IN THE MEDICAL TRIBUNAL OF NEW SOUTH WALES

THE MEDICAL PRACTICE ACT 1992

No: 40031/05

DEPUTY CHAIRPERSON: His Honour Judge Keleman SC

MEMBERS: Dr S Renwick
Dr J Mair
Dr S Toh

HEARING DATES: 5 to 8 June 2006

DATE OF DECISION: 30 June 2006

IN THE MATTER OF

DR A

Pursuant to Clause 6 of Schedule 2 of the Medical Practice Act 1992 the Tribunal has ordered:

(i) that the name and address of the respondent and any other information that could identify him not be published; and
(ii) that the name and address of the patient, her daughter and daughter's husband not be published.

STATEMENT OF DECISION

Pursuant to the Medical Practice Act 1992 (the Act) the Tribunal has before it for inquiry a complaint made by the Health Care Complaints

Commission (HCCC) that Dr A, the respondent, has been guilty of unsatisfactory professional conduct within the meaning of section 36 of the Act.

Section 36 (as amended), in so far as is relevant to this inquiry, is defined as follows:

> "Any conduct that demonstrates that 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".

The specific complaint before the Tribunal is that the respondent, a medical practitioner registered under the Act, has been guilty of unsatisfactory professional conduct within the meaning of section 36 of the Act in that he has demonstrated that the judgment possessed, or care exercised, by him in the practice of medicine is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.

The complaint before the Tribunal differed from the original complaint made against the respondent by the HCCC. The original complaint also made a claim against the respondent of professional misconduct within the meaning of section 37 of the Act. However, at the commencement of

this inquiry the complainant made a number of amendments to the original complaint, for which leave was sought and granted, and which, inter alia, effectively withdrew the more serious claim of professional misconduct and also omitted a number of particulars of complaint.

The particulars of the amended complaint before the Tribunal are as follows:

PARTICULARS

Prior to 13 December 20XX, the respondent had seen Patient S in his rooms and had diagnosed cancer of the left breast. On 13 December 20XX, the respondent assisted Dr S in undertaking a right total mastectomy on Patient S. Prior to the performance of the right total mastectomy, the respondent:

1. Failed to correctly or clearly complete Patient S' consent form that the surgery for which Patient S (who was an elderly woman suffering dementia) should undergo, was for a left, not a right, mastectomy.
2. Failed to correctly or clearly complete the "Admission Request" form seeking the admission of Patient S to A Hospital.

3. Failed to have his personal medical records, including investigations concerning his diagnosis of Patient S, available in theatre prior to Patient S undergoing a right mastectomy.
4. Authorised the commencement of a right mastectomy on Patient S when there was no independent verification available that a right mastectomy was indicated (for example, no x-rays, ultrasounds, pathology results or surgeon's own records).
5. Failed to cause the proposed right mastectomy to be postponed until verification of the correct procedure was procured.
6. Caused a right mastectomy to be undertaken on Patient S at A Hospital when:
    - (a) there was no indication for same;
    - (b) Patient S' condition indicated only a left mastectomy; and
    - (c) neither Patient S nor the person responsible to authorise medical treatment on her behalf had given informed consent to a right mastectomy.

Following surgery on the right breast on 13 December 20XX, the respondent:

8. Failed to acknowledge in Patient S' hospital progress notes that the wrong breast had been excised.

Senior Counsel for the respondent, during the course of the inquiry, informed the Tribunal that the respondent:

(i) Admitted particulars 1, 2, 5 and 6 as to fact and further admitted that in combination those particulars supported the complaint of unsatisfactory professional conduct;

(ii) Admitted particulars 3 and 8 as to fact, but contended that each of those particulars, either individually or in combination with other particulars, did not amount to unsatisfactory professional conduct; and

(iii) Did not admit particular 4 as to fact or that such particular, even if established, either individually or in combination with other particulars, amounted to unsatisfactory professional conduct.

The onus of proving the complaint against the respondent (including the particulars of complaint) remains with the HCCC at all times. The standard of proof necessary is the civil standard, requiring comfortable satisfaction on the balance of probabilities, having regard to the seriousness of the allegation to be determined and the gravity of the consequences to the respondent should a finding be made that he had been guilty of unsatisfactory professional conduct (see **Briginshaw v Briginshaw** (1938) 60 CLR 336 at 360-363, **Bannister v Walton** (1993)

30 NSWLR 699 at 711-712 and **Lindsay v The Health Care Complaints Commission** [2005] NSWCA 356 at para 7).

The complaint before the Tribunal is concerned with the circumstances surrounding a right mastectomy performed in error at A Hospital on the 13 December 20XX upon a 78 year old woman suffering dementia, who had been admitted to the hospital for surgery following the discovery of a cancerous 2cm tumour in her left breast.

The relevant factual circumstances surrounding the performance of wrong side surgery on the patient on the 13 December 20XX are not in dispute and are, in any event, established to the satisfaction of the Tribunal from the evidence adduced on this inquiry.

At that time the patient, a 78 year old female, who was suffering from dementia, was residing as a patient in a nursing home. Her general practitioner, Dr W, found a lump in her left breast and as a consequence referred the patient for a bilateral mammogram and ultrasound, which were carried out on 21 November 20XX. The reporting radiologist indicated that, corresponding to the palpable lump, the examination revealed an irregular 14mm lesion lying at the 3 o'clock position 5cm

from the left nipple, which had the appearance of a primary breast malignancy.

On 25 November 20XX Dr W referred the patient to the respondent, a general surgeon. The respondent was and is still regarded as a highly skilled and competent surgeon. He was first registered as a medical practitioner in NSW in January 19XX after graduating with second class honours from Sydney University. In June 19XX, at his first attempt, he passed the final fellowship examination of the Royal Australasian College of Surgeons. In 19XX he was appointed Visiting Surgeon at A Hospital, B District Hospital and Q Private Hospital.

