Medical Practitioners Disciplinary Tribunal

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DECISION NO: 18/97/10C

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

IN THE MATTER of a charge laid by a Complaints Assessment Committee pursuant to Section 93(1)(b) of the Act against **M** medical practitioner of xx

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mr P J Cartwright (Chairperson)

Dr F E Bennett, Dr J M McKenzie, Dr D C Williams,

Mrs H White (Members)

Mr R Caudwell (Secretary)

Mr B A Corkill (Legal Assessor)

Mrs E Huse (Stenographer)

Hearing held at xx on Thursday 20 November 1997

APPEARANCES: Mr M F McClelland for the Complaints Assessment Committee ("the CAC").

Mr C J Hodson assisted by Mr R Ablett Hampson for Dr M ("the respondent").

DECISION:

1. THE CHARGE:

1.1 **THE** respondent is charged by the CAC, pursuant to Section 93(1)(b) of the Medical Practitioners Act 1995, that on the 13th day of March 1996 his management and treatment of A was inadequate **IN THAT**

(1) Having experienced difficulty identifying the anatomical structures in the course of his operating on the said A, for a left hydrocele repair, he failed to wait for the assistance he had summoned to arrive, and proceeded with the operation when he should not have done so; **AND**

(2) Having so proceeded, he divided the spermatic cord which resulted in the non-viability and removal of the left testicle

(3) The above particulars 1 and 2 of the charge when considered singularly and cumulatively amount to professional misconduct."

2. THE BACKGROUND:

2.1 **A** was born on 30 July 1993. His parents are xx and xx B.

2.2 **IN** November 1995 A developed a lump in his groin area and his general practitioner referred him to the A & E Department at xx Hospital. He was seen on 23 November 1995 and a probable acute hydrocele was diagnosed. He also had a small umbilical hernia. A was discharged but was placed on the urgent waiting list for ligation of the patent processus vaginalis. The possibility of operating on both the hydrocele and hernia at the same time was considered.

2.3 **A** was next seen by Dr C, consultant urologist with the Department of Urology at xx Hospital. Dr C was to repair the hydrocele and A was referred to Dr D, general and paediatric surgeon at the Department of Surgery at xx Hospital, to confirm that his umbilical hernia required surgical attention.

2.4 **AT** about 7.30 am on 13 March 1996 A was admitted to hospital for the two operations to be carried out.

2.5 **MRS** B accompanied A to the theatre at about 10.00 am that morning where she met two nurses and the consultant paediatric anaesthetist, Dr E. She was told that she would be able to see A in recovery at 11.00 am.

2.6 **ON** that day Dr C was away sick and it was decided that the morning list would be performed by a registrar under the supervision of Dr F, Consultant Urologist at the Department of Urology at xx Hospital. The list comprised two circumcisions and two paediatric hydrocele repairs. The list was given to Dr M to perform unassisted by any other surgeon. Another registrar, Dr G, was

to correct the umbilical hernia at the conclusion of the hydrocele operation. At the time Dr M was a urology registrar with limited previous experience in performing hydrocele operations.

2.7 **THE** standard hydrocele operation takes about 15-30 minutes. Having completed the two circumcisions, Dr M commenced operating on A at 10.15 am, the surgery being completed between 12.15 and 12.30 pm.

2.8 **HAVING** made the incision, Dr M was confronted with what he has described as a large amount of cremasteric muscle which resulted in him experiencing difficulty in observing the actual landmarks for the procedure.

2.9 **AFTER** some considerable time of trying unsuccessfully to establish the landmarks, and in response to Dr E who noticed he was in difficulty, Dr M asked that Dr D be called for assistance. Dr E left the operating theatre and contacted Dr D who was at an outpatient clinic in the hospital.

