



## PROFESSIONAL STANDARDS COMMITTEE INQUIRY

Constituted under Part 8 of *the Health Practitioner Regulation National Law (NSW)*

to hold an Inquiry into a Complaint in relation to:

**Dr Michael Francis Ward**  
**MED0001264074**

Date/s of Inquiry:	17 & 18 August 2017
Committee members:	Mr Robin Handley, Chairperson Dr Nicholas Willcocks Dr Irene Rotenko Ms Yvonne Rowling
Appearance for Health Care Complaints Commission:	Mr Scott Maybury, instructed by Ms Lucy Cannon, Legal Officer, HCCC
Appearance for Dr Michael Francis Ward:	Mr Patrick Rooney, instructed by Mr Tony Mineo, solicitor, Avant Mutual Group
Date of decision:	13 September 2017
Decision	The Committee made findings of unsatisfactory professional conduct and determined to reprimand Dr Ward and impose the conditions on his registration and educative orders set out in paragraph 63 below.
Publication of decision:	Refer to page 17 of this decision for details of non-publication directions

1. On 8 and 9 January 2015, Patient A, a 42 year old man, attended the Emergency Department of Mudgee Hospital complaining of shortness of breath and an ongoing persistent headache. On both occasions, he was discharged after treatment. On 10 January, Patient A attended his General Practitioner (GP) who ordered further investigations and prescribed ventolin.
2. On 11 January, when Patient A again attended the Emergency Department he was seen by Dr Ward who was working there as a weekend GP locum. Patient A was triaged by Registered Nurse (RN) Kristy Rodgers and was discharged not long after being seen by Dr Ward.
3. On the next day, 12 January, Patient A was taken to the Emergency Department, where he suffered a respiratory collapse and, as a result, a severe hypoxic brain injury. He was transferred to Orange Hospital where he spent six weeks, including three weeks in a coma. Patient A now requires 24 hour care and resides in an aged care facility.
4. The Health Care Complaints Commission (HCCC) instigated an investigation into Dr Ward's conduct in this matter following a complaint from Patient A's mother. As a result of its investigation, on 16 December 2016, the HCCC lodged complaints with the Medical Council of NSW alleging that Dr Ward was guilty of unsatisfactory professional conduct. Such complaints require an inquiry by a Professional Standards Committee.
5. Having examined the evidence, the Committee found that Dr Ward's conduct constituted unsatisfactory professional conduct and made orders for the protection of the health and the safety of the public.

## **BACKGROUND**

6. Dr Ward graduated with the degrees of BSc from the University of Queensland in 1985 and BMed from the University of Newcastle in 1995. He became a Fellow of the Royal Australian College of General Practitioners in 2000. Dr Ward also has postgraduate qualifications in behavioural science from La Trobe University (1998), and in healthcare management from George Washington University (2009) and Harvard University (2011). He has worked in Australia, the United States and the United Kingdom.
7. In 2013, Dr Ward commenced working as a GP in Melbourne, while also working as a weekend GP locum for NSW Health. It was in the latter capacity that he was working at Mudgee Hospital on 11 January 2015. The Emergency Department at Mudgee Hospital has five beds. The doctors' and nurses' station is in close proximity to the beds, which can be clearly seen by medical and nursing staff from the station.
8. When Patient A presented at the Emergency Department on 8 January 2015 at 21.02, RN Rodgers recorded in the progress notes that he was suffering from shortness of breath and persistent headache (after hitting his head on a bathroom

door) and was “quite distressed and tachypnoeic”. He was seen by Dr Peter Bryant who prescribed Klacid for Patient A’s chest infection and nurofen for his headache, and discharged him with a letter for his GP at Mudgee Medical Centre proposing that Patient A should have a CT brain scan and a further review at the Medical Centre. Dr Bryant noted that Patient A was hypertensive and his ECG showed left ventricular hypertrophy and, therefore, suggested consideration of referral for an echocardiogram.

9. Patient A presented again at the Emergency Department at 04.48 next morning, 9 January, when he was seen by RN Amanda Lynch. She noted that he complained again of shortness of breath and persistent headache, and was again tachypnoeic (24 breaths/minute) and hypertensive, with BP 182/113 mmHg. She treated Patient A with panadeine, and noted that his tachypnoea settled rapidly. Dr William Monkhouse saw Patient A at 08.22 hrs, noted that Patient A was still suffering a headache despite taking paracetamol, and that he reported being short of breath, although on examination his chest was clear. Dr Monkhouse recorded treatment as being simple analgesia plus a CT scan of the head as an outpatient, as planned by Dr Bryant.
10. On 11 January, Patient A presented at the Emergency Department at 15.50 complaining of shortness of breath and intermittent chest pain. He was triaged by RN Rodgers who noted that he was “quite anxious and tachypnoeic on presentation”. Nurse Rodgers conducted an ECG, the results of which were similar to those of the ECG on 8 January. RN Rodgers’ evidence is that in accordance with her usual practice, she believes that on presenting the patient to Dr Ward (who was the weekend GP locum), she would have given him the record of the ECG – “placing it under his nose”, although she has no specific recollection of doing so. Having reviewed Patient A, Dr Ward diagnosed bronchitis, and added a short course of prednisolone to his existing treatment, noting that a chest x-ray and multiple blood tests had been scheduled for the next day (a Monday) with review by his GP the following day (a Tuesday). Dr Ward noted that Patient A was again hypertensive, and advised in his notes that he could be discharged “if ob improves”. Patient A was subsequently discharged by Registered Midwife (RM) Alison Hearne at 17.04. He was not provided with a letter of discharge.
11. On 12 January at 18.00, Patient A’s friend brought him to the Emergency Department in severe respiratory distress. During treatment and resuscitation, he suffered a cardiac arrest from which he was resuscitated, and subsequently transferred by a retrieval team to Orange Base Hospital.
12. On 4 March 2015, the HCCC received a written complaint from Patient A’s mother about his treatment and instigated an investigation. The HCCC notified Dr Ward of its investigation by letter dated 22 May 2015 and invited Dr Ward to respond, which he did on 16 June 2015. The HCCC subsequently wrote to Dr Ward on a number of occasions seeking further information, to which he duly responded.

