General Practitioner, Dr B
Medical Centre

A Report by the
Health and Disability Commissioner

(Case 18HDC01905)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a two-year-old child by a general practitioner (GP) during a consultation at a medical centre. Both the mother and the GP agree that the child was tired, restless, wriggling, and becoming upset at the appointment.

2. During the appointment, the GP inflicted physical contact to the child's face using all or part of her hand. The nature of the contact has been disputed by both parties, and has been described both as a "slap" (by the mother) and a "tap" (by the GP).

3. Both the GP and the medical centre were very apologetic for the GP's actions. Both took various steps to address the incident and improve practice. The GP submitted personal and work-related mitigating factors, and disputed that the contact was a slap, but accepted that her actions were unprofessional, and acknowledged that she should have taken other courses of action, such as stopping the examination, giving the child time to settle down, or referring him to another doctor.

Findings

4. The Commissioner considered that the GP's response to the child's behaviour was inappropriate, and that it was unnecessary to make a finding on the precise nature of the physical contact. The Commissioner considered that, that there was any contact to the child's face, unrelated to a clinical assessment, was disrespectful to both the child and his mother, and a serious departure from accepted standards.

5. The Commissioner found that the GP failed to provide services with reasonable care and skill, and, accordingly, that she breached Right 4(1) of the Code. The Commissioner also found that the GP's physical contact with the child's face was disrespectful to him, and therefore that the GP also breached Right 1(1) of the Code.

6. The Commissioner made adverse comment about the medical centre.

7. The Commissioner considered that following the incident, the GP took appropriate actions to address the stressors she described. He noted that from the information gathered, the incident appeared to be out of character for the GP, and did not consider this incident to be reflective of her general competence, nor likely to occur again. He considered that nevertheless, accountability must be had for the incident that occurred.

Recommendations

8. Given the appropriate actions taken by the GP and the medical centre following the incident, the Commissioner made no further recommendations. However, he entrusted to the GP and the medical centre that the learning taken from this case would be carried into future practice.

Complaint and investigation

9. The Commissioner received a complaint from Ms A about the services provided to her son, Master A, by Dr B at the medical centre. The following issues were identified for investigation:

- *Whether Dr B provided Master A with an appropriate standard of care in September 2018.*
- *Whether the medical centre provided Master A with an appropriate standard of care in September 2018.*

10. The parties directly involved in the investigation were:

Ms A	Complainant/consumer's mother
Dr B	Provider/general practitioner (GP)
Medical centre	Provider/general practice

11. Also mentioned in this report:

Mr C	Pharmacist
RN D	Registered nurse
Mr E	Medical centre manager

12. Further information was received from the New Zealand Police.

13. Expert advice was obtained from HDC's in-house clinical advisor, GP Dr David Maplesden (Appendix A).

Information gathered during investigation

Introduction

14. On 19 September 2018, Ms A took her son, Master A (two years old at the time of events) to an appointment with Dr B at the medical centre. Master A had been unwell for the preceding few days, and had conjunctivitis and a fever.

15. Ms A alleges that during the appointment with Master A, Dr B slapped Master A on the cheek.

16. Master A was initially seen that day by Registered Nurse (RN) D. RN D noted that Master A was alert and "very fussy on exam. Chaotic in room". She also documented that Master A was "very difficult to examine" as he was "kicking, screaming, [and] attempt[ing] to throw a wooden toy" at her. RN D documented that she was unable to complete the examination and booked Master A for an urgent clinic appointment with Dr B later that day, scheduled for 6.45pm.

19 September 2018 — the incident

17. Ms A and Master A returned to the clinic in the evening.

18. Dr B said that by way of explanation, but not an excuse, her workload was exceptionally and unusually busy on this date. She started work at 10.15am, was double and triple booked throughout the day, did not take breaks due to workload, and her last appointment was with Master A after closing hours.

19. Mr E, the manager of the medical centre, confirmed that Dr B had been triple booked, was covering for another doctor, and had some particularly complex cases. He noted that she was also the "late doctor" on duty until 7pm and had not taken any breaks, and had been in constant demand from nursing staff as well as patients.