2.10 **WHILE** Dr E was out of the operating theatre and before Dr D arrived, the respondent recommenced careful dissection. After a short period he believed he had successfully re-established the landmarks. Therefore he continued with the operation by mobilising what he thought was the spermatic cord and the hydrocele sac; he believed that he had completely mobilised the patent processus vaginalis away from the spermatic cord. He then divided the hydrocele sac but on doing so immediately realised that he had not adequately dissected the hydrocele sac from the spermatic cord and that he had not only therefore divided the hydrocele sac but also the spermatic cord.

2.11 **DR** D arrived about 5-10 minutes after the spermatic cord had been divided. He concluded that the testicle was non-viable. Dr F, who was in charge of the list, had also been called. He was operating on his own list at xx Hospital. He arrived about 30 minutes later and also concluded that the testicle was non-viable.

2.12 **DR** E met with Mr and Mrs B and explained to them that A's spermatic cord had been damaged by Dr M in the course of the operation and it was likely that A would lose his left testicle. Dr F explained to them that if the testicle was not removed there was a risk of A becoming sterile; he strongly recommended that the testicle be removed. Mr and Mrs B consented. Dr M then completed the operation by removing the left testicle.

2.13 **A's** recovery was relatively uneventful. He was re-admitted in June 1996 when his umbilical hernia was successfully operated on, it having been decided not to proceed with this operation when complications arose in the hydrocele procedure.

3.0 EVIDENCE FOR THE CAC:

3.1 xx B AND xx B:

3.1.1 **MRS** B, the mother of A, was told by the urologist at xx Hospital that the lump was a sac of fluid and that it could be operated on in a straightforward manner. The urologist told her that the matter was urgent, but that the hospital was closing down for three months over Christmas. She wanted the operation to be performed before the end of June, if possible, as she was pregnant with her second child.

3.1.2 **ON** 7 March 1996, Mrs B went into the hospital to sign a consent form for the operation on A's behalf. This was a pre-admission interview and she went in with A. She cannot recall who the doctor was that she saw. She understood that Dr C would be doing the hydrocele operation and someone else would do the hernia, although she cannot recall the name. It was explained to her then what a hydrocele was but nothing about any risk that was involved.

3.1.3 **ON** the day of the operation Mrs B took A to xx Hospital together with Mr B and his parents. He had some preliminary tests. A nurse told her that he was going under anaesthetic at about 10.00 am and that they would be able to see him in recovery at 11.00 am. It was her understanding that Dr C or Dr D would perform the operation and that the hernia and the hydrocele would be done at the same time. She did not recall meeting Dr M.

3.1.4 **MRS** B took A to the theatre and went into the anaesthetist's room with him, as only one person was allowed to go in with him. When she went in at 10.00 am with A she met two nurses and the anaesthetist Dr E. She then waited with Mr B and came back at 11.00 am. She was told by the nurse there was no news. She asked again at 11.30 and was again told there was no news. She was quite stressed by this stage, especially as she was pregnant at the time. Just before noon a nurse came and told Mrs B and her husband that the doctor wanted to see them in theatre. They saw Mr F. He explained to them in technical terms what had happened with the hydrocele operation. He explained that the hydrocele cut had damaged the spermatic cord and that it was likely A would lose his left testicle. Mrs B was surprised that Dr M had performed the

operation as at no stage was she told that Dr C was away or that Dr M was replacing him. Mrs B did not know anything about Dr M. If she had known that a registrar was going to be performing the operation unsupervised, she believed she would have asked for the operation to be delayed until a more experienced doctor was available. She was not given that opportunity.

3.1.5 **AFTER** Mrs B was told what had happened to A she was quite shocked. They asked Mr F what he recommended and he said that if it was his own child he would recommend removal of the testicle. Mrs B recalled Mr F said there was about a 5% chance that the testicle would survive. He explained to them there was some risk of A becoming sterile if the testicle was left. They took his advice and told him to remove the left testicle. Mr F told the parents he would finish the operation. He did not apologise or mention that what had happened was an error or mistake. The operation was completed and they saw A in recovery at approximately 12.30.