13. In the course of its investigation, the HCCC obtained an expert report, dated 12 May 2016, together with a supplementary report dated 27 June 2016, from Dr Jeannie Ellis, a Fellow of the Australian College of Rural and Remote Medicine with training and experience in emergency medicine. Dr Ellis concluded that Dr Ward's conduct was significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.
14. On 16 December 2016, the HCCC lodged two complaints with the Medical Council of NSW. The first complaint alleges that Dr Ward is guilty of unsatisfactory professional conduct as defined in s 139B(1)(a) of *the Health Practitioner Regulation National Law (NSW)* (the National Law) in that he:

“engaged in conduct ‘that demonstrates the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of the practitioner’s profession is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience’”.
15. The second complaint alleges that Dr Ward is guilty of unsatisfactory professional conduct pursuant to s 139(1)(b) of the National Law in that he contravened a provision of the *Health Practitioner Regulation (NSW) Regulation 2010* (now repealed) (the Regulation) by failing to keep adequate medical records in accordance with Schedule 2 of the Regulation.

The relevant provisions of the National Law and the 2010 Regulation are set out in **Attachment 1**.

16. In reaching our decision, the Committee had regard to oral evidence given in person by Dr Ward and Dr Jeannie Ellis (the HCCC's expert witness), and by telephone by Dr William Monkhouse, RN Kristy Rodgers, and Dr Vincent Roche (Dr Ward's expert witness). The Committee also had regard to the documents produced by the parties. We applied the standard of proof of reasonable satisfaction and in doing so we were mindful of the gravity of the allegations and the consequences for Dr Ward if we find them proven.

## **ISSUES**

17. The two complaints, both relating to Patient A, are set out in full at **Attachment 2**.
18. We consider the particulars or details of the two complaints below and state our findings in relation to each based on the evidence before us and having heard submissions on the evidence from the parties. However, before considering the particulars, it is useful to briefly summarise Dr Ward's evidence.

### **Dr Ward's Evidence**

19. Dr Ward gave evidence that he has a clear recollection of treating Patient A who had presented at the Emergency Department at about 4.00pm on 11 January 2015 and

been triaged by Nurse Rodgers. She gave Dr Ward a verbal presentation of the patient, noting his recent history in the Emergency Department and that he had been cleared of cardiac issues on previous presentations. Dr Ward acknowledged having no specific recollection of whether Nurse Rodgers brought the ECG she had taken to his attention, although he thought her verbal presentation would have included mention of the ECG. His usual practice is to review all past ECGs, which would have included here that of 8 January 2015, and all previous notes on the system, although he would not necessarily have recorded this. He said that if he had seen the ECG of 11 January in isolation, he would have ordered a troponin test.

20. Dr Ward said he took a history from Patient A and made a clinical examination. In a letter to the HCCC dated 8 September 2015, Dr Ward said Patient A's "general demeanour was noted, in particular that he was comfortable at rest, was of good colour, was not short of breath at the time, and spoke in full sentences". Dr Ward recalled that Patient A was sitting in the middle bed in the Emergency Department, Bed 4. Dr Ward asked him whether he had chest pain, to which he replied "No". Had he said 'Yes", Dr Ward said he would have immediately put him on the 'Chest Pain Pathway'. Dr Ward examined the patient's chest and checked his vital signs, and learned that he was to have further investigations the next day arranged by his GP. He noted that Dr Bryant, in his discharge letter for Patient A on 8 January, had made no mention of chest pain. In cross-examination, Dr Ward said he did not recall Nurse Rodgers telling him that the patient had intermittent chest pain. She presented him as suffering from shortness of breath. (The Committee notes that RN Rodgers' notes on the Electronic Medical Record Information System (EMR system) appear to have been entered after her verbal presentation to Dr Ward and three minutes after Dr Ward entered his own notes on the EMR system.)
21. Dr Ward said Patient A was having asthma-like episodes and still suffering from shortness of breath while taking ventolin. The patient having denied chest pain, shortness of breath became Dr Ward's focus. Dr Ward said the patient he saw was stable and he did not consider that a chest x-ray was required that (weekend) afternoon. He diagnosed bronchitis and prescribed prednisolone, which he said generally works well and quickly, but he did not exclude the possibility of other diagnoses. He said he does not recall Patient A advising him of a productive cough but this was mentioned in Dr Bryant's notes from 8 January. He considered it was reasonable for Patient A to be managed as an outpatient and expressed some diffidence about being thought to interfere with a local GP's management of his patient in such a country area. Dr Ward said he took comfort from the fact that the patient, who was from out of town, was, that night, staying close by and would be seeing his GP for further investigation and review.
22. Dr Ward said that after seeing Patient A, he made his own notes on the EMR system. He would have told the nurses that Patient A could be discharged once his blood pressure and other vital signs had settled. Patient A's vital signs were recorded on the system. Dr Ward acknowledged that he did not personally discharge Patient A nor issue him with a discharge letter, which he agreed would have been best practice and had been his usual practice in the past. He had been having problems

composing discharge summaries on the EMR system, and it was only some months later that another GP showed him how to generate a discharge summary using the system. Dr Ward also said it appeared the system had failed to record further notes he believes he had sought to enter into the system about Patient A. He referred to the experience of Dr Elizabeth Kennedy, GP Anaesthetist at Mudgee Hospital, who had been called in to assist in Patient A's treatment on 12 January 2015 at the time of his respiratory collapse. In the Progress Notes for Patient A, Dr Kennedy referred to notes she had "written last night however no evidence of them on the system". Dr Kennedy therefore entered further notes to record the treatment she had undertaken.

23. The Committee noted that Patient A had been in the Emergency Department on 11 January for about one hour and 15 minutes from the time of presentation to discharge. Dr Ward said the Department was very busy that day and acknowledged that his assessment of Patient A had been quick. (The Committee estimated that he had spent not more than about 10-12 minutes with the patient.)
24. Dr Ward was asked about whether his practice had changed arising out of his experience in this matter. Firstly, he expressed his deep regret about the outcome for Patient A and his condolences for Patient A and his family. He said he has learned a lot from this matter and his practice of medicine has changed significantly. He now thinks more broadly about patients, would admit a patient more readily, has taken steps to be more of a team player, and has sought to address the shortcomings in his record keeping. He has also presented this case anonymously to a group of GPs in London, and has consulted with other GPs on how he should have approached this case.