The respondent, following the referral from Dr W, saw the patient in his rooms on 27 November 20XX. The patient, who spoke Russian and limited English, was accompanied by her daughter, who not only acted as translator, but also physically assisted her mother, who walked with extreme difficulty. The respondent took a history, most of which was provided by her daughter, and examined the patient. On examination, he found a palpable 2cm lump in her left breast, which he diagrammatically indicated in his notes was located approximately in the 2 o'clock position some distance from the left nipple. He considered that clinically and mammographically the left breast lump to be highly suspicious of

malignancy. He advised the daughter that subject to confirmation of malignancy, there were two surgical treatment options for her mother, namely, a lumpectomy and radiotherapy or a mastectomy.

In accordance with his normal practice he discussed with the daughter the risks and complications of the two surgical treatments and drew illustrations. He also provided her with a manual published by the National Breast Cancer Centre to assist her to make an informed decision on behalf of her mother.

The respondent asked the daughter to telephone him on 4 December 20XX when the results of a fine needle aspiration biopsy (FNAB), which he would be ordering to confirm the malignancy, would be known and also to ascertain from her what treatment option she had chosen for her mother's operation. This first consultation lasted approximately one hour.

The fine needle aspiration biopsy was performed on 4 December 20XX and malignancy in the lump in the patient's left breast was confirmed. The resulting cytopathology reports were forwarded to the respondent.

The respondent’s normal practice is to see such patients at two separate consultations. The first consultation is to discuss the diagnosis, potential types of treatment and the risks involved. The second consultation is to answer the patient’s questions, organise the consent forms and arrange the patient’s hospitalisation.

The patient’s daughter, as arranged, telephoned the respondent on the evening of 4 December 20XX. The respondent told her that the FNAB results had confirmed malignancy. The daughter informed the respondent she opted for her mother to have a mastectomy, as she did not feel her mother would be able to cope with the rigours of the required radiotherapy after the lumpectomy.

To enable the patient to be admitted to A Hospital, it then became necessary for the respondent to complete sections of the A Hospital “Admission Request” form. This form, which also incorporated the patient consent form, required the surgeon, in this case the respondent, to provide appropriate information, including details of the procedure to be performed under “Patient Details” on page 2 of the 8 page document and also in the “Patient Consent” section at page 5.

The respondent gave evidence, which the Tribunal accepts, that it had been his invariable practice to complete this form in the presence of the patient and it was his protocol or routine to do that at his desk while consulting his clinical records. However on this occasion, due to the patient's mental and physical disabilities the respondent did not think it appropriate to ask the patient to return to his rooms for a second consultation. Due to the patient's dementia she was equivalent to a young child, not able to act on her own behalf or provide consent to any procedure. The daughter informed the respondent that she had her mother's power of attorney and therefore he suggested that she come to his surgery to pick up the admission request form. They made arrangements for that to be done the next day and then when the consent form was signed to deliver it to A Hospital.

On the following day, the respondent had started seeing patients shortly after 8am and it was a particularly busy morning session during which he saw a total of 22 patients and also planned to attend a multi-disciplinary "breast" meeting at midday at A Hospital. During the course of that busy morning the daughter's husband arrived at the respondent's rooms to collect the form on his wife's behalf. At this time the respondent's waiting room was full and he had been expecting the daughter to arrive not her husband. The respondent gave evidence, which the Tribunal

accepts, that he had not anticipated seeing the daughter's husband at that particular time of the morning, although he frankly conceded that there was nothing to stop him asking the daughter's husband to wait to enable him to comply with his usual protocol of completing the form while consulting his clinical records.

The respondent then filled in the admission request form at his receptionist's desk in between appointments, without consulting his clinical records, relying on his recollection of the side on which the procedure was to be performed, and as a consequence mistakenly recorded the procedure required as a right mastectomy (using the letter R as shorthand for "right") instead of "left mastectomy", under both the "Patient Details" section at page 2 of the admission request form and in the "Patient Consent" section at page 5. The daughter's husband was instructed that the form needed to be delivered to A Hospital so that the surgery could be scheduled for the coming weeks.

Arrangements were made for the patient's operation to be scheduled at A Hospital on Friday 13 December 20XX but contrary to normal practice the patient did not attend a pre-admission clinic at A Hospital, which is arranged by the hospital.

According to the evidence of the respondent, which the Tribunal accepts, the purpose of the pre-admission clinic is to ensure that the paperwork is done properly, that the patient is fit for surgery, and if not, to have an anaesthetic consultation, and also to verify the procedure to be carried out and to have some pre-admission tests carried out, such as a chest X-ray and other tests, ordered by the respondent on the patient's admission request form.

There is insufficient evidence before the Tribunal to enable it to determine the reasons for the patient not attending the pre-admission clinic.

On Thursday 12 December 20XX at about 5pm the patient was admitted to A Hospital, having been transferred from the nursing home. An entry made by an enrolled nurse in the patient's hospital progress notes records, inter alia, that the patient was admitted to the ward as a booked admission for a right mastectomy under the respondent, with chest X-ray, ECG and pathology tests to be performed. The entry also indicates that the patient, who "has dementia" was brought in by her daughter who remained in attendance.

The Tribunal accepts the evidence of the respondent that normally if the patient does not attend a pre-admission clinic he is advised by the clinic, which did not occur on this occasion in respect of the patient.

Additionally, contrary to normal hospital practice, the patient did not have a formal admission clerked by a resident medical officer (RMO).

The respondent has given evidence, which the Tribunal accepts, that a formal admission clerked by a RMO, involves the taking of a full history from the patient or if the patient is unable to do so from the patient's relatives, confirming the reason for their surgery and what the diagnosis is, and explaining the procedure to the patient.

Again there is insufficient evidence before the Tribunal to enable it to determine the reasons for the patient not having an admission clerked by a RMO.

Earlier that afternoon at about 3:13pm, some two hours before the patient was admitted, the nursing home in which the patient had been residing and from which the patient had been transferred to A Hospital, sent by facsimile to the A Hospital documents relating to the patient consisting of 5 pages, which included a patient transfer form that contained various

details of the patient and the written note “booked for surgery 13/12/XX LEFT MASTECTOMY”.

