MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

PO Box 24463, Manners Street, Wellington • New Zealand
13th Floor, Mid City Tower • 139-143 Willis Street, Wellington
Telephone (04) 802 4830 • Fax (04) 802 4831
E-mail mpdt@mpdt.org.nz
Website www.mpdt.org.nz

DECISION NO: 263/03/102D

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

IN THE MATTER of a charge laid by the Director of Proceedings pursuant to Section 102 of the Act against **ANDREW BRUCE SIMMONDS** medical practitioner of Lower Hutt

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Miss S M Moran (Chair)

Dr J C Cullen, Professor W Gillett, Dr A D Stewart,

Mrs H White (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Wellington on Thursday 7 and Friday 8 August 2003

APPEARANCES: Ms K P McDonald QC and Mr J Tamm for Director of Proceedings

Ms G Phipps for Dr A B Simmonds.

Introduction

1. Dr Simmonds is an orthopaedic surgeon practising from Lower Hutt. On 3 April 2003 the Director of Proceedings (the Director) laid a charge of professional misconduct against him.

The Charge

2. The charge alleged that while caring for his patient, Mrs Babington, Dr Simmonds acted in such a way that amounted to professional misconduct in one respect, in that on 3 November 1999, having failed to take adequate steps to ensure that the correct surgical site had been identified on Mrs Babington, he commenced surgery on the wrong site.

3. Dr Simmonds denied the charge.

4. The charge was heard in Wellington on 7 and 8 August 2003. Following the conclusion of the evidence and the submissions of counsel the Tribunal retired to consider its decision.

5. On 11 August 2003 the Tribunal issued a decision determining that Dr Simmonds was not guilty and dismissed the charge. Full reasons are now set out in this supplementary decision.

Witnesses for the Director of Proceedings

6. The Director of Proceedings called six witnesses.

(a) The complainant Shirley Ann Babington now resident in Australia.

(b) B of xx who is a theatre nurse and who was on day duty in the role of the circulating nurse at the relevant time on 3 November 1999.

(c) D who is a theatre nurse and who was on duty in another theatre at the relevant time on 3 November 1999.

(d) C a theatre nurse who was on duty in the role of the scrub nurse at the relevant time on 3 November 1999.

(e) A a theatre nurse who was on duty as the xx nurse at the relevant time on 3 November 1999 and whose evidence was given by affidavit.

(f) Professor James Geoffrey Horne, Professor of Surgery at the Wellington School of Medicine and practising as an orthopaedic surgeon. Professor Horne was called as an expert.

Witnesses for Dr Simmonds

7. Dr Simmonds gave evidence on his own behalf and called four witnesses:

(a) Professor Alan Forbes Merry a Professor of Anaesthesiology at Auckland University and practising as a specialist in anaesthesia and chronic pain. Professor Merry was called to give expert evidence about safety in health care which is his major research interest.

(b) Denis Raymond Atkinson, Orthopaedic Surgeon of Hastings (by affidavit).

(c) Christopher John Bossley, Orthopaedic Surgeon of Wellington (by affidavit).

(d) Peter David Tobin, Anaesthetist of Lower Hutt (by affidavit).

Expert Witnesses

8. The Tribunal was appreciative of the expert testimony provided by Professor Horne and Professor Merry.

9. Professor Merry's major research interest is safety in healthcare on which subject Dr Simmonds called him as an expert. Counsel for the Director of Proceedings objected to Professor Merry's evidence on the ground it was not relevant and on the ground that it

sought to provide opinion evidence which was essentially the province of the Tribunal. However, the Tribunal agreed to hear Professor Merry.

10. While the members of the Tribunal appreciated Professor Merry's attendance and found his evidence of interest in a general sense, we did not have regard to it in either our deliberations or in reaching our conclusion. It did not influence our thinking. In any event, portions of Professor Merry's evidence went no further than to make observations about human behaviour and what might motivate it. The members of the Tribunal do have some independent knowledge of such matters and the ability to make their own judgments and draw their own conclusions from the evidence.

Name Suppression Applications and Orders

11. The name suppression applications and orders made are dealt with later in this decision.

Onus of Proof

12. The onus of proof is borne by the Director of Proceedings.

Standard of Proof

13. As to the standard of proof, the Tribunal must be satisfied that the relevant facts are proved on the balance of probabilities. The standard of proof varies according to the gravity of the allegations and the level of the charge. If the charge against the practitioner is grave then the elements of the charge must be proved to a standard commensurate with the gravity of what is alleged.

14. The requisite standard of proof in medical disciplinary cases was considered by Jeffries J in *Ongley v Medical Council of New Zealand* (1984) 4 NZAR 369 in which the High Court adopted the following passage from the judgment in *Re Evatt: ex parte New South Wales Bar Association* (1967) 1 NSWLR 609:

> *"The onus of proof is upon the Association but is according to the civil onus. Hence proof in these proceedings of misconduct has only to be made upon a balance of probabilities; Rejfek v McElroy: [1966] ALR 270. Reference in the authorities to the clarity of the proof required*

> *where so serious a matter as the misconduct (as here alleged) of a member of the Bar is to be found, is an acknowledgement that the degree of satisfaction for which the civil standard of proof calls may vary according to the gravity of the fact to be proved".*

15. The same observations were made by a full bench of the High Court in *Gurusinghe v Medical Council of New Zealand* [1989] 1 NZLR 139 at 163 in which it was emphasised that the civil standard of proof must be tempered "having regard to the gravity of the allegations". This point was also made by Greig J in *M v Medical Council of New Zealand (No.2)* (unreported HC Wellington M239/87 11 October 1990):

> *"The onus and standard of proof is upon the [respondent] but on the basis of a balance of probabilities, not the criminal standard, but measured by and reflecting the seriousness of the charge".*

In *Cullen v The Medical Council of New Zealand* (unreported HC Auckland 68/95, 20 March 1996) Blanchard J adopted the directions given by the legal assessor of the Medical Practitioners Disciplinary Committee on the standard required in medical disciplinary fora.

> *"The MPDC's legal assessor, Mr Gendall, correctly described it in the directions which he gave the Committee:*
>
> > *"[The] standard of proof is the balance of probabilities. As I have told you on many occasions, … where there is a serious charge of professional misconduct you have got to be sure. The degree of certainty or sureness in your mind is higher according to the seriousness of the charge, and I would venture to suggest it is not simply a case of finding a fact to be more probable than not, you have got to be sure in your own mind, satisfied that the evidence establishes the facts."*

No Issues of Credibility

16. The Tribunal wishes to state at the outset that it was impressed by the honesty and integrity of all the witnesses. Where the Tribunal has rejected certain pieces of evidence or preferred the evidence of one or more witnesses over another, it is not to be taken as any adverse reflection on the witness or witnesses whose evidence has not been preferred. In some instances, a witness might be adamant about some piece of evidence yet have no

recollections or differing recollections about other aspects of the evidence. It is merely a reflection that by the time of the hearing, the events under scrutiny were almost four years old. Where there has been any confusion or uncertainty, the benefit of the doubt, as the law requires, has been given to Dr Simmonds.

Background Events and Evidence

17. In October 1999 Mrs Babington, then aged 67 years, attended her general practitioner, Dr Doddridge, regarding a painful right knee.

18. She was referred to Dr Simmonds whom she first consulted on 8 October 1999. He diagnosed a probable torn medial meniscus to her right knee.

19. After discussion between Mrs Babington and Dr Simmonds, it was agreed he would carry out an arthroscopy with resection of the degenerate medial meniscus tear.

20. During the course of the consultation, Mrs Babington told Dr Simmonds of pain she had been experiencing to the big toe of her right foot. Following discussion it was also agreed that Dr Simmonds would perform a right toe extensor tenotomy (tendon release procedure) at the same time as the arthroscopy on her right knee.