### **Submissions on the Facts**

25. Mr Maybury, for the HCCC, submitted that the Committee should accept Nurse Rodgers' evidence that she brought the ECG to the attention of Dr Ward and that she would have told him, as recorded in her notes, that Patient A was experiencing intermittent chest pain. Mr Maybury noted that on each of Patient A's presentations to the Emergency Department, although not all his reported symptoms were consistent, he was experiencing hypertension and shortness of breath. Dr Ward was aware of Patient A's recent prior presentations and was responsible for making an independent assessment and determining appropriate treatment. Nurse Rodgers' account of the patient's intermittent chest pain should have been sufficient to trigger a focus on this. The fact of the patient not reporting a productive cough on this third presentation should have indicated that a diagnosis of bronchitis was not supported by the evidence.
26. Mr Maybury submitted that Dr Ward's Progress Notes for Patient A were clearly inadequate, as both expert witnesses recognised. The fact of Dr Ward not providing a discharge letter for the patient was of particular concern given that Patient A's GP needed to know what had happened at the patient's most recent presentation at the Emergency Department.

27. Mr Rooney, for Dr Ward, disputed that there was a history of chest pain. He noted Dr Ward's evidence that in answer to his questioning Patient A about whether he was suffering chest pain, he had answered 'No'. This was the reason for Dr Ward focusing on respiratory issues. Dr Ward excluded cardiac issues and, therefore, the NSW Chest Pathway (see below) was not triggered.

### **Particulars of Complaint One**

*1. On 11 January 2015, the practitioner relied on the verbal advice of a member of nursing staff, RN K Rodgers, that Patient A had been "cleared" by his previous attending doctors from a cardiology point of view.*

28. Dr Ward agreed that Nurse Rodgers, having triaged Patient A, gave Dr Ward a verbal presentation of the patient noting his recent history in the Emergency Department and that he had been cleared of cardiac issues on previous presentations. The Committee notes Dr Ellis's opinion that it was reckless to simply accept oral advice from nursing staff. However, we accept Dr Ward's evidence that he made his own independent assessment, noting that when, in answer to a question from Dr Ward, Patient A denied having chest pain, Dr Ward's attention became focused on the patient's shortness of breath and its treatment. We agree with Dr Ellis, with whom Dr Roche agreed on this point, that "[i]t is a red flag that this man has presented for a fourth time in 4 days to a health care facility", and that this should have alerted Dr Ward to the need for him to be more diligent in his assessment and admit Patient A (at least as an Emergency Department Short Stay admission) in order to undertake a more thorough assessment. As noted below, Dr Ward's Progress Notes were also grossly inadequate. These matters contributed to our general impression that Dr Ward's conduct was significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience, as discussed below.

*2. The practitioner failed to verify Patient A's cardiac status by checking for the patient's notes, conducting an ECG, ordering tests for serial troponins and a chest X-ray, and asking the patient who saw him in the Emergency Department on his previous presentation and obtaining the notes from the GP rooms.*

29. The events in question took place over two and a half years ago and Dr Ward had no specific recollection of whether or not Nurse Rodgers brought the ECG that she had taken to his attention. He said his usual practice is to review all past ECGs, but he did not initial the ECG in this case and made no mention of it or the previous one in his notes on the EMR system. There is no evidence as to whether he reviewed the patient's past Progress Notes. Dr Ward did not order a troponin test – he was focused on the patient's respiratory problems – but noted that a chest x-ray had been arranged for the next day (a Monday). In the particular circumstances, the Committee agreed with Dr Roche that it was not reasonable to criticise Dr Ward for not obtaining the patient's notes from his GP's practice. However, we were critical of his lack of documentation: his failure to document the steps he took in reviewing the patient's history and what conclusions, if any, he drew from such a review. Without such

documentation, it is difficult to assess Dr Ward's conduct beyond finding no evidence as to whether he checked the patient's Progress Notes or whether he asked the patient about his previous presentations to the Emergency Department.

*3. On 11 January 2015, the practitioner failed to take an adequate history in relation to Patient A, including details of his two prior presentations to the ED, and his presentation to his GP.*

30. The evidence of Patient A's Progress Notes indicates that Dr Ward did not take an adequate history, especially given that this was Patient A's third presentation to the Emergency Department within a few days. Had Dr Ward done so, he would have been better placed to explore a differential diagnosis.

*4. On 11 January 2015, the practitioner failed to conduct an adequate clinical assessment of Patient A and to make adequate investigations of Patient A, given his history and presentation in that he did not:*

- a. undertake a detailed physical examination;*
- b. order an ECG be taken;*
- c. admit Patient A for a short stay admission for investigations including cardiac monitoring, a chest x-ray, and blood tests for serial troponins;*
- d. place the patient on the chest pain pathway in accordance with NSW Health Policy "Chest Pain Evaluation (NSW Chest Pathway)".*

31. While not recorded in Patient A's Progress Notes, Dr Ward states that he undertook a clinical examination of the patient. In his response to the HCCC dated 8 September 2015, Dr Ward said his examination included a respiratory and cardiac assessment, and that he noted the patient's general demeanour: that he was comfortable at rest, was of good colour, was not short of breath at the time, and spoke in full sentences. Dr Ward said he noted Patient A's vital signs including his blood pressure, pulse rate and respiration rate, and found his oxygen saturation to be satisfactory. No abnormalities were detected on auscultation of the lungs and heart and, in particular, the patient's "chest auscultation was noted to be normal ie without crackles or wheezes".