20. Due to appointment times running late, Master A was not seen by Dr B until approximately 7.15pm to 7.20pm. Both Ms A and Dr B agree that Master A was tired, restless, wriggling, and becoming upset at the appointment.

21. Both Ms A and Dr B agree that during the appointment, Dr B made physical contact with Master A's face; however, the nature of the contact is disputed.

22. Dr B documented the incident in the clinical notes as follows:

> "Urgent clinic — very busy. Was my last patient. Mum came in with [Master A] who was crying … I said several times he should stop it … [Master A] kicked several times against me against my L[eft] leg whilst mum could not hold him and mum holding him, he also chew on paper and throw it against me. Tried to grab paper from my desk. As he throw his chewed paper at me I slapped him very lightly against his L[eft] cheek, I apologised immediately …"

23. Dr B documented in an incident report[1] and also told HDC that Master A resisted being brought into her consultation room but she and Ms A managed to entice him in, and he began playing with the toys immediately. Following discussion with Ms A, Dr B picked him up and sat him on Ms A's lap to examine him. Dr B recalled that as soon as she started to examine Master A, he began to cry, wriggle, and kick. He threw chewed-on paper at her. She tried to calm him down by asking him to stop kicking and throwing paper, verbally reassuring him that it would be over soon, and using distracting techniques.

24. Dr B said that she had completed examining his lungs and the right side of his head. Dr B said she was already close to Master A's face, now examining his left ear and eye. Master A was struggling, and he kicked Dr B in the stomach. In a shock reflex, she tapped Master A's cheek with her fourth and fifth fingers. She said that it was a light tap and not a forceful motion, and without an intention to harm. She stated that she did not slap Master A across his face, and that she was holding an otoscope with her other fingers, and this did not touch Master A.

[1] Incident report date initiated 20/9/2018.

25. Ms A disputes Dr B's version of events. Ms A's incident report form[2] documented:

> "During his check over, my son became [frustrated] and packed a tantrum where he flung his arms and legs and kicked doctor [Dr B] where she then slapped him across the face."

26. Ms A told HDC that Master A did not throw chewed paper at Dr B, and there was no paper that he could access. Ms A also stated that Dr B did not use "distracting techniques", but did tell Master A twice to stop wriggling and that it would soon be over, and then raised her voice.

27. Contrary to Dr B's account, Ms A recalled that Dr B had finished examining Master A, and therefore the otoscope was not in Dr B's hand. Master A's right leg struck Dr B's leg, and Dr B reacted by rolling her chair forward and slapping Master A across the face. The slap was loud and shocking.

28. Ms A told HDC that she was completely shocked, and said, "[Y]ou just hit my son — that is totally [expletive] unprofessional." Dr B stated that she accepts that it is a natural parental reaction to assume that there is punitive intent, but that there was no intent on her part to be punitive.

29. Ms A recalled that Dr B began to apologise, but Ms A took Master A and left the room. Ms A told the receptionist what had occurred, and also other staff members, as they came out to reception.

30. The incident report forms by Dr B and a pharmacist, Mr C, document that following the incident, they observed Master A sitting quietly in the waiting room, not distressed, seeming physically comfortable and calm.

31. Ms A contacted Master A's godmother, who came to the medical centre and requested an incident form. Ms A was provided with a copy of the practice's information, incident reporting form, and details of the staff members present, and was advised that the practice's complaints/incident office would be in contact the next morning. Ms A stated that she would have completed the form immediately, but she was ushered out as it was closing time.

32. Mr E told HDC that he was contacted by Mr C that evening, and informed of what had occurred. Mr E contacted Dr B and discussed the incident.

33. That evening, Ms A contacted the New Zealand Police and provided a statement. The police records state: "[W]hile the child was being held by his mother has kicked the doctor and the doctor slaps the child on the cheek."

[2] Incident report dated 19/9/2018.

20 September 2018

34. The following day, Mr E spoke with the manager of another branch of the practice and asked her to request incident reports from the staff involved. Incident reports were completed by Dr B, the receptionist, the practice nurse, Mr C, and Ms A.