21. That same day, Dr Simmonds reported to Dr Doddridge setting out the history and referring to the examination.

22. Mrs Babington's surgery was scheduled for midday on 3 November 1999.

23. During the morning of that day, Mrs Babington was admitted to Boulcott Hospital, a private clinic, as a day surgery patient. She was the last patient on Dr Simmonds' operating list. For reasons beyond Dr Simmonds' control, the theatre started late and the operating list was running two hours behind schedule.

24. As a result it was not until 2pm when Ms A, the xx nurse, collected Mrs Babington from the ward. She went through the pre-operative check list with Mrs Babington to ensure the paperwork was complete; went over the consent form with her; and checked with her that

she understood what was to happen. Mrs Babington confirmed it was her right knee which was to be operated on, which was what was stated on the consent form.

25. Mrs Babington was then taken to a waiting area while Ms A went into theatre to prepare for the anaesthetic.

26. Dr Simmonds said he spoke with Mrs Babington in the presence of Dr E, the xx, while Mrs Babington was in a waiting area. He read the patient's notes and confirmed with her that as well as the right knee arthroscopy she was also to undergo the right toe flexor tenotomy. This latter procedure was not written on the consent form and was added in by Dr E with Mrs Babington's oral and written consent. Dr Simmonds said he was concerned to ensure that he did not lose sight of the need to carry out the toe surgery as this was not surgery that he normally carried out at the same time as an arthroscopy. He said he was aware of the risk of it being overlooked being a relatively minor and quick procedure.

27. Mrs Babington confirmed that Dr Simmonds and Dr E saw her and spoke with her while she was in a waiting area.

28. Dr Simmonds stated that he and Dr E then took Mrs Babington from the waiting area to theatre.

29. Mrs Babington said that Dr Simmonds then *"did a most unusual thing"* in that he pushed her bed over to the operating table by himself. However, Dr Simmonds explained that the area where Mrs Babington was placed prior to surgery was in the recovery area. The nursing staff were aware that if a patient had to wait in that particular place (where Mrs Babington was), the patient could see into the operating theatre. Accordingly, Mrs Babington's bed was placed in a position so that she was facing in the opposite direction away from theatre. In order to get her into theatre, it was necessary to rotate her bed 180°, a task normally difficult to accomplish with only one person. Dr Simmonds said it was his normal practice to take the foot end of the bed and either the xx nurse or (as on this occasion) Dr E would take the head of the bed and he (Dr E) would therefore be in such a position that Mrs Babington may not have been aware of his presence. The

Tribunal accepts Dr Simmonds' evidence and his explanation that the moving of the bed in these circumstances was normal practice and that this was what occurred on this occasion.

30. Mrs Babington was taken to theatre, covered by a "cuddly" rug, and was transferred to the operating table. Mrs Babington stated that when she was taken into the theatre she was somewhat surprised at what seemed to be a very jovial atmosphere that *"the radio was "blaring", everyone seemed in a very happy mood"* and she thought it appeared like a scene from *"Mash"*. The reference to music has some relevance as will be apparent later in this decision.

31. Once Mrs Babington was taken to theatre Ms A, the xx nurse, took Mrs Babington's notes to Ms B, the circulating nurse. Ms A then proceeded to assist Dr E.

32. In her written evidence, Ms B stated her involvement with Mrs Babington began when Mrs Babington arrived in theatre. She greeted her and introduced her to the scrub nurse, Ms C, who was scrubbing up.

33. Ms B stated that she checked the consent forms and the operating list to make sure that the correct patient and the correct operation site had been marked. She noted that the operation was to take place on the right leg but observed that there was no mark on the limb.

34. Reference was made to more than one set of notes. While in theatre, the patient's notes were on the circulating nurse's table. The surgeon had his own notes on another table and there was an operating list on the wall. No doubt, the xx would have had his own notes or at least access to the notes referred to.

35. Ms B was adamant that she told Dr Simmonds that the limb was not marked and that she confirmed with him that the operation was to be on the right leg.

36. When asked by counsel for the Director of Proceedings to elaborate on her written evidence, Ms B said that when she told Dr Simmonds that the limb was not marked she was standing at the scrub bay with the patient's notes. She said she could not remember

where Dr Simmonds was standing at the time. When asked if she had an impression as to what part of the theatre he was in, she replied that he was close enough for her not to have to yell at him.

37. Dr Simmonds said he had no recollection of any such conversation with Ms B and nor would he have failed to respond to an experienced nurse telling him there was a particular issue, had he heard her. The Tribunal refers to this matter later.

38. Ms B stated that Ms C proceeded to begin her trolley preparation while she herself began opening equipment and preparing for surgery. Nurse B stated that she heard Dr Simmonds speak with Mrs Babington asking her if this was the leg and heard Mrs Babington say "*Yes*" but stated that she did not know which leg Mrs Babington acknowledged as she was opening equipment at the time in accordance with her role. Ms B stated she had her back to Mrs Babington all the time during the conversation between Mrs Babington and Dr Simmonds.

39. When asked by counsel for the Director of Proceedings to elaborate as to where Mrs Babington was at the time the asserted conversation took place between Mrs Babington and Dr Simmonds, Ms B said that Mrs Babington "*was lying on the actual operating table*".

40. However, a careful analysis of all the evidence calls into doubt Ms B's evidence that she told Dr Simmonds the limb was not marked and also calls into doubt that Dr Simmonds had a conversation with Mrs Babington while the latter was on the operating table.

41. Following the completion of the surgery, a meeting ("*a de-briefing session*") of the theatre team took place during which an "*Incident/Accident Complaint Report*" was completed (Exhibit 9). It was recorded as having been compiled by Ms B as Team Leader. It was produced at the hearing by Dr Simmonds' counsel and Ms B confirmed it was in her handwriting. It was signed by Ms B, Ms C, Ms A and Ms D. Ms B stated that Dr E was also present, which evidence the Tribunal accepts, but notes Dr E did not sign the report, and did not give evidence before the Tribunal; and Dr Simmonds was not

present at the meeting as he had to attend an out-patients' clinic for which he would already have been late.

42. The *"Incident/Accident Complaint Report"* indicated there were two separate discussions that morning between Mrs Babington and Dr Simmonds. It referred to the discussion which also included Dr E (see para. 26 above). It then recorded *"Mrs Babington was then taken into theatre. Mr Simmonds spoke again with the patient who was now on the operating table, he pulled back the cover on L) side and commented that he had not put an arrow on the leg but tapped the L) leg and said this is the leg we are doing and the patient confirmed this. (The patient had not been premeded)."*

43. Dr Simmonds' counsel questioned Ms B about the report, suggesting that certain aspects of the report were inconsistent with Ms B's evidence-in-chief.

44. One aspect was that the report stated it was Dr Simmonds and not Ms B who had commented on the unmarked limb. Another issue raised was the order of events in the report which was different from Ms B's evidence.

45. Another aspect put to Ms B was that the report recorded that the left leg was being confirmed in circumstances where Ms B was aware it should be the right leg, which was contrary to her evidence.

46. Ms B said she was aware it was the right leg that was to be operated on, but stated that the left leg was also discussed during the pre-operative examination on the operating table. She said she was unaware of the total conversation and could not recall exactly what was discussed but maintained her evidence was correct.

47. Ms B stated that the incident report was the result of a *"combination of pooled information"* of those present at the debriefing session.

48. However, the evidence of the witnesses given at the hearing (other than Ms B's) did not establish that a second discussion between Mrs Babington and Dr Simmonds took place

when Mrs Babington was on the operating table; and nor did it establish that there was a discussion between them about Mrs Babington's left leg.