32. The Committee accepts that, on the balance of probabilities, Dr Ward did conduct an adequate, albeit brief, physical examination, although he did not adequately document it. He did not order an ECG - one had already been taken by Nurse Rodgers. Patient A was discharged about one hour and 15 minutes after first presenting at the Emergency Department, indicating that, given that this was the third presentation to the Emergency Department in a few days, his assessment was not as comprehensive as it should have been. Patient A was not admitted for cardiac monitoring, which Dr Ward did not consider was indicated, Dr Ward did not organize a blood test for serial troponins, and he did not order a chest x-ray, although a chest x-ray had already been organised by Patient A's GP for the following day. Dr Ward said he did not place Patient A on the NSW Chest Pathway because, in answer to a question, Patient A told him that he was not suffering from chest pain. The Committee notes Dr Roche's opinion that in the absence of relevant clinical signs, it

was reasonable to wait until the next day for the chest x-ray and, Patient A having denied chest pain, Dr Roche would not expect the NSW Chest Pathway to have been triggered.

*5. On 11 January 2015, the practitioner failed to personally review the ECG conducted by RN K Rodgers.*

33. As stated above, Dr Ward's evidence is that he has no specific recollection of Nurse Rodgers bringing the ECG she had taken to his attention, but her evidence indicates that it is likely that she did so and, assuming she did so, it is likely that Dr Ward would have reviewed it. Mr Rooney pointed to Dr Ward's evidence that if he did review the ECG, there were no acute issues and therefore no real concerns. Dr Roche said in evidence that had Dr Ward seen the ECG, it is possible that this might have triggered initiating the NSW Chest Pathway, although it appears Dr Ward was already focused on the patient's problem being respiratory in nature. The Committee agreed that the ECG was no different to the one taken on 8 January but that it certainly needed follow up.

*6. The practitioner's management plan of Patient A was that Patient A could be discharged with chest x-ray and follow up with his GP the following day if his observations improved. The plan was inadequate in that he:*

- a. failed to thoroughly review Patient A's previous presentations and his risk factors for cardiac disease and;*
- b. if a cardiac cause of chest pain and shortness of breath was not identified, to do a thorough search for other causes of such symptoms.*

34. The Committee is satisfied from the evidence that Dr Ward's plan for Patient A was inadequate and, therefore, that this particular is proven. This was the patient's third presentation to the Emergency Department within a few days and this should have alerted Dr Ward to the need for him to undertake a more thorough assessment, of other possible causes of Patient A's symptoms, including acute coronary syndrome, congestive cardiac failure and pulmonary embolism. Dr Ellis was also critical of Dr Ward's proposed management of the patient's bronchitis. Moreover, she and Dr Roche were critical of Dr Ward prescribing prednisolone for Patient A in the particular circumstances of this case.

*7. The practitioner's diagnosis lacked sufficient clinical justification in that his diagnosis was that Patient A was suffering from bronchitis. However cough is not mentioned in the triage on 11 January 2015, or in the practitioner's entry in the patient's clinical records.*

35. There is no mention of Patient A suffering from a cough in Nurse Rodgers' triage notes on 11 January 2015 nor in Dr Ward's notes on the EMR system. Dr Ward's diagnosis of bronchitis was the subject of criticism by both Dr Ellis and Dr Roche, the latter being "mildly critical". The Committee is satisfied from the evidence that Dr Ward's diagnosis of bronchitis lacked clinical justification - his notes on the diagnosis

are very brief and, in our view, inadequate - and he did not consider the possibility of there being a cardiac cause for the patient's shortness of breath.

*8. The practitioner failed to arrange for Patient A to be admitted to the hospital, in circumstances where this was the patient's third presentation to the hospital, and fourth presentation to a health facility, with shortness of breath, significantly raised blood pressure and chest pains.*

36. The Committee notes Dr Roche's opinion that "there should have been, at a minimum, a short stay admission for cardiac monitoring and serial troponins, a more thorough history taken and a more thorough physical examination taken, prior to the decision to discharge the patient". Dr Roche said in evidence that in the absence of chest pain, shortness of breath might still indicate cardiac problems. Dr Ellis was also critical of Dr Ward's failure to admit the patient in order to undertake further investigations. The Committee is satisfied from the evidence that this particular is proven. The history of Patient A's presentations to and treatment in the Emergency Department dictated the need on this third presentation for a more thorough investigation and assessment.

*9. The practitioner failed to conduct a further review of Patient A on 11 January 2015 after his initial assessment.*

37. The evidence indicates that Dr Ward did not undertake a further review of Patient A after his initial assessment and before the patient's discharge. This particular is proven. In the Committee's view, given that this was the patient's third presentation to the Emergency Department within a few days, Dr Ward should have personally undertaken a further review of the patient before deciding whether or not he could be discharged.

*10. The practitioner gave an inappropriate direction that Patient A could be discharged by nursing staff on 11 January 2015.*

38. Given the inadequacy of Dr Ward's assessment of Patient A, and the fact of this being the patient's third presentation to the Emergency Department within a few days, the Committee is satisfied that it was inappropriate for Dr Ward to direct that the patient could be discharged by the nursing staff, although we recognise that little might have been expected to change in the hour or so since Dr Ward's initial assessment. We reject Mr Rooney's submissions that it was sufficient here for Dr Ward to have set the parameters for the patient's discharge. The Committee notes that Patient A was discharged by Nurse Hearne, who entered her notes on the EMR system at 17.04. She stated Patient A's:

"BP remains elevated. MO aware and reassured pt. He has LMO appointment on Tuesday following pathology and x-ray on Monday.

Given spacer to use with ventolin. Advise [sic] and education given re use.

Given advice on calming himself, to sleep sitting up if necessary."

39. In her report, Dr Ellis stated “[t]he persistently elevated blood pressure was yet another red flag that Dr Ward failed to consider in his consultation with the patient”.

*11. The practitioner failed to provide Patient A with a discharge letter.*

40. Dr Ward acknowledged that he had failed to do so. He said he had had difficulty with composing discharge letters on the EMR system. He agreed that Patient A should have been issued with a discharge letter. The Committee notes a discharge letter was particularly important in this case given the patient’s recent history and the fact that he was scheduled to see his GP for review and follow up two days later, on Tuesday 13 January. The information contained in a discharge letter – for example, clinical signs, treatment regime initiated - would be of significant assistance to the patient’s GP in determining future treatment. Dr Roche noted that if Dr Ward had generated a discharge summary, he might have realised that some of his notes on the EMR system were inadequate or missing.