35. Mr C's incident report form documented:

> "… I went to check on [Dr B]. [Dr B] was okay, and advised that during the consultation with the child she had been unable to examine him because he was kicking [her]. [Dr B] advised she had lightly slapped the young boy on the face to get him in an attempt to have the young boy stop kicking her …
>
> [Dr B] and I discussed the incident at 7:40pm, she advised that [Master A] had been chewing on paper and throwing this at [her]. [Dr B] had asked [Master A] to stop this on two occasions. When attempting to examine [Master A] after asking him to stop throwing paper at her, [Master A] kicked her in the stomach and leg. She lightly slapped the young boy to get him to stop kicking her. She felt this action was inappropriate and apologised to the mum in the waiting room."

36. Dr B also made another entry into her clinical notes on 20 September 2018 (no time stamp):

> "As per yesterday: to complete my notes as it was a bit confused after what has happened. … [Master A] did not want to get examined at all but wanted to play. Mum was sitting in her chair asking [Master A] to come along. [Master A] was resisting to be hold and examined, trying to hit me. I told him a few times to stop it as I otherwise could not examine him. When I examined his L[eft] ear he started to kick against my leg and aimed also for my stomach. This happened very quickly and this is when I slapped him lightly against his cheek. I apologised immediately …"

37. It is disputed who telephoned whom, however on the morning of 20 September 2018, Ms A and Mr E spoke at approximately 10am, and arranged to meet at Ms A's home.

38. Mr E and another staff member attended the meeting. They apologised on behalf of the practice and discussed the incident. Mr E stated that they emphasised "in no uncertain terms that [Dr B] acted inappropriately and it should not have happened".

39. Mr E said that they offered counselling to Ms A in good faith, to try to support her. He said that they discussed next steps, including transferring care to a new doctor, and providing counselling and supervision for Dr B. Mr E also told Ms A that Dr B wished to apologise in person.

Subsequent events

40. Mr E stated that on 21 September 2018, the medical centre provided Ms A with a letter of apology on behalf of the practice, as requested. Dr B also provided a written apology the next day.

41. Mr E confirmed that meetings occurred with Dr B to ensure that she had arranged counselling and attended the practice's peer group to discuss the incident.

42. The New Zealand Police investigated the incident. The outcome was a formal warning to Dr B for assault on a child, following consultation with Ms A.

Further information — Ms A

43. Ms A told HDC that if there had been only a small tap, she would never have reacted in the way she did, and she would have accepted an apology. However, she stated that this was a "full slap", and it was the shock of seeing a doctor do this to her son that caused her to make a complaint.

Further information — Dr B

44. Dr B told HDC that English is not her first language, and she was very upset when typing up her notes. After discussion with her colleagues, she learned that the correct expression was "tap", not "slap" as documented in her notes.

45. Dr B is very sorry for her actions, and for the upset and distress caused to Master A, Ms A, and their family. Dr B stated that her actions were completely out of character, and it was a one-off incident she is certain will never happen again. She said that she is not a violent or aggressive person, and deeply regrets what happened.

46. While she maintains that it was a shock reflex without any intent to harm, she accepts that her actions were unprofessional.

47. Dr B acknowledged that she should have taken other courses of action, such as stopping the examination, giving Master A time to settle down, or referring him to another doctor. She deeply regrets not stopping the examination.

48. Further to the work stressors she submitted above (paragraph 18), she also advised that in her personal life, she had been going through a recent sudden bereavement of a close family member.

49. Dr B advised that as a result of the incident, the practice put in place measures to manage her workload, and she meets with the directors of the practice regularly. She is involved in relevant processes with the Medical Council of New Zealand. She has also received counselling and psychological support.

50. Dr B has learned how to handle stress better, and also attended a relevant seminar held by the Medical Protection Society. Dr B said that she is now aware of the importance of taking breaks, even with an unavoidable workload. She noted that a take-away point from the seminar was that doctors are prone to disregard their own bodily and mental needs and symptoms. She said that recognising your own limitations and taking care of yourself were quite new concepts for her, and that this was never talked about when she went through medical school, let alone recognised as important factors for well-being and resilience.

