Case Commentary

Case History

Henry Chappell was a 56 year old man who had been smoking since he left school at 16 years (approximately 40 years of smoking a pack per day). He presented to his general practitioner with haemoptysis and a chest X-ray showed a solitary tumour nodule near the centre of the right lung. After further investigation, he was referred to a thoracic surgeon who recommended removing Henry's lung, as there was no evidence of the cancer spreading to other parts of his body. On the day of the operation the surgeon arrived slightly late and somewhat flustered from a difficult operation at another hospital. Mr Chappell was already anaesthetised and positioned on the table, hidden under the drapes. The operation was uneventful and Mr Chappell returned to the ward in the early evening.

The following morning the routine post-operative chest X-ray was taken. The surgeon reviewed it on her ward round that afternoon. To her horror she discovered that the one remaining lung was the one with the tumour and that she had removed the wrong lung. Any further surgery was impossible. On reviewing the sequence of events, it became obvious that there had been a transcription error made from her correctly filled-out request for admission to the actual booking-slip, and that this error had been continued throughout the process of hospitalisation. Although the consent form had also contained the error, the house surgeon had not checked with the patient the side of the affected lung and Mr Chappell had not noticed the error on the form (he had not been wearing his reading glasses when signing). The pre-operative chest X-ray had been taken when he was an outpatient and was not reviewed by the house staff pre-operatively. Due to her haste and lateness of arrival, the surgeon had not stopped to check the notes or the X-ray prior to the operation. Mr Chappell was now certain to die from his previously curable cancer.

What should the surgeon do?

Commentary One

Nicola Peart

Senior Lecturer in Law, University of Otago

Re: The surgeon's removal of Mr Chappell's healthy lung

The first thing the surgeon should do is to contact her lawyer, because this case is likely to give rise to complaints to the Health and Disability Commissioner and to the Medical Council. Civil and criminal proceedings against the surgeon are also a possibility.

On the facts as stated, the surgeon's act of removing the healthy lung instead of the diseased one will be covered by the Accident Rehabilitation and Compensation Insurance Act 1992 ('ARCI Act') as a medical misadventure. Mr Chappell will argue that he suffered a 'personal injury resulting from a medical error'. 'Medical error' is defined in section 5 of the Act as 'a failure of a registered health professional to observe a standard of care and skill reasonably to be expected in the circumstances'.

The surgeon's removal of the wrong lung is clearly a medical error. The fact that this was the result of a clerical error on the admission slip, which had not been picked up on admission by the house surgeon, will not affect this finding. Her failure to check the notes and to review the chest X-ray before the operation to confirm which of the two lungs was diseased was a serious error on the part of the surgeon. It was a fatal oversight which will cost Mr Chappell his life, when a simple check might have cured him of the disease. Clearly the surgeon has not met the standard of care expected in these circumstances.

While the patient may receive some compensation from the Accident Compensation Corporation – and it will not be much – that will not conclude the matter for the surgeon. If the Corporation considers that the surgeon's actions may be attributable to negligence, it is obliged to report the circumstances to the Medical Council with a view to the institution of disciplinary proceedings (s5 (10)).

Assuming that ACC does refer this case to the Medical Council, the Council will be obliged to refer the matter forthwith to the Health and Disability Commissioner ('Health Commissioner') to determine whether the surgeon breached the Code of Health and Disability Services Consumers' Rights ('the Code of Rights'). Section 86 of the Medical Practitioners Act ('MPA') requires the Medical Council to suspend its actions until the matter has been dealt with under the Health and Disability Commissioner Act (HDC Act).

Code of Rights

The Health Commissioner may already be involved in the case, for example if Mr Chappell has made a complaint under Right 10 of the Code of Rights. Irrespective of the route by which the case comes to the Health Commissioner's attention, she is empowered to investigate a case of this sort to determine whether the actions of the surgeon constitute a breach of the Code (ss31-40 HDC Act). The Code and the complaints procedures have already been described in volume 5 of the Otago Bioethics Report, and reference should be made to these contributions for a more complete picture.