*12. The practitioner failed to give Patient A advice to re-present to the hospital should his condition deteriorate.*

41. There is no evidence that this advice was given to Patient A. Dr Ward stated that giving such advice to a patient is his standard practice. However, in this instance he did not discharge the patient. The Committee is satisfied that this particular is proven.

### **Particulars of Complaint Two**

1. *The practitioner failed to make adequate medical records in accordance with Schedule 2 of the Regulation in that the practitioner failed to:*
  - a. *record sufficient information relevant to his assessment and diagnosis of Patient A;*
  - b. *record sufficient information relevant to Patient A’s history or his examination of Patient A;*
  - c. *record sufficient information relevant to any review by the practitioner of Patient A’s ECG results;*

*in circumstances where this was the third presentation by Patient A to the ED within 4 days.*

42. Dr Ward states that it appears the EMR system may have failed to record further notes he believes he had entered on the system. There is, however, no evidence on the system to support this contention. Dr Ward referred to the experience of Dr Elizabeth Kennedy, GP Anaesthetist, who had been called to assist in Patient A’s treatment at the time of his respiratory collapse on 12 January. In notes entered on 13 January, Dr Kennedy referred to notes she said she had written the previous night of which there was no evidence on the system. Dr Roche acknowledged that in January 2015 there could have been problems with use of the FirstNet EMR system. Had Dr Ward conducted a further review of the patient before discharge and generated a discharge letter, he might have been alerted to the fact that any notes he believed he had entered had not been saved on the EMR system.

43. Dr Roche commented that “a four line record of this consultation is grossly inadequate to record history, examination, ECG results, assessment or diagnosis of this patient”. Dr Ellis is also “highly critical”. She said in evidence that if a patient is allowed to go home after a third presentation, this must be justified and well-documented.
44. The Committee found Dr Ward’s notes on the EMR system to be very brief and is satisfied that they fail to adequately record Dr Ward’s assessment of Patient A or provide sufficient information in support of his diagnosis. We do not accept Mr Rooney’s submission that there was sufficient detail in Dr Ward’s notes to assist a GP in taking over treatment of the patient.

**DOES DR WARD’S CONDUCT AMOUNT TO UNSATISFACTORY PROFESSIONAL CONDUCT?**

45. It is necessary for the relevant provisions of the National Law and their application to be briefly explained. Section 139B of the National Law states relevantly:

***Meaning of "unsatisfactory professional conduct" of registered health practitioner generally***

*(1) Unsatisfactory professional conduct of a registered medical practitioner includes each of the following:*

*(a) Conduct significantly below reasonable standard*

*Conduct that demonstrates that the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of practitioner’s profession is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.*

*(b) Contraventions of this Law or regulations*

*A contravention by the practitioner (whether by act or omission) of a provision of this Law, or the regulations under this Law or under the NSW regulations, whether or not the practitioner has been prosecuted for or convicted of an offence in respect of the contravention.*

46. The phrase "significantly below" is not defined in the National Law. However, in the Second Reading Speech when the National Law’s predecessor, the *Medical Practice Act 1992* (which contained a similar definition of unsatisfactory professional conduct), was introduced to Parliament, it was stated that:

*47. The first main purpose of the bill is to refocus the Health Care Complaints Commission (HCCC) on investigating serious complaints about health service providers. To achieve this, Commissioner Walker recommended that unsatisfactory professional conduct be redefined so that only significant instances involving lack of skill, judgment, or care will result in an investigation or disciplinary action. .... the reference to 'significant' in that context may refer to a single act or omission that demonstrates a practitioner's lack of skill, judgment or care, or it may refer to a pattern of conduct. In any individual case, that will depend on the seriousness of the*

*circumstances of the case.*

48. The word 'significant' has been described as meaning "not trivial, of importance, or substantial": *Re A Medical Practitioner and the Medical Practice Act* [40010 of 2007].
49. The HCCC bears the onus of establishing that Dr Ward is guilty of 'unsatisfactory professional conduct', the standard of proof required being the civil standard of reasonable satisfaction, subject to the requirement for the Committee to be 'comfortably satisfied' given the seriousness of the consequences for Dr Ward should the Committee make findings adverse to his professional standing: *Briginshaw v Briginshaw* (1938) 60 CLR 336.
50. As stated above, the Committee's general impression is that Dr Ward's treatment of Patient A was inadequate in circumstances where this was the patient's third presentation to the Emergency Department of Mudgee Hospital within a few days. Judging by Dr Ward's grossly inadequate Progress Notes about the patient, Dr Ward's history taking, clinical examination, assessment and overall treatment were significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience. We are 'comfortably satisfied' from the evidence and our findings that Dr Ward is guilty of unsatisfactory professional conduct pursuant to s 139B(1)(a) in so far as his conduct was *significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.*
51. Further, we are comfortably satisfied Dr Ward is guilty of unsatisfactory professional conduct pursuant to s 139B(1)(b) in so far as he breached the NSW Regulation – clause 7 and Schedule 2 of the *Health Practitioner Regulation National Law Regulation 2010* - by failing to meet the required standard for medical records.

#### **ARE ORDERS OR DIRECTIONS WARRANTED?**

52. Having found that Dr Ward is guilty of unsatisfactory professional conduct, the Committee must consider whether to exercise its powers under Part 8 Division 3 Subdivision 3 of the National Law and, in particular, whether to exercise its powers under s 146B(1). This states relevantly:

##### ***146B General powers to caution, reprimand, counsel etc [NSW]***

- (1) *A Committee may do one or more of the following in relation to a relevant health practitioner the subject of a complaint referred to it-*
  - (a) *caution or reprimand the practitioner;*
  - (b) *direct that the conditions, relating to the practitioner's practising of the practitioner's profession, it considers appropriate be imposed on the practitioner's registration;*
  - (c) *order that the practitioner seek and undergo medical or psychiatric treatment or counselling (including, but not limited to, psychological counselling);*

- (d) *order that the practitioner complete an educational course specified by the Committee;*
- (e) *order that the practitioner report on the practitioner's practice at the times, in the way and to the persons specified by the Committee;*
- (f) *order that the practitioner seek and take advice, in relation to the management of the practitioner's practice, from the persons specified by the Committee.*

53. Section 3A of the National Law states the objectives of the National Law as it applies in NSW:

*In the exercise of functions under a NSW provision, the protection of health and the safety of the public must be the paramount consideration.*

54. It is well-established that the role of the Committee in exercising its powers is protective of the public interest and not focused on punishment of the individual concerned, notwithstanding that orders made may be punitive in effect: *Lee v Health Care Complaints Commission* [2012] NSWCA 90, per Basten JA at [20].