There is insufficient evidence to enable the Tribunal to find that those documents faxed from the nursing home on 12 December 20XX reached the file containing the patient’s hospital progress notes before the wrong surgical procedure was performed on her the following day. The Tribunal is also unable to determine on the limited evidence before it what happened to those documents within the hospital system from the time they were faxed to the hospital, until they eventually reached the patient’s file some time after the wrongful procedure was performed.

On the morning of 13 December 20XX the respondent had three operations scheduled at A Hospital. The patient’s operation was the third on his operating list. The patient was taken to the operating theatre during the morning. She was not accompanied by her daughter or other relative to the operating theatre and because of her dementia and poor English, the final pre-operative handover check between the ward nurse and operating theatre nurse did not occur. The Tribunal accepts the evidence of the respondent that that handover would generally involve the ward nurse identifying the patient to the operating theatre nurse and providing the patient’s date of birth and name, the procedure to be carried out, the

doctor performing the operation, the treating doctor and nature of the operation, and if the patient had been unable to communicate in English or rationally, the normal routine that was to be expected was that the patient would be accompanied to the operating theatre by a relative or person who could act on behalf of the patient.

There again is insufficient evidence before the Tribunal to enable it to determine the reasons for the patient not being escorted to the operating theatre from the ward by her daughter or other relative.

The first contact the respondent had with the patient on the day of the procedure was when he saw her in the anaesthetic bay, an annexe of the operating theatre. According to the respondent's evidence, which the Tribunal accepts, his normal procedure in the anaesthetic bay was to go through the patient's hospital file to ensure that the pre-operative tests were done and the consent form in the admission request form was signed, but not to make a thorough examination of all the file. The Tribunal also accepts the respondent's evidence that that is what he did on this occasion, and that it did not occur to him at the time that his reference to a right mastectomy in the consent form was a mistake. The respondent also did not have with him in the operating theatre, his own clinical records for the patient, as it was not his normal practice at the

time to do so. The Tribunal also accepts the respondent's evidence that he did not conduct a physical examination of the patient in the anaesthetic bay as she was considerably upset and he believed it would upset her too much, although he later agreed in cross-examination that he could have examined her after she was anaesthetised and before she was draped for surgery.

The Tribunal also accepts the evidence of the respondent that, contrary to hospital policy, the patient's medical records from the nursing home and her X-rays were not in the operating theatre. The Tribunal is satisfied from the evidence before it that the only documents and records in the operating theatre at that time comprised the patient's admission request form, which contained the two erroneous entries made by the respondent for a right mastectomy, the results of the tests he had ordered in the admission request form and the patient's hospital progress notes, which also contained the entry made on the patient's admission by an enrolled nurse for a right mastectomy, which no doubt occurred as a result of reference to the erroneous procedure that the respondent had written on the admission request form. The Tribunal is not satisfied on the evidence before it that any other documents or records relating to the patient were in the operating theatre at that time or later during the operation.

The Tribunal also accepts the evidence of the respondent that prior to the operation commencing on the patient he had wrongly assumed that the usual hospital protocols, namely, attendance at the pre-admission clinic, a formal admission clerked by a resident medical officer, and a formal handover from the ward nurse to the operating nurse in the presence of a relative, which are designed to avoid mistakes such as wrong side surgery, had been implemented, and that it was only after the surgery was performed and the mistake came to light that the respondent learned that these protocols had not been implemented in respect of the patient.

After the respondent saw the patient in the anaesthetic bay, it was his evidence, which the Tribunal accepts, that it was his normal procedure to scrub, don his surgical gown and apply surgical drapes to the patient, which he believes he did on this occasion.

The respondent himself did not carry out the surgery on the patient. He assisted a registrar, Dr B , who carried out the operation and who arrived in the operating theatre only after the patient had been draped.

It must be stressed from the outset that it has never been suggested by the complainant or the respondent that Dr B bears any responsibility for the wrong side surgery performed on the patient. The respondent, has always

accepted full responsibility for what occurred, frankly acknowledging, that he was the person who was responsible for the care of the patient and it was he who authorised Dr B to perform the surgery on the patient, which occurred under the respondent's supervision.

Dr B at the time was an experienced surgical registrar at A Hospital, however he was not the respondent's surgical registrar. He became involved in these events after he received a telephone call earlier that morning from Dr C , the respondent's surgical registrar, advising him that he was running late and requesting him to help the respondent perform his surgical list.

By the time Dr B arrived in the operating theatre, the patient was already under general anaesthetic and she was prepared and draped for a right mastectomy, with her right breast exposed. The respondent, who was scrubbed, asked Dr B if he wanted to do a mastectomy. Dr B answered in the affirmative. Dr B said in evidence that he did not look at the patient's notes as he assumed that as the respondent, a consultant, was present, it would have been checked by the consultant prior to the operation.

Dr B, who was gloved, examined the patient's exposed right breast, her left breast was covered by the drapes. His evidence, which the Tribunal accepts, is that while he did not find any obvious lump in her right breast he did find some lumpiness at 12 o'clock consistent with what he understood was the mass previously diagnosed as cancer. Dr B stated in evidence that he discussed this with the respondent and then the respondent also examined the patient's right breast. The respondent's evidence was that he had no recollection of examining the patient's breast but believed Dr B had done so, and that he had no recollection of any discussion with Dr B after Dr B examined the patient's right breast. While the Tribunal is able to find that in the operating theatre Dr B examined the patient's right breast and believed he found lumpiness, the Tribunal is not able to find that the respondent examined the patient's right breast in the operating theatre, nor is it able to determine the content of the discussion, if any, that Dr B said followed, having regard to the circumstances, that both Dr B and the respondent were giving evidence about what had occurred in the operating theatre some 2½ years ago, at a time when what was occurring was believed to be routine and not out of the ordinary, and that the respondent was unlikely to have then forgotten that when he saw the patient in his rooms on 27 November 20XX, some 2½ weeks before the operation, his examination revealed, not lumpiness, but the presence of a 2 cm lump, which is confirmed in

both his clinical records and in his report to the patients' general practitioner on 28 November 20XX.