49. Mrs Babington's own evidence did not confirm that her conversation with Dr Simmonds took place on the operating table. She was specifically asked about this by Dr Simmonds' counsel and it was readily apparent from her answer that she was in the waiting area when Dr Simmonds and Dr E spoke to her.

> *"…it was in the theatre but around to the side of it, I wasn't actually on the table, I was facing that way towards the wall, and that's when they came to me to sign the thing and Mr Simmonds whirled me around to the table part of it. It wasn't a separate room.*
>
> *Did anyone refer to it as a waiting bay just outside the door to theatre, do you remember anyone using that term?*
>
> *I just remember being in I suppose you'd call it a bay, yes.*
>
> *And it's there that you were spoken to by both the doctors …*
>
> *Yes."*

50. Further, Mrs Babington in evidence-in-chief stated that when she was taken to theatre she was then xx by Dr E and her next memory was waking in the recovery room.

51. With regard to the left leg, Mrs Babington was adamant that the left leg was never discussed – *"the left leg was never ever mentioned, … I am really emphatic that the left leg was never mentioned"*.

52. Ms C stated that her involvement with Mrs Babington began when Ms B showed her Mrs Babington's form while she (Ms C) was scrubbing at the scrub bay. Ms C said she checked the consent form with Ms B and commented to her on the lack of arrow or other marking on the right leg which was the leg to be operated on and stated that Ms B informed Dr Simmonds that the limb was not marked.

53. Ms C was asked by counsel for the Director of Proceedings to elaborate on this piece of evidence. Counsel asked *"… you say there that B informed the surgeon that the limb*

was not marked, did you hear her do that". Ms C replied *"No, well I don't remember hearing her do it."*

54. When asked about the alleged conversation, as set out in the incident report, between Mrs Babington on the operating table and Dr Simmonds, Ms C confirmed that this part of the report was not a part of her recollection – *"This isn't a part that's recording your recollection … no it's not".*

55. Ms A, the xx nurse, gave her evidence by affidavit. She was not available to elaborate on her evidence, as she is presently employed overseas. However, the Tribunal is entitled to draw reasonable inferences from her affidavit taking into account all of the evidence before the Tribunal.

56. Ms A deposed that she spoke to Mrs Babington in Ward 3 at approximately 2pm. She went through the pre-operative checklist with Mrs Babington to make sure all the necessary paperwork was complete; went over the consent form and checked that the operation which had been consented to, was the same as that written on the theatre checklist; and checked with Mrs Babington that she understood what was to happen. Mrs Babington confirmed with Ms A that it was the right knee that was to be operated on, which was what was stated on the consent form. Mrs Babington was then taken to the waiting bay and Ms A went into theatre to prepare for the xx and assist the xx.

57. Ms A further deposed *"I did not hear any mention of either left or right leg made by anyone at all in theatre."*

58. Ms D (whose evidence is more fully referred to below) did not hear any discussion between Mrs Babington and Dr Simmonds because Mrs Babington was already anaesthetised when Ms D entered the theatre.

59. Dr Simmonds was adamant in his evidence that he had no recollection of hearing Ms B remind him that the limb was not marked; and the Tribunal notes that the only discussion with Mrs Babington about which he referred to in his evidence was the one he had with her and Dr E in the waiting bay.

60. When Dr Simmonds was asked if there were any notes about any concern Mrs Babington had with the left knee, Dr Simmonds said there were not. He confirmed Mrs Babington's evidence. He did not recall there ever being any complaints about problems with her left knee.

61. Ms B stated that throughout the relevant events her back was to Mrs Babington as she was standing alongside Ms C at the scrub trolley. However, when questioned by a member of the Tribunal, Ms C said that she herself would have been standing at the scrub table in the sterile field (closest to and with her back to the patient) while the circulating nurse (Ms B's role) would have been standing outside the sterile field on the opposite side of the table to Ms C.

62. If the Tribunal accepts Ms C's evidence this means that Ms B would therefore have been facing the patient.

63. There is significant uncertainty regarding certain aspects of the evidence, particularly Ms B's.

64. In these circumstances, the Tribunal is not satisfied the evidence established that there was a discussion between Mrs Babington and Dr Simmonds once Mrs Babington was in theatre on the operating table; and nor is it satisfied that there was any discussion between them regarding Mrs Babington's left knee.

65. The Tribunal finds that the conversation which took place between Mrs Babington and Dr Simmonds was in the waiting bay, as previously described. It is therefore unlikely that Ms B would have heard the conversation between them as she was in the theatre at the time.

66. In view of the uncertainty surrounding these aspects of the evidence, the Tribunal is not prepared to find that Ms B did remind Dr Simmonds that the limb was not marked.

67. After being transferred to the operating table, Mrs Babington was anaesthetised while Dr Simmonds put up the x-rays on the viewer.

68. Dr Simmonds explained it was then his practice to examine the knee with the patient asleep (a manipulation under anaesthesia) and he recalled in this case that, having examined the affected knee, he checked the good knee to see if there was any difference. As Professor Horne opined, this is good practice.

69. He said that if anyone were observing him they would have seen him manipulating the right knee to be operated on and the other knee for a comparison.

70. In accordance with his usual practice, Dr Simmonds said he then went to the scrubbing bay to scrub. This involves going to a stainless steel basin in one corner of the theatre in order to thoroughly sterilise the hands and forearms before putting on the surgical gown and gloves. This takes approximately two minutes.

71. Dr Simmonds explained that at this stage it is his normal practice to think carefully about the procedure he is to undertake, correlating the x-rays in his mind with the pre-operative manipulation. He also recalled reminding himself, regarding Mrs Babington's case, not to forget the planned surgery for the toe.

72. It is common practice, when undertaking these kinds of procedures, for the surgeon to use as an aid, a *"monitor"* (a television screen) set on a structure sometimes called the *"tower"*. The tower is a multi-level structure with shelves on which there are normally three major modules, namely, a mechanism for the arthroscopy camera; a device for recording the arthroscopy in the form of a video recorder or photographic recorder; and some equipment for driving instruments that are used at the time of the arthroscopy. It may also contain other equipment.

73. The correct positioning of the tower is essential as the surgeon has to view the television screen which shows an image of the interior of the joint during the operation.

74. Where the tower is positioned will depend on the surgeon's preference. Professor Horne said he liked to have it on the opposite side of the table to where he was operating as it enabled him to get the best view of the joint at the same time as working with his hands to manipulate the instruments that are inside the joint.

75. It is readily apparent from Dr Simmonds' evidence that his preference also was for the tower to be placed on the opposite side.

76. On this occasion, the tower was placed on Mrs Babington's right side (the incorrect side) thereby indicating that the side intended for surgery was the left side.

77. Ms B explained that the tower is usually positioned after the patient is anaesthetised by the anaesthetic nurse who is then free to position it, but that it can be the role of the anaesthetic nurse, the circulating nurse, or *"whoever is not tied up doing something at the time"* to position it.

78. Ms B could not recall when the tower was positioned or who positioned it on this occasion but said it was not her as she was assisting Ms C to get her instruments ready.

79. Both Ms C and Dr Simmonds said they did not position it either.

80. Ms A, the xx nurse, who gave her evidence by affidavit deposed (paragraph 6):

> *"Once Mrs Babington was brought into theatre I took her notes over to Staff Nurse B who was the circulating nurse. I then proceeded to assist the anaesthetist to put in an IV cannula and from that time onwards I was concerned with assisting the anaesthetist, organising monitors, passing airways and other equipment and moving equipment into correct places"* (emphasis ours).