55. During the course of the hearing, having heard the evidence and submissions from the parties on that evidence, the Committee informed the parties of its tentative findings and of the orders it was considering, and allowed an adjournment to enable them to formulate any further submissions with regard to how the Committee should exercise its powers. Counsel then addressed the Committee on those submissions.

### **Submissions**

56. Mr Maybury submitted that a reprimand is appropriate in the circumstances of this case. The case involves a complex patient and given what he described as Dr Ward's apparent lack of insight into the seriousness of the incident, Mr Maybury submitted that a condition should be imposed on Dr Ward's registration restricting him to group practice for at least several years.

57. Mr Maybury submitted that it is appropriate in view of the carry over of health record keeping into the general practice environment to order that Dr Ward undertake a Health Records online module and then be subjected to a follow up audit of his health records. Mr Maybury agreed with the Committee's tentative suggestion that requiring Dr Ward to undertake the Australian College of Emergency Medicine (ACEM) 'Certificate in Emergency Medicine' before again working as a Locum GP in an Emergency Department was appropriate.

58. Mr Rooney submitted that a caution was more appropriate than a reprimand in this case. Dr Ward is prepared to undertake the Health Records online module proposed by the HCCC and will agree to undertaking the ACEM Certificate before again working as a GP Locum in an Emergency Department. With regard to the audit of his medical record keeping after having completed the Health Records online module

proposed by the HCCC, Mr Rooney submitted that this was not necessary given Dr Ward's evidence that he has recently been audited against national benchmarks.

### **Consideration**

59. Given the seriousness of the outcome in this case and the Committee's findings as to the part played by Dr Ward, the Committee decided that a reprimand was more appropriate than a caution.
60. Although Dr Ward told the Committee that he has already taken steps to improve his medical record keeping, the Committee decided his undertaking the Health Records online module would be of benefit and assist him in improving his record keeping. Undertaking such a module does not require a major commitment of time. We decided not to impose a requirement that his records should be subject to an audit, noting that he is presently working in general practice and has been the subject of recent benchmarking, the results of which he produced for the Committee and appear satisfactory.
61. The Committee's principal concern is in relation to the possibility of Dr Ward again working as a GP Locum in Emergency Medicine. A GP Locum in Emergency Medicine should be considered a senior position. As stated above, the protection of health and the safety of the public is the paramount consideration in exercising our powers. In our view, to be confident that Dr Ward has the knowledge and skills to work in an Emergency Department and provide the treatment that the public can reasonably expect, he should undertake further training in emergency medicine to equip him with the relevant knowledge and skills. To this end, the Committee determined to impose a condition on his registration that before he again undertakes work as a GP Locum in Emergency Medicine, he should undertake and satisfactorily complete the ACEM Certificate in Emergency Medicine.
62. The Committee noted the character reference provided for Dr Ward by Dr Mohammad Umair Siddiqui dated 11 July 2017. The Committee is satisfied from hearing Dr Ward's evidence, and noting his cooperation with the HCCC's investigation, that he has a genuine desire to address the shortcomings identified in this inquiry. He presented as a sincere doctor committed to achieving the best results for his patients and, on a number of occasions during the hearing stated his sincere regret for the outcome for Patient A.

### **DETERMINATION AND ORDERS**

63. The Committee therefore determined to exercise its powers under s 146B of the National Law as follows:
  1. To reprimand Dr Ward.
  2. To impose the following conditions on his registration:
    - (a) To complete within 6 months of 13 September 2017 'MIPS Health Records online module' organised by Medical Indemnity Protection Society Limited. The practitioner must:

- (i) within 2 months of 13 September 2017 provide evidence to the Medical Council of NSW of his enrolment in the above-mentioned course;
  - (ii) within 2 months of completing the above-mentioned course, provide documentary evidence to the Council that he has satisfactorily completed the course;
  - (iii) bear responsibility for any costs incurred in meeting this condition.
  - (iv) In the event that 'MIPS Health Records online module' is unavailable, the practitioner must propose to the Council for approval a similar course to be undertaken in accordance with the requirements of this condition no later than 2 months from 13 September 2017.
- (b) The practitioner must obtain Medical Council of NSW approval prior to changing the nature or place of his practice to one involving practice in an Emergency Department, including as a locum General Practitioner.
- (c) (i) If approved to practise in an Emergency Department, the practitioner must, within 3 months of such approval, enrol in either:
- the Australasian College of Emergency Medicine's six month 'Certificate in Emergency Medicine', or
  - the Emergency Medicine component of training for the Fellowship of Australian College of Rural and Remote Medicine and provide evidence to the Medical Council of NSW of his enrolment in and satisfactory completion of one of the above courses.
- (ii) the practitioner must bear responsibility for any costs incurred in meeting this condition.
- (iii) In the event that the Australasian College of Emergency Medicine's six month 'Certificate in Emergency Medicine' becomes unavailable, and the practitioner prefers not to undertake the Emergency Medicine component of training for the Fellowship of Australian College of Rural and Remote Medicine, the practitioner must propose to the Council for approval a similar course to be undertaken in accordance with the requirements of this condition no later than 3 months from the Council's approval to practise in an Emergency Department.
- (iv) the practitioner must provide evidence to the Council of having satisfactorily completed one of the above courses before undertaking any work as the senior doctor in an Emergency Department.

## **APPEAL AND REVIEW RIGHTS**

64. Dr Ward has the right to appeal this decision to the NSW Civil and Administrative Tribunal. An appeal must be lodged with the Tribunal within 28 days of the date of these written reasons.

65. Dr Ward also has the right to seek a review by the Medical Council of NSW of the Committee's order to impose conditions. Should Dr Ward's principal place of practice be anywhere other than NSW at the time of seeking a review of conditions, Dr Ward may make an application for review to the National Board.