The operation commenced at 11:20am. With the respondent assisting, Dr B performed a right total mastectomy on the patient. Following the operation the patient was transferred to recovery where she remained until 1:53pm when she was transferred back to the ward.

At about 2pm that afternoon at Q Private Hospital the respondent commenced his operating list consisting of 8 patients.

During the course of the afternoon the patient developed complications. Dr C, the respondent's registrar, was asked to examine the patient, as both Dr B and the respondent were in theatre. Following examination it was apparent to Dr C that the patient was bleeding excessively from the site of the right mastectomy and a drain appeared to be blocked. In order to manage the bleeding problem it was necessary for her to be returned to theatre to have the bleeding point identified and tied off. This further surgical procedure required a new consent to be signed. As Dr C was organising this consent with the patient's daughter, she mentioned to Dr C that she thought the cancer had been in her mother's left breast, although there was some uncertainty. DrC then immediately conveyed

the news of the complications and the daughter's comments to the respondent who was then in theatre at Q Private Hospital. At about 4pm Dr C informed Dr B of the daughter's comments. Dr B examined the patient and confirmed the complications observed by Dr C, which required her return to the operating theatre. Dr B also examined the patient's hospital progress notes to confirm the correct side for the mastectomy and observed that apart from the original admission request form identifying the procedure as being a right mastectomy, there were no documents or records from the nursing home, radiology or pathology that could confirm the correct side which would normally be with the patient's hospital progress notes. In order to obtain paperwork to confirm the correct side Dr B made a number of inquiries, including with the nursing home, which resulted in the nursing home faxing to A Hospital, just before 5pm, a copy of the respondent's report to the general practitioner dated 28 November 20XX and the radiology report for the patient's bilateral mammogram and ultrasound, which both identified the presence of a palpable lump in the patient's left breast.

Dr B then telephoned the respondent and advised him they had operated on the wrong breast and that the patient needed to go to the theatre for drainage and exploration of the operation wound site. The respondent

requested Dr B to contact the family and ask them to come to the hospital to meet him.

The respondent hurried to A Hospital as soon as he was able to finish what he was doing in theatre at Q Private Hospital. At about 6pm the respondent arrived at A Hospital, where, with the benefit of the further material faxed from the nursing home that afternoon, he realised that the error originated from the wrong descriptions of the required surgical procedure he had written on the admission request form, which incorporated the consent form. Around the same time the respondent met the patient's daughter and son-in-law and in the presence of Dr B and at least two operating theatre nurses the respondent who did not in any way endeavour to conceal anything, spoke frankly to the family and explained what had occurred, acknowledging that the mistake was his. He also told the family that he took full responsibility for the mistake, which he deeply regretted, and for which he sincerely apologised. The respondent also explained that it was necessary for the patient to be returned to theatre to deal with the complication from the earlier surgery and that if consent was given he would be prepared to operate on the correct breast at the same time to avoid the need for a third operation later. The respondent also told the family that if they wished he could arrange for another surgeon to take over the care of the patient and provide a second

opinion. The family, who were understanding and supportive of the respondent, responded by indicating that they had full confidence in him and did not want another surgeon involved. The patients' daughter provided further written consent for the surgical removal of her mother's left breast.

Very late on the working day of 13 December 20XX, a nurse manager at the hospital received a verbal report of the wrong side surgery performed on the patient, which included details of the error made by the respondent in the admission request form and the respondent's meeting with the family and their response.

Later on the evening of 13 December 20XX, the patient was returned to the operating theatre, where the respondent, assisted by Dr B, commencing at about 9pm, performed the further surgery, involving the wound exploration and left mastectomy. Fortunately there were no further post operative complications for the patient.

On 13 or 14 December 20XX the respondent contacted the patient's general practitioner, and advised him of the wrong side surgery performed on the patient and his subsequent meeting with her family. The respondent also informed him that he was distraught that such an

event had happened and that he accepted full responsibility for the event. The general practitioner, who knew the respondent professionally for many years, describing the respondent as a highly competent surgeon of the highest personal integrity, whose skill as a breast surgeon was recognised throughout the A B Area Health Service, stated that when the respondent contacted him on this occasion he noticed from the outset that the respondent, who was normally very calm and jocular, was extremely serious and distressed.

On Monday 16 December 20XX, formal steps were initiated within the hospital to conduct a review and inquiry into the cause of the wrong side surgery incident, with which the respondent fully co-operated.

The patient remained in A Hospital until 21 December 20XX when she was transferred back to the nursing home.

The respondent, who continued to oversee the patient's care while she remained in hospital making a full recovery, reviewed the patient in his rooms on two subsequent occasions on 21 July 20XX and 15 December 20XX. There were no signs of any occurrence of cancer anywhere in her body. On each of these two occasions the patient was accompanied by her daughter, who never expressed antagonism towards the respondent or

sought a referral to another surgeon and at all times was very sympathetic to his plight. The respondent did not see the patient after 15 December 20XX for a number of reasons. First, it became increasingly difficult for her to attend his rooms due to her physical and mental incapacity, and, secondly, the respondent had concerns about the appropriateness of continuing to see her as a consequence of his awareness of the interest in 20XX of the HCCC.

Following this unfortunate episode of wrong side surgery on 13 December 20XX the respondent has made several changes to his practice to ensure that an event of this type does not happen again.

Additionally, as a consequence of the wrong side surgery performed on the patient in this instance, the Royal Australasian College of Surgeons, the NSW Health Department and the Macarthur Health Service have all issued guidelines, procedures and/or policies to address wrong patient, wrong side and wrong site surgery.