81. The Tribunal is conscious that Ms A was not available to elaborate on her evidence (as she is presently employed overseas) but on a fair assessment of all the evidence before the Tribunal it is probable that it was Ms A who positioned the tower on the incorrect side.

82. Although it cannot be stated with absolute certainty, it is also probable, from a consideration of all the evidence, that the tower was positioned shortly after Mrs Babington was anaesthetised.

83. While Dr Simmonds was scrubbing, Ms D entered theatre 2. She was on day duty in theatre 1, involved in an operation taking place in that theatre and was not scrubbed. She went into theatre 2 to collect some equipment. She noticed that a patient (Mrs Babington) was on the operating table asleep.

84. Ms D said she was not scheduled to be involved in Mrs Babington's operation in theatre 2 but that it is the practice of the Boulcott Clinic that assistance is given if a theatre nurse is passing through another theatre and is asked to assist and is free to do so.

85. She stated that while she was looking for her equipment, Dr Simmonds asked her if she could apply the tourniquet while she was there. Dr Simmonds confirmed in his evidence he made this request of Ms D.

86. Ms D said that while Dr Simmonds was scrubbing at the scrub bench she noticed that it was Mrs Babington's left leg which was exposed. The Tribunal infers from all the evidence that this may have occurred following the examination by Dr Simmonds of Mrs Babington's knees while she was under anaesthesia and when the cuddly rug would have been disturbed. Ms D said she touched the exposed leg and said *"this leg?"* to which Dr Simmonds nodded and said *"yes"*. She said that at that point in time she was standing next to the patient on the patient's left facing towards the door. She stated that Dr Simmonds was scrubbing at the scrub bay (approximately 5.5 metres away) (with his back to her) and that *"he just turned his head and looked"* (indicating a quick turn of the head) and did not say anything other than *yes* that she could recall.

87. While scrubbing, Dr Simmonds said he had a clear recollection that Ms D entered theatre and, as she was not engaged in a task, he asked her to apply the tourniquet. However, he had no recollection of her asking him *"this leg?"* or of his response.

88. Ms D said she was unable to comment, when asked by Dr Simmonds' counsel, whether it were possible Dr Simmonds may not have heard or fully heard her question.

89. Ms D could not remember which side the tourniquet applicator was on. She got it out and applied it to the left leg, which was the exposed leg (not the right leg which was the one

intended for surgery), collected her equipment, and left. She said Dr Simmonds was still scrubbing at the bench and said *"thank you"*. She had no further involvement in the operation.

90. Ms B stated she did not hear either Dr Simmonds or Ms D mention which leg the tourniquet was to be put on but recalled Ms D asking Dr Simmonds *"is this the leg?"* She said she did not see or hear which leg was indicated.

91. Ms C recalled Ms D entering the theatre and recalled Dr Simmonds saying he had not put on the tourniquet, but said she did not see the tourniquet being applied.

92. The next step in the procedure was for the knee to be painted with alcoholic chlorhexadine and draped. The draping involves a significant amount of material which, in Mrs Babington's case, covered her almost entirely except for the head.

93. Nurse B stated she did not see the exposed leg or the draping up or painting of it.

94. Dr Simmonds could not recall if it was he who painted the leg but accepted he did.

95. The Tribunal accepts Ms C's evidence that it was Dr Simmonds who painted the leg and either the xx nurse or the xx who held the leg while he did so.

96. It also accepts Ms C's evidence that she and Dr Simmonds carried out the draping, possibly with the assistance of a third person who would have been either the xx or the xx nurse.

97. Surgery was then commenced on the left knee.

98. Ms B said that as the circulating nurse she had to complete paperwork and went to the theatre register to write the operation in it. As she was doing so she saw that all the theatre staff were sitting on the left hand side of the patient and realised that the incorrect leg was being operated on. She immediately alerted Dr Simmonds.

99. There were a number of options open to Dr Simmonds. As Mrs Babington was already subject to an anaesthetic and as there were already two small incisions in her left knee and the arthroscope in place, he deemed it reasonable to complete a limited arthroscopic examination of the knee so that she had the benefit of a report on possible degeneration of the cartilage. No arthroscopic surgery as such took place on the left knee. He considered it appropriate to finish the procedure as investigative only on the left knee (the total time involved including the prepping and draping would have been 4 to 5 minutes) and then carry out the arranged procedure on the right knee and toe, which he did. In making this decision, Dr Simmonds consulted with the xx, Dr E, who confirmed that Mrs Babington was tolerating the anaesthetic well and that he had no objection to Dr Simmonds' proposed course of action.

100. Professor Horne acknowledged, in answer to a question from the Tribunal, that while he personally may have made a different decision, Dr Simmonds' decision to proceed, in the given circumstances, was an entirely reasonable one.

101. Surgery was completed at 3.07pm following which Mrs Babington was taken to recovery.

What went wrong?

102. Dr Simmonds told the Tribunal that he had prepared his written evidence from the notes, his memory of events and records of it and after walking himself back through the events of Mrs Babington's surgery.

103. He acknowledged at the outset that he had made an error which he profoundly regretted and for which he felt he could never sufficiently apologise.

104. Dr Simmonds explained his usual practice. While, at the time of Mrs Babington's surgery, protocols were not in place at Boulcott (nor apparently in many other hospitals throughout New Zealand), it was nevertheless Dr Simmonds' practice at that time, and had been since 1977, to mark the surgical site by drawing a prominent green arrow on it. There is only one type of pen which effectively marks the limb indelibly. This was normally kept in the operating theatre.

105. Dr Simmonds was not able to say why he did not follow, on this occasion, his usual practice of marking the knee but confirmed it was extremely unusual for him to have diverted from this practice. He explained that occasionally Dr E, with whom he has worked for a long time, might mark the site in advance of him but on this occasion neither did so.

106. Another possibility was that, on this occasion, the pen was not readily locatable.

107. Dr Simmonds referred to the evidence that he was asked by Ms D to confirm the correct knee at a time when he was scrubbing. He said he had no recollection of being asked that question but had tried to come up with an explanation and tried to see if he could actually remember a question rather than thinking about what he had read throughout this enquiry which, he said, had seen the matter investigated in three phases before the Director of Proceedings and this Tribunal. He stated he would not have heard, and agreed to the left knee having a tourniquet placed on it, for the following reasons:

(a) Music was playing.
(b) He was scrubbing at the time which meant there was the additional sound of water hitting the stainless steel basin into which he was scrubbing.
(c) His left side was facing the theatre, that is, his hearing impaired side. He therefore could not assist in explaining why there was a view that he had confirmed the incorrect side.
(d) Instruments were being arranged and there was substantial clattering and background noise as well as conversations between the nursing staff.

108. Dr Simmonds informed the Tribunal that like many orthopaedic surgeons he suffers from some deafness in the high pitch ranges in his left ear. He explained that this is caused by the equipment which is used in orthopaedic surgery and that even if he enjoyed having music played when he worked, which he does not, this slight hearing impediment meant that he would find the theatre communication easier without music playing.

109. With regard to the reference to music, the evidence confirmed that when music is playing in theatre it is from a radio situated on a trolley alongside the area of the scrub bay, and would be playing at the time the surgeon is in the process of scrubbing.

110. When asked by a member of the Tribunal to clarify what she meant by the radio *"blaring"*, Mrs Babington said it was *"quite loud"*, more at the level *"teenagers have theirs"*, *"a bit louder than you would have at home"*, *"louder than you would expect in an operating theatre"*.

111. The circulating nurse could not recall whether music was playing in the theatre on this occasion but said, if it were, it would not have been *"overly loud"* as Dr Simmonds does not like music in theatre. She said she was able to hear adequately in theatre.

112. The scrub nurse could not remember if music were playing, but had difficulty accepting Mrs Babington's evidence that it would have been *"blaring"* when she was taken to theatre.