3.1.6 **AT** approximately 5.30 pm Dr M came and saw Mr and Mrs B. They asked him what had happened. He said that it was just one of those things. Mr and Mrs B were quite shocked by this stage and quite upset about the whole issue. Mrs B recalled Dr M saying that when he realised what he had done his heart sank.

3.1.7 **MRS** B said at no stage was there any explanation of the risks. They later understood, from having received the file, that Dr M had assessed there being a 1 in 100 chance that A would lose a testicle. They were not told about all of what went on in the two hours A was under anaesthetic.

3.1.8 **A** was kept in hospital over night and discharged the next day at about 9.00 am.

3.1.9 **DR** M telephoned on Sunday 17 March at about 6.00 pm to check on A and asked if Mr and Mrs B had any questions. Mrs B was too upset to speak with him and handed the telephone to her husband. They had no further contact with Dr M. Later they sought legal advice and an ACC claim for medical misadventure was ultimately accepted.

3.1.10 **MR** and Mrs B have no doubt that the removal of the left testicle will affect A. Already he knows that he is slightly different to his younger brother.

3.2 KEVIN CRAIG PRINGLE:

3.2.1 **KEVIN** Craig Pringle, Associate Professor of Paediatric Surgery at the Wellington School of Medicine, was called by Mr McClelland as an independent expert on behalf of the CAC. Associate Professor Pringle graduated from the University of Otago with a degree MB Ch B in 1970 and was admitted as a Fellow of the Royal Australasian College of Surgeons in 1975.

3.2.2 **IN** order to understand the important issues in this case, Associate Professor Pringle explained it is necessary to lay out the basic anatomy of inguinal hernias and hydroceles. In his opinion it is also important to note that these are very different in children when compared with adults. The most important differences are that in children the tissues are much more friable and more easily torn and there is considerably smaller margin for error. In general, the structures are finer than one sees in adults, and there are very

significant differences in the techniques that one uses to dissect out the various structures in children as distinct from adults.

3.2.3 **AS** a consultant paediatric surgeon discussing the issues of a hydrocele repair in an infant of two years of age, Associate Professor Pringle said he would not normally mention the possibility of damage to testicular vessels or the vas, except in passing. In his opinion the incidence of damage to the testicular vessels and the vas deferens should be much less than 1% in most people's hands. In his personal practice of something in excess of over 20 years Associate Professor Pringle has been the Assistant Surgeon in three cases where the vas deferens was divided as part of the surgical procedure. When he has been the surgeon the incidence is much less than 1% of cases.

3.2.4 **IN** cases where Associate Professor Pringle was not going to be present at the operation, when his registrar is to perform the surgery, he will always advise the parents, making sure that they know and understand that the person performing the operation will be a registrar who will be supervised (often from a distance) by another surgeon. Under these circumstances, he always gives the parents the option of not having the procedure performed by the registrar. However, in a vast majority of cases under his care, the operation is actually performed by the registrar, with him scrubbed in and acting as first assistant.

3.2.5 **FROM** the operation note dictated by the respondent, Associate Professor Pringle said it seemed to him that the incision may well have been a little high, possibly as high as 1 cm above the actual site that he should have been dissecting. Once the incision has

been made a little high, Associate Professor Pringle explained it becomes much more difficult to identify the cord structures and the cremasteric fascia which is the next critical step in isolating the vessels and vas and the hernia sac from the surrounding tissue.

3.2.6 **ASSOCIATE** Professor Pringle acknowledged it is important to note that in a child with a very small patent processus vaginalis it can be extremely difficult to identify the actual patent processus vaginalis and separate this from the testicular vessels and the vas. Certainly once the vessels and the vas had been divided, there was no hope of repair.

3.2.7 **HAVING** lost his way, and given what he understood to be the respondent's level of experience with the subject procedure, Associate Professor said he considered that it would have been unlikely for the respondent to have re-established the correct plane of dissection and safely continued with the procedure. In his opinion the respondent should have waited for help, although he could understand his reasons for not doing so.

