Orthopaedic Surgeon/Anaesthetist/Theatre Nurse/ Anaesthetic Nurse/Scrub Nurse

A Private Hospital

A Report by the

Health and Disability Commissioner

(Case 00/06857)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Consumer
Mr B	Consumer's husband
Dr C	Orthopaedic Surgeon
Dr D	Anaesthetist
Ms E	Theatre Nurse (Registered General and Obstetric Nurse, a private hospital)
Ms F	Anaesthetic Nurse (Registered Comprehensive Nurse, the private hospital)
Ms G	Scrub Nurse (Registered Comprehensive Nurse, the private hospital)
Ms H	Enrolled Nurse (the private hospital)
Dr I	Orthopaedic Surgeon (a second private hospital)
Ms J	Theatre Nurse Manager (the private hospital)
Dr K	General Practitioner
Dr L	General Practitioner

Independent expert advice was obtained from an orthopaedic surgeon, an anaesthetist and a theatre nurse.

Complaint

On 11 July 2000 the Commissioner received a complaint from Mrs A about the services she received from Dr C and a private hospital. An investigation commenced on 18 October 2000 with notification to Dr C and the private hospital and, following initial enquiries, the investigation was extended on 12 December 2000 to include the theatre team working with Dr C during Mrs A's surgery. The complaint is as follows:

Dr C
Dr C, orthopaedic surgeon, failed to provide services of an appropriate standard to Mrs A on 3 November 1999 by:

- *Mistakenly operating on Mrs A's wrong knee.*
- *Continuing with the procedure on the correct knee, when it was discovered that the wrong knee had been operated on, thus putting both knees out of action at the same time.*
- *Not using reasonable care and skill when operating on the correct knee.*

These actions resulted in Mrs A's mobility being compromised and resulted in pain of both knees, which required two subsequent operations and permanent disfigurement.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Dr D
Dr D, anaesthetist, failed to provide services of an appropriate standard to Mrs A on 3 November 1999 by:

- *Not checking correctly that Mrs A was to have her right knee operated on. Instead Mrs A's left knee was wrongly operated on.*

Ms E
Ms E, circulation nurse, failed to:

- *Provide services of an appropriate standard to Mrs A on 3 November 1999 by not correctly checking Mrs A was to have her right knee operated on as per the consent form of the private hospital's Policies and Protocols. These state that a check needs to be made that the operation site is correctly marked. Instead Mrs A's left knee was wrongly operated upon.*

Staff Nurse G
Staff nurse Ms G failed to:

- *Provide services of an appropriate standard to Mrs A on 3 November 1999 by not correctly checking that Mrs A was to have her right knee operated on as per the consent form and the private hospital's Policies and Protocols. These state that a check needs to be made that the operation site is correctly marked. Instead Mrs A's left knee was wrongly operated upon.*

Anaesthetic Nurse Ms F
Anaesthetic nurse Ms F failed to:

- *Provide services of an appropriate standard to Mrs A on 3 November 1999 by not correctly checking Mrs A was to have her right knee operated on as per the consent form and the private hospital's Policies and Protocols. These state that a check needs to be made that the operation site is correctly marked. Instead Mrs A's left knee was wrongly operated upon.*

Additionally the investigation included the following complaint:

Dr C

- *A further operation to her right knee on 19 January 2000 by Dr C was not performed with adequate care and skill, in that Mrs A continued to experience discomfort and decreased mobility following this operation.*

Information gathered during investigation

On 8 October 1999 67-year-old Mrs A was referred by her general practitioner, Dr K, to orthopaedic surgeon Dr C, with a torn medial meniscus in her right knee.

On the morning of 3 November 1999 Mrs A was admitted to a private hospital as a day surgery patient for a right knee arthroscopy and medial menisectomy, and a right second extensor tenotomy. According to the theatre list, Mrs A's surgery was scheduled for 1200 hrs that day and the theatre team was Dr C (the surgeon conducting the operation), Dr D (the anaesthetist) and Nurses E, F and G. They had all worked with one another on various surgical operations over a number of years.

The theatre list was running approximately two hours behind schedule and, around 1400 hrs that day, Ms F, anaesthetic nurse, went to collect Mrs A from the ward. Ms F went through the pre-operative checklist with Mrs A, which included checking the consent form to ensure the correct operation had been consented to and was the same as that written on the theatre list: "a right arthroscopic menisectomy, knee". Mrs A confirmed with Ms F that it was her right knee to be operated on, as shown on the consent form and theatre list. Ms F then proceeded to take Mrs A down to the inpatient waiting bay before continuing on into theatre to prepare for the anaesthesia.

Together, Dr C and Dr D visited and spoke to Mrs A in the waiting bay. As part of his routine pre-anaesthetic preparation, Dr D spoke to Mrs A about her medical and surgical history and checked the medical history questionnaire that she had completed. Dr C discussed with Mrs A that as well as the right knee arthroscopy to which she had consented and was scheduled for, there was an additional procedure to be done, namely a right toe extensor tenotomy. Mrs A consented to this additional procedure and, as Dr D had a pen with him, he added the additional procedure to the consent form in the presence of Dr C and Mrs A. Dr D then asked Mrs A to countersign it. Neither site was marked on Mrs A.

Soon afterwards, Dr D helped wheel Mrs A into the operating theatre and, together with Ms F, commenced preparation for induction of anaesthesia. Mrs A complained that at that time there was loud music playing in the operating theatre and a 'MASH'-like atmosphere.

Ms E greeted Mrs A in the operating theatre and introduced herself and Ms G, who was scrubbing up. Ms E checked the consent form against the theatre list to ensure that Mrs A was the correct patient and that the surgical procedure was correct. As part of standard pre-operative checks, Nurses E and G both checked the consent form and noticed that the site for surgery was not marked. At that time, according to the nurses' responses to the Commissioner, Ms E informed Dr C that the limb was not marked. Ms G then went to set up the trolley, opening equipment and preparing for the surgery.

While Dr C was still scrubbing up, Dr D and Ms F were attending to the anaesthesia of Mrs A, and Nurses G and E were busy organising the equipment, paperwork and preparing for

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surgery. At that point Ms H came into theatre to collect some equipment. Ms H was not part of this theatre team.

Ms H informed me that as she was looking for her equipment, Dr C asked her to apply the tourniquet to Mrs A's leg. Ms H noticed that Mrs A's left (incorrect) leg was exposed and tapped the leg, asking Dr C if that was the correct leg. Ms H states that Dr C said "Yes", and so she proceeded to apply the tourniquet around Mrs A's left thigh. This took her about one minute. Ms H states that she did not notice whether the limb was marked. Dr C thanked her and she left the theatre with her equipment. Dr C stated in his response to the complaint that he does not know how the error was made, but thought that perhaps he had been examining the left knee when Ms H entered the room, as he usually checks both the knee for surgery and the 'fit' knee. Therefore, when he had asked her to apply the tourniquet, she had mistakenly believed she was to apply it to the left leg. Nurses E, F and G all confirm that they were aware of Ms H entering theatre, knowing she was not part of that theatre team, and being asked by Dr C to apply the tourniquet to Mrs A's leg. However, none of them saw her apply it, nor was specific reference made to a particular leg – right or left.

Shortly after the tourniquet was applied, Dr C painted Mrs A's tourniqued left (incorrect) knee and Ms G assisted him in draping the left leg in preparation for surgery. Dr D and Ms F were focused on the anaesthetic, and Ms E was attending to the paperwork checks.

It is worthy of note that Dr C, and Nurses E, F and G note in their responses to me that they had sighted the consent form, knew that surgery was intended for Mrs A's right (not left) knee, and that the operation site had not been marked. Dr D informed me that while he was aware that the patient had consented to the operation on her right knee, he was not specifically aware that the operation site had not been marked.

According to the Incident/Accident Complaint Report Dr C commenced surgery on Mrs A's left (incorrect) knee at 1442 hrs. After the operation commenced, Ms F left the theatre to get some supplies. Ms E, on writing up the operation in the theatre register, noticed that the theatre staff were sitting on the left-hand side of Mrs A and realised that the incorrect (left) leg was being operated on and alerted Dr C immediately. Dr C assessed the situation and noted that the left knee did demonstrate some minor articular damage, and so completed the surgery to the left knee. According to the Incident/Accident Complaint Report, this procedure was completed at 1453 hrs. Dr C further assessed that the arthroscopy was unlikely to give rise to significant disability and so decided to continue the operation on Mrs A's right (correct) knee. Dr D had no objection to this as Mrs A was tolerating the anaesthetic well. According to Ms F, she was called back into theatre by Dr D, who informed her that the wrong side had been operated on.

The surgery was completed without further event. Mrs A was taken to Recovery where Dr C informed her of the error and apologised unreservedly to her. He also apologised on behalf of the hospital and the staff.

Incident report
While Mrs A was in Recovery, the theatre team, with the exception of Dr C, met to discuss the incident. At the time of the meeting they completed the Incident/Accident Complaint Report. Dr C sent a copy of that report to me, although I was informed by Dr D that Dr C was not actually involved in drafting this report. The 'Description of Event' section of the report states:

> "[Mrs A] was seen in waiting bay by [Dr C] (surgeon), limb was not marked at that time but patient had discussion with the surgeon and [Dr D] (anaesthetist) about which limb was being operated on (R) and the additional surgery of the extensor tenotomy also to her (R) foot, this was added to the consent form and signed by [Mrs A] and [Dr D]. See additional sheet".

Dr D notes, however, that while he did write the additional toe operation onto the consent form he did not sign the consent form.

In the 'Immediate Action Taken' section it notes:

> "… surgeon notified and correct limb then operated on. Patient informed of incident by [Dr C] in recovery unit. Principal nurse, anaesthetist and surgeon spoke again to [Mrs A] and husband in ward."