113. The Tribunal finds that Ms D did ask *"this leg?"* but also finds that Dr Simmonds either did not hear her question or misheard it.

114. At the time, he was standing some 5.5 metres from Ms D with his back to her.

115. The Tribunal finds that music was playing but was not blaring (as Mrs Babington has suggested) but that it was playing at a sufficient level together with other background noises (as described by Dr Simmonds) which caused him either not to hear or to mishear Ms D's question.

116. Dr Simmonds said he was aware that there was an operating list on the theatre wall to which all theatre staff have access.

117. The Tribunal accepts Dr Simmonds' evidence that he would never have knowingly consented to the tourniquet being applied to the wrong leg.

Who was responsible?

118. Professor Horne was called by the Director of Proceedings as an expert. He offered in his written evidence the following opinion:

> *"It is clear from the statements that the nursing staff who collected the patient from the holding area, and received the patient in the operating theatre, checked the side and site upon which surgery was planned. It is recorded in their statements that Mr Simmonds was notified that the appropriate leg had not been marked. Safe practi[c]e in surgery is always a team effort, but when a surgeon operates on the wrong side or site, the ultimate responsibility lies with the surgeon. Mr Simmonds admitted that he did not mark the side and site of the proposed surgery. In my opinion the primary responsibility for the error that occurred lies with Mr Simmonds."*

119. Professor Horne's opinion was based, among other things, on the understanding that Dr Simmonds was notified that the appropriate leg had not been marked. The Tribunal has already found that this aspect of the evidence is sufficiently uncertain and unclear and is not prepared to find that Dr Simmonds was so informed.

120. Nevertheless, the Tribunal accepts (as did Dr Simmonds himself) that the primary responsibility for the error lies with Dr Simmonds. As the consultant surgeon, he ultimately carried that responsibility.

121. However, as Professor Horne has opined, safe practice in surgery *"is always a team effort"*.

122. Professor Horne's opinion was sought whether the marking of the limb was the only mechanism for ensuring that the correct site was operated on. He replied *"No it certainly is not the only mechanism. It's one of a number of steps that are taken to minimise the chance of something untoward happening. … the nurses do a number of checks and the surgeon checks and as part of that whole check list one part is to mark the area."* While he said the practice was highly recommended, the purpose of which was to reduce the risk of wrong side and site surgery, he was aware that in current practice not every surgeon marked the side or site on every occasion. If one did not, it would increase the obligation to verify the correct side.

123. The Tribunal has observed that in the incident report the regrettable outcome was referred to as *"A team error"*.

124. When asked by Dr Simmonds' counsel why the event was described as a *"team error"* in the report, Ms C responded *"because we are a team … it is as a team that we work."*

125. Dr Denis Atkinson is an orthopaedic surgeon practising in Hastings. He was asked by the Health and Disability Commissioner (following Mrs Babington's complaint) to provide an opinion to enable the Commissioner to form his own opinion on whether the standard of care provided for Mrs Babington on 3 November 1999 was provided with reasonable care and skill.

126. On 15 October 2001, Dr Atkinson provided a written opinion to the Commissioner. He stated at paragraph 5.3:

> *"5.3 Mr Simmonds failed in a duty of care to Mrs Babington on 03/11/99 by incorrectly operating on her left knee, having obtained consent to proceed with surgery on the right knee. There was a collective responsibility of all theatre staff involved in Mrs Babington's care to ensure that the correct operation and site of surgery was performed on 03/11/99. At the time of Mrs Babington's surgery in 1999, there did not appear to be a clear protocol for correct site surgery at the Boulcott Clinic. There appeared to be some informal processes but all staff were not aware of their roles. All documentation to confirm the correct site in Mrs Babington's case was complete [sic] diligently. However, at the commencement of surgery a double check was not performed to confirm that the correct site was to be operated on."* (emphasis ours)

127. We accept Dr Atkinson's opinion of *"collective responsibility"* in these particular circumstances.

128. What occurred here was a chain of events which culminated in an adverse outcome. Those events included the following:

(a) An unavoidable late theatre start and the fact that the operation list was running two hours behind schedule due to a delay in scheduled operating times. Although no

witness specifically suggested that this was a contributing factor, the Tribunal was left with the impression that this was one of the contributing factors.

(b) The surgeon's diversion from his normal practice of marking the limb.

(c) The fact that the tower was placed on the right side (that is, the incorrect side) of Mrs Babington which would indicate that surgery was intended for the left side.

(d) The fact that it was Mrs Babington's left leg which was exposed when Ms D entered the theatre.

(e) The request to Ms D to apply the tourniquet when she was not part of the theatre team for the particular surgery (although this was a common practice at Boulcott).

(f) The general background noises of a busy theatre including the music together with Dr Simmonds' slight hearing impediment and the fact that he was some distance from Ms D with his back to her scrubbing at the time with running water all of which would have affected his ability to hear or hear accurately Ms D's question.

(g) The failure of the back up mechanisms, that is, the failure of the other members of the theatre team all of whom are competent and committed professional persons to notice that the left leg was being operated on despite knowing that surgery was intended for the right leg.

Professional Misconduct – the legal position

129. The starting point for defining professional misconduct is to be found in the judgment of Jefferies J in *Ongley v Medical Council of New Zealand* (above) when he posed the test in the following way:

> *"Has the practitioner so behaved in a professional capacity that the established acts under scrutiny would be reasonably regarded by his colleagues as constituting professional misconduct? … The test is objective and seeks to gauge the given conduct by measurement against the judgment of professional brethren of acknowledged good repute and competency, bearing in mind the position of the Tribunal which examined the conduct."*

130. In *Pillai v Messiter* [No.2] (1989) 16 NSWLR 197 the New South Wales Court of Appeal took a slightly different approach to judging professional misconduct from the test formulated in *Ongley*. The President of the Court considered the use of the word

"*misconduct*" in the context of the phrase "*misconduct in a professional respect*". He stated that the test required more than mere negligence. At page 200 of the judgment Kirby P. stated:

> "*The statutory test is not met by mere professional incompetence or by deficiencies in the practice of the profession. Something more is required. It includes a deliberate departure from accepted standards or such serious negligence as, although not deliberate, to portray indifference and an abuse of the privileges which accompany registration as a medical practitioner.*"

131. In *B v The Medical Council* (unreported HC Auckland, HC11/96, 8 July 1996) Elias J said in relation to a charge of "conduct unbecoming" that:

> "*… it needs to be recognised conduct which attracts professional discipline, even at the lower end of the scale, must be conduct which departs from acceptable professional standards*".

Her Honour then proceeded to state:

> "*That departure must be significant enough to attract a sanction for the purposes of protecting the public. Such protection is a basis upon which registration under the Act, with its privileges, is available. I accept the submission of Mr Waalkens that a finding of unbecoming is not required in every case where error is shown. To require the wisdom available with hindsight would impose a standard which is unfair to impose. The question is not whether the error was made but whether the practitioner's conduct was an acceptable discharge of his or her professional obligation.*"

Her Honour also stressed the role of the Tribunal and made the following invaluable observations:

> "*The inclusion of lay representatives in the disciplinary process and the right of appeal to this Court indicates the usual professional practice while significant, may not always be determinative: the reasonableness of the standards applied must ultimately be for the Court to determine, taking into account all the circumstances including not only usual practice, but patient interest and community expectations, including the expectation that professional standards are not to be permitted to lag. The disciplinary process in part is one of setting standards.*"

132. In *Staite v Psychologists Board* (1998) 18 FRNZ 18 Young J traversed recent decisions on the meaning of professional misconduct and concluded that the test articulated by Kirby P in *Pillai* was the appropriate test for New Zealand.