It is too soon to tell how this Code is likely to be interpreted, but based on the facts as stated, the Health Commissioner is bound to find that there has been a breach of the Code. Right 4(1) is of particular relevance to this case as it requires health care providers to deliver services with reasonable care and skill. The removal of a healthy lung instead of the diseased one does not appear to meet this standard.

If the Health Commissioner is of the opinion that the surgeon has breached the Code of Rights, she may report her opinion to the Medical Council together with such recommendations as she thinks fit, includ-

ing a recommendation that disciplinary proceedings be taken against the surgeon (s45 HDC Act).

She may also refer the matter to the Director of Proceedings, who has the power to decide whether to institute proceedings before the Complaints Tribunal, or before any other tribunal, such as the Medical Disciplinary Tribunal, or even before a court of law. In making this decision the Director may have regard to the wishes of the patient. The Director must also give the surgeon the opportunity to be heard before instituting any proceedings (s49 HDC Act).

If the case comes before the Complaints Tribunal, it will determine whether the surgeon has acted in breach of the Code of Rights, in which case it may grant one or more of the remedies listed in section 54 of the HDC Act. These remedies include a declaration that the defendant has breached the Code, an award of damages to the patient, an order that the defendant perform acts to redress the loss or damage suffered and any other relief the Tribunal thinks fit. The Tribunal also has the power to make an award of costs against the defendant.

In this particular case the Tribunal will not be able to award compensatory damages, because the breach is a medical misadventure which is covered by the ARCI Act (s52(2)), and any compensation will be determined in accordance with the provisions of that Act. But the patient may receive punitive damages if the Tribunal finds the actions of the surgeon to be 'in flagrant disregard' of the rights of the patient (s57(1)(d)). As the Complaints Tribunal has yet to hear a complaint in regard to the Code of Rights, it is unclear when a patient's rights will be held to have been flagrantly disregarded so as to warrant punishing the service provider. But it is quite possible that this is such a case.

Medical Practitioners Act 1995

This may still not be the end of the matter for the surgeon. Disciplinary proceedings may also be instituted against the surgeon in accordance with the provisions of the 1995 Medical Practitioners Act. The case can come before the Medical Disciplinary Tribunal either through the Medical Council or through the Director of Proceedings. If the Medical Council takes the initiative, it will set up a Complaints Assessment Committee to determine whether the case should be considered by the Medical Practitioners Disciplinary Tribunal (s93 MPA). This Committee has the power to lay a charge and prosecute the case before the Tribunal. If the Director of Proceedings decides to lay a charge he or she will prosecute the case before the Tribunal.

In the circumstances of this case the surgeon is likely to be charged with disgraceful conduct in a professional respect or with conduct unbecoming a medical practitioner (s109 MPA). If found guilty of the first charge the surgeon may be removed from the register. On the second charge the surgeon can at most incur a fine of up to $20,000. She may also be suspended or ordered to practise under supervision (s110 MPA).

Civil liability

While the above proceedings are the most likely ones to be instituted against the surgeon, Mr Chappell may wish to take civil action against the surgeon, either in addition or as an alternative to the complaints processes under the HDC Act and the MPA Act. However, as the injury which Mr Chappell has suffered is covered by the ARCI Act, any civil claim will again be limited to punitive damages. The availability of such damages in cases such as this one was recently confirmed by Justice Tipping in *McLaren Transport Ltd v Somerville* (High Court Dunedin, 13 August 1996). His Honour held that punitive damages may be awarded 'if, but only if, the level of negligence is so high that it amounts to an outragous and flagrant disregard for the Plaintiff's safety meriting condemnation and punishment'.

The words used by Justice Tipping are similar to the requirements for punitive damages in the HDC Act. So it may be assumed that it will make little difference in which forum these damages are claimed. As the proceedings of the Complaints Tribunal are likely to be less formal and cheaper than any case before the District Court or High Court, a civil claim seems an unattractive option for the patient to pursue.