On the section of the report entitled 'Event Follow Up' the report notes:

> "… error occurred because usual procedure of consultant surgeons marking the limb for surgery did not occur
> – even though nursing colleague from the next theatre was asked to apply the tourniquet and did so communicating with the consultant as to which side this error still occurred consultant surgeon should apply own tourniquet only consultant did not do so.
> All team members involved requested to meet for debriefing session."

In the section entitled 'Action taken to remedy underlying cause and prevent a reoccurrence', the report notes:

> "a team error
> as the patient was the last of the day this debriefing session occurred immediately. Incident discussed – resulting in a memo to all orthopaedic consultants."

As Mrs A was coming round from the anaesthetic Dr C approached her and informed her of the erroneous operation to her left knee and explained what had occurred. Dr C informed me that he apologised for the incorrect operation. Mrs A does not recall Dr C apologising and informed me that he said he was "embarrassed" and "did not know how it happened". While these accounts differ, it is not significant.

Mrs A was admitted to the ward overnight on 3 November 1999. While in the ward, Dr C explained to her that the hospital wanted her to stay overnight, at no charge, since she lived some distance away. Dr C visited Mrs A on the ward the next day, prior to her discharge, and once more repeated his apology for what had happened. Dr D also spoke to Mrs A and her husband while she was in the ward.

Dr C and Dr D subsequently offered to waive their fees.

Dr C – wrong site surgery issue
In his response to the complaint, Dr C agreed that the responsibility of operating on the correct site was his and reiterated his apology. However, Drs C and D both comment on the importance of working as a team in theatre.

Dr C indicated his level of experience of arthritic injury and noted that he had been performing arthritic surgery since the late 1970s when it became a common therapeutic tool. Over this period of time he has performed hundreds of arthroscopies and has not operated on the wrong side. His current average number of arthroscopies per month would be between 10 and 12. Dr C added that since the event on 3 November 1999, prevention of this all-too-common occurrence has been his goal. Dr C advised that following the incident he developed a protocol designed to prevent the re-occurrence of wrong site surgery. The hospital also advised me that a protocol had been developed, but maintained that the protocol had in fact been developed by the Clinic's own staff without the involvement of Dr C. In a telephone discussion with one of my staff, Ms J emphasised that the policy was developed by the hospital staff. She noted that she understood Dr C was subsequently involved in its wider dissemination among other bodies, but stated that the initial work was done within the hospital.

The protocol developed by the hospital after the incident is as follows:

> "1. It is the surgeon's responsibility to identify the limb in an appropriate manner.
>
> 2. It is the nursing responsibility to ensure that these checks have been carried out and that the patient will not be admitted to the operating room until they are completed.
>
> This policy essentially centres around limiting responsibility and being clear about who is responsible for what procedure. The surgeon does the following:
>
> 1. Discusses with the patient just prior to theatre, what surgery is to be carried out, and on which limb the surgery is to be conducted. The area is then marked with a wide indelible pen in such a way that the indelible mark will appear on the prepared site on the operating room table so that it is not obscured by the drapes.

2. If a tourniquet is applied to the limb it is the surgeon's responsibility to apply that tourniquet.

The nursing responsibility is as follows:

1. The anaesthetic nurse is responsible for checking that before the patient is taken into theatre, all the appropriate documentation is completed and that the site has been marked clearly with an indelible pen close to the site of the surgery (the patient does not proceed to the operating theatre unless the site is marked).

2. When the patient reaches theatre it is the role of the circulating nurse within the theatre to check that the consent form is signed, a note is made of any allergies, and that the operation site is marked with an indelible pen close to the site at surgery."

Dr C notes that the key to success of a protocol is that the operating team must work as a team with defined roles, and that checking and re-checking is necessary in order to avoid lapses that may occur on busy or stressful days. Dr C informed me – and this was confirmed by the hospital – that the protocol has been given to the Medical Misadventure Unit of ACC at their request, and the document has also been circulated more widely in an endeavour to reduce the risk of wrong site surgery in New Zealand.

Dr C provided copies of the hospital's protocols and policies that were in use at the time of the operation on 3 November 1999. Dr C also provided me with a copy of a memorandum dated 4 November 1999 drafted by Ms J, Theatre Nurse Manager, and circulated by the hospital to orthopaedic consultants, in response to the incident on 3 November 1999. The subject of the memorandum was identifying limbs for surgery. The memo states:

"With regards to identification of patient's limb for surgery could I please ask of you that the patient's limb be identified with an indelible pen prior to surgery.

It would be appreciated if you could mark the appropriate limb prior to the patient entering theatre, e.g. when they are in the:

Day surgery change room;
Inpatient waiting bay.

To further confirm correct limb identification, the tourniquet is also to be applied by the consultant.

Neither roles are to become nursing responsibilities."

Dr C added that in the past, at his request, Dr D, his anaesthetist, had occasionally marked the site for surgery.

The private hospital – response to the incident
The private hospital informed me that it immediately acknowledged that the error had occurred. As already noted, members of the theatre team, with the exception of Dr C, held a meeting to discuss the incident. I have also noted above that the hospital circulated a memorandum to all orthopaedic consultants formalising the previously informal practices in relation to marking of the surgical site. The hospital also informed me that a memorandum was entered into the theatre book for theatre staff.

A staff meeting was held a few days later, and the incident was discussed. Discussions focused on the action nurses might take if the surgeons involved did not follow appropriate procedures. The pre-operative checklist was also amended to acknowledge the fact that the surgical site needed to be marked.

The Clinic also informed me that their staff developed policies relating to the marking of limbs, application of tourniquets, and checking in of patients to theatre. The hospital noted that these policies have been reviewed on a number of occasions since 1999, and also that the role descriptions for each of the nurses have been reviewed and the scope of service for the Perioperative Unit developed.

Finally, the hospital concluded:

> "The [hospital] is committed to the development and implementation of quality systems. These systems have been developed to the level where the [hospital] achieved accreditation through Quality Health New Zealand in 2001."

Dr C – issue of operating with reasonable skill and care on correct knee
In response to the allegation of failing to exercise reasonable care and skill when operating on the correct knee, Dr C stated:

> "It is noted that this patient had articular cartilage damage as well as a torn cartilage in the posterior horn of the meniscus. This was restricted but only a limited amount of improvement could be accomplished as the articular cartilage damage was likely to have contributed to the disability. The loose fragments of meniscus were trimmed but the remaining part of the posterior horn was probably not normal. A decision at that point had to be made as to whether an extensive menisectomy was carried out which may prejudice that articular surface of the knee or to operate more conservatively. I opted at the time to only remove that part of the meniscus which was obviously damaged and causing mechanical symptoms in the hope that further, more sensitive surgery, could be avoided. As it turned out [Mrs A] did not improve."

Dr C further stated:

> "[Mrs A's] right knee demonstrated arthroscopic evidence of articular cartilage damage of a significant degree in associate with a damaged medical meniscus. In

> essence, it is an early arthritic knee. The response to arthroscopic debridement of this type of knee is unpredictable. While many patients benefit substantially from removing loose pieces of meniscus and indeed loose fragments of articular cartilage, the outcome is not always good."

The medical records provided by Dr C show that he examined Mrs A on 12 November 1999, eight days after the first surgery. Dr C noted in the records:

> "[Mrs A] had an arthroscopic menisectomy about 12 days ago. She has done very well from this and has excellent function. She has already removed the bandages because they were annoying her and they are fine with the wounds well healed. I have done an extensor tenotomy on the second toe. She is going to do all her own physiotherapy and I have suggested to her that I would be happy to see her again as necessary."

Dr C examined Mrs A again on 10 December 1999 and 14 January 2000, at which times he recorded that she complained of some discomfort in her right knee. Dr C recommended that she have a second arthroscopy of her right knee, to which she agreed.

On 19 January 2000, at the private hospital, Dr C carried out a second arthroscopy of Mrs A's right knee. The anaesthetist and theatre nurses were different from those involved in the first operation on 3 November 1999. Mrs A noticed that there was no music playing in the theatre on this occasion. Following the surgery Mrs A was discharged later that day.

On 31 January 2000 Dr C wrote to Dr K advising him of the second surgery and noting that Mrs A was making good progress.

On 7 March 2000 Dr K referred Mrs A to Dr I, an orthopaedic surgeon at another private hospital. In his letter of referral Dr K stated:

> "[Mrs A] has been treated by [Dr C] with arthroscopy, firstly in November 1999 and again in January. [Mrs A] is unhappy with her progress, although her confidence in [Dr C] is probably affected by him operating on the wrong side in the original operation. [Mrs A] may well only require reassurance that things will settle down in time, but I feel she would be happier with another specialist opinion on the state of her knees."

On 6 June 2000, at the second private hospital, Dr I performed a third arthroscopy and medial menisectomy on Mrs A's right knee. In response to the Commissioner, Dr I stated:

> "The most likely reason for [Mrs A's] right knee to be in the state it was in was secondary to osteoarthritis with a possible post arthroscopic synovitis secondary to previous arthroscopic surgery to the right knee. I do not think there was anything that particularly could have been done to prevent the state of her right knee, all attempts have been made surgically to try and correct the internal derangement which I felt was

> entirely appropriate and unfortunately there is nothing specific that could have been done to prevent the onset of arthritis and this was probably going to happen no matter what course of action she took."

Dr I further stated:

> "With respect to her left knee this did not seem to be causing her any undue discomfort when I last saw her on the 15th of May 2000."

Ms E

Ms E is a registered nurse and obstetric nurse. She has been employed by the first private hospital since August 1985, holding the position of staff nurse and team leader. She has worked with Dr C since 1975, first at a public hospital, then at the private hospital, but does not work on all of his operating lists. She has worked with Dr D for about four years.

Ms E confirmed that she is familiar with the policies and procedures entitled "Role of the Circulating Nurse". She added that at the time of Mrs A's surgery, when Dr C and Dr D were working together, Dr D would normally apply the tourniquet.