3.2.8 **IN** Associate Professor Pringle's opinion, the major mistake that the respondent made was that, having asked for assistance he then proceeded with the operation, and ultimately divided the whole spermatic cord. Certainly in his opinion, once the respondent had been informed that help was on its way, he should have waited for that help to have arrived before dividing anything. In the view of Associate Professor Pringle it would have been acceptable for the respondent to have continued the dissection and outlined the various structures that he intended to divide, but not to proceed with division until he had had some confirmation that he was at least going to divide the

correct structures. Associate Professor Pringle concluded *"Having become lost he should not have undertaken anything which was irretrievable"*.

3.2.9 **READING** the summary of figures of paediatric procedures performed by the respondent as at March 1996, Associate Professor Pringle noted that he had never operated on a hydrocele before. He said he felt quite strongly that the respondent should never have been put in the position of being asked to do his first hydrocele unsupervised. However Associate Professor Pringle acknowledged it would have been extremely difficult for the respondent to refuse to do the case, especially if he had no doubts as to his technical ability to complete the operation satisfactorily.

4.0 EVIDENCE FOR THE RESPONDENT:

4.1 M:

4.1.1 **THE** essence of the evidence given by the respondent is encapsulated in paragraph 4 of his written brief which he confirmed on oath at the hearing:

"I performed this operation with a consultant paediatric anaesthetist (Dr E) providing the anaesthetic. The operation commenced at 1000 hours and was completed by 1215 hours. I began the operation by making a typical groin incision starting from the pubic tubercle towards the anterior superior iliac spine for a distance of about 4 cm. Cautery was then utilised to go down through the superficial layers to the external oblique fascia which was then opened down to the external ring. At that stage the landmarks were rather confusing because of the large degree of cremasteric muscle. After approximately 10 minutes work I found that I had re-established the landmarks of the operation and I felt

comfortable to proceed. Dr G (general surgical second year registrar with paediatric experience) arrived at this stage to perform the umbilical hernia repair and he scrubbed and then assisted me. Dr E the anaesthetist had perceived I may have been having some difficulty establishing these anatomical landmarks and asked if I required any help. I said that I would appreciate his calling Mr D, the paediatric surgeon who said he would come. Dr E went to contact Mr D who was in his OP clinic. I asked Dr E when Mr D might arrive; he responded he would come as soon as he could. I mobilised what I believed to be the spermatic cord and the hydrocele sac. I was confident that after some further dissection I had completely mobilised the patent processus vaginalis away from the spermatic cord having re-established the landmarks to my satisfaction. Therefore I divided the hydrocele sac and transfixed the proximal portion and then divided at the suture. Immediately I realised a mistake. I had not in fact adequately dissected the hydrocele sac from the spermatic cord with the result that I had not simply divided the hydrocele sac along, but had also involved the spermatic cord itself."

4.1.2 **IN** summary, the respondent acknowledged that he had made a mistake. This lay in not adequately identifying the anatomy before proceeding. The call to the consultant, Mr D, had been initiated by a degree of confusion relating to the landmarks. He proceeded only because he felt that he had adequately re-established the landmarks.

4.2 EDWIN PATTERSON ARNOLD:

4.2.1 **ASSOCIATE** Professor Arnold gave expert evidence on behalf of the respondent. He has been a Fellow of the Royal College of Surgeons of England since 1966 and of the

Royal Australasian College of Surgeons since 1977. He is Associate Professor of Urology at xx School of Medicine and a Consultant Urologist at the xx Hospital.

4.2.2 **THE** respondent's log book shows that during his first year of training in xx he had had the following experience of operations done in the inguinal canal including orchidopexies for undescended testicles, and congenital hernias, all of these being in paediatric patients:

"21 procedures were done with him assisting the consultant surgeon, 8 where he was the operator and was assisted by the consultant surgeon, and 12 where he was the Operating Surgeon concerned. All of these 41 procedures involved dissections of the cord including vas deferens and the artery and vein to the testicle, and dissecting them from the patent processus vaginalis sac where present."