#### **NON-PUBLICATION ORDER**

65. The non-publication order made on 13 July 2017 in respect of Patient A continues so that the names and addresses of the person in this written statement of decision are not to be published.

#### **DISTRIBUTION OF DECISION**

66. We will provide a copy of this written statement of our decision to Dr Ward, the Commission, the National Board, the complainant Mrs Lola Williams (Imrie).

A handwritten signature in black ink, appearing to read 'R. Handley', with a stylized flourish at the end.

Robin Handley  
Chairperson

13 September 2017

## Attachment 1

### Health Practitioner Regulation National Law (NSW) No 86a

#### **Section 139B Meaning of “unsatisfactory professional conduct” of registered health practitioner generally [NSW]**

(1) **"Unsatisfactory professional conduct"** of a registered health practitioner includes each of the following-

- (a) Conduct that demonstrates the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of the practitioner's profession is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.
- (b) A contravention by the practitioner (whether by act or omission) of a provision of this Law, or the regulations under this Law or under the NSW regulations, whether or not the practitioner has been prosecuted for or convicted of an offence in respect of the contravention.
- (c) A contravention by the practitioner (whether by act or omission) of-
  - (i) a condition to which the practitioner's registration is subject; or
  - (ii) an undertaking given to a National Board.
- (d) A contravention by the practitioner (whether by act or omission) of a decision or order made by a Committee or the Tribunal in relation to the practitioner.
- (e) A contravention by the practitioner of section 34A(4) of the [Health Care Complaints Act 1993](#).
- (f) Accepting from a health service provider (or from another person on behalf of the health service provider) a benefit as inducement, consideration or reward for-
  - (i) referring another person to the health service provider; or
  - (ii) recommending another person use any health service provided by the health service provider or consult with the health service provider in relation to a health matter.
- (g) Accepting from a person who supplies a health product (or from another person on behalf of the supplier) a benefit as inducement, consideration or reward for recommending that another person use the health product, but does not include accepting a benefit that consists of ordinary retail conduct.
- (h) Offering or giving a person a benefit as inducement, consideration or reward for the person-
  - (i) referring another person to the registered health practitioner; or
  - (ii) recommending to another person that the person use a health service provided by the practitioner or consult the practitioner in relation to a health matter.
- (i) Referring a person to, or recommending that a person use or consult-
  - (i) another health service provider; or
  - (ii) a health service; or
  - (iii) a health product;if the practitioner has a pecuniary interest in giving that referral or recommendation, unless the practitioner discloses the nature of the interest to the person before or at the time of giving the referral or recommendation.
- (j) Engaging in overservicing.

(k) Permitting an assistant employed by the practitioner (in connection with the practitioner's professional practice) who is not a registered health practitioner to attend, treat or perform operations on patients in respect of matters requiring professional discretion or skill.

(l) Any other improper or unethical conduct relating to the practice or purported practice of the practitioner's profession.

(2) For the purposes of subsection (1)(i), a registered health practitioner has a "**pecuniary interest**" in giving a referral or recommendation-

(a) if the health service provider, or the supplier of the health product, to which the referral or recommendation relates is a public company and the practitioner holds 5% or more of the issued share capital of the company; or

(b) if the health service provider, or the supplier of the health product, to which the referral or recommendation relates is a private company and the practitioner has any interest in the company; or

(c) if the health service provider, or the supplier of the health product, to whom the referral or recommendation relates is a natural person who is a partner of the practitioner; or

(d) in any circumstances prescribed by the NSW regulations.

(3) For avoidance of doubt, a reference in this section to a referral or recommendation that is given to a person includes a referral or recommendation that is given to more than one person or to persons of a particular class.

(4) In this section-

"**benefit**" means money, property or anything else of value.

"**recommend**" a health product includes supply or prescribe the health product.

"**supply**" includes sell.

### **Section 146B General powers to caution, reprimand, counsel etc [NSW]**

(1) A Committee may do one or more of the following in relation to a relevant health practitioner the subject of a complaint referred to it-

(a) caution or reprimand the practitioner;

(b) direct that the conditions, relating to the practitioner's practising of the practitioner's profession, it considers appropriate be imposed on the practitioner's registration;

(c) order that the practitioner seek and undergo medical or psychiatric treatment or counselling (including, but not limited to, psychological counselling);

(d) order that the practitioner complete an educational course specified by the Committee;

(e) order that the practitioner report on the practitioner's practice at the times, in the way and to the persons specified by the Committee;

(f) order that the practitioner seek and take advice, in relation to the management of the practitioner's practice, from the persons specified by the Committee.

(2) If the relevant health practitioner is not registered, a direction may still be given under this section but has effect only so as to require the conditions concerned to be imposed when the health practitioner is registered.

(3) If a Committee acting under this section makes an order or directs that any

condition be imposed on a health practitioner's registration, the Committee may order that a contravention of the order or condition will result in the health practitioner's registration in the health profession being cancelled.

(4) The order or condition concerned is then a **"critical compliance order or condition"** .

**Health Practitioner Regulation (NSW) Regulation 2010** (in effect at the time the complaints were lodged; repealed with effect from 1 September 2016).

### **Clause 7 Records relating to patients**

(1) A medical practitioner or medical corporation must, in accordance with this Part and Schedule 2, make and keep a record, or ensure that a record is made and kept, for each patient of the medical practitioner or medical corporation.

(2) A contravention of subsection (1) by a medical practitioner does not constitute an offence but may constitute behaviour for which health, conduct or performance action may be taken.

(3) ...

(4) ...

### **Schedule 2, Clause 1 Information to be included in record**

(1) A record must contain sufficient information to identify the patient to whom it relates.

(2) A record must include the following:

(a) any information known to the medical practitioner who provides the medical treatment or other medical services to the patient that is relevant to the patient's diagnosis or treatment (for example, information concerning the patient's medical history, the results of any physical examination of the patient, information obtained concerning the patient's mental state, the results of any tests performed on the patient and information concerning allergies or other factors that may require special consideration when treating the patient),

(b) particulars of any clinical opinion reached by the medical practitioner,

(c) any plan of treatment for the patient,

(d) particulars of any medication prescribed for the patient.