In her role as team leader she had responsibility for managing the list flow, equipment, breaks, and turnover. It was not her responsibility to orientate each individual nurse to his or her role. The theatre manager (Ms J) had that responsibility. There was no formal theatre nurse training or education when she commenced work as a theatre nurse. Dr C would normally have painted the leg and draped it with the assistance of the scrub nurse.

Ms E advised me that it was not usual practice for a nurse who was not part of the theatre team to enter the theatre and carry out tasks.

Ms F

Ms F is a registered comprehensive nurse. She was an employee of the private hospital from January 1999 to June 2000 in the position of staff nurse in the operating theatre. She worked most Wednesdays in theatre with Dr C and Dr D. During her time at the hospital she was not made aware of the policies or procedures "Role of the Anaesthetic Nurse" or any other policy that stated she had to check that the site for surgery was marked. She had no orientation to her position.

On 3 November 1999 Ms F was carrying out the role of anaesthetic nurse.

Ms G

Ms G is a registered comprehensive nurse and had been working as a staff nurse in the operating theatre at the private hospital since 10 March 1994. On 3 November 1999 she was the scrub nurse for Mrs A's operation. She advised me that she had had no formal orientation to her role but was aware of the policies and procedures for the role of scrub nurse.

Ms G advised me that although she had checked the consent form for Mrs A's surgery, and knew that the right knee was to be operated on, she still assisted Dr C in draping and preparing the left knee on 3 November 1999.

Ms H
Ms H is an enrolled nurse and has been working in the operating theatre at the private hospital for the past eight years.

Dr D
Dr D is a specialist anaesthetist vocationally registered with the New Zealand Medical Council since 1984. He holds a fellowship of the Australian and New Zealand College of Anaesthetists and is registered with the College's maintenance of professional standards programme (MOPS).

In his response to the complaint, Dr D stated that the anaesthetist has no responsibility in relation to patient consent for surgery. Nor was it his responsibility to mark the surgical site. He also stated that at the time of Mrs A's surgery on 3 November 1999:

> "[L]imbs were not routinely marked prior to day-stay surgery. I accept that we work as a team and if any of the team had noticed anything untoward (even if it was someone else's area of responsibility) there would be an obligation to speak out promptly. Unfortunately, this did not occur soon enough in [Mrs A's] case."

Dr D referred me to the Australian and New Zealand College of Anaesthetists "Guidelines on the Duties of an Anaesthetist" and "The Pre-Anaesthetic Consultation".

Other Issues

The private hospital
In a letter to me dated 3 April 2001, Ms J, Theatre Nurse Manager, the private hospital, stated:

> "You ask who was responsible for orientating nurses to theatre. No particular staff member was designed the role of educator, preceptor or buddy. For a number of years we remained an unchanged team of experienced theatre nurses. For ongoing education, keeping up to date was through:
>
> - Networking with other colleagues in other departments/hospitals.
> - Our local pre-operative interest group.
> - Study days.
> - Attending conferences.

- In services.
- Subscription to international peri-operative journals.

1998 saw us increasing our staff of which one new member drafted a two-week schedule for experienced staff to use and follow. We did not have the resources for a designated educator – using existing staff to provide an informal support/teaching role when available.

1999 saw us taking a new graduate from the full understanding that we had no formal training programme in place – the informal outline involved set pathway involving the nursing staff and the medical staff providing support, guidance and teaching when/where available.

The outline was anaesthetic nurse role/scrub assistant role, progressing into the recovery areas and attending the recovery course at [a public] Hospital. The scrub nurse role followed this was brief as the staff member moved to [a public] Hospital Perioperative unit for further experience.

2000/2001 has seen us taking on more staff – some experienced in the area, some completely new to the area. Orientation programmes have improved as has our staffing levels allowing us to buddy more successfully.

You asked who was responsible for making nurses aware of the policies and protocols of theatre.

Ultimately the responsibility for any policy and/or procedure introduced into the department is my responsibility. Our policies are either organisation wide or department specific. Our department procedures have always involved the staff on the floor so they are working with a format that they can actually practise. We communicate in a variety of ways:

- Regular staff meetings, (monthly).
- Communication book.
- Communication board.
- In-services.
- Study days/seminars.
- Conferences.
- Local pre-operative interest group.
- International perioperative journals."

The private hospital is a limited liability company. It employs Nurses E, F and G but does not employ Dr C or Dr D. They are specialists who hold clinical privileges to use the facilities at the hospital. Health professionals must apply to hold these privileges, and the applicants are screened by members of the credentials committee of the hospital. Privilege agreements may

be terminated. Only surgeons with clinical privileges at the hospital are permitted to use the facilities or to admit patients to the hospital. The rules governing independent practitioners using the hospital facilities at the time were set by the credentials committee of the hospital.

The hospital stated through its legal counsel that it did not have any liability in relation to Dr C or Dr D, as the Clinic does not employ either doctor.

Independent advice to Commissioner

Orthopaedic surgeon

Independent expert advice was obtained from an orthopaedic surgeon, Dr Denis Atkinson. Dr Atkinson is a Fellow of the Royal Australasian College of Surgeons and a Fellow of the New Zealand Orthopaedic Association. A full transcript of Dr Atkinson's advice is appended to this report as Appendix 1.

A summary of the key points of Dr Atkinson's advice is as follows:

> "[Dr C] has provided a reasonable and skilled standard of care for the degenerative condition of [Mrs A's] right knee.
>
> [Dr C] failed to provide [Mrs A] a reasonable and skilled standard of care by erroneously operating on her left knee on 03/11/99.
>
> Identification of site and procedure in surgery is a collective responsibility of the operating surgeon and nursing staff. Strict adherence to current Health Department protocols should help minimise the complication of wrong site surgery."

Further information received from Dr Atkinson included a copy of the Royston Hospital protocol. He stated that he believed it was circulated to orthopaedic surgeons in New Zealand in late 1999, and understood that the recommendations were endorsed by the New Zealand Orthopaedic Association at that time. He stated that this is the background to his comments concerning [Mrs A].

Anaesthetist

Independent expert advice was obtained from an anaesthetist, Dr Malcolm Futter. Dr Futter is a member of the New Zealand Society of Anaesthetists, Associate Member of the American Society of Anaesthetists, a Fellow of the Australian and New Zealand College of Anaesthetists, Fellow of the Royal College of Anaesthetists, member of the Society of Paediatric Anaesthesia and founding member of the Society of Paediatric Anaesthesia of New Zealand and Australia. Dr Futter's advice is appended to this report as Appendix 2.

A summary of the key points of Dr Futter's advice is as follows:

> "[The private hospital] and all relevant health professionals had some responsibility in ensuring the overall provision of care was of an appropriate standard.
>
> Practices should have followed agreed policies and guidelines.
>
> Primary responsibility for ensuring the correct surgery was performed lay with the surgeon.
>
> The anaesthetist's primary responsibility was to provide anaesthesia and perioperative care and secondarily, if it was apparent to him, to advise others when aspects of the patient's care for which they in turn were responsible, were not of an acceptable standard.
>
> In entering information onto the consent form, [Dr D] may have unwittingly assumed more responsibility for the conduct of the surgery than he intended or was appropriate."

Theatre nurse

Independent expert advice was obtained from a theatre nurse, Ms Gill Raven. Ms Raven is a registered general and obstetric nurse, and has postgraduate qualifications in nursing, midwifery and medical law. A copy of her advice is appended to this report as Appendix 3.

A summary of the key points of Ms Raven's advice is as follows:

> "Having read the statements of the nursing staff in theatre on the 3rd November 1999 it remains unclear as to who held the leg while the painting and draping of [Mrs A's] leg took place. This person along with the scrub nurse should have noticed that they were preparing the wrong leg for surgery, given that they checked the patient's consent form and the printed operating theatre list. The three staff members assigned to [Mrs A's] case state that they checked the consent form but all failed to notice that the wrong leg was prepared and subsequently operated on. It is my assertion that both the scrub nurse and the circulating nurse have a duty to check the consent form, equally the anaesthetic nurse should have this knowledge.
>
> [The private hospital's] policy for checking in patients clearly states that one component of the anaesthetic nurse's role is to check the consent form and to pass on appropriate information to the Anaesthetist and Circulating Nurse. The policy for the circulating nurse similarly states that this person is responsible for checking the consent form.
>
> Individually the Registered Nurses are responsible for checking the patient's consent form, checking this against the printed theatre list, and informing the surgeon of the omission to mark the limb. They are under a duty to safeguard the welfare of the

> patients in their care. Individually and collectively they have omitted to alert the surgeon to his error, however [Dr C] too has a duty to care for his patient as he has overall responsibility to undertake the correct surgery."

Two matters arising out of Ms Raven's advice need clarification. In response to my provisional opinion, Ms E informed me that at no stage during the procedure did she leave the operating theatre. She notes that Ms Raven may have mistakenly assumed that she had to leave the theatre to fill in the register. However, at the [private hospital] the paperwork is kept on a trolley in the theatre.

Ms E also notes that Ms Raven states that "individually and collectively [Ms E and Ms G] have omitted to alert the surgeon to his error [in failing to mark the limb]. Ms E notes that this is not in fact correct, as she did bring the omission to Dr C's attention. I accept this, and have formed my opinion on this basis.

Responses to provisional opinion

All parties responded to my provisional opinion. However, the main thrust of the submissions is discussed within the body of the section entitled "Commissioner's Opinion".

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint.

RIGHT 4

Right to Services of an Appropriate Standard

1) *Every consumer has the right to have services provided with reasonable care and skill.*

…

5) *Every consumer has the right to co-operation among providers to ensure quality and continuity of services.*

Opinion: Breach – Dr C

Right 4(1)

In my opinion Dr C breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights in operating on Mrs A's incorrect knee on 3 November 1999.