Further information — the medical centre

51. Mr E, the manager of the medical centre, apologised to both Master A and Ms A on behalf of the practice, for what had been an upsetting and distressing time for them. Mr E stated that the incident should never have happened.

52. Mr E said that as a practice, their patients' health and well-being are always their first concern. He advised that the practice has not attempted to cover up or downplay Dr B's actions, and they were saddened to learn that Ms A felt that they were more concerned with risk minimisation than Master A's well-being, as this was not the case.

53. Mr E advised that they believe the practice responded promptly and appropriately in what were difficult circumstances to navigate. The practice has taken the matter seriously, and has reminded all doctors, health practitioners, and other staff at the practice of their professional obligations towards patients. The medical centre provided evidence of the internal incident report forms completed by staff, and the actions taken by the medical centre in relation to the incident.

54. Mr E stated that he is sorry that Ms A felt ushered outside after the incident, and that it is regrettable that she was not given the opportunity to fill out the incident form before going home, and that on reflection, this should have been made possible.

55. Mr E said that at the time he was not aware of the issues on this particular day, and from a patient attendance perspective the day was busy but not unusually so. However, he confirmed the work stressors submitted by Dr B (paragraph 19).

56. As a practice, Mr E stated they have taken steps to manage Dr B's and other clinicians' workloads. He said that they looked at their doctors' patient numbers to ensure that they were not unreasonable and unmanageable, and spoken individually to doctors to get their views and adjusted where needed. The practice also spoke to all nursing staff to ensure that they spread their requests for assistance across doctors rostered on for the day.

57. The practice has put in place a new system for managing demand, which has assisted significantly in keeping down the number of patients needing to see a doctor face to face, and has spread out the work across all doctors working on the day. All doctors have been spoken to about the need to take breaks irrespective of workload, and to ensure that they take regular leave. The practice does not permit staff to double book patients without first having discussed it with the doctor. Mr E confirmed that the practice continues to meet with Dr B to support her in her work.

Responses to provisional decision

Ms A

58. Ms A was given an opportunity to comment on the "information gathered" section of the provisional report. Ms A maintained that Dr B slapped Master A (and that it was not a tap or a flick of the fingers), which was why she was so shocked and immediately left the room and made a complaint. She accepted that Master A was tired, unwell, and restless due to

his pain, but in her view, the portrayal of his behaviour has been exaggerated in an attempt to justify or minimise the doctor's response.

Dr B

59. Dr B was given an opportunity to comment on the provisional report, and advised that she had no further comment to make.

Medical centre

60. The medical centre was given an opportunity to comment on the provisional report, and advised that it had no further comment to make.

Opinion: Dr B — breach

61. On 19 September 2018, two-year-old Master A had an appointment with Dr B at the medical centre, as he had been unwell for the preceding few days. During the appointment, Dr B inflicted physical contact to Master A's face using all or part of her hand. The contact has been described as a "slap" or "tap". For the purposes of this decision, it is not necessary for me to make a finding on the precise nature of the contact to Master A's face. What is clear is that this incident was unwelcome and unprofessional. Further, the act has eroded the trust that Ms A had in Dr B as Master A's doctor.

62. I acknowledge the mitigating factors that Dr B has submitted in relation to this incident. In particular, I note:

- The workload and personal stressors present at the time of the events.
- Master A was difficult to examine and kicked her.
- Her actions were reflexive.

63. My in-house clinical advisor, Dr Maplesden, advised:

> "I think the importance of health providers prioritising their own self-care cannot be over-emphasised, and the World Medical Association recognised this in 2017 with an amendment to the Declaration of Geneva (The Physicians Pledge): *I will attend to my own health, well-being, and abilities in order to provide care of the highest standard*."

64. Dr Maplesden advised that "having to deal with irritable or uncooperative paediatric patients is not an uncommon scenario in primary care, and the provider should have strategies in place to handle such situations with professionalism". He also noted that the Medical Council of New Zealand[3] states that a doctor must: "make sure [they] treat patients as individuals and respect their dignity and privacy; be courteous, respectful and reasonable".