4.2.3 **IN** Associate Professor Arnold's view the differences in anatomical dissection and the expertise required to operate for orchidopexies compared to hernias/hydroceles are in fact minimal, and as many as 50-60% of cases of undescended testes have an associated hydrocele sac, which requires the same dissection skills as for an isolated hydrocele. Therefore Associate Professor Arnold said he disagreed with the opinion of Associate Professor Pringle that Dr M should not have been placed in the position of being asked to operate.

4.2.4 **IN** Associate Professor Arnold's opinion the respondent's experience was greater than most British Registrars at a similar stage of training and beginning to operate on similar

types of cases. He believes that in the respondent's case he had the experience necessary to undertake the subject procedure at that time.

4.2.5 **HAVING** sought assistance and while awaiting the arrival of the surgeon, in Associate Professor Arnold's view it was appropriate for the respondent to continue with careful dissection. If the anatomy then were to have clarified, it would have been appropriate for him to continue the procedure. If the anatomy then were to have remained unclear, then the registrar should have awaited the arrival of assistance.

4.3 COLIN ULRIC MCRAE:

4.3.1 **MR** McRae, currently practising urology in xx and the Clinical Director of the Department of Urology at xx Hospital, also gave expert evidence on behalf of the respondent. Mr McRae graduated from the University of Otago MB Ch B in 1965, was admitted as Fellow of the Royal Australasian College of Surgeons of England in 1970 and as Fellow of the Royal Australasian College of Surgeons in 1973. He is the current President of the Royal Australasian College of Surgeons.

4.3.2 **MR** McRae disagreed with Associate Professor Pringle that mentioning the possibility of damage to testicular vessels or the vas would only be done in passing. He believes that as there is a significant risk of damage to them it should be discussed with the parents.

4.3.3 **ASSOCIATE** Professor Pringle's interpretation that the respondent's incision may have been too high is not unreasonable, but must be seen as being purely speculative.

4.3.4 **MR** McRae said he agreed totally with Associate Professor Pringle that it can be extremely difficult to identify the appropriate structures and that this was the essence of the problem which arose.

4.3.5 **HAVING** worked with the respondent, Mr McRae said he did not believe that he regarded calling for help as an admission of incompetence, as suggested by Associate Professor Pringle.

4.3.6 **MR** McRae expressed total disagreement with Associate Professor Pringle's belief that the respondent should have waited for help and not proceeded. Mr McRae explained:

"It is a normal part of operating for even experienced surgeons to at times find initial uncertainty about the anatomy in any procedure. Careful dissection then usually displays the anatomy allowing the operation to proceed. This is clearly the way in which Dr M proceeded, to continue to dissect, whereupon he reached a point where he believed he had displayed the anatomy accurately. In this he was mistaken as subsequent events showed but I believe his decision to continue with careful dissection was appropriate at that time. Indeed Dr Pringle indicates "It would have been acceptable for him to have continued the dissection and outlined the various structures that he intended to divide". This is what Dr M did and believed he had clearly established the anatomy and then proceeded to divide the structures. He was incorrect in believing he had displayed the anatomy properly and therefore divided the cord. The decision to proceed with the dissection I

believe was appropriate. Dr M clearly made a mistake but I believe he followed a reasonable path for a surgeon to undertake."

5. SUBMISSIONS:

5.1 **MR** McClelland invited the Tribunal, on the evidence before it, to conclude that despite experiencing significant difficulties over a period of some time which in the interests of his patient required the respondent to call for assistance, for whatever reason he chose not to. Mr McClelland submitted that judged against the standards of a reasonably competent registrar in similar circumstances, the respondent should have sought assistance on his own initiative, rather than the initiative of the anaesthetist, much earlier.