When the respondent gave evidence before the Tribunal he admitted that in relation to his care of the patient he was guilty of unsatisfactory conduct and he agreed that his admission carried with it the concession that his conduct fell significantly below that which was expected of a

doctor of his experience or training. He explained that was so because of the mistake he made in making what he described as a typographical error with the consent form, resulting in the wrong operation being undertaken. He also added he should have been more scrupulous in his checking through the procedures. He also later agreed in cross-examination that in the case of treating patients with dementia or young children there was a need to take extra care. He also accepted in cross-examination that with the benefit of hindsight, given that the only information he had in the operating theatre that a right mastectomy was indicated was the admission request form, which incorporated the consent form containing his erroneous description of the procedure required, he should have, before proceeding with the operation, contacted his receptionist to ascertain what his notes contained, the patient's general practitioner, the nursing home, or the patient's daughter.

While the respondent admits he is guilty of unsatisfactory professional conduct arising from the combination of particulars 1, 2, 5 and 6 which he admits, he does not admit particular 4 as to fact, and while admitting particulars 3 and 8 as to fact, he contends that those particulars either individually or in combination with other particulars do not amount to unsatisfactory professional conduct.

The facts giving rise to particulars 1, 2, 3, 5, 6 and 8 of the complaint are not disputed. Having regard to the evidence adduced, including the respondent's admissions, the Tribunal is satisfied that the complainant has established each of those particulars.

In relation to particular 4, which is disputed as to fact, it is contended on behalf of the respondent that as there was a physical examination of the patient's right breast conducted by Dr B during which he detected lumpiness (as opposed to a lump) prior to the commencement of the removal of the right breast, the Tribunal could not be satisfied there was no independent verification available that a right mastectomy was indicated.

Particular 4 is that the respondent:

> "authorised the commencement of a right mastectomy on Patient S when there was no independent verification available that a right mastectomy was indicated (for example, no x-rays, ultrasounds, pathology results or surgeon's own records)."

The parties do not dispute that "verification" in the context in which it appears in particular 4 has its normal dictionary meaning, namely, the act

of ascertaining the truth or correctness of a situation, in this case, that a right mastectomy was indicated.

While the respondent gave evidence that the purpose of such a physical examination as that conducted by Dr B on the patient's right breast, was to verify the lump, it in fact did not do so in the present instance. The Tribunal is satisfied that, without verification from independent supporting evidence, from sources such as mammogram and ultrasound film or their reports, the surgeon's own clinical records for the patient, and/or other reports confirming the existence, nature and location of the cancer, particularly, histopathology reports or, as in this case, cytopathology reports (which were forwarded to the respondent following the fine needle aspiration biopsy he had ordered for the patient), the physical examination conducted by Dr B on the patient's right breast, detecting not a lump but lumpiness, could indicate at best nothing more than a possibility that the cancerous mass was in the patient's right breast, rather than the left breast.

Accordingly, the Tribunal is not satisfied that in the present instance the physical examination conducted by Dr B of the patient's right breast was capable of amounting to independent verification that a right mastectomy was indicated. As there was no other information available in the

operating theatre to the respondent at the time he authorised the commencement of the right mastectomy on the patient, other than the admission request form and hospital progress notes with the erroneous handwritten entries for a right mastectomy, the Tribunal is satisfied that the complainant has established particular 4.

While particulars 3 and 8 are not disputed as to fact, the respondent contends that those particulars either separately or in combination with other particulars do not amount to unsatisfactory profession conduct.

Particulars 3 and 8 are that the respondent:

> "3. Failed to have his personal medical records, including investigations concerning his diagnosis of Patient S, available in theatre prior to Patient S undergoing a right mastectomy."

> "8. Failed to acknowledge in Patient S' hospital progress notes that the wrong breast had been excised."

In relation to particular 3, and whether the conduct to which it relates amounts either separately or in combination with other particulars to unsatisfactory professional conduct, it is the respondent's evidence that, it was not his practice at the time to have his own clinical records for the

patient with him in the operating theatre. However, it should be noted that since the present event the respondent takes his patient clinical records into the operating theatre, as he believes it is a good safety check, and it is one of a number of changes the respondent has made to his practice to avoid such an event happening again.

The evidence relied upon by the complainant, to support its assertion that the failure of the respondent to take his own clinical records for the patient into the operating theatre amounts separately or in combination to unsatisfactory professional conduct, is contained in a peer review report from Dr W.K. Hunter, consultant surgeon, dated 4 January 2005, which was obtained on behalf of the complainant.

Dr Hunter had been asked by the complainant to comment specifically in response to a number of questions concerning aspects of the care provided by the respondent to the patient. However, before dealing with the particular evidence relied upon by the complainant it is appropriate in order to provide context for that evidence to refer to portions of the final part of his report, which are as follows:

> "**9. Do you have any other comments regarding (the respondent's) care and treatment of (the patient)?**
>
> (The respondent) made three very significant errors.

1. His typographical error when filling out the consent form and not going through the consent form with the patient's daughter at the time of signing.
2. Proceeding with the operation on the right side when he had not been able to confirm the consent form either by direct communication with the patient's daughter, or with his admitting registrar or resident, or not examining the patient. The only other alternative was to cancel the operation.
3. Not documenting in the notes his error.

Apart from these errors, I think (the respondent's) behaviour has been exemplary and his treatment both adequate and appropriate.

He acknowledged his mistake as soon as he discovered it, he discussed this with the relatives immediately, and he embarked upon an appropriate course of action for the benefit of his patient. He has also indicated that he has instituted measures in his own practice to prevent a repetition of this error.

I would also comment that there was a system error within the hospital in that the error on the consent form was not picked up on admission to the hospital by the nursing staff, that admission by a doctor apparently did not take place, and that the "handover" of a mentally incapable patient to the theatre staff should have involved the patient's daughter."