Criminal liability

It may be of greater concern to the surgeon that she may face criminal charges. Her failure to use reasonable care and skill in performing the operation may warrant a charge of injuring by unlawful act (s190 Crimes Act). A conviction on this charge depends on the degree of negligence required for the crime. At the time of writing this commentary ordinary negligence was sufficient for a conviction, but it seems likely that the Crimes Act will be amended to require a higher standard of care. The Bill which is currently before Parliament requires a major departure from the standard of care expected of a reasonable person in those circumstances (s150A Crimes Amendment Bill No 5 of 1996). While there can be little doubt that the surgeon would be guilty on the ordinary standard of negligence her breach may be sufficiently serious to justify a conviction on the higher standard of care.

If Mr Chappell dies within a year and a day of the operation, the surgeon may even be charged with criminal manslaughter for failing to use reasonable care and skill in performing the operation (s155 Crimes Act). The time of death is crucial for a manslaughter charge. S162 of the Crimes Act will relieve the surgeon from criminal responsibility for Mr Chappell's death if he does not die within a year and a day of the operation, as the death will be too remote from the alleged cause.

Conclusion

The legal consequences outlined above paint a grim picture for the surgeon. No doubt she is already suffering enormously for her mistake, even if none of these complaints and charges are brought against her. She is unlikely ever to make this mistake again, nor is she likely ever to forget. But society demands some form of public accountability for errors such as these, particularly when the result is so disastrous for the patient.

Commentary Two

Professor John Morton

Christchurch School of Clinical Medicine

What should the surgeon do?

On the brief evidence given, the surgeon has made an honest error, which will have far-reaching and serious consequences for Henry Chappell, the surgeon, the institution and many associated persons.

Accidents of this nature occur in all human activity and are not, in themselves, evidence of moral error. The surgeon can best demonstrate her

integrity, by subsequent honourable action.

She must first ensure that Henry Chappell's continuing physical and mental care, is given very careful thought and attention. She must inform Henry Chappell what has happened and discuss with him (and his family) who will be responsible for continuing care. Under the circumstances, the patient may want his care taken over by another surgeon. She should make it clear to him and his family that this can be arranged, if that is their wish.

The surgeon should inform her employers, her insurers and her staff of what has happened. She should immediately prepare a detailed account of every step in the work-up of the case, the information provided in the informed consent process, and every other particularity. Opinion, unsupported by evidence, should be avoided. There is an example of this in the summary provided. 'Mr Chappell was now certain to die from his previously curable cancer.' Many patients with apparently solitary tumours near the centre of the lung, with no evidence of spread, are bound to die from lung cancer even after the lung is removed and this should have been made clear to the patient when the surgical option was being considered.

While all the events are fresh in their memory, detailed accurate reports should be written by every individual involved. These are bound to be necessary later, and it is best if the facts of the case are recorded as soon as possible after the event.

As this case illustrates, catastrophic events of this kind involving, as they do, several members of a team, tend to be the product of a series of particular acts or omissions none of which, when considered in isolation, need have disastrous consequences. Careful attention therefore needs to be given to discovering practical ways of refining, or introducing additional checks and safeguards to the standard official procedure, so that if one person makes an error it will automatically tend to be picked up further down the track by another member of the team. Human error is always a possibility and no one is morally obliged to be infallible. However, where co-operative actions are involved, as is nearly always the case in the provision of health services, we have an obligation to devise ways of reducing the chance of cumulative error to a minimum, even though it will never be possible to eliminate it altogether.

The surgeon should seek counselling for her staff and herself. This is important, both for those involved, and for the welfare of future patients.

Australian Bioethics Association: Fifth Annual Conference

Melbourne: Thursday 3 to Sunday 6 April 1997

International House
The University of Melbourne
241 Royal Parade
Parkville
Victoria

Proposed Programme

The conference will open with the Christine Martin Memorial Lecture, to be given by Professor Richard Zaner. The next three days will include concurrent sessions for submitted papers, and plenary sessions on the conference special themes:

- cross-cultural ethics
- the new genetics
- ethical issues in nursing
- the body
- feminist ethics and ethics of care
- ethics and narrative

Call for Papers

Proposals for papers on all aspects of bioethics are invited. Preference may be given to those which address the special themes of the conference.

Registration Fees (A$)

	ABA member		*non-member*	
	full	concession	full	concession
full	190	120	210	140
daily	100	70	120	90

Deadline for submission of abstracts is 15 February 1997.

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