthopaedics, Christchurch. I have been in the employ of the Canterbury District Health Board since 1994.

You have asked me to limit my comments to the care provided at [Hospital 2] as you have also sought an opinion from a Rural Hospital Specialist, presumably pertaining to the care provided initially at [Hospital 1].

The assessment and care at [Hospital 1], however, remains central to the outcome in this case and cannot be completely disregarded. While the vision of hindsight is 20/20, it is without doubt regrettable that the patient didn't have an X-ray evaluation as part of her index evaluation.

In the patient's report she suggests that local anaesthetic was placed into the area of the wound or dislocation.

This would be unusual if it is, in fact, what happened and it would be more normal for the patient to have had a ring block to enable appropriate wound toilet prior to suturing. Clearly the experience that she had had at [Hospital 1] influenced her reaction to proposed treatment in [Hospital 2] in the following days.

According to the records that I have reviewed, when [Ms A] presented on the 16th of November, she had a healed transverse volar wound on her thumb and after X-ray underwent a ring block (an appropriate form of anaesthesia for a minor thumb procedure) to reduce the fracture dislocation, which was carried out and appropriately splinted with a modified Zimmer aluminium splint. Given that the wound was apparently healed at this stage and sutures had been removed, albeit with some difficulty, not doing further wound irrigation and washout other than the usual preparation prior to a ring block would seem appropriate.

It would seem the patient did not receive any analgesia on discharge, which is clearly an omission.

It would, however, be expected that a chronic dislocation, once reduced, would be significantly more comfortable and it may have been assumed that the patient already had analgesia from her earlier hospital presentation. Nonetheless, it would be expected that if not given, at least inquiries whether the patient was likely to need any analgesia to take home would be sought.

I note that the patient experienced further pain, swelling and discomfort and as a consequence, after a long delay in the Emergency Department at [Hospital 2], went to [the urgent care clinic] where she was seen, swabbed and given oral antibiotics. While the doctors at [the urgent care clinic] noted she had a follow up appointment the next day with the Orthopaedic Service, she would have been far more appropriately managed with urgent re-referral back for further debridement of her infection, elevation and commencement of intravenous antibiotics.

The surgical management that the patient underwent with repeated explorations and debridements on the 20th, 23rd and 26th of November were all entirely appropriate. Because of the ongoing clinical problems, on the 26th it was very appropriately decided to temporarily stabilise the IP joint with a transarticular K-wire, thus obviating the need for any external splintage, which would likely have been of only limited effectiveness.

All of these procedures are able to be carried out completely satisfactorily with good regional anaesthesia (a local anaesthetic ring block), but could equally be carried out under general anaesthesia. Many factors will influence the decision for surgery to be done under local rather than general anaesthesia, including accessibility to operating theatre time, the patient's co-morbidities and current fasting status.

Note is made in the documentation that there was no typed operative note from [Dr D] on the second washout on the 23rd of November. This is regrettable that for whatever reason (be it that dictation was either not made or lost in the system), however, clear contemporaneous handwritten annotation of the surgical procedure was made in the notes as would normally be expected.

Regarding the appropriateness of the care of [Dr C], Orthopaedic Consultant, there is no suggestion from reviewing the case file that his care was other than professional and appropriate. I understand there were concerns that there is no formal annotation of the Consultant consultation with a colleague who was a bona fide Hand Surgeon. Again, this would be ideal to be recorded in the notes, however, if the consultation was just to confirm that appropriate care was being delivered and not to change the plan of care, then there might reasonably not have been any significant recording of this as opposed to a request to formally transfer the care to another colleague.

On reading through all the information, it is clear that [Ms A] feels that a sentinel factor in her developing an infection was the wound was not properly managed when she first

presented to [Hospital 2] and has also expressed concern that she was having physiotherapy to her thumb inappropriately.

While with the vision of hindsight, as has been noted by others, reopening her wound and further washing and debriding it on the 16th of November may have lessened the subsequent events, this would be an unusual practice in a wound that had apparently healed. I would concur with the view of the Doctors who have expressed the opinion that her infection would have been initially contracted through her initial open fracture dislocation, although the physical trauma of late manipulation in an inflamed area would no doubt have had an influence in the activation of what was apparently a latent infection.

With respect to [Ms A's] concern about physiotherapy, the therapy she was having, albeit the fact that her interphalangeal joint was already quite severely damaged due to the sepsis, was completely appropriate. There would seem to be no doubt that articular cartilage had been damaged and lost due to the sepsis in her joint, however, the end result in terms of the residual range of motion of her joint would only become clear over time when residual function could be assessed.

The key issue in reconstructive surgery involving the thumb is fundamentally to maintain length, hence preserving the patient's length even if the IP joint ends up stiff or surgically fused is to be desired. It would seem, from reviewing all the correspondence, that this may well not have been communicated to [Ms A] in terms that she could appreciate or understand.

In summary, while Ms A, unfortunately, has had a poor outcome from a significant open injury, I do not believe there were any significant breaches of accepted care or practice at [Hospital 2]. As noted initially, the fundamental errors were as part of her initial assessment and then the delay in diagnosing the underlying fracture dislocation.

While, in retrospect, further opening and debriding the volar wound at the time of her reduction and stabilisation in [Hospital 2] may have improved the situation and outcome, I think the decision making of the Doctors involved at that time was appropriate. Similarly the ongoing management decisions were also appropriate.

With respect to policies at [the DHB] of any systematic issues, the one of informed consent has been raised by the patient. All patients have the right to be appropriately informed of the risks, benefits and alternatives to the treatment which is being recommended. Unfortunately, the rather generic nature of hospital consent forms to acknowledge this discussion can be a cause of some tension. If the patient required further information before consenting to have her various procedures performed, there is no suggestion in either the clinical record or the patient's emails that she sought further information which was withheld. Clearly she has had a poor outcome from an unfortunate clinical situation and I am sure this, with retrospect, colours her view to issues of consent.

I am not familiar with the current administrative structure of acute orthopaedic care in [the region], however, on the face of it, it does seem a little confusing that patients who are seen in the Acute and Emergency Department are then referred to be seen and managed by Consultants in private. I assume this relates to ACC funding and accessibility of emergency care, but one would expect that acute patients would be able to be seen in a timely manner by duly qualified specialist staff in the Public Hospital as required. There is, however, nothing in the information provided to me to suggest that this is not the case in emergencies.

If you have any further questions please feel free to contact me directly.

Kind regards

JOHN MCKIE
MB chb, FRACS
Orthopaedic Surgeon
Med Council No: 13530"

Further clarification was received from Dr McKie on 8 October 2020:

"The failure to apparently enquire about or provide analgesia would constitute a minor breach of expected standard of care.

21 January 2021

Thank you for the further information and request for comment.

I have reviewed the documents provided attached to this email.

I fully accept the responses made by both parties and feel them to be credible and reasonable.

The absence of clear documentation that an inquiry was made regarding a patient's analgesic requirements does not mean that such a question was not asked or considered, rather that the discussion was not documented. I suggest such discussions are seldom minuted in the notes, however in this case where the patient claims no such decision took place, it becomes a case of 'he said, she said …'.

I have no further substantive comments to make and see no reason to change my report."