The evidence in relation to particular 3 relied upon by the complainant

from Dr Hunter's report is as follows:

"**4. Do you have any concerns about (the respondent's) participation in the surgery to undertake a right mastectomy:**

i. when his diagnosis and indications were for a left mastectomy and axillary dissection for left breast cancer?

ii. In the absence of the medical record from the nursing home and the hospital?

iii. In the absence of his own records, the mammograms and breast ultrasound records in the operating theatre?

I think I have answered this question in 3 above. I believe that there had to be some confirmation of the correct side to operate on either from (the respondent's) notes, or preferably from the mouth of the daughter who was present at the initial consultation."

Question 3 and his answer are as follows:

"**3. Regarding the first operation:**
Do you believe it was reasonable for (the respondent) to perform the operation when

i. Neither he nor another practitioner had done a final check to confirm details and the diagnosis with the patient or her relatives prior to operating?

ii. A final examination of the patient prior to operating had not been undertaken?

iii. In circumstances where the final handover check between the ward nurse and theatre nurse had not occurred because of (the patient's) dementia and poor English?

If (the respondent) had had his own notes present with him in theatre, then I don't believe it was essential for the admitting officers notes to be present. However, (the respondent) did not have his notes with him in theatre, and the only indication of which side should be operated on was the consent form. It was therefore prudent to confirm this either by consulting the admitting officers notes, speaking with the daughter, or examining the patient. It was reasonable for (the respondent) not to distress the patient who apparently objected to any examination, which makes it more important for the daughter to have been present at some point, to confirm the correct side.

Even a phone call to the daughter would have been prudent, and failing that being available, then an examination of the patient with the help of some sedation or after induction, would have been the

> correct course. The lump in the left breast apparently was palpable according to all the notes.
>
> I believe to proceed with the operation without some check as to the side warrants severe criticism, because the consent form is a powerful argument and was present, and that this severe criticism would attract a similar disapproval from the general body of our peers."

It is readily ascertainable that Dr Hunter in his report does not specifically deal with the issue of whether the failure by the respondent to have his clinical records for the patient with him in the operating theatre amounts to a departure from the standard reasonably expected of a practitioner of an equivalent level of training or experience.

The only evidence, which deals specifically with this issue, is contained in two peer review reports from Dr P. Creegan, a consultant surgeon, obtained on behalf of the respondent.

In his first report of 9th August 2004, Dr Creegan wrote that the complainant's conduct was exemplary but for three exceptions. One of those exceptions was what he described as:

> "Absence of (the respondent's) personal records to be available (to him) and his co-workers at the time of the operation".

In his second report of 20 February 2006, in respect of particular 3, Dr Creegan wrote:

> "My usual practice is to have my own notes available in the operating room in both public and private hospitals. This, however, is not a universal approach and different approaches are taken by different surgeons and in different hospitals. This frequently reflects the background and training of the individual surgeon and as such, if only to have notes available in the theatre, would not normally attract criticism or disapproval of the general body of (the respondent's) peers."

The complainant submits that in this regard there is inconsistency between the two reports of Dr Creegan. However the Tribunal is unable to accept that submission.

The Tribunal is satisfied that the effect of what Dr Creegan states on this issue is simply that while he would not describe as exemplary the respondent's conduct in not having his own clinical records relating to the patient available to him in the operating theatre, having regard to his knowledge that it was not a universal practice amongst surgeons to take their clinical records with them into the operating theatre, depending on their background and training, the subject conduct would not normally attract criticism or disapproval of the general body of the respondent's peers.

In all the circumstances, the Tribunal is not satisfied that the complainant has established from the evidence before the Tribunal that the respondent’s conduct in not having his own clinical records for the patient with him in the operating theatre fell significantly below the standard of judgment or care reasonably expected of a practitioner of an equivalent level of training or experience, whether considered separately or in combination with other particulars.

Accordingly, the complainant has failed to satisfy the Tribunal that particular 3, either separately or in combination with other particulars, establishes unsatisfactory professional conduct on the part of the respondent.

In relation to particular 8, that the respondent failed to acknowledge in the patient’s hospital progress notes that the wrong breast had been excised, the evidence before the Tribunal is that while the patient’s hospital progress notes refer to the various operative procedures carried out on the patient on 13 December 20XX , there is no reference in the notes to the right mastectomy being carried out in error or by mistake.

The respondent’s evidence was that while it would have been appropriate for him to make such an entry in the patient’s hospital progress notes, it

was the general duty and part of the training of the registrar or resident medical officer to document things in the patient's hospital progress notes and he had assumed and expected that when the error was first noted by his surgical registrar, at a time when he (the respondent) was in theatre at the Q Private Hospital, it would have been documented by either Dr C or Dr B . It was his evidence that the only time he would have written something in the notes would have been either in their absence or where he felt they may have incorrectly assumed or written things. It was also his evidence that at the time of the meeting with the family he felt incredibly stressed and devastated by the events, which had just occurred, and their priority had been to look after the family and do the best they possibly could for the patient in the circumstances.

The respondent gave evidence, which the Tribunal accepts, that he first learned in 20XX that there was no entry made in those notes about the error, following the involvement of the HCCC. The respondent agreed in cross-examination that in hindsight it was important for the sake of the hospital, the patient's care and his own sake to document what had occurred, although, as he stated earlier, he did not know that was his role.

The complainant contends the word "acknowledge" in particular 8 encompasses not only a failure by the respondent personally to make an

entry in the patient's hospital progress notes recording the error, but also a failure on his part to cause others to record the error in those notes. While the Tribunal has strong reservations that the meaning of "acknowledge" has the broad meaning for which the complainant contends, the Tribunal will proceed on the assumption that the complainant's contention is correct.

The complainant principally relies upon evidence from Dr Hunter's peer review report of 4 January 2005 to found its contention that the conduct, the subject of particular 8, amounts either separately or in combination to unsatisfactory professional conduct.