133. In referring to the legal assessor's directions to the Psychologists Board in the *Staite* case, Young J said at page 31:

> *"I do not think it was appropriate to suggest to the Board that it was open, in this case, to treat conduct falling below the standard of care that would reasonably be expected of the practitioner in the circumstances – that is in relation to the preparation of Family Court Reports as professional misconduct. In the first place I am inclined to the view that "professional negligence" for the purposes of Section 2 of the Psychologists Act should be construed in the Pillai v Messiter sense. But in any event, I do not believe that "professional negligence" in the sense of simple carelessness can be invoked by a disciplinary [body] in [these] circumstances …".*

134. In *Tan v Accident Rehabilitation Insurance Commission* (1999) NZAR 369 Gendall and Durie JJ considered the legal test for "professional misconduct" in a medical setting. That case related to the doctor's inappropriate claims for ACC payments. Their Honours referred to *Ongley* and *B v Medical Council of New Zealand*. Reference was also made in that judgment to *Pillai v Messiter* and the judgment of Young J in *Staite v Psychologists Registration Board.*

135. In relation to the charge against Dr Tan the Court stated at page 378:

> *"If it should happen that claims are made inadvertently or by mistake or in error then, provided that such inadvertence is not reckless or in serious disregard of a practitioner's wider obligations, they will not comprise "professional misconduct". If however, claims for services are made in respect of services which have not been rendered, it may be a reasonable conclusion that such actions fell seriously short of the standard required of a competent and reasonable practitioner. This may be especially the case if such claims are regularly made so as to disclose a pattern of behaviour".*

136. In the Tribunal's view, the test as to what constitutes professional misconduct has changed since Jefferies J delivered his judgment in *Ongley*. In the Tribunal's opinion the following

are the two crucial considerations when determining whether or not conduct constitutes professional misconduct:

(a) There needs to be an objective evaluation of the evidence and answer to the following question:

Has the doctor so behaved in a professional capacity that the established acts and/or omissions under scrutiny would be reasonably regarded by the doctor's colleagues and representatives of the community as constituting professional misconduct?

(b) If the established conduct falls below the standard expected of a doctor, is the departure significant enough to attract a disciplinary sanction for the purposes of protecting the public and/or maintaining professional standards, and/or punishing the doctor?

137. The words *"representatives of the community"* in the first limb of the test are essential because today those who sit in judgment on doctors comprise three members of the medical profession, a lay representative and chairperson who must be a lawyer. The composition of the medical disciplinary body has altered since Jeffries J delivered his decision in *Ongley* in 1984. The new statutory body must assess a doctor's conduct against the expectations of the profession and society. Sight must never be lost of the fact that in part, the Tribunal's role is one of setting standards and that in some cases the community's expectations may require the Tribunal to be critical of the usual standards of the profession: *B v Medical Practitioners Disciplinary Tribunal* (above). In *Lake v The Medical Council of New Zealand* (unreported High Court Auckland 123/96, 23 January 1998, Smellie J) the learned Judge stated: *"If a practitioner's colleagues consider his conduct was reasonable the charge is unlikely to be made out. <u>But</u> a Disciplinary Tribunal and this Court retain in the public interest the responsibility of setting and maintaining reasonable standards. What is reasonable as Elias J said in <u>B</u> goes beyond usual practice to take into account patient interests and community expectations."*

138. This second limb to the test recognises the observations in *Pillai v Messiter, B v Medical Council, Staite v Psychologists Board* and *Tan v ARIC* that not all acts or omissions which constitute a failure to adhere to the standards expected of a doctor will in themselves constitute professional misconduct.

139. In the recent High Court case of *McKenzie v MPDT* (unreported High Court Auckland, CIV 2002-404-153-02, 12 June 2003), Venning J endorsed the two question approach taken by this Tribunal when considering whether or not a doctor's acts/omissions constitute professional misconduct. The same judgment of the High Court cautioned against reliance in this country upon the recent judgment of the Privy Council in *Silver v General Medical Council* [2003] UK, PC33.

Did Dr Simmonds' Error Amount to Professional Misconduct?

140. The Tribunal readily acknowledges that the public expects and is entitled to expect that healthcare systems are as failsafe as possible and, where shortcomings or deficiencies come to light, that all steps are taken to make improvements on a continuing basis.

141. The Tribunal accepts that Dr Simmonds' failure to ensure that the correct surgical site had been identified was a most regrettable matter but, bearing in mind the relevant legal tests, the Tribunal was unanimous that in the particular circumstances such failure did not amount to an offence inviting disciplinary sanction.

142. It is not every error or mistake which automatically gives rise to a disciplinary offence and punishment.

143. In this instance, as the Tribunal has found, there was a chain of events (referred to at paragraph 128 hereof) which culminated in an adverse outcome. The Tribunal has had regard to all of the relevant circumstances and while, as the consultant surgeon, Dr Simmonds must bear the primary responsibility for the error, it would be wrong and unfair to consider his actions in a vacuum. He was a member of a team. The Tribunal is aware that he is the only member of the team who has been charged and, while we have made no adverse criticism of the role undertaken by any other member of that team, we find that Dr

Simmonds' role in the unfortunate outcome was not such as to invite a finding of professional misconduct.

Post-Operative Events

Apology

144. Dr Simmonds told the Tribunal he is usually pedantic and is aware that some theatre staff find him to be too slow and cautious. He said that the fact that this error occurred when it is his normal practice to try and take care has been a difficult issue for him to come to terms with. The Tribunal accepts that Dr Simmonds expects high standards of himself. The Tribunal also accepts Dr Simmonds' evidence that whatever he says cannot truly reflect the extent of his sorrow and deep mortification that this occurred.

145. The Tribunal finds that as soon as Mrs Babington was awake following her surgery Dr Simmonds went to see her in the recovery room, explained what had happened and apologised profusely; that once she had time to settle in the ward, he visited her again, this time in the company of Dr E and a senior nurse and told her again what had occurred and again apologised; and that he saw Mrs Babington the following day and again explained what had occurred and again apologised.

146. In August 2002, following the Health and Disability Commissioner's final opinion, a letter was sent to Mrs Babington care of the Commissioner. It was signed by Dr Simmonds, Dr E, Ms B and Ms C. It stated:

> *"The entire surgical team involved in your operation apologise to you for the error which occurred during your surgery. We realise it has caused you and your family considerable distress. Each of us has considered our own role in the error and adjusted our practice as a result to ensure this mistake is not repeated."*

147. Dr Simmonds, through his counsel, also offered to meet with Mrs Babington. At the hearing, Dr Simmonds publicly expressed his regret and sorrow at what had occurred and apologised yet again. The Tribunal has no doubt that each of Dr Simmonds' apologies were motivated by a genuine concern for Mrs Babington and were sincere.

Changes Made

148. This incident caused changes to be made at Boulcott Clinic (as indicated in the surgical team's letter of apology and by Dr Simmonds in his evidence) to eliminate, insofar as possible, repetition of any such error.

149. With regard to marking the limb, at the time of Mrs Babington's surgery, protocols were not in place at Boulcott. The Tribunal has already observed that such protocols were not in place in many other hospitals throughout New Zealand. Dr Simmonds told the Tribunal that as a response to this event a clear protocol was developed at Boulcott with cross-checking to ensure correct site and side of surgery was accomplished. Since then, Dr Simmonds said the protocol had been revised regularly and that as recently as two weeks prior to the hearing there was further consideration of changes.

150. A further change which was implemented was for the nurses at Boulcott to decide that only the surgeon would apply the tourniquet.

151. With regard to the playing of music in theatre, Dr Simmonds stated his preference is that the theatre he works in is silent. He explained that as a surgeon, he is part of a team and within the team there is a strong preference for music. He said there is a stated belief by a number of theatre health professionals that music assists them with their work, a belief which he respected.