5.2 **MR** McClelland explained it was the CAC's case, having sought help, that the respondent should have waited for it to arrive. Mr McClelland explained there were no urgent factors which required the respondent to recommence the operation unaided or unassisted; as events unfolded A remained under the anaesthetic until approximately 12.30, at least another 1¼ hours after the call for assistance. There were no other factors, in Mr McClelland's view, which necessitated the respondent pressing on without waiting for the help he called for.

5.3 **FOR** the respondent Mr Hodson was critical of Mr McClelland's argument that the respondent, despite unsuccessfully trying for some 20-30 minutes to re-establish the landmarks, did not on his own initiative call for help. Mr Hodson explained that this surgery, like any other surgical procedure, was a team operation and that it was always open to the CAC to call Dr E to give his opinion whether there was any particular significance in him suggesting that assistance be sought. Mr Hodson reminded the Tribunal of the evidence given by the respondent, that although

Dr E may well have suggested putting out a call for assistance, that it was a conclusion which the respondent had reached himself already, and that his articulation of it was made almost contemporaneously with Dr E's suggestion.

5.4 **MR** Hodson emphasised that in his view the most important aspect was the respondent's honest and firmly held belief that he had re-established landmarks. If this case was to be classified as professional misconduct, then Mr Hodson argued it would be hard to imagine a situation in which it could ever be said that a doctor had the appropriate degree of skill and experience to go on and make important decisions. In conclusion Mr Hodson submitted that the charge had not been established to the appropriate standard of proof.

6.0 LEGAL PRINCIPLES:

6.1 **THE** respondent faces one charge of professional misconduct.

6.2 **THE** Tribunal has the power to amend the charge during the hearing pursuant to Clause 14 of the First Schedule of the Medical Practitioners Act 1995. It was determined by the Tribunal that no amendment to the charge was necessary.

6.3 **THE** Tribunal must determine whether the facts alleged in the charge have been proved to the required standard. It is well established in professional disciplinary cases that the civil, rather than the criminal, standard of proof is required, namely proof to the satisfaction of the Tribunal, on the balance of probabilities. At the same time, however, the cases recognise that the degree of satisfaction which is called for will vary according to the gravity of the allegations.

6.4 **IF** the facts are established to the required standard, then the Tribunal must go on to determine whether the conduct established by the proven facts amounts to professional misconduct.

6.5 **THE** definition of professional misconduct is well established. In *Ongley v Medical Practitioners Disciplinary Committee* [1984] 4 NZAR 369, at 374 to 5, Jefferies J stated in the context of the 1968 Act:

"To return to the words "professional misconduct" in this Act. .....

In a practical application of the words it is customary to establish a general test by which to measure the fact pattern under scrutiny rather than to go about and about attempting to define in a dictionary manner the words themselves. The test the Court suggests on those words in the scheme of this Act in dealing with a medical practitioner could be formulated as a question. 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? With proper diffidence it is suggested that 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 composition of the tribunals which examine the conduct. Instead of using synonyms for the two words the focus is on the given conduct which is judged by the application to it of reputable, experienced medical minds supported by a layperson at the committee stage."

6.6 **THE** charge combines two complaints by alleging a course of conduct on the part of the respondent. The Tribunal will consider each particular independently, then cumulatively, in the context of the overall charge that the respondent's management and treatment of A B on 13 March 1996 was inadequate. In *Duncan v Medical Practitioners Disciplinary Committee* [1986] 1 NZLR 513 at 537 the Court of Appeal described the approach to a cumulative charge as follows:

"When there is a comprehensive charge as well, the Council should go on to consider it after determining the separate charges. Having made the findings on the separate charges, they should arrive at a conclusion as to the overall gravity of the conduct of which they found the practitioners guilty."

7.0 FINDING:

7.1 **AS** to Particular 1 of the charge, there is little dispute that Dr M experienced difficulty identifying the anatomical structures in the course of the operation on A. The issue to be determined by the Tribunal is whether, as particularised in the charge, it was appropriate for the respondent to proceed with the operation in such circumstances. It is the CAC's submission and the expert opinion of Associate Professor Pringle, that the respondent should not have proceeded with the operation in such circumstances.