Advice from my independent orthopaedic advisor confirmed this view. However, even in the absence of expert advice, the matter is in my view self-evident; a surgeon who operates on a patient undoubtedly has an obligation to ensure that the correct operation is being performed on the correct site. Anything less prima facie amounts to negligence on the part of the surgeon and is thus a breach of Right 4(1) of the Code. In the present case there is nothing to mitigate Dr C's failure. Dr C himself admits the mistake and has not offered any plea in mitigation.

From the time of the incident, Dr C acknowledged the mistake, took responsibility and apologised. He has at no stage tried to deflect the responsibility he bears for the incident and has assisted my Office over the course of this investigation. This is to his credit. However, Dr C must bear primary responsibility for the wrong site surgery taking place. He was the person ultimately responsible for the correct progression of the surgery and he failed in this fundamental duty. Furthermore, the situation is aggravated by the fact that nurses did point out to Dr C that the operative site had not been marked. This was a clear signal of the potential for a mistake to occur, and one that in my opinion should have prompted Dr C to address the issue. The situation is also aggravated by the fact that Dr C, knowing the operative site was not marked, then asked a nurse who was not a member of the theatre team to apply the tourniquet while she was in the theatre on unrelated business.

The responses of other providers have strongly submitted that my opinion should reflect the differing degrees of responsibility that each member of the theatre team bears. I accept that while other providers also breached the Code in relation to this incident, the primary responsibility was that of Dr C, and I wish to make that point clear. That is not in any way to detract from the fact that others in the theatre team also had professional responsibilities. It is simply an acknowledgment that, as the surgeon, it was primarily incumbent on Dr C to ensure that the leg upon which he was operating was the correct one.

In my view Dr C failed to exercise reasonable skill and care and thus breached Right 4(1) of the Code. The mistake was a serious one, which has caused a considerable amount of distress to the patient.

A theatre team is called a 'team' for good reason; while each member has his or her own primary responsibilities, there must be some measure of collective responsibility when serious errors occur. It is my opinion that to a degree other members of the team are also accountable for what occurred. I shall discuss this in more detail later in this report.

Opinion: No Breach – Dr C

Right 4(1)
I accept the advice of my expert advisor that Dr C acted with reasonable care and skill both in deciding to operate on Mrs A's correct knee once the initial mistake was discovered and also in performing that operation and the subsequent one.

In relation to the issue of whether the operation on the correct knee should have been performed immediately, my orthopaedic advisor noted:

> "[Dr C's] decision to proceed to operate on [Mrs A's] right knee following inadvertent surgery on the left knee was appropriate and professionally sound. … [Mrs A] was stable under her anaesthesia. The procedure to the left knee involved two small arthroscopic portals and saline lavage of the joint. Such a procedure was unlikely to cause the patient any immediate post-operative problems with mobility and would be unlikely to cause any long-term morbidity.
>
> The alternative was for [Dr C] to have the patient wakened from anaesthesia and to leave the condition of her right knee untreated. This would have required further surgery and further induction of anaesthesia, putting Mrs A at greater risk."

In relation to the issue of whether Dr C exercised reasonable care and skill in operating on Mrs A's correct leg, my advisor noted:

> "[Dr C's] surgery to [Mrs A's] right knee was appropriate and of an adequate standard. … Subsequent surgeries and radiographs of [Mrs A's] right knee have confirmed a progression of the osteoarthritic process in the medial compartment of the joint immediately adjacent to the damaged medial meniscus. It is this underlying process that is the cause of [Mrs A's] ongoing symptoms. … Arthroscopic meniscal surgery in the degenerate knee has an unpredictable outcome. Arthroscopic treatment of a degenerate meniscus may give short term relief of mechanical symptoms but underlying osteoarthritic changes are likely to cause progressive pain in the medium term. Arthroscopic intervention in these circumstances may fail to improve in up to 30% of cases."

Accordingly I am satisfied that Dr C acted reasonably, first in relation to his decision to proceed with the operation on the correct leg once the incorrect site was discovered and, secondly, in his performance of the subsequent surgery on the correct knee. I therefore consider that Dr C did not breach Right 4(1) of the Code in relation to this aspect of Mrs A's complaint.

Opinion: No Breach – Dr D

Right 4(1)
There is no doubt that Dr D performed his anaesthetic duties entirely appropriately. The issue for determination is the degree to which he should be held accountable for the wrong site surgery.

Dr D was present when Mrs A signed the consent form in respect of the correct knee. Dr D also took the additional step of adding to the consent form in relation to the right toe extensor tenotomy that was to be performed at the same time, and obtaining Mrs A's signature. Dr D involved himself in the consent process and was specifically aware that the surgery was to be performed on the right knee.

My expert anaesthetist advisor noted that, in the normal course of events, the anaesthetist would not be required to take any active steps to ensure the correct knee was operated on. Had he noticed the mistake he would have had an obligation to draw it to the attention of the surgeon. However, my advisor also noted that in the present case Dr D went beyond his standard duties as anaesthetist and entered information relating to the surgery onto the consent form. In these circumstances my advisor considered that Dr D may have "unwittingly assumed more responsibility for the conduct of the surgery than he intended or is appropriate".

Dr C informed me – and this was also commented on by my expert advisor – that in the past Dr D has marked the surgical site on the patient. It is therefore apparent that Dr D has in the past adopted – and on this occasion did adopt – responsibility over and above that which an anaesthetist would normally carry, and this was a practice known to his theatre colleagues.

However, I accept that at the critical times – when Mrs A was being prepared for surgery and as the surgery was commencing – Dr D had other key responsibilities. At that point his primary responsibility was to ensure the appropriate and safe administration and monitoring of Mrs A's anaesthetic. There is no doubt that he did so. It would be onerous to expect Dr D, in addition to his anaesthetic duties, also to be aware of the inappropriate preparation of the patient and the mistake at the time the surgery commenced.

Accordingly, I am satisfied that Dr D exercised reasonable skill and care, and thus did not breach Right 4(1) of the Code.

In my provisional opinion I criticised some aspects of Dr D's practice relating to his inappropriate involvement in the consent process by marking information on the consent form, and inappropriate marking of the surgical site prior to surgery. Dr D made detailed submissions in relation to this matter.

First, Dr D emphasised that in noting the further operation on the consent form, he was in no way involving himself in the consent process. Dr D noted that he did not discuss the surgery with Mrs A – that was the role of Dr C. Dr D emphasised that there was no suggestion that he was involved in the surgery itself. He submitted that he was instead simply acting "in a

spirit of co-operation" in the "innocent role of scribe" for Dr C. He also noted that he did not himself sign the consent form, and concluded that the criticism contained in my provisional opinion was "both erroneous and somewhat mischievous".

There is no basis for Dr D to suggest that my original comments were mischievous. However, I accept his explanation of his involvement in the pre-operative paperwork being done by Dr C. I can understand that in the interests of collegiality and co-operation it could appear pedantic to refuse to undertake a minor administrative task such as entering of information onto a consent form. Nevertheless, I recommend that Dr D consider the comments of my expert in this regard. There is a fine line between "acting in a spirit of co-operation" and "unwittingly assuming more responsibility than is intended or is appropriate". I simply flag this issue for Dr D to consider in his future practice.

In my provisional opinion I also commented on Dr D's previous practice of, on occasion, marking the operative site for the surgeon. Dr D noted in relation to this point that the marking was always done at the express direction of the surgeon. Furthermore, since a previous incident involving wrong site surgery on a patient's hip, he had already ceased this practice.

Opinion: Breach – Ms E

Right 4(1)

Ms E was the circulating nurse during the operation on 3 November 1999. My expert advisor, Ms Gill Raven, advised me that in her experience the circulating nurse is "in charge of the theatre during the course of a list to which she is assigned. The circulating nurse has an overall view of the needs related to the surgery undertaken."

Ms E was the person, other than Dr C, who was in the best position to appreciate the mistake that was being made when the surgery was commenced on the incorrect leg. Ms E had checked the consent form and the operating list to ensure that Mrs A was the correct patient for the correct operation. Ms E also checked whether the operation site was marked, noted that it was not, and brought this to the attention of the surgeon, Dr C. Ms E was also the person who noticed that the operation was in fact being performed on the incorrect leg and brought this to Dr C's attention.

Ms E adhered to the appropriate policies and procedures and, having noticed that the correct operation site was not marked prior to the surgery, brought this to Dr C's attention. However, Ms E's responsibility did not end with notifying Dr C of the omission. She had a professional responsibility to ensure the safety and wellbeing of the patient; she was not entitled to simply rely on Dr C's knowledge of the omission, nor to assume that Dr C would ensure the omission was corrected.

Ms E heard Dr C ask Ms H to apply the tourniquet to Mrs A's leg. Ms E knew that Ms H was not part of the theatre team, that Dr C had not specifically mentioned the right leg to Ms H, and that the surgical site was not marked. In these circumstances, I consider that a reasonably prudent circulating nurse in Ms E's position would have ensured that the tourniquet was applied properly to the appropriate site, and that surgery was ready to proceed in the correct manner.

Ms E and her lawyer made detailed submissions in response to my provisional opinion. In her submissions Ms E accepted that she bore some responsibility for the safety and welfare of the patient. However, she advised me that she considered she was entitled to expect Dr C to rely on the advice she had given him in relation to the limb being unmarked. She stated that, in the past, when she had advised surgeons of omissions, they had acted on her advice. After noticing that the limb was unmarked, and advising Dr C accordingly, Ms E said that she focused on assisting the scrub nurse.

Ms E noted:

> "I accept that I could have followed through with him to check that he had marked the limb, but I fully expected that my advice would be listened to and acted upon by him as it had been on previous occasions."