(3) The record must include notes as to information or advice given to the patient in relation to any medical treatment proposed by the medical practitioner who is treating the patient.

(4) A record must include the following particulars of any medical treatment (including any medical or surgical procedure) that is given to or performed on the patient by the medical practitioner who is treating the patient:

(a) the date of the treatment,

(b) the nature of the treatment,

(c) the name of any person who gave or performed the treatment,

(d) the type of anaesthetic, if any, given to the patient,

(e) the tissues, if any, sent to pathology,

(f) the results or findings made in relation to the treatment.

(5) Any written consent given by a patient to medical treatment (including any medical or surgical procedure) proposed by the medical practitioner who treats the patient must be kept as part of the record relating to that patient.

## **Attachment 2**

### **COMPLAINT**

#### **HEALTH PRACTITIONER REGULATION NATIONAL LAW**

Executive Officer  
Medical Council of NSW  
Punt Road  
**GLADESVILLE NSW 2111**

The **Health Care Complaints Commission** of Level 13, 323 Castlereagh Street, Sydney NSW, having consulted with the **Medical Council of New South Wales** in accordance with sections 39(2) and 90B(3) of the *Health Care Complaints Act 1993* and section 145A of the *Health Practitioner Regulation National Law (NSW)* (“*the National Law*”)

#### **HEREBY COMPLAINS THAT**

**Dr Michael Ward** (“the practitioner”) of Suite 32, 199 Toorak Road, SOUTH YARRA VIC 3141 being a medical practitioner registered under the *National Law*,

#### **COMPLAINT ONE**

is guilty of unsatisfactory professional conduct under section 139B(1)(a) of the *National Law* in that the practitioner has:

- i. engaged in conduct that demonstrates the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of medicine is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.

Each of the particulars of this Complaint in itself justifies a finding of unsatisfactory professional conduct. In the alternative, when two or more of the particulars are taken together, a finding of unsatisfactory professional conduct is justified.

#### **BACKGROUND TO COMPLAINT ONE**

The practitioner was first registered as a medical practitioner in 1996. In 2000, the practitioner became a fellow of the Royal College of General Practitioners.

At all times relevant to the particulars of this Complaint, the practitioner was working as a locum medical officer at Mudgee Hospital (“the hospital”) in the Emergency Department, as an interstate weekend GP locum.

Patient A attended the Emergency Department (“ED”) on 8 January 2015, and presented with a 7 day history of headache after a head injury, and shortness of breath overnight. Patient A was prescribed an antibiotic, and was discharged with a follow-up for a brain scan and hypertension investigations.

On 9 January 2015, Patient A re-presented to the Emergency Department with shortness of breath and complaining of a persistent headache. He was discharged after settling.

On 10 January 2015, Patient A attended his GP who ordered investigations and prescribed Ventolin.

On 11 January 2015, Patient A re-presented to the Emergency Department. Patient A was triaged at 16:06 and discharged at 17:04.

## **PARTICULARS OF COMPLAINT ONE**

1. On 11 January 2015, the practitioner relied on the verbal advice of a member of nursing staff, RN K Rodgers, that Patient A had been “cleared” by his previous attending doctors from a cardiology point of view.
2. The practitioner failed to verify Patient A’s cardiac status by checking for the patient’s notes, conducting an ECG, ordering tests for serial troponins and a chest X-ray, and asking the patient who saw him in the Emergency Department on his previous presentation and obtaining the notes from the GP rooms.
3. On 11 January 2015, the practitioner failed to take an adequate history in relation to Patient A, including details of his two prior presentations to the ED, and his presentation to his GP.

4. On 11 January 2015, the practitioner failed to conduct an adequate clinical assessment of Patient A and to make adequate investigations of Patient A, given his history and presentation in that he did not:
  - a. undertake a detailed physical examination;
  - b. order an ECG be taken;
  - c. admit Patient A for a short stay admission for investigations including cardiac monitoring, a chest x-ray, and blood tests for serial troponins;
  - d. place the patient on the chest pain pathway in accordance with NSW Health Policy "Chest Pain Evaluation (NSW Chest Pathway)".
5. On 11 January 2015, the practitioner failed to personally review the ECG conducted by RN K Rodgers.
6. The practitioner's management plan of Patient A was that Patient A could be discharged with chest x-ray and follow up with his GP the following day if his observations improved. The plan was inadequate in that he:
  - a. failed to thoroughly review Patient A's previous presentations and his risk factors for cardiac disease and;
  - b. if a cardiac cause of chest pain and shortness of breath was not identified, to do a thorough search for other causes of such symptoms.
7. The practitioner's diagnosis lacked sufficient clinical justification in that his diagnosis was that Patient A was suffering from bronchitis. However cough is not mentioned in the triage on 11 January 2015, or in the practitioner's entry in the patient's clinical records.
8. The practitioner failed to arrange for Patient A to be admitted to the hospital, in circumstances where this was the patient's third presentation to the hospital, and fourth presentation to a health facility, with shortness of breath, significantly raised blood pressure and chest pains.
9. The practitioner failed to conduct a further review of Patient A on 11 January 2015 after his initial assessment.
10. The practitioner gave an inappropriate direction that Patient A could be discharged by nursing staff on 11 January 2015.

11. The practitioner failed to provide Patient A with a discharge letter.
12. The practitioner failed to give Patient A advice to re-present to the hospital should his condition deteriorate.

## **COMPLAINT TWO**

is guilty of unsatisfactory professional conduct under section 139B(1)(b) of the *National Law* in that the practitioner has contravened a provision of the *Health Practitioner Regulation (New South Wales) Regulation 2010 (repealed)* (the Regulation).

## **BACKGROUND TO COMPLAINT TWO**

As for Complaint One.

## **PARTICULARS OF COMPLAINT TWO**

1. The practitioner failed to make adequate medical records in accordance with Schedule 2 of the Regulation in that the practitioner failed to:
  - a. record sufficient information relevant to his assessment and diagnosis of Patient A;
  - b. record sufficient information relevant to Patient A's history or his examination of Patient A;
  - c. record sufficient information relevant to any review by the practitioner of Patient A's ECG results;

in circumstances where this was the third presentation by Patient A to the ED within 4 days.