

THE MEDICAL TRIBUNAL

Constituted by	Judge H.G. Murrell S.C. Dr Bruce Doust Emeritus Professor Walter Glover AO Dr Maureen Gleeson
Matter Number	40010 of 2005
Complainant	Health Care Complaints Commission
Respondent	Dr X
Counsel for the Complainant	Ms A Katzmann SC
Counsel for the Respondent	Mr T Molomby SC
Solicitor for the Complainant	Ms Karen Mobbs
Solicitor for the Respondent	Ms Sondra Riley
Hearing Dates	1 - 2 March 2006
Place of Hearing	Sydney
Judgment Date	2 March 2006
Place of Judgment	Sydney
Orders	Non Publication Order that the name and address of the patient and his brother not be published. Non Publication Order that the name and address of respondent not be published.

Statement and Reasons for Decision

1. In January 2003, G's family was devastated to learn that 28-year-old G had Burkitt's lymphoma involving the central nervous system, an aggressive cancer which carries a poor prognosis.
2. In the same month, Dr X commenced work as a radiology registrar at St. George Hospital. Dr X graduated from Sydney University in 19XX. Between 1999 and 2001, he worked as an intern, RMO1 and SRMO at Royal Prince Alfred Hospital. In 2002, he worked as an unaccredited radiology registrar at Sutherland Hospital. When he commenced employment at St George Hospital, he had no experience with chemotherapeutic drugs. Between January and 24 March 2003, there were eight occasions when Dr X was asked to perform a lumbar puncture and administer chemotherapeutic drugs intrathecally (i.e. into the cerebrospinal fluid). He was advised about wearing protective clothing, but received no other training.
3. On 17 January 2003, G was admitted to the Hospital to commence the McGrath Protocol, a chemotherapy regime, under Professor Manoharan of the Haematology Department. The regime involves several cycles of chemotherapeutic drugs. Different drugs are administered on different occasions. Because of G's size, when a chemotherapeutic drug required intrathecal injection, the injection was administered in the Radiology Department, where imaging could be used to guide the lumbar puncture. On four occasions prior to 24 March 2003, it was Dr X who placed G's lumbar puncture and administered his chemotherapeutic drugs.
4. On 24 March 2003, G was taken to the Radiology Department. Contrary to the usual practice, he was not accompanied by his

chemotherapeutic drugs. An orderly was sent to obtain the drugs. The orderly spoke to a nurse, who went to the refrigerator where the drugs were stored. The nurse located G's two medication charts and two sealed bags, each of which contained a drug-filled syringe. One syringe contained methotrexate, a drug which is administered intrathecally. The medication chart for the methotrexate stated that the administration route was intrathecal.

5. The second syringe contained vincristine, a drug which is administered intravenously and which, when administered intrathecally, is generally fatal. The medication chart for the vincristine stated that the administration route was intravenous. Affixed to the vincristine syringe was a label which said "Intravenous... Vincristine ...Avoid Extravasation FATAL IF GIVEN INTRATHECALLY". In the syringe bag was a second label, which included the notation "Avoid Extravasation FATAL IF GIVE ". Extravasation is the leakage of a chemotherapeutic drug from a blood vessel into the surrounding tissue.
6. The orderly took both syringe bags and the two medication charts to the Radiology Department. There was a change of nursing shift in the Radiology Department and a new nurse began to assist Dr X just before G's procedure commenced.
7. The Tribunal accepts Dr X's evidence that he looked at the medication chart and the syringe labels and checked the patient's name against the drugs (see also the nurse's first statement, Exhibit B2, tab 20, para7). Dr X knew almost nothing about methotrexate or vincristine.
8. Dr X failed to ascertain the correct administration route for each drug, either by reading the medication chart/syringe label or by consulting

an appropriate colleague. He assumed that each drug was to be administered intrathecally. Because, usually, only chemotherapeutic drugs designed for intrathecal administration were sent to the Radiology Department, because he appeared to be repeating a procedure with a patient whom he knew and, perhaps, because of his subordinate status within the hospital, he "went on autopilot". It is a common experience that, once an assumption is made, one sees only what one expects to see. Dr X's grave and elementary failure to ascertain the proper drug administration route for vincristine was to prove fatal for G.

9. Dr X administered both drugs intrathecally. After the procedure, he signed a procedure report, failing to note the "FATAL IF GIVE" sticker, which had been affixed before he signed the report.
10. Over the next three days, G experienced symptoms of neurotoxicity. The symptoms were attributed to other causes associated with the lymphoma from which G was suffering. It was not until 28 March 2003 that the error was discovered. There was an attempt to flush out the drug, which, predictably, proved futile.
11. On 21 April 2003, G died.
12. Tragically, the incident of 24 March 2003 was similar to an incident on 4 January 2001 at Nottingham in the United Kingdom. An inquiry into the Nottingham incident identified 13 prior cases where patients had died or been paralysed by maladministered spinal injection. In April 2001, the UK Department of Health published recommendations for the prevention of intrathecal medication errors.