In relation to the issue of Ms H coming into theatre and applying the tourniquet, despite not being a member of the theatre team, Ms E noted that she did not see what Ms H was doing with Dr C in relation to tourniqueting the limb. Ms E said that she heard them talking and considered that Ms H was not a stranger to the particular type of operation, tourniqueting a limb, or to Dr C. Ms E stated that she was not as concerned as she would have been had Ms H not been a nurse about whom she was confident.

Ms E also noted that at that stage she had just informed Dr C that the limb was not marked and therefore did not expect that he would tell Ms H to tourniquet the wrong limb. Had she been aware that the wrong limb had been indicated, Ms E would have prevented Ms H from applying the tourniquet.

Ms E's lawyer submitted that my opinion that Ms E was not entitled to rely solely on Dr C correcting his omission was inconsistent with my opinion that there is an expectation that there will be sufficient co-operation and communication amongst team members to minimise the risk of harm to the patient. I do not agree that these positions are inconsistent. From the perspective of the patient there is an expectation that members of a theatre team will be collectively responsible for the patient's welfare, and that communication and co-operation will be effective to achieve this end. However, this expectation of collective responsibility for patient welfare does not supplant individual responsibility. It is entirely consistent to expect collective responsibility from team members, *and* individual responsibility as health professionals. In the present case the team undoubtedly failed; the actions of individuals also failed to meet appropriate standards. That is not an inconsistent position.

Ms E's lawyer submitted strongly that it was entirely reasonable for Ms E to have relied on her expectation that Dr C would correct the omission once she had pointed it out to him. The crux of the submissions was that:

> "A circulating nurse should be able to rely on the fact that once she has advised another senior team member of an omission, that team member, whose responsibility it was in the first place not to make the omission, will correct it."

In relation to the issue of the tourniqueting of the limb, it was submitted:

> "It was reasonable of [Ms E] to assume that [Dr C] would have indicated the correct leg and would not tell [Ms H] to tourniquet the wrong leg. This is because:
>
> a) [Ms E] had on other occasions advised surgeons, including [Dr C], of matters including omissions and they had acted on her advice;
>
> b) She had advised [Dr C] not only that the limb was not marked but also which limb was to be operated on; and
>
> c) After she had advised [Dr C] that the leg was not marked and reminded him which leg was to be operated on, she heard [Dr C] speak with [Mrs A] and ask her if this was the leg to be operated on and she heard [Mrs A] say yes;
>
> d) She heard [Ms H] ask him if the leg she was tapping was the correct one and she heard [Dr C] say yes; and
>
> e) [Dr C] was part of the theatre team and it was reasonable to expect that he would act upon his circulating nurse's advice."

I have carefully considered these submissions from both Ms E and her lawyer but I remain of the view that Ms E breached the Code. It was unreasonable for Dr C to instruct Ms H to tourniquet the wrong limb; it was also unreasonable for him to operate on the wrong limb. That is not in doubt. However, I do not accept that Ms E was entitled to entirely rely on her notification to Dr C. The submissions of Ms E and her lawyer on the issues certainly explain the reasons why Ms E relied on the fact that she had pointed out the omission, and why she did not check the tourniquet. Those reasons are credible. But, in my view, they do not constitute a reasonable excuse for Ms E's failure to prevent the wrong site surgery. In the circumstances of this case, that was her responsibility.

In the words of my expert advisor, Ms E was the person "in charge of the theatre during the course of a list to which she is assigned". As discussed above, Ms E was aware that the limb was not marked, and was aware that a nurse from outside the theatre team had come into theatre and had applied a tourniquet to the patient's limb. In the circumstances, as the person in charge of the theatre, and the person with the "overall view of the needs related to the surgery", I think a reasonable circulating nurse in Ms E's position would have ensured that the earlier omission had been corrected prior to the surgery commencing.

Ms E informed me that following this incident she has changed her practice and does not expect a surgeon to take her advice. However, she does note that she should be entitled to rely on her team members.

Ms E also made submissions in relation to the respective levels of culpability of herself and Dr C as the surgeon. Ms E discussed Dr C's actions and concluded:

> "Whilst I am not trying to avoid responsibility on my part I feel that my responsibility for this serious error is much less than [Dr C's]. You say that there were two occasions on which the risk was made evident to me, yet you have not acknowledged that the risk was created by [Dr C] on those two occasions. … I would ask that this be reflected in your opinion and the weight of responsibility be more fairly adjusted to take into account his creation of the risks that you consider I should have prevented."

I accept Ms E's submissions in relation to this issue, and have already noted elsewhere in this opinion that I do not consider that the individuals involved share equal responsibility for the incident. Ms E appropriately accepts that she should bear some responsibility for the mistake. There was sufficient information available to her to have prompted her to take further steps to ensure the patient's safety.

For these reasons, in my opinion Ms E failed to act with reasonable care in failing to prevent surgery commencing on the incorrect leg, despite at least two occasions on which the risk was made evident. Accordingly, I consider that Ms E breached Right 4(1) of the Code.

Opinion: Breach – Ms G

Right 4(1)

Ms G noticed during her pre-operative procedures that the correct surgical site was not marked. She was aware that Ms E had brought this to Dr C's attention. Despite this, Ms G assisted Dr C to drape Mrs A's incorrect leg.

Ms G knew which knee the operation was supposed to be performed on. She had checked the consent form. She had noticed that the correct operation site was not marked and was aware that this had been brought to the surgeon's attention. Yet Ms G assisted in draping the incorrect leg. In my opinion Ms G's responsibility did not end at the time she became aware that the surgeon knew the surgical site was not marked. She had a continuing responsibility, in the words of my expert nursing advisor, to "safeguard the welfare of the patient's care". Although it may seem reasonable to assume that in assisting in theatre she could take her lead from the surgeon, Ms G is herself a trained professional with responsibilities to her patients. The fact that the surgeon mistook the leg to be operated on is no excuse for Ms G "assisting in procedures that she should have known were wrong. Ms G had an independent professional responsibility as part of the theatre team and could not simply rely on the surgeon to direct

proceedings. Where she possessed knowledge clearly indicating a serious mistake was about to be made, Ms G had a responsibility to recognise the situation and to respond appropriately.

In her response to my provisional opinion, Ms G accepted that she had some responsibility for the safety and welfare of the patient. However, it was apparent that Ms G felt strongly that while she accepted partial responsibility, her actions arose directly out of mistakes made by Dr C.

In relation to the issue of draping the incorrect limb, Ms G noted that she did not see the painting and tourniqueting of the limb. This was because her role as scrub nurse involved her setting up the trolley with the appropriate instruments. In doing this her back was to the patient and therefore to the surgeon as well. Ms G turned towards the patient only after the limb was painted, to assist with the draping.

Ms G submitted that she assisted with draping a limb that had already been 'marked' by Dr C, in that a tourniquet had already been applied and the limb painted. Ms G noted:

> "I accept I could have checked it was the correct [limb] and now I do check, but I feel I am not equally responsible with [Dr C] for the error of the wrong limb being operated on. I feel that I was 'set up' to drape the wrong limb because it was tourniqueted and painted by the surgeon. Also I did not drape on my own. I assisted [Dr C] to drape the limb. [Dr C] is a member of the theatre team and I reasonably expected him to have acted on Staff Nurse [E's] advice that the limb was not marked and so have taken all precautions not to tourniquet and paint and drape the wrong limb. This is not an unreasonable expectation given that after scrubbing, the surgeon's role is to tourniquet, paint and drape whereas the scrub nurse and circulating nurse have other roles they have to be very focussed on such as setting up instruments and counting swabs etc."

Ms G's lawyer also made detailed submissions on her behalf. Essentially, these submissions are similar to Ms G's. The key submission is as follows:

> "… [O]nce a tourniquet has been applied it can reasonably be expected (because of the previous checks that should have taken place when applying the tourniquet by the surgeon) that it is on the correct limb. … [Ms H] could reasonably in the circumstances rely on the two 'marks' of the tourniquet and of the painting carried out by [Dr C]. … A reasonably prudent scrub nurse in [Ms G's] position would not foresee that the surgeon would make **four** major errors behind her back. … A reasonably prudent scrub nurse would expect to be able to trust him not to create such significant risks."

I have carefully considered the submissions of Ms G and her lawyer. As with Ms E, these submissions are essentially an explanation of the reasons why Ms G acted as she did in taking her lead from the surgeon and assisting him to drape the incorrect limb. I do not consider that

the submissions really address the underlying issue of whether Ms G had an independent professional responsibility to identify the error.

I acknowledge Ms G's admission of partial responsibility. To a certain extent I agree with her submission that she was set up to fail by the actions of Dr C, but this cannot excuse her from any responsibility. Ms G had a professional responsibility, independent to that of the surgeon, to do what was reasonably within her power to ensure the safety of the patient. While I understand that she might feel aggrieved that she was let down by the surgical team leader, it is nevertheless important to recognise that there were several points at which she could have prevented the mistake occurring. In assisting a surgeon to drape a limb, a nurse is not acting in the role of an untrained, unskilled extra pair of hands. In my view, where a trained nurse has knowledge directly relevant to the performance of a task, that knowledge must be applied in a way that is in the interests of the safety of the patient. Ms G knew which leg the operation was to be performed on as she had checked the consent form. She should have applied that knowledge. This case demonstrates the dangers of failing to exercise such individual responsibility and instead relying on the professional responsibility of others.

Ms G's lawyer also submitted that it would be difficult to tell whether an exposed limb was the left or right one. I am not making a finding on that point but in any event do not see that it alters the situation. Even if it were difficult to tell simply by observation, in the process of draping it would be a simple task to verify which side of the body the limb was on.

In determining my opinion that Ms G breached Right 4(1) of the Code I am not indicating that Ms G shares equal responsibility with Dr C for the incident. What I am saying is that irrespective of what was or was not done by the surgeon, Ms G herself had professional responsibilities that she should have exercised to prevent this mistake occurring. A theatre team must operate with a system of checks and balances. While individuals should in the normal course of events be able to rely on team members, they cannot disassociate themselves from their own involvement in major errors simply because they incorrectly took their lead from the mistakes of another member of the team. If that were the case, there would be no checks or balances within the system.