The evidence from Dr Hunter's report that is relied upon is as follows:

> "**5. Do you have any concern about (the respondent) not documenting any clinical notes that:**
>
> **i. the incorrect operation had been performed?**
> **ii. ….**
> **iii. ….**
>
> I believe (the respondent) behaved very appropriately and adequately by immediately acknowledging to the relatives that a mistake had been made and doing this in person. I am quite certain that the general body of our peers would approve of his behaviour once the mistake had been discovered and acknowledged.
>
> The fact that an incorrect operation had been performed should have been documented by either (the respondent), which would have been preferable, or by his registrar or resident, or by the nursing staff. The fact that this was not carried out was clearly inadequate and inappropriate and warrants a severe degree of

> criticism. I believe this criticism would be the opinion of the general body of our peers."

Dr Creegan states in his first peer review report of 9 August 2004 as follows:

> "1. I believe (the respondent's) care of (the patient) was exemplary, with three exceptions. These are:
> 1. A typographical error in which the symbol for the right side was used rather than the left side.
> 2. Absence of (the respondent's) personal records to be available to (him) and his co-workers at the time of operation.
> 3. The failure to document in the continuation notes that discussion had occurred with (the patient's) daughter regarding the discovery of the wrong site surgery, and the need for re-operation for the postoperative haematoma.
>
> 2. …..
> Whether this departure from standard would invoke disapproval is difficult to say. I believe there are a number of other problems which had compounded the mistake that (the respondent) originated with his Left/Right typographical mistake. I will refer to these below. On balance, I do not believe that the mistake as such would be such as to invite disapproval of a significant group of his peers.
>
> 3. …..
> Disapproval, if any, could only be adjudged as minor."

In his second peer review report of 20 February 2006, Dr Creegan in respect of particular 8, wrote as follows:

> "(The respondent) did not personally note in the patient's file that the incorrect side had been operated upon. However, it is abundantly clear from the rest of the notes, it is acknowledged in his letter to the general practitioner, and inevitably implied in the consent form for the second procedure, that this error had occurred. Whilst in small rural hospitals, without resident and registrar support, it would be normal practice for the admitting medical officer to make entries in the notes, this is not routine practice in

> large hospitals, and in particular where the surgeon is working with an advanced trainee and resident. Thus, there is no departure from an acceptable standard of care, no criticism would be directed to this point, and this would not attract the disapproval of the general body of (the respondent's) peers."

The complainant seeks to have the Tribunal disregard the evidence of Dr Creegan where it differs from Dr Hunter for a number of reasons. However, Dr Hunter does not specifically address in his report, either directly or indirectly, the fundamental issue of whether the standard reasonably expected of a practitioner of an equivalent level of training or experience to that of the respondent required the respondent to either personally record in the patient's hospital notes that the wrong breast had been removed or cause someone else to do it. Dr Hunter states, inter alia, that the incorrect operation "should have been documented by either (the respondent), which would have been preferable, or his registrar or resident, or by the nursing staff", and that "the fact this was not carried out was clearly inadequate and inappropriate and warrants a severe degree (of) criticism". However Dr Hunter most significantly does not state that the standard reasonably expected of a practitioner of an equivalent level of training or experience to that of the respondent created or gave rise to a duty or otherwise required the respondent to make that entry or ensure it was made by some other person.

Even if the Tribunal were inclined to reject the evidence of Dr Creegan, which it is not, there would be insufficient evidence based on what Dr Hunter states in his report for the Tribunal to find that the failure of the respondent personally to record in the patient's hospital notes that the wrong breast had been removed or to cause some other person to make such a recording, either separately or in combination with other particulars, amounted to a departure from the standard of judgment or care reasonably expected of a practitioner of an equivalent level of training or experience to that of the respondent.

In any event the Tribunal, despite the complainant's submissions to the contrary, accepts what Dr Creegan states in his second report in relation to particular 8, which, as it transpires, is largely consistent with the evidence of the respondent on this issue.

Accordingly the complainant, on the evidence before the Tribunal, has failed to satisfy the Tribunal that particular 8, either separately or in combination with other particulars, establishes unsatisfactory professional conduct on the part of the respondent.

There has been no final submission made on behalf of the respondent that if the Tribunal is satisfied particular 4 has been established, that it does

not amount, in combination with other particulars, to unsatisfactory professional conduct on the part of the respondent. That position is not surprising, as the ambit of the combined effect of particulars 5 and 6(a) and (b), which the respondent admits both as to fact and that in combination with other particulars amount to unsatisfactory professional conduct on the part of the respondent, largely subsume the terms of particular 4.

The Tribunal is satisfied that in combination the conduct which is the subject of particulars 1, 2, 4, 5 and 6 amounts to unsatisfactory professional conduct on the part of the respondent.

Accordingly, the Tribunal is satisfied that the complainant has proved that the respondent is guilty of unsatisfactory professional conduct.

It now becomes necessary for the Tribunal to determine what orders, if any, are appropriate following the finding that the respondent is guilty of unsatisfactory professional conduct.

In so far as is relevant the various powers open to the Tribunal following such a finding are contained in sections 61(1) and 62 of the Act. Section 62 deals with the power to fine and section 61(1) lists various

discretionary powers including, the power to caution or reprimand, and impose conditions on a practitioner's registration.

The complainant submits that the Tribunal should reprimand the respondent. The respondent on the other hand submits that in all the circumstances it would be appropriate for the Tribunal to make no order.

The complainant contends that following an amendment made to the definition of unsatisfactory professional conduct in s.36 of the Act, which amendment came into effect in March 2005, there is now no longer the discretion to make no order.

In **Health Care Complaints Commission v A Medical Practitioner** [2001] NSWCA 158 it was held that while s.61 did not expressly include the discretion to make no order, there was nevertheless such a discretion. The complainant contends that as a result of the amendment made to the definition of unsatisfactory professional conduct in s.36 of the Act in 2005 there is now no longer such a discretion as the amendment significantly "raised the bar" on the type of conduct that could amount to unsatisfactory professional conduct. Prior to the amendment unsatisfactory professional conduct was relevantly defined as:

> "Any conduct that demonstrates a lack of adequate knowledge, skill, judgment or care by the practitioner in the practice of medicine."