13. St George Hospital responded to the March 2003 incident by introducing protocols which resemble the 2001 UK recommendations. Intrathecal medications to be given in the Radiology Department are brought from the oncology pharmacy by the oncology clinical nurse consultant (who has special training in the use of chemotherapeutic drugs), who liaises with the doctor administering the drug. Access to the chemotherapy storeroom has been restricted. Vincristine is now prepared in a syringe which is obviously too large for intrathecal administration, and is now accompanied by a large yellow warning sign cautioning "*For intravenous use only. Fatal if given by other routes. Do not remove preparation from the bag until immediately before administration.*" . When intrathecal chemotherapy is to be given in combination with intravenous cytotoxics, the intrathecal chemotherapy is dispensed after the intravenous chemotherapy has been administered. The Radiology Department Policy and Procedure Manual now includes a procedure for administration of intrathecal chemotherapy following lumbar puncture.
14. The Health Care Complaints Commission complains that Dr X was guilty of unsatisfactory professional conduct because he engaged in conducted demonstrating a lack of adequate knowledge, skill, judgement or care in the practice of medicine.
15. Dr X accepts that he was guilty of unsatisfactory professional conduct in that he failed to check the route of administration for vincristine, although it was indicated both on the medication chart and on the syringe label. He accepts that his failure to check the route was a failure to adhere to an elementary medical practice. He accepts that his fault is diminished neither by the associated faults of others nor by the systemic failures which undoubtedly existed.

16. It may be true that, as at the peer reviewer Dr Fabiny, observed, *"many radiologists in Dr X's position, given the circumstances, may have made the same error"*, but, as Dr X acknowledged, the purpose of multiple checking procedures is undermined if each check is not made independently. It is fundamental that a doctor ascertain the proper administration route before administering a drug.
17. The Tribunal is comfortably satisfied that Dr X was guilty of unsatisfactory professional conduct in that the conduct of failing to ascertain the correct administration route for vinristine demonstrated a lack of adequate knowledge, skill, judgement or care in the practice of medicine. The particulars of the complaint are established.
18. The complainant submitted that, when the error was revealed, Dr X was slow to admit fault, that he has shown inadequate contrition, and that he has not fully accepted responsibility for his conduct.
19. The Tribunal rejects those submissions. The capacity to express contrition varies between individuals. Factors such as personality and cultural background may affect the circumstances and way in which contrition is expressed. The references tendered by Dr X, particularly that of Dr Palmer, St George Hospital staff specialist in medical imaging, corroborate Dr X's evidence that he was concerned to apologise to the family and failed to do so only because he was advised against such a course. Dr Palmer stated that, as soon as the error was revealed, Dr X *"was distraught, immediately expressing his regret and wishing to apologise and grieve with those involved."* Having observed Dr X giving evidence and read his references, the Tribunal considers that he has accepted responsibility for his conduct. The Tribunal accepts that he is now fastidious in his attention to

proper procedure. The Tribunal is convinced that the conduct will not be repeated.

20. The Tribunal considers that the only available appropriate response to the conduct is a reprimand and orders which ensure that those responsible for Dr X's training during the remainder of his period as a registrar are aware of the conduct. By majority, the Tribunal has decided that it is not necessary that the Royal Australian and New Zealand College of Radiologists be made aware of Dr X's identity as there is no risk that the conduct will be repeated.
21. Although the complaint proceeded as a complaint of unsatisfactory professional conduct, rather than professional misconduct, and the complainant did not seek the suspension or deregistration of the doctor, the Tribunal considers that it was appropriate for the matter to be brought before it. The case raises matters of public interest. First, it is desirable that the profession be reminded of the need to adhere to elementary procedural principles. Second, the context of institutional systemic failure disorder in which the conduct occurred is a matter of public interest.
22. Finally, it was appropriate that the proceedings be held in a public forum because the individual and systemic faults which have been aired in the proceedings resulted in a man's death. The Tribunal acknowledges the grief of G's family, sympathises with the family and, hopes that these proceedings will bring some sense of closure to the family and that they will assist to prevent the future occurrence in Australia of such a tragic incident.

Orders

- 23.
1. The Tribunal reprimands Dr X for his unsatisfactory professional conduct in failing to ascertain the correct administration route for vincristine before he administered it to a patient on 24 March 2003.
 2. The Tribunal orders that, within 28 days, Dr X provide his current employer with a copy of this statement of decision (including the reasons).
 3. The Tribunal orders that, prior to commencing any employment as a radiology registrar with a different employer, Dr X provide that employer with a copy of this statement of decision (including the reasons).
 4. Respondent to pay the complainant's costs of the proceedings.

Request

24. The Tribunal requests that the Medical Board provide a copy of this statement of decision (including the reasons) to:
- The Chief Medical Officer for the Commonwealth
 - The Director, Department of Health, in each Australian state and territory
 - The Royal Australian and New Zealand College of Radiologists
 - The Royal Australian and New Zealand College of Physicians.
 - The Chief Executive Officer, South Eastern Area Health Service.

Deputy Chairperson
Judge H G Murrell SC

Member
Dr Bruce Doust

Member
Emeritus Professor Walter Glover AO

Member
Dr Maureen Gleeson