I also accept that Ms G's back was turned while Ms H was tourniqueting the limb and Dr C was painting it. Had Ms G seen Ms H tourniqueting the incorrect limb and Dr C subsequently painting it, she would potentially have been alerted to the impending mistake. However, despite this point, my opinion remains that Ms G had sufficient information upon which she should have acted to prevent the wrong site surgery occurring. Ms G had checked the consent form and knew on which limb the surgery was supposed to proceed. In these circumstances, I consider that Ms G failed to exercise reasonable care and skill in then proceeding to assist Dr C to drape the incorrect leg.

For the reasons outlined above, I consider that Ms G failed to exercise reasonable care in performing her duties in theatre, especially in assisting with the draping of the incorrect leg and then failing to notice that the operation was being performed on the incorrect leg. Accordingly, I consider that Ms G breached Right 4(1) of the Code.

"Swiss cheese" model
In her submissions, Ms G's lawyer discussed the "Swiss cheese model" of organisational accidents, and related it to the present case. The conclusion of her analysis is that the ultimate error of the wrong site surgery was a consequence of a number of other preceding failures, many of which were 'active' errors by Dr C.

It is not realistic for me to seek to critique this analysis. That is not the purpose of my report, which is to state my opinion whether the providers under investigation breached the Code. The "Swiss cheese" analysis goes deeper than that, and is aimed at identifying the reasons behind the accident, so that the risk of this accident may be minimised in the future.

That is a valid and important way to respond to adverse events. It is not, however, the Commissioner's function. Ultimately, there is nothing in the analysis that changes my view that the providers involved had an individual professional responsibility in respect of Mrs A's surgery, and that in some cases they breached the Code. My opinion is entirely consistent with root cause analysis, but approaches the issue from a Code perspective, rather than an organisational risk management perspective.

Opinion: No Breach – Ms F

Right 4(1)
As part of her pre-operative duties Ms F discussed the consent form with Mrs A. She checked that the operation consented to was the same as the one written on the theatre checklist. She also checked that Mrs A knew what was going to be happening and confirmed that it was her right knee that was to be operated on.

In her response to the complaint, Ms F informed me that once Mrs A was taken into theatre she was engaged in "assisting the Anaesthetist, organising monitors, passing airways and other equipment and moving equipment into the correct places". She informed me that after the operation started she helped move equipment, then left the theatre to get supplies.

It is unfortunate that once the surgery commenced, Ms F did not notice that it was being performed on the incorrect leg, especially after she had earlier taken the trouble to confirm the matter with Mrs A. However, I accept that Ms F was otherwise occupied once the surgery commenced and had duties to attend to other than ensuring the correct progression of the surgery. Had she noticed the error, she would of course have had a professional obligation to immediately notify the rest of the team, but given the nature of her duties during the particular operation, I do not consider that it was a culpable failing on her part that she failed to notice.

In the circumstances, I do not consider that Ms F's failure to notice the surgery being performed on the incorrect leg was a failure to provide services with reasonable care and accordingly I do not consider that Ms F breached Right 4(1) of the Code.

Opinion: No Breach – Dr C/Dr D/Ms G/Ms E/Ms F

Right 4(5)

In my opinion there was a collective responsibility on the members of the theatre team to ensure the safety and wellbeing of the patient. A team is called a team for a very good reason; there is an expectation that there will be sufficient co-operation and communication amongst its members to minimise the risk of harm to the patient. For a team to function as such there must be a sense of collective responsibility for ensuring patient safety. In the present case that clearly did not happen.

In my provisional opinion I set out my view that as a result of this team failing there was a collective breach of Right 4(5) of the Code. However, having read the submissions of some of the individuals affected by that breach finding, I have altered my view and now no longer consider that the failing of the team amounted in law to a breach of the Code.

I maintain my view that it is critical for a theatre team to operate as a team rather than as a group of individuals with separate and independent responsibilities. Acting as a team of necessity involves effective communication and co-operation. In the present case I consider it clear that the communication and co-operation among the team as a whole was deficient. In my view there must be an acknowledgment of the necessity of collective responsibility for a team of trained health professionals operating as a team within the operating theatre environment. In this case, the team ultimately failed.

However, there is no such legal entity as a 'theatre team'. In law, a theatre team is simply a group of individuals with individual responsibilities. Having read the submissions of Dr D and Ms G, I accept that finding them individually in breach of the Code in relation to this issue is potentially unfair, given that I have found that at an individual level they met their professional responsibilities. If the theatre team were a legal entity I would have no hesitation finding that it breached the Code in this case.

Opinion: Breach – The private hospital

Right 4(1)

Policies to prevent wrong site surgery

The private hospital should bear some responsibility for its lack of policies and procedures specifically relating to the avoidance of wrong site surgery. Wrong site surgery is not a new phenomenon. It is a risk that should be directly in mind by any health care institution that provides surgical services. In fact, in his response to the complaint, Dr C notes that 30% of orthopaedic surgeons will, over the course of their career, at some point make this mistake. In my opinion a responsible hospital in the private hospital's position would have had in place a

dedicated policy for all medical and nursing theatre staff to adhere to, outlining key steps in pre-operative procedure to prevent wrong site surgery and allocating responsibility for the performance of those key tasks.

If such a policy had been in place, the mistake that occurred in Mrs A's case may have been prevented. If there had been a policy directive as to who was to mark the operative site, and when that was to occur, Dr C might well not have been so complacent, appearing to assume that the matter would have been cross-checked by theatre nursing staff. If there had been a clear policy directive as to who was to apply the tourniquet, the confusion arising out of the involvement of Ms H may have been avoided. Without a clear policy directive on these key pre-operative steps, it is not surprising that eventually a mistake occurred.

The actions of the hospital following this particular incident to an extent confirm my view that wrong site surgery policies should always have been in place, and that the hospital management was also of this view. The day following the incident, a memorandum to all orthopaedic consultants was distributed noting that they were responsible for marking the limb and applying the tourniquet. This memorandum was subsequently developed into more formal policies. But, as noted above, wrong site surgery was a well-recognised risk long before Mrs A became a victim. Although Mrs A's case prompted the hospital to re-evaluate its policies and to set new standards, it should not have been necessary for it to be galvanised into this action by an adverse event. This was a case of shutting the stable door after the horse had bolted.

In response to my provisional opinion, the private hospital accepted that it should have had in place a policy for all medical and nursing staff, designed to prevent wrong site surgery occurring. The hospital noted:

> "In hindsight such a policy may have assisted the staff in clarifying their respective roles and responsibilities. The importance in requiring the surgeon to mark and tourniquet the limb needed to be underlined."

However, the hospital submitted that although no such policies were in place, this was in line with the practice at other hospitals at the time. The hospital referred to that part of the advice I received from Dr Denis Atkinson which noted that routine marking of the surgical site by a surgeon pre-operatively was not standard practice in New Zealand. The hospital also noted that at the time of the incident, neither the College of Surgeons nor the Orthopaedic Association had information available in relation to standard practices to be adopted.

That may be the case. Nevertheless, I maintain my opinion that even in the context of the common practice at the time, the hospital should have done more prior to the incident to minimise the possibility of wrong site surgery. As noted above, a long time before Mrs A's case wrong site surgery was a well-recognised potential problem facing any hospital providing surgical services. For the purposes of forming my opinion as to whether a provider has breached the Code, I am not bound by the medical practice prevailing at the relevant time. I am entitled as Commissioner to demand stricter, patient-focused standards of health providers

when the practices commonly adopted by those providers, and indeed the wider medical community, fail to minimise well-recognised risks. It is no defence for a provider to point to other providers who also failed to adequately address the same risk. A common practice may still breach the Code.

In the present case, the risk of wrong site surgery occurring was sufficiently well recognised that, in my opinion, the private hospital failed in its duty to Mrs A in not having in place specific policies designed to minimise the risk of occurrence. The failure to specifically recognise and attempt to mitigate the risk of wrong site surgery through dedicated policies amounted to a failure to provide surgical services with reasonable care. I therefore consider that the private hospital breached Right 4(1) of the Code.

Other Comment

As noted earlier in this report, from the outset of this investigation Dr C has admitted responsibility for the error, and did not attempt to deflect responsibility for the mistake onto others. Furthermore, over the course of the investigation he has provided me with considerable information in relation to the policies and protocols in place, both current and historical, at the private hospital.

In my provisional opinion I made a number of comments critical of the private hospital and the manner in which it approached this investigation. It is now apparent to me, having spoken to both staff at the hospital and its legal counsel, that the private hospital has not been reluctant to admit responsibility for the incident. In its response to my provisional opinion, the hospital provided me with a raft of information regarding action it has taken following the incident, both immediately following the incident and in the longer term.

I am now satisfied that the hospital did in fact take the matter seriously and responded appropriately to the issues highlighted by the incident. In my view it appears that the previous miscommunication between my Office and the hospital was the result of an unhelpful focus being placed on unduly technical legal argument by the Clinic's previous legal advisors, to the detriment of the substantive issues raised by the investigation.

Training of theatre nursing staff
At the time of Mrs A's operation, the hospital did have in place policies for individual members of the theatre nursing team, outlining their duties and responsibilities. It is apparent, however, from information obtained from the nurses involved and the Theatre Nurse Manager at the hospital, that little systematic training was given to nurses with respect to these policies, or indeed to any other matters relating to nursing practices at the hospital.

Ms F, in the role of anaesthetic nurse, informed me that she was not aware of the policy relating to the role of the anaesthetic nurse. The hospital in its response informed me that the

Nursing Co-ordinator had provided Ms F with copies of the appropriate protocols for each of the roles she held at the hospital. Clearly there is a conflict of evidence here. I accept that it is possible that Ms F was given a copy of the anaesthetic nurse protocol. However, I also consider it likely that although a copy of the protocol may have been given to Ms F, the content of the policy was never reinforced to her, nor did she receive formal training as to the content of the policy.