[3] Medical Council of New Zealand, *Good Medical Practice* (2016).

65. Dr Maplesden concluded:

> "I believe the relevant factor here is that a health professional has deliberately struck the face of a two year-old patient … reflex or intended, and whether this contact was a tap or a slap the action must still be regarded as a severe departure from accepted practice."

66. I accept Dr Maplesden's advice. I remind Dr B of her responsibility to her patients and to herself, to ensure that she is monitoring her own well-being and workload. This clearly was not managed adequately at the time of the events, although I note that further steps have been taken by Dr B to address this following these events. I consider this appropriate.

67. I also accept Dr Maplesden's advice that it would not be unusual for Dr B to experience irritable or uncooperative young patients when they are unwell. Whilst I do not condone any patient kicking their doctor, I expect appropriate mechanisms to be in place to respond to this, if and when this occurs. It must also not be disregarded that Master A was an unwell two-year-old, and Dr B is an adult medical professional.

68. I consider that Dr B's response to Master A's behaviour on 19 September 2018 was inappropriate, and I am critical of this. She plainly should have known better, and, as she has acknowledged, utilised many possible strategies available to her to prevent the appointment escalating to this point.

69. Lastly, as I have previously stated, it is not necessary for me to make a finding on the precise nature of the physical contact to Master A's face. Being guided by Dr Maplesden, that there was any contact to Master A's face, unrelated to a clinical assessment, was disrespectful to both Master A and his mother, and a serious departure from accepted standards.

Conclusion

70. Despite the mitigating factors, for the reasons set out above, I do not consider that these can excuse Dr B's clearly unacceptable act. As a result of Dr B's act, the therapeutic relationship between her and her patient has completely broken down.

71. Accordingly, I find that Dr B failed to provide Master A services with reasonable care and skill, and, accordingly, that she breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[4] I also consider that Dr B's physical contact with Master A's face was disrespectful to Master A, and therefore that Dr B also breached Right 1(1) of the Code.[5]

72. As noted above, I consider that Dr B has taken appropriate actions since this incident to address the stressors she described. I note that she is closely involved in appropriate processes with the Medical Council of New Zealand. From the information gathered, it does appear to be an incident quite out of character for Dr B. I do not consider this

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

incident to be reflective of her general competence, nor does it seem likely that it would occur again. Nevertheless, accountability must be had for the incident that occurred.

Opinion: Medical centre — adverse comment

73. As a healthcare provider, the medical centre is responsible for providing services in accordance with the Code.

74. The medical centre had in place policies related to the Code of Rights, incident management, and complaints policy and procedure. Dr Maplesden advised that these are all fit for purpose.

75. I note that Dr B submitted that her workload was exceptionally and unusually busy on 19 September 2018. She started work at 10.15am, was double and triple booked throughout the day, did not take breaks due to workload, and her last appointment was with Master A after closing hours.

76. Mr E, the manager of the medical centre, confirmed that Dr B had been triple booked, was covering for another doctor, and had some particularly complex cases. He noted that she was also the "late doctor" on duty until 7pm, and had not taken any breaks and had been in constant demand from nursing staff as well as patients.

77. Since these events, the medical centre has implemented a new system for managing workloads, has placed greater restrictions around double and triple booking of doctors, and has adjusted workloads for its doctors. Whilst I accept that clinical staff have individual responsibility for managing their workload and well-being, I am concerned to read about the pressures Dr B was under on the day in question, and I consider that the medical centre should have taken remedial steps earlier. Whilst I am mindful of Dr B's submissions about her workload, I do not consider that the medical centre breached the Code.

Recommendations

78. I note that Dr B has provided a formal written apology to Ms A.

79. Given the appropriate actions taken by Dr B and the medical centre following this incident, I have no further recommendations. However, I trust that Dr B and the medical centre will carry with them the learning taken from this case into future practice.

Follow-up actions

80. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Medical Council of New Zealand and the Royal New Zealand College of General Practitioners, and they will be advised of Dr B's name.