7.2 **AS** was observed by Mr Hodson, there was quite a marked difference in the evidence given by the expert witnesses. The Tribunal upholds Mr Hodson's submission, where there is a clear difference in respective medical opinions, that there is no black or white answer. In Mr Hodson's

view, where there are two lines of reputable expert medical opinion, each is open to acceptance by a Tribunal such as this Tribunal. We agree.

7.3 **IN** summary, it was Associate Professor Arnold's view that the respondent had had an adequate experience of operations in the inguinal canal to undertake the surgery in question. He had the unfortunate experience of operative difficulties and a serious complication ensued. No-one would deny that a mistake was made, and the operation went wrong. All would have preferred a totally different outcome, particularly the B family and the respondent. But it must be remembered, in Associate Professor Arnold's opinion, that even in the best and most experienced surgical hands, the vessels and/or the vas deferens can be damaged.

7.4 **LIKEWISE**, in summary, although Mr McRae conceded that the respondent clearly made a mistake, he believed that his decision to continue a careful dissection to see if he could establish the landmarks was appropriate, even though he knew his problem was largely due to or at least contributed by his inexperience. Given that the respondent was put in a situation of conducting an operating list in a largely unsupervised capacity, Mr McRae concluded that the respondent acted appropriately.

7.5 **IN** preferring the evidence of Associate Professor Arnold and Mr McRae, the Tribunal has taken into account an acknowledgement made by Associate Professor Pringle which it considers has considerable significance. It will be remembered Associate Professor Pringle considered it was important to note that in a child with a very small patent processus vaginalis, *"it can be extremely difficult to identify the actual patent processus vaginalis and separate this from the testicular vessels and the vas"*. In answer to a question posed by the Chairperson to Mr

McRae, it was his response, in the Chairperson's use of the vernacular, that even a *"seasoned operator"* such as an experienced consultant urologist, could make the mistake which, most unfortunately, was made by the respondent.

7.6 **AS** to Particular 2, there is no dispute that having proceeded, the respondent divided the spermatic cord which resulted in the removal of the left testicle.

7.7 **HAVING** carefully considered all of the evidence, both lay and expert medical evidence, the demeanour of the witnesses, the legal principles and comprehensive submissions of counsel, the Tribunal finds that the most unfortunate accident which happened must be classified as a non-culpable error which ought not to attract, on the particular facts of this case, any sanction in the nature of professional misconduct. Therefore the charge is dismissed.

7.8 **BEFORE** concluding this Decision the Tribunal will comment on a number of matters arising which it considers are of a public interest nature.

8.0 PRE-ADMISSION FAILURE TO PROPERLY INFORM:

8.1 **THE** evidence of Mr and Mrs B is undisputed. They had explained to them what a hydrocele is, but nothing about any risk that was involved. It was presented as a straightforward operation.

8.2 Recommendation:

8.2.1 **THE** xx CHE should heed the advice of the expert evidence which was given in this case.

8.2.2 **ACCORDING** to Associate Professor Arnold, damage to the blood supply of the testes can occur in the best of surgical hands. Accordingly it is a risk which should always be discussed with parents before the operation. Likewise it was the opinion of Mr McRae that the possibility of damage to testicular vessels or the vas is a significant risk which should always be discussed with the parents.

9.0 CONSULTANT/REGISTRAR:

9.1 **AT** all times the parents understood that Dr C, the consultant, was going to perform the hydrocele repair and that someone else would do the hernia. Although the respondent gave evidence that he introduced himself to Mrs B as the operating surgeon, Mrs B does not remember this.

9.2 Recommendation:

PARENTS such as Mr & Mrs B, with a clear expectation of surgery to be performed by a consultant, should always have it explained if the person performing the operation will be a registrar. This explanation should be given in such a way that the parents know and understand the situation fully. Within a public hospital setting it should be understood that the hospital does not guarantee who will actually perform the operation.