I have no reason to doubt Ms F's statement that she was not familiar with the policy relating to the role of the anaesthetic nurse. I accept that individuals bear a considerable degree of responsibility for familiarising themselves with appropriate relevant protocols. However, at an organisational level the employer must accept an equal measure of responsibility in terms of ensuring that systems are in place not only to provide employees with the appropriate paperwork, but also to facilitate the implementation of the policies in practice. On the basis of the information made available to me during the course of this investigation, I do not consider that there was a system in place at the hospital to ensure the appropriate implementation of policies and protocols.

My opinion is strengthened by information obtained from Ms J, the Theatre Nurse Manager at the time of Mrs A's operation in 1999. Ms J confirmed that there were no set systems in place for the training or orientation of nurses. It appears that training of new nurses and orientation to the hospital's policies and procedures was somewhat ad hoc and unsystematic.

Also of concern is the fact that the scrub nurse and the circulating nurse, both experienced nurses, when faced with situations fraught with the possibility for error, recognised this possibility but did not respond appropriately, possibly because the existing policies did not go far enough in stipulating the necessity for positive action once errors had been noticed. I note that the issue of how nursing staff should react in the face of non-compliance by a surgeon was discussed at a meeting of nursing staff following the incident. Had that issue been encapsulated in formal protocols prior to the incident and discussed with all staff, the instant case may never have occurred.

The hospital has advised me that there is now an organisation-wide orientation package for all new employees. Employees must complete this before undertaking area-specific orientation. Formal job descriptions and role descriptions have also been developed, as well as organisation-wide manuals of policies and procedures. The hospital informed me that these have been upgraded to achieve accreditation with Quality Health New Zealand.

Joint Commission on Accreditation of Healthcare Organisations

In preparing my opinion in relation to this matter I accessed material from the website of the Joint Commission on Accreditation of Healthcare Organisations (JCAHO) relating to wrong site surgery. The JCAHO is one of the leading standards-setting and accreditation bodies in the United States. The JCAHO has accredited more than 17,000 health care organisations and programmes throughout the country. A copy of a relevant article is appended to this report as Appendix 13. I note below some of the main points of interest in the article:

- In 2001, the New York State Department of Health released guidelines relating to preventing wrong site surgery, emphasising enhanced communication among theatre team members, three independent verifications including marking or identifying the correct site, and having the surgeon see and speak with the patient in the peri-operative area.

- The American College of Surgeons stresses the importance of teamwork in the surgical situation. The Executive Director of the College stated: "There must be cooperative openness between the surgeon and the nurses. … The two groups must both take responsibility, and if there are questions, they should stop and clarify to be sure everyone is on the same page. No one should make assumptions."

- The JCAHO reiterates the importance of risk reduction strategies, and suggests that organisations develop processes that include:

  (i) marking the surgical site and involving the patient in the marking process;

  (ii) creating and using a verification checklist using documents such as medical records, x-rays and other imaging studies;

  (iii) obtaining oral verification of the surgical site in the operating theatre from each member of the theatre team;

  (iv) monitoring compliance with these procedures;

  (v) surgical teams taking time in the theatre to verify the correct operative site, using active communication techniques.

Actions

Apology

I have noted in this report that although individuals were at fault in this incident, there was ultimately a team failing as well. While as a matter of law I have been unable to determine that the team as a whole was in breach, in the circumstances I think it would be appropriate if a letter of apology, signed by the entire surgical team, was written to Mrs A. This apology is to be sent to the Commissioner's Office and will be forwarded to Mrs A.

I also recommend that the private hospital apologise to Mrs A for its involvement in the matter. Again, this apology is to be sent to the Commissioner's Office and will be forwarded to Mrs A.

Dr C

I acknowledge that Dr C has always admitted responsibility for this mistake. I also acknowledge the assistance he has given my Office over the course of this investigation. However, this was a mistake that should never have happened and there was undoubtedly a serious failing on the part of Dr C. It is for this reason that I intend to refer this investigation to the Director of Proceedings to consider whether further action is warranted. In her deliberations, the Director of Proceedings will no doubt consider the role that Dr C played in the incident and determine whether further action against him personally is required.

Ms E

In response to my provisional opinion, Ms E noted that she has reviewed her practice following this incident. Ms E informed me that she has put in place the following changes:

(a) She will not permit any procedure to commence without the limb being checked between the scrub nurse and the circulating nurse;
(b) If a patient arrives in theatre with the limb or surgical site not marked, she will ensure the patient is not anaesthetised until the limb is marked by the surgeon after discussion with the patient, as well as checking the consent form and the clinical notes;
(c) She will not permit the operation to commence if the correct limb is not marked by the surgeon;
(d) She personally checks that the correct limb has been marked;
(e) She does not permit any visiting nurse to take part in a team procedure. If a surgeon asks a visiting nurse to perform a procedure, she advises the surgeon that the visiting nurse cannot take part;
(f) She does not permit nurses to tourniquet limbs;
(g) She ensures that marking pens are kept in theatre as well as other areas they might be needed;
(h) While assisting the scrub nurse in opening packs, she keeps an eye on the whole team, as well as the patient.

It is encouraging to note the degree to which Ms E has proactively considered the issues raised by this incident, and taken steps in her own practice to ensure a similar mistake is not repeated. In the circumstances I do not intend to make further recommendations in respect of Ms E.

Ms G

In response to my provisional opinion, Ms G advised that she has already reviewed her practice to ensure that a similar mistake does not happen again. She informed me that she has put in place the following changes:

(a) She never drapes a limb that is not marked, and never drapes a limb where she cannot visibly see the mark;

(b) She never drapes a limb that she has not checked with her circulating nurse to be correctly marked, and she notes that she is prepared to hold up an operation if the limb is not correctly marked;
(c) She now sets up her trolley facing the patient so that she can see the limb being painted and tourniqued.

Ms G also noted that a new checklist will require the circulating nurse to tick a box to confirm that both the circulating nurse and the scrub nurse have sighted the correctly marked limb. Ms G noted that she will not let the circulating nurse check the box unless she herself has sighted the correctly marked limb.

I am encouraged by the practice changes Ms G has implemented and in the circumstances do not wish to make any further recommendations.

Ms F
Ms F informed me that she too has made changes to her practice in light of this incident. Ms F advised that she has put in place the following changes:

(a) She will not take patients to theatre unless the correct limb/site is marked;
(b) If a patient arrives in theatre without the limb marked, she checks the correct site and asks the surgeon to mark it in front of her;
(c) While assisting the anaesthetist, she also tries as much as possible to keep an eye on the whole team.

As with the other nurses, I note with approval these changes and make no further recommendations.

The private hospital – Sentinel events investigation
In my provisional opinion I recommended that the private hospital review its practices in relation to internal investigation of serious events, with particular reference to the Ministry of Health and Standards New Zealand 'Sentinel Events Workbook'.

I am pleased to note that in response to my provisional opinion the private hospital informed me that it has reviewed its practice accordingly. In my view it is critical that organisations such as the private hospital undertake a full investigation and root cause analysis of serious events such as wrong site surgery. This is essential to identify underlying systemic issues contributing to adverse outcomes.

Audit by Quality Health New Zealand
I note that the private hospital is now a Quality Health New Zealand accredited hospital. I therefore recommend that Quality Health New Zealand audit the hospital to determine whether it has appropriate systems and policies in place to prevent a recurrence of this type of incident. Over the course of this investigation I have identified a number of issues at a systemic

level that I believe contributed to the adverse outcome. I therefore recommend that the audit cover matters such as:

- whether there are policies and protocols in place specifically designed to prevent wrong site surgery;
- whether these policies and protocols provide a sufficient degree of protection. For example, do they indicate what action is to be taken in the event that a pre-operative error is identified? Mrs A's case has demonstrated that although pre-operative errors may be identified, this does not in itself guarantee that those errors will be remedied;
- whether there are sufficient mechanisms in place to ensure all staff are familiar with the hospital's standard policies and protocols;
- whether sufficient training is given to staff in relation to implementing those policies;
- whether the hospital has robust policies in place relating to the internal investigation of sentinel events.

Other Actions

I have decided to refer this matter to the Director of Proceedings in accordance with section 45(f) of the Health and Disability Commissioner Act 1994 to determine whether any further action should be taken.

A copy of this opinion will be sent to the Medical Council of New Zealand, and the Nursing Council of New Zealand. A copy with identifying details removed will be sent to the Australian and New Zealand College of Anaesthetists, the Royal Australasian College of Surgeons, the New Zealand College of Nurses, and the Private Hospitals Association of New Zealand, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

I will also forward a copy of this opinion to Quality Health New Zealand to assist it with any audit of the private hospital in light of my recommendations.

APPENDIX 1

Full Report by Dr Denis Atkinson – Expert Advisor – Orthopaedic Surgeon.

1.0 Purpose:

1.1 To obtain independent orthopaedic surgical expert advice, which will enable the Commissioner to form an opinion on whether the standard of care provided by [Dr C], orthopaedic surgeon, was provided with reasonable care and skill.

To obtain clinical input from an orthopaedic specialist which will assist in ensuring that all issues, which should be covered during the investigation, have been explored.

2.0 Personal Profile:

2.1 I, Denis Atkinson, am a Fellow of the Royal Australasian College of Surgeons and a Fellow of the New Zealand Orthopaedic Association.

I am a vocationally registered Orthopaedic Surgeon, having been in Public and Private Orthopaedic Practice for 17 years.

I have a specialist interest in knee surgery, and am the immediate past present of the New Zealand Knee Society.

I am a member of the Board of Continuing Professional Development of the Royal Australasian College of Surgeons Melbourne.