81. A copy of this report with details identifying the parties removed, except the expert 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 advice to the Commissioner

The following expert advice was obtained from HDC's in-house clinical advisor, GP Dr David Maplesden:

"1. Thank you for the request that I provide clinical advice in relation to the complaint from [Ms A] about the care provided to her (then) two-year old son, [Master A], by [Dr B] of [the medical centre]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors. I have reviewed the information provided: [complaint from Ms A] and further response dated 9 April 2019; response from [Dr B] dated 19 March 2019 and further response dated 25 July 2019; [medical centre] GP notes, incident reports and incident management documentation; relevant [medical centre] policy and procedure documents.

2. [Master A] was brought to [the medical centre] by his parents on the morning of 19 September 2018 with a several day history of runny nose and fevers and more recent development of right eye then left eye redness and swelling. He was triaged by practice nurse [RN D] who noted *right eye red and swollen, watery drainage noted, left eye slightly swollen + runny nose ?hayfever vs infection.* [RN D] booked [Master A] for an urgent appointment slot with [Dr B] later in the day. There was some difficulty noted in [Master A's] nurse assessment documented as: *Child alert, very fussy on exam. Chaotic in room … Child very difficult to examine, unable to complete exam. Child kicking, screaming, attempted to throw a wooden toy at me but was stopped by parents. Attempting to hit his own parents as well.*

3. [Dr B] saw [Master A] as her last patient on a fully-booked urgent list about 1845hrs on 19 September 2018. Documented assessment findings include: *T 36.3, chest was clear, ENT nad, R eye was mildly congested Impr. Urti with conjunctivitis.* Treatment was provided as antibiotic eye ointment (Chlorsig) — the prescription left for [Master A] at the front desk following the incident described below. The documented clinical assessment and management appears appropriate for the presentation and diagnosis.

4. [Ms A] states in her complaint that [Dr B] began checking [Master A] and *was looking in his ears and mouth and then his eyes. [Master A] was tired and unwell and began to wriggle — flinging his limbs around. His right leg struck [Dr B's] leg and she moved forward and slapped [Master A] across the face.* [Ms A] states she immediately protested at [Dr B's] actions and then took [Master A] out of the consultation room. The complaint includes: *When [Dr B] slapped [Master A], she not only harmed him, leaving a red mark on his face and doubtless frightening him, but her actions also meant the consultation was cut short.* [Ms A] elaborates on the incident in response to reviewing [Dr B's] recollection of events (see below). She states the incident occurred after [Dr B] had completed examining [Master A's] ears and she had put down the otoscope. [Master A] was facing the doctor after having been held sideways on each side for the ear examinations to occur. [Master A] kicked out when the doctor leaned towards him and contacted the doctor on her leg. *It rolled the chair back slightly and [Dr B] reacted and instantly rolled it forward and slapped [Master A] on the face … The slap was loud and shocking and [Ms A's] instant response was to grab her son and get*

him out of the room. [Ms A] acknowledges that both of [Master A's] cheeks were flushed but *this was a full slap and it was the shock of seeing a doctor do this to her son which has caused her to make and to continue with this complaint.*

Comment: Based on [Ms A's] recollections, I believe the reported actions of [Dr B] represent a severe departure from accepted practice. The Medical Council of New Zealand[1] states the doctor must: *make sure you treat patients as individuals and respect their dignity and privacy; be courteous, respectful and reasonable.* Having to deal with irritable or uncooperative pediatric patients is not an uncommon scenario in primary care, and the provider should have strategies in place to handle such situations with professionalism. To slap a two-year-old patient in the manner and circumstances described by [Ms A] was unprofessional, discourteous and disrespectful to both the patient and his mother. I am not qualified to comment on the legal aspects of such behaviour.