152. Professor Horne stated that in the theatres in which he works music is always played. While some members of the team may have different tastes, what is important is that the team work as a happy cohesive unit the key to which *"is a bit of give and take"*.

153. Dr Simmonds said that since the incident with Mrs Babington, he no longer agrees to having music played whilst he is in theatre. He is aware there is always some tension between wanting to have a team which is happy, and said some claim this is achieved by having music played which is not the wish of people like himself. He has since discussed this with colleagues and was surprised by how many put up with music although disturbing for them.

154. Dr Simmonds concluded that the lesson all could learn from it is the importance of each theatre team discussing this issue with patient safety as the primary focus.

155. There has been some discussion regarding the wisdom of asking someone who is not a member of the particular theatre team (such as Ms D) to undertake a task. Ms D is an experienced theatre nurse and according to both her and Dr Simmonds they have worked together on and off for the better part of a decade. Ms D stated that it is the practice of Boulcott Clinic that assistance be given if a theatre nurse is passing through another theatre and is asked to assist and is free to do so. There was no suggestion that this had given rise to any problem prior to the present incident. However, Dr Simmonds commented in his evidence that by asking someone who was less busy but not part of the team for the particular surgery he may have solved one problem of getting a task done but created another by involving someone who was not aware of the nature of the surgery to be carried out. He surmised that maybe the answer was never to do this, but that such an approach could be counter-productive to a staff who co-operate. He noted it was worth further debate.

Name Suppression Application by the Nurses, Dr E and Boulcott Clinic (also known as Boulcott Hospital)

156. On 7 May 2003 Dr Simmonds applied for an order suppressing his name and any information which might lead to his identification. His application was heard on 5 June 2003.

157. On 13 June 2003 the Tribunal issued a written decision with reasons making an order in Dr Simmonds' favour but on an interim basis only until the commencement of the hearing.

158. Dr Simmonds did not seek to renew his application for name suppression which expired at the commencement of the hearing. That order lapsed and is accordingly discharged.

159. On 13 June 2003 Mr Alastair Sherriff of Buddle Findlay solicitors at Wellington applied for orders permanently prohibiting the names of the following (the Applicants):

(a) Dr E (the xx)

(b) Ms B

(c) Ms D

(d) Ms C

(e) Boulcott Clinic Limited (sometimes referred to as Boulcott Clinic and/or Boulcott Hospital).

160. No similar application was made on behalf of Ms A (the xx nurse). This may have been an oversight as she is presently residing and employed overseas.

161. Submissions were filed subsequently and the application heard by telephone conference on 31 July 2003.

162. Dr Richard Stanley Grenfell is the Managing Director of Boulcott Clinic Limited, which owns and operates the private hospital in Lower Hutt known as Boulcott Hospital (and sometimes as Boulcott Clinic). He gave evidence by affidavit sworn 12 June 2003 in support of permanent orders suppressing publication of the names of the persons referred to at paragraph 159(a) to (e) above.

163. Dr Grenfell deposed:

(a) That in November 1999 when this incident occurred the hospital had protocols in place relating to patients undergoing surgery consistent with practice at the time in other similar situations. These did not, in specific terms, stipulate marking of the proposed surgical site. At that time routine marking of the surgical site by a surgeon pre-operatively was not standard practice in New Zealand. Immediately after the incident, the hospital theatre manager tried to obtain information and policies both from the College of Surgeons and from the Orthopaedic Association but neither organisation had any standard policies or information available on routine marking of surgical sites. Following this incident, the Health Department and the Orthopaedic Association endorsed and circulated a policy later in 1999. The Health and Disability Commissioner, in his final opinion, referred to guidelines relating to wrong site surgery released by the New York State Department of Health but these were released in 2001, long after the surgery in question in this case.

(b) Boulcott Hospital is continuously reviewing its processes, protocols and quality systems. As a result, in 2001 the hospital received accreditation with Quality Health New Zealand.

(c) The Health and Disability Commissioner, in his final opinion, found that Boulcott Hospital had breached the code in not having specific policies designed to minimise the risk of wrong-sided surgery occurring but, to Dr Grenfell's knowledge, such processes were not standard in New Zealand in 1999. He referred to the Commissioner's conclusion that the Commissioner was "*Not bound by the medical practice prevailing at the relevant time …*".

(d) The Commissioner accepted that the hospital had acted appropriately towards Mrs Babington and with regard to its protocols and policies following this incident. Although the matter was referred to the Director of Proceedings, the Director determined that no further action be taken insofar as the hospital or nurses were concerned.

(e) The Health and Disability Commissioner concluded his report with a promise to remove the identifying details before publishing his report; and that the promise of confidentiality will be defeated if there is publication of the name of Dr Simmonds, Dr E, the Boulcott Hospital or the medical staff of the hospital as a result of the Tribunal's proceedings.

(f) If Boulcott Hospital's name is published in the Tribunal proceedings Dr Grenfell considers there is a real risk of damaging the reputation of the other health professionals who work at the hospital who will not have had the opportunity to be heard including other surgeons, anaesthetists and practitioners. He cited, for example, that there are four orthopaedic surgeons who operate at the hospital apart from Dr Simmonds.

(g) If Dr Simmonds' name is not suppressed the matter is likely to be linked to Boulcott Hospital. Damage to the hospital's reputation is likely and it would be unfair on the staff, especially in the light of the fact that the Director of Proceedings had determined to take no further action in respect of any professionals other than Dr Simmonds.

(h) There is no public interest need requiring publication of Boulcott's name in 2003 in relation to an event in 1999, in the light of the policies and protocols introduced

subsequently and the hospital's accreditation in 2001. There have been no other instances of wrong site surgery arising in the hospital since 1999 of which Dr Grenfell is aware.

164. Counsel for Boulcott Clinic, (Mr Sherriff) filed a memorandum which referred to and relied on Dr Grenfell's deposition and referred to relevant legal principles. He emphasised that he considered the application made on behalf of the applicants was a very narrow and focused one while recognising and respecting the statutory presumption contained in the Medical Practitioners Act that hearings be held in public. He argued that the applicants were not seeking that any part of the hearing be in private or any evidence be suppressed other than names; and that the applicants did not want to suppress details of *what* occurred but simply *where* the events occurred.

165. Ms Isobel Eggerton also participated as counsel for Dr E. She endorsed and adopted Mr Sherriff's submissions, and added that Dr E had been cleared by the Health and Disability Commissioner of any breach. She said it was likely that Dr E's role would be discussed at the hearing (of the charge against Dr Simmonds) and that he would not be able to respond to any criticism which might be made of him. She submitted there was no logical reason for not granting him name suppression and informed the Tribunal that it had not been determined at that stage if he would be giving evidence.

166. The Director of Proceedings referred to her earlier written submissions regarding Dr Simmonds' application for name suppression (heard on 5 June 2003) and in a supplementary memorandum re-affirmed the principles relating to name suppression, namely the principles of open justice and the public interest, balanced against the privacy interests of the applicants.

167. Additionally, the Director submitted that it was incorrect for Dr Grenfell and Mr Sherriff to state that failing to grant suppression in this matter would be *"inconsistent"* with action taken by the Health and Disability Commissioner which issue related to the fact that the Commissioner removes names/identifying details from any opinion he places on his website.

168. The Director submitted that the Tribunal's process, as it relates to discipline, is a separate one from that of the Commissioner which is a different process with different thresholds. She gave as an example the clear distinction between the disciplinary threshold and that which constitutes a breach of Right 4(1) under the Code of Health and Disability Consumers' Rights.