The complainant submits that as the present definition now requires that the subject conduct must significantly fall below the standard reasonably expected of a practitioner of an equivalent level of training or experience, there is no longer a discretion to make no order.

It is significant that when the legislature chose to amend the definition of unsatisfactory professional conduct in s. 36, it chose not to amend section 61 in any way. The powers available to the Tribunal pursuant to section 61 remain discretionary and while the forensic challenge to have the Tribunal make no order may be made more difficult by the amendment to section 36, the Tribunal holds that in an appropriate case the discretion to make no order still remains.

The jurisdiction of the Tribunal is protective in nature, not punitive (see, for example, **Health Care Complaints Commission v Litchfield** (1997) 41 NSWLR 630 at 637). In the exercise of its protective jurisdiction the Tribunal is required to take into account the maintenance of the standards of the medical profession, the maintenance of public confidence in the

medical profession and the protection of the community (**Gayed v Walton**, NSW CA, unreported, 31 July 1997 at page 6).

The unchallenged extensive character evidence relating to the respondent that comes from a wide range of medical practitioners and other health professionals, including many eminent medical practitioners, many of whom have known the respondent for a very long period of time, can only be described as of the highest quality and overwhelmingly compelling and favourable.

That character evidence demonstrates that the respondent is universally held in very high regard by health professionals and patients alike. He is regarded as an extremely competent, responsible, and caring surgeon. His reputation, in the district in which he has practised both as a surgeon and an individual has been described as "second to none". The qualities that have contributed to that reputation include a high level of surgical skill and professionalism, sound clinical judgment, high ethical and moral standards, dedication to his work and patients, and a high standard of mentoring and teaching of other health professionals. Not surprisingly the respondent has an extremely busy practice. Health professionals, including medical practitioners and nurses who know him, despite their knowledge of the present incident, would unhesitatingly continue to

entrust their health care and that of their family to him. Significantly the family of the patient involved in this incident, despite being told of the error, retained full confidence and trust in the respondent, demonstrated by their willingness to have the respondent perform the further necessary surgical procedures on the patient and entrusting the respondent with the patient's post-operative care and ongoing management.

The respondent is an active and constructive participant in the regular morbidity and mortality meetings in the Department of Surgery at A Hospital. He was also previously a long-standing and committed member of the Q Critical Care Committee, which reviewed and recommended action on reported adverse events.

From the outset the respondent not only accepted full responsibility for what occurred, but expressed his genuine remorse. He not only apologised immediately to the patient's family, but shortly after telephoned the patient's general practitioner, and informed him. The respondent has never tried to shift responsibility on to others or elsewhere. The Tribunal accepts that from the time the respondent learned of his error he has been devastated and remains so to the present day. Having had the benefit of observing the respondent give evidence before the Tribunal, it is abundantly apparent that the respondent remains

profoundly affected and disturbed by his conduct, which he rightly feels has resulted in harm to the patient. There is no doubt that he remains genuinely remorseful for his conduct, and as one of his character witnesses has stated, he has no harsher critic than himself.

The complainant accepts there is no likelihood of recurrence of such an event occurring in the future on the part of the respondent as a result of a number of changes the respondent has made to his practice immediately following this incident. These changes are designed to ensure, amongst other things, that the required procedure recorded on the admission request and consent forms is verified by him from the outset, that the consent form is signed in his presence by the patient, or if necessary, by the person responsible for the patient if the patient is not competent to give consent, and that prior to surgery commencing there is independent verification available in theatre and beforehand for the correct procedure from a number of independent sources, including his clinical records for the patient, X-rays, results of investigations and other records.

The evidence demonstrates that the present incident is an aberration on the part of the respondent in what can only be described as an otherwise exemplary career during which he has served the community well in over thirty years of surgical practice.

Wrong side surgery, as with wrong site and wrong patient surgery, is totally avoidable if proper care is taken. This unfortunate incident should never have occurred.

The cause of the removal from the patient of the wrong breast had its genesis in the errors the respondent made when he wrote the incorrect description of the required procedure on the admission request form and the consent form (which was incorporated into the admission request form), without consulting his clinical records for the patient, breaking his own protocol.

While the Tribunal is satisfied that there were a number of unexplained procedural failures within the system at A Hospital, which procedures if they had taken place may have detected and corrected the respondent's errors in the admission request form, the respondent, prior to the surgical procedure being carried out, knowing the patient suffered dementia and could not act on her own behalf, and wrongfully assuming that those hospital procedures had occurred, did nothing to independently verify that a right mastectomy was indicated and authorised the surgery to commence on the patient's wrong side, where the only records then available to him and upon which he relied in the operating theatre indicating that a right mastectomy was required was the admission

request form, containing his then undetected errors, which form he completed without consulting his clinical records for the patient, relying solely on his recollection.

Despite giving full weight to the respondent’s overwhelmingly compelling character evidence and other favourable subjective circumstances, the Tribunal is satisfied that in all the circumstances the unsatisfactory professional conduct established against the respondent demonstrates so grave a departure from the proper standards, that in order to maintain the standards of the medical profession and, particularly, public confidence in the medical profession, nothing less than a reprimand is required.

On the application of the complainant, the Tribunal recommends that the Medical Board pursuant to s.165(4) of the Act provides a copy of this statement of decision to the Chief Executive of the South West Sydney Area Health Service and the Chief Executive Officers of each of the Health Departments of the Commonwealth and each of the States and Territories, the Royal Australasian College of Surgeons and the Australian Medical Association.

As a result of the late amendment of the complaint by the HCCC and the resolution of the various matters in dispute, some of which were resolved in the respondent's favour, the parties have agreed in written submissions that the respondent should pay 70% of the complainant's costs of these proceedings.

The following orders are made:

1) The Tribunal reprimands the respondent;
2) The respondent is to pay 70% of the complainant's costs of these proceedings; and
3) Exhibits may be returned after 28 days.