5. [Dr B] states in her initial response that [Master A] was initially reluctant to come into the consultation room when called but she and his mother managed to persuade him in whereupon he began playing with toys in the consultation room. [Dr B] picked [Master A] up and placed him on [Ms A's] lap in order to examine him. [Master A] was agitated, wriggling and kicking and was throwing chewed-up paper at [Dr B]. This behaviour continued despite verbal reassurance and other distracting techniques. [Dr B] managed to examine [Master A's] chest and right ear/eye. She then leant forward to examine his left ear, steadying his head with her left hand while holding the otoscope in her right hand. *[Ms A] was pressing his head/right cheek against her chest to keep him still. [Master A] continued to struggle and kicked me in the stomach. It was at this point that I acted in a shock reflex. My hand was in a restricted position, close to his face and with the otoscope in between my thumb, second and third finger. I bent my fourth and fifth finger, as well as slightly twisting my hand, resulting in a light tap (not slap) to his cheek with my fourth and fifth fingers. The otoscope did not touch him. As soon as I reacted, I realised what I had done. I was shocked myself and immediately apologised. There was definitely no intent to harm [Master A].* The notes written by [Dr B] immediately following the incident record [Master A's] agitated behaviour and *as he throw his chewed paper at me I slapped him very lightly against his cheek.* In notes made on 20 September 2018 (and identified as retrospective) [Dr B] wrote: *When I examined his L ear he started to kick against my leg and aimed also for my stomach. This happened very quickly and this is when I slapped him lightly across the cheek.* [Dr B] states that the term 'slap' was made in the context of English being her second language, and the action was described more accurately later as a light tap.

Comment: I believe the only circumstance when the action described by [Dr B] might be deemed professionally acceptable is if it was an unavoidable unintended contact resulting from [Master A] moving suddenly while [Dr B] was undertaking an appropriate clinical examination. While not stated explicitly by [Dr B], it appears the

[1] Medical Council of New Zealand. Good Medical Practice. 2016. https://www.mcnz.org.nz/assets/standards/85fa1bd706/Good-Medical-Practice.pdf Accessed 10 September 2019

contact she made with [Master A's] cheek was deliberate and not directly related to the examination being undertaken, and my subsequent comments are based on this premise. It does not appear [Dr B's] action was designed to prevent [Master A] harming himself and I do not believe it was an appropriate action to stop [Dr B] being harmed (kicked). While [Dr B] states there was no attempt to deliberately harm or cause distress to [Master A], I think a natural parental reaction would be to assume there was punitive intent and there was therefore potential to cause both the child and parent significant distress regardless of the 'severity' of the contact. Even if the incident was a 'light tap', rather than a significant slap, if it was an intended rather than accidental contact I believe it was unprofessional and a significant departure from accepted practice ie the deliberate physical contact as described, whether the punitive intent was perceived or real, that does not constitute part of a recognised clinical procedure, and is not regarded as necessary to safeguard the patient or provider, cannot be regarded as accepted practice. The degree of departure from accepted practice is somewhat difficult to define — is a 'light tap' a less disrespectful and unprofessional action than an obvious slap in the circumstances described? I believe the relevant factor here is that a health professional has deliberately struck the face of a two year-old patient as a punitive measure, reflex or intended, and whether this contact was a tap or a slap the action must still be regarded as a severe departure from accepted practice.

6. I have reviewed the various incident reports and actions taken by [the medical centre] since the incident occurred and I believe these were timely and are appropriate. Best practice might have been to have provided [Ms A] with an incident form to complete before she left the practice on 19 September 2018 and this has been acknowledged by the practice. The relevant policy documents reviewed are all fit for purpose.

7. [Dr B] has discussed in her responses various factors she has identified as contributing to her actions on 19 September 2018, including immediate workload and extreme personal stressors. I think the importance of health providers prioritising their own self-care cannot be over-emphasised, and the World Medical Association recognised this in 2017 with an amendment to the Declaration of Geneva (The Physicians Pledge): *I will attend to my own health, well-being, and abilities in order to provide care of the highest standard*[2]. [Dr B] has taken appropriate actions since this incident to address the stressors she describes (although the complaints process itself is an inevitable stressor), and she appears well-supported by [the medical centre]. I think these actions, together with the observations recorded by colleagues that the incident described was very much out of character for [Dr B], means there is little chance of such an incident being repeated. Nevertheless, the distress caused to [Ms A] and impact this incident has had on her trust of the medical profession must be acknowledged."

[2] https://jamanetwork.com/journals/jama/fullarticle/2658261 Accessed 9 September 2019