10. ANXIETY OF NOT KNOWING:

10.1 **THE** parents understood A was going under anaesthetic at 10.00 am and that they would be able to see him in recovery at 11.00 am. Having been told at 11.00 am and 11.30 am that there was no news, Mrs B said she became stressed at this stage, especially as she was pregnant at the time. It was not until just before noon that a nurse came and told the parents that the doctor

wanted to see them in theatre. After she was told what had happened to A, Mrs B said she was quite shocked.

10.2 Recommendation:

WHILST the Tribunal accepts that difficulties may arise during an operation, they add increased stress to the operators. The Tribunal believes that stress on the relatives also increases with the passage of time. Accordingly every effort should be made for some professional person to communicate as comprehensively as possible with such relatives.

11.0 CONSULTANT COVER FOR THE OPERATING LIST:

11.1 AS was observed by Mr McClelland, this case raises a number of issues relating to the systems, policies and protocols relevant at the time at the Department of Urology at xx Hospital.

11.2 IT is of some concern to the Tribunal that it seemed to be unclear just who was responsible for the immediate supervision of the respondent.

11.3 ASSOCIATE Professor Arnold explained seeking assistance when in doubt is a very important aspect of surgical training. He explained structures are in place in any hospital which indicate that the consultant under whose care the patient is admitted, should be called for any advice or about any concerns.

11.4 ASSOCIATE Professor Arnold further explained that in the case of sick leave or unavoidable absence, arrangements should have been quite clear, that the consultant on acute call for the week must be contacted for all emergencies. If he/she were to be unable to provide that cover,

then one of the other three consultants would be nominated by the Urology Unit. Operating theatres, the emergency department, the urology ward, the unit secretaries and the registrars need to know and understand these lines of communication, Associate Professor Arnold explained.

11.5 **IT** was acknowledged by Associate Professor Arnold that the Urology Department at xx Hospital accepts that it might not have been clear to the respondent what were the appropriate lines of communication. Since this operative problem arose Associate Professor Arnold said the system and lines of communication have been documented to avoid any future recurrence of the problems. He explained that the role of any systems failure has been expressed and acknowledged publicly by the Clinical Director of Urology and since then has been the subject of independent inquiry by the Health and Disability Commissioner, who has yet to report.

11.6 **Recommendation:**

NO specific recommendation seems necessary provided the review system for the supervision of trainees in the operating theatres at xx Hospital is ongoing and proceeding satisfactorily. Associate Professor Arnold explained that this aspect, plus out patients, urodynamics and other aspects of surgical practice at xx Hospital, is continually under review, both by the Royal Australasian College of Surgeons and locally. In Associate Professor Arnold's view no trainee should operate without a consultant ready and available to assist if necessary. Practically, however, he said it would be impossible for every operation to be performed by a consultant surgeon. So the decision as to when a trainee is well enough trained to do his/her first operation, is a matter of assessment and judgement by the consultants concerned, and takes into account the numbers of procedures undertaken by that particular person.

12.0 PROSTHESIS:

12.1 APPARENTLY a discussion has taken place with Mr and Mrs B concerning the insertion of a prosthetic testicle in the scrotum when A is older. It is understood from Associate Professor Arnold that this procedure is best deferred until the patient is through puberty so that a prosthesis approximately the same size as the opposite testicle can be selected.

12.2 Recommendation:

GIVEN that the claim made on A's behalf in medical misadventure has been accepted by ACC, it would be reasonable to assume that ACC will cover this cost at the appropriate time. A commitment to this effect should be sought from ACC now. Mr and Mrs B have the support of this Tribunal should they also wish to seek an assurance from the xx CHE that any costs not covered by ACC will be met by it.

DATED at Auckland this 11th day of December 1997

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P J Cartwright

Chairperson

Medical Practitioners Disciplinary Tribunal