169. The Director submitted that the Tribunal's process may also be distinguished from that of the Commissioner and that the Tribunal operates under the presumption of openness set out in the Medical Practitioners Act while the Commissioner has no statutory obligation to identify providers in his finalised opinion; and further, that the Commissioner's practice is not to identify providers pending disciplinary proceedings.

170. The Director explained that where a matter is referred by the Commissioner to the Director, the Commissioner's opinion will either be withdrawn from his website or simply withheld from it.

171. She stated that the reason for this is to preserve the Tribunal's function in determining name suppression applications, including the suppression of identifying details, and so as not to fetter the Tribunal's discretion in determining such applications. The Commissioner's policy is also to link the relevant opinions to the disciplinary findings (on the Tribunal's website) at the conclusion of the proceedings.

172. The Director accordingly submitted that as the Commissioner's opinion in question has been withheld from his website it had no bearing on the current proceedings in terms of the issue of suppression.

173. In other respects, it appeared from the Director's written submissions and from her stance at the hearing on 31 July 2003 that she would abide the Tribunal's decision.

174. On 4 August 2003 the Tribunal issued a decision making interim orders prohibiting the publication of the names of the hospital, Dr E, and the three named nurses until the conclusion of Dr Simmonds' hearing at which time it would be in a more informed position to consider whether it should make final orders regarding all or any of the applicants.

175. In that decision, the Tribunal stated that if it were not persuaded at the conclusion of Dr Simmonds' hearing that it should make final the interim prohibition orders in respect of one or more of the applicants (that is, the three named nurses, Dr E and the hospital) then it would give that or those applicants a further opportunity to address the Tribunal before the applications were dealt with on a final basis.

176. At the conclusion of the present hearing, the Tribunal was satisfied that it should make final orders prohibiting from publication the names of the xx and the four nurses who were identified at the hearing.

177. However, the Tribunal was not persuaded that it should make a final order suppressing the name of Boulcott Clinic. Accordingly, it gave Mr Sherriff the further opportunity to appear before the Tribunal to make further submissions (which he did). He re-affirmed and emphasised his earlier submissions.

178. The Tribunal informed him that it considered it appropriate to make final orders suppressing the names of the xx and the nurses but had reservations regarding the hospital.

179. Mr Sherriff said he did not see that it was in the public interest to refuse name suppression to Boulcott Clinic regarding one incident which occurred some four years ago except for historical purposes.

180. The Tribunal raised with Mr Sherriff an additional matter, that is, the fact that the Dominion Post newspaper had that morning (8 August 2003) published an account of the Tribunal's proceedings and named Wellington Hospital rather than Boulcott Clinic as the hospital involved. Mr Sherriff was aware of this. The Tribunal understood this would be brought to the attention of the newspaper.

The relevant principles applicable to name suppression

181. The Tribunal has, on previous occasions, set out the principles which apply regarding applications by medical practitioners for suppression of their name pending determination of charges by the Tribunal. (See Decision No. 216/02/95C; Decision No. 221/02/97C; Decision No. 230/03/100D)

182. When considering the principles applicable to name suppression involving medical disciplinary cases the starting point is section 106 of the Medical Practitioners Act 1995.

183. Section 106 of the Act provides:

> *"(i) Except as provided in this section and in section 107 of this Act, every hearing of the Tribunal shall be held in public.*
>
> *(ii) Where the Tribunal is satisfied that it is desirable to do so, after having regard to the interests of any person (including (without limitation) the privacy of the complainant (if any)) and to the public interest, it may make any 1 or more of the following orders:*
>
> *(a) An order that the whole or any part of a hearing shall be held in private:*
>
> *(b) An order prohibiting the publication of any report or account of any part or any hearing by the Tribunal, whether held in public or in private:*
>
> *(c) An order prohibiting the publication of the whole or any part of any books, papers, or documents produced at any hearing:*
>
> (d) *… an order prohibiting the publication of the name, or any particulars of the affairs, of any person."*

184. Section 106(1) is mandatory in that it provides that *every* hearing of the Tribunal *shall* be held in public but then vests in the Tribunal a discretion to grant name suppression in appropriate cases.

185. When the Tribunal is considering an application for an order prohibiting publication of the name of any person it must have regard to *the interests of any person* and to *the public interest.*

186. The *interests of any person* include the nurses, Dr E and Boulcott Clinic.

187. Section 106(2) requires the Tribunal to have regard to *"the public interest"* when considering an application for name suppression.

188. It should be made clear that there is ***all*** the difference between a matter which is ***in*** the public interest as distinct from a matter which is ***of*** public interest, that is, of curiosity to the public.

189. It is in the former sense which the Tribunal must address. This concept was dealt within the case of *S v Wellington District Law Society* [2001] NZAR 465 relating to an application for name suppression by a lawyer subject to a disciplinary proceeding. A full bench of the High Court, when considering the relevant provision in the Law Practitioners Act 1982 (not dissimilar from s.106(2) in the Medical Practitioners Act 1995), observed:

> *"… the public interest to be considered, when determining whether the Tribunal, or on appeal to this Court, should make an order prohibiting the publication of the report of the proceedings, requires consideration of the extent to which publication of the proceedings were to provide some degree of protection to the public, the profession or the Court. It is the public interest in that sense that must be weighed against the interests of other persons, including a practitioner, when exercising a discretion whether or not to prohibit publication".*

Decision as to Name Suppression

Boulcott Hospital

190. With regard to the identification of the hospital, we have already recorded in this decision the various and continuing improvements which have been made as a result of this matter.

191. The Tribunal accepts the Director of Proceedings' submission that the Tribunal's process is different from the Health and Disability Commissioner's process. This Tribunal operates under the presumption of openness.

192. The Tribunal is not convinced by the reasons advanced by Mr Sherriff. We do not accept that publication of the name of the hospital will damage the reputation of other staff; and nor does the Tribunal accept that speculation about any potential damage to the hospital's reputation should be given much weight.

193. The Tribunal has been careful to refer in this decision to all of the positive changes made since this matter occurred.

194. In the particular circumstances, the Tribunal does not accept that the presumption of openness should be displaced by perceived and, in the Tribunal's view, speculative concerns about reputation.

195. Dr Grenfell observed that if Dr Simmonds' name was not suppressed, the matter was likely to be linked to Boulcott Hospital. That is a matter to which the Tribunal had regard when considering the issue of name suppression for the hospital.

196. The reality is that Dr Simmonds' name was not suppressed. Dr Simmonds did not seek to renew his application for name suppression. If he had, the Tribunal would not have been disposed to grant it unless there was some compelling evidence additional to that which was advanced when he first made his application.

Dr E and the Nurses

197. The Tribunal has carefully considered whether the presumption of openness now requires that the interim suppression orders in respect of Dr E and the nurses should be discharged.

198. The Tribunal notes that none of these persons were charged and, on the facts, as the Tribunal has found them, there is no good reason why these orders should not be made permanent.

199. In these circumstances, it is appropriate that their names should continue to be suppressed.

Orders and Conclusion

200. The Tribunal therefore makes the following orders:

(a) The charge of professional misconduct laid against Dr Simmonds is dismissed.

(b) A permanent order prohibiting the publication of the names of the following persons:

(i) Ms B

(ii) Ms D

(iii) Ms C

(iv) Ms A

(v) Dr E

(c) The interim order prohibiting publication of Boulcott Clinic Limited (also known as Boulcott Hospital) is discharged. The Tribunal suspends the effect of this particular order for a period of five working days from the date of this decision.

(d) As a result of the Tribunal's decision, there are no issues as to penalty or costs.

DATED at Wellington this 20th day of November 2003

.....

S M Moran

Deputy Chair

Medical Practitioners Disciplinary Tribunal