I have performed competence reviews of orthopaedic surgeons in New Zealand pursuant to the Medical Practitioners Act 1992.

3.0 Documents and Records Reviewed:

- Complaint documentation supplied by [Mrs A] and her lawyer – labelled 'A'.
- Interview with [Mr B] and copy of attached letter from [Mrs A] – labelled 'CB/1'.
- Copy of the clinical file – labelled 'AS/6' – 'AS/12' inclusive and 'LC/1'.
- Responses from [Dr C] – labelled 'B'.

- Copies of Policies and Protocols of [the private hospital] – labelled 'AS/3', 'AS/4' and 'AS/5'.
- [Mrs A's] x-rays – labelled 'C'.
- Response from [the private hospital] Ltd dated 3 April 2001 – labelled 'J'.
- Responses from [Dr I] – labelled 'C'.
- Copy of clinical file from [Dr I] labelled 'GK/1' and 'GK/2'.
- Copy of the incident report – labelled 'AS/2'.
- Copy of memo from [the private hospital] to Orthopaedic Consultant dated 04/11/99 and labelled AS/1.
- Copy of ACC decision and independent report received by HDC on 19/06/01 – labelled 'SW/1'.
- Copy of statement from [Ms E] – labelled 'E'.
- Copy of statement from [Ms H] – labelled 'F'.
- Copy of responses from [Ms G and Ms F] – labelled 'G' and 'H' respectively.
- Response and correspondence from [Dr K] – labelled 'D'.
- Letter from [Dr C] dated 21/09/2001 – labelled 'J'.

4.0 Description of treatment [Mrs A] received from [Dr C]:

4.1 [Mrs A] was referred to [Dr C] on 08/10/99 with a painful right knee. [Dr C] interviewed and examined [Mrs A] and diagnosed a degenerative tear of her right meniscus. [Dr C] saw no radiological evidence of significant arthritic change in her right knee. However, [Dr C] states in the report of 25/10/00 'B' *… I did indicate to her that there was a possibility that at her age it is possible for some articular damage to complicate this surgery. I offered [Mrs A] an arthroscopic menisectomy or debridement, whichever was necessary. …* Dr C identified that [Mrs A] had a deformity of her right second toe for which he recommended surgical correction at the time of her right knee surgery. Surgery was scheduled for the [the private hospital] in [a public hospital] on 03/11/99.

4.2 [Mrs A] was admitted to the [private hospital] as a Day Case procedure on 03/11/99.

4.3 [Dr C] interviewed and examined [Mrs A] prior to her anaesthesia. He obtained written consent to perform arthroscopic surgery on the right knee and a right second toe tenotomy.

4.4 [Dr C] did not mark the operative sites prior to [Mrs A's] admission to the operating theatre.

4.5 On arrival in theatre, [Mrs A] was concerned in regards to the informal environment, '*she remembers the feeling of being in MASH with loud music playing and a jovial staff attending to her surgery*'.

4.6 At the time of [Mrs A's] surgery 03.11.99 no formal policy of marking limbs for operative site identification existed at [the hospital]. Policies for patient and procedure identification existed at [the hospital]. Policies for patient and procedure identification were part of the protocols 'AS/3', AS/4', 'AS/5', for the role of a circulating nurse, scrub nurse and anaesthetic nurse.

4.7 Pre-operative confirmation of the patient's identity and operative procedure were made by the admitting nurse and anaesthetic nurse. Further confirmation of the patient's identity, nature of operation and operative site were made by the circulating nurse and scrub nurse.

4.8 The circulating nurse informed [Dr C] that no mark to identify operative site was present.

4.9 Prior to proceeding with the operation [Dr C] performed an examination under anaesthesia of the right knee. For comparison he then examined the left knee. [Dr C] then proceeded to scrub.

4.10 A [hospital] staff member not involved in [Mrs A's] surgery was then asked to apply the tourniquet to [Mrs A's] leg. The staff member proceeded to apply the tourniquet to the left leg, having obtained verbal confirmation from [Dr C]. This error was not recognised by the theatre staff directly involved in [Mrs A's] care and preparations for surgery on the incorrect leg continued.

4.11 [Dr C] proceeded to an arthroscopy of [Mrs A's] left knee. The circulating nurse when completing the operative register recognised the incorrect surgical site and alerted the surgical team. The arthroscopy to [Mrs A's] left knee commenced at 14.42 hours and was completed at 14.53 hours.

4.12 [Dr C's] operative note of 03/11/99 confirmed the medial compartment of [Mrs A's] left knee showed some early osteoarthritic changes. A normal medial meniscus was present. No resection of the meniscus or operative intra-articular procedure was performed on the left knee joint other than the introduction of the arthroscope and irrigation of the joint with saline.

4.13 Recognising his error, [Dr C] proceeded to prepare and perform arthroscopic surgery to the right knee joint. [Dr C's] operative note of 03/11/99 confirms in the right knee there was a complex tear of the posterior horn of the medial meniscus. The torn section of the meniscus was resected. However, [Dr C] noted some difficulty because of a *"relatively poor view and access"*. Articular degenerative changes were noted in the medial compartment of the knee joint. The operative record confirmed that the meniscus was trimmed to a satisfactory peripheral margin. At the completion of the right knee surgery an extensor tenotomy to the right second toe was performed.

4.14 An incident/accident report and complaint report was completed relating to the wrong site surgery on 03/11/99 'AS/2'. This report records, '*… patient informed of incident by [Dr C] in Recovery Unit. The principle nurse, anaesthetist and surgeon spoke again to [Mrs A] and husband in the ward …*'

4.15 [Dr C] in his report to the Health and Disability Commissioner 25/10/00 records '*… for my part I unreservedly accept responsibility, and as soon as [Mrs A] was awake following her surgery, apologised to her profusely that this had happened'*.

4.16 [Dr D], Consultant Anaesthetist, records in his report to the Health and Disability Commissioner of 16/05/00 'D' *'In the recovery room, after surgery was completed, both [Dr C] and I were anxious to inform and reassure [Mrs A] as soon as possible. We were aware that in the early phase of recovery from an anaesthetic a patient may have limited comprehension or recall of any discussion. We made a point of discussing the situation with [Mrs A] and her husband both in the recovery room and in her ward room. There was no attempt made to lessen the seriousness of the error and a sincere and deep apology was offered on several separate occasions.'*

4.17 Anaesthetic nurse [Ms F] 'H' reports '*… during my time at [the hospital] I was not aware of any protocol or policy that stated that I was to check the operation site was correctly marked. I had no orientation to my position. I am definitely clear that no such protocol or policy was ever brought to my attention'*.

4.18 [Mrs A] was admitted to the [hospital] for overnight stay following her surgery. She was reviewed by [Dr C] the following morning and was discharged home.

4.19 [Dr C] reviewed [Mrs A] ten days following surgery. He records in his report to the Commissioner 'B' – 13/11/00, '*She subsequently went home and was seen by me ten days after her surgery. My records indicate that her left knee was entirely satisfactory and she had little or no discomfort from this. The right knee however, still was sore but a little more comfortable.'*

4.20 [Mrs A] was further reviewed by [Dr C] on 10/12/99 with persistent right knee pain. [Dr C] felt her symptoms were not inconsistent with her operative findings and subsequent surgery. He recommended a course of physiotherapy and arranged further review. [Mrs A] was further seen by [Dr C] on 14/01/00. She continued to suffer from a lot of the right-sided knee pain. [Dr C] was concerned that there was a persistent unstable fragment of the meniscus causing symptoms. He recommended to [Mrs A] that further arthroscopy be performed. This was arranged as a Day Case procedure at the [hospital] on 19/01/00.

4.21 [Mrs A] in correspondence to the Health Commissioner (undated) 'CB/1' '… *I was taken into a very small room with a chair and table just off the theatre where I was given a gown and bootees to get changed into. This I did and after about 10 mins, an anaesthetist came and took my blood pressure and asked if I took any medication. (No one looked at my leg.) I was then told to walk into the theatre and climb up on the operating table. (I think they put a stool there to assist me.) I then reminded [Dr C] to mark my leg this time!* …'.

4.22 [Dr C] performed an arthroscopy on the right knee on 19/01/00. His operative findings confirmed an underside horizontal cleavage tear to the medial meniscus remnant. Accompanying this there had been deterioration to the adjacent articulate cartilage on the medial femoral condyle. [Mrs A] was discharged on the day of surgery. She had a moderate amount of bloody ooze from her wounds on the first post-operative day.

4.23 She was reviewed by [Dr C] on 31/01/00 at which time [Dr C] recorded [Mrs A] was making good progress. She was advised to continue with physiotherapy with a plan for him to review her within one month.

4.24 [Mrs A's] symptoms in the right knee did not improve and in consultation with her general practitioner she sought a second opinion. Following interview and examination it was [Dr I's] opinion that [Mrs A's] symptoms to the right knee were consistent with post-operative synovitis. He recommended a conservative approach with continued observation and use of anti-inflammatory medications. To exclude intra-articular pathology and osteonecrosis [Dr I] arranged for an MRI scan to be performed.

4.25 The MRI scan was performed by [a private radiology clinic] on 03/04/00. [Dr I] reviewed [Mrs A] on 04.05.00. The pain in her right knee had deteriorated. [Dr I] felt in view of her clinical findings and the MRI findings that there was a possible residual tear of the posterior horn of the medial meniscus. He recommended further arthroscopic surgery with a view to complete extension of the posterior horn of the medial meniscus. [Dr I] warned [Mrs A] that there was a 70% chance of improvement of her knee following this procedure.

4.26 [Mrs A's] surgery was performed at [a second private hospital] on 06/06/00. A complex tear of the posterior horn of the medial meniscus remnant was noted. Adjacent to there was an area of complete articular cartilage loss on the adjacent femur. A further resection of the medial meniscus remnant was performed. [Mrs A's] immediate post-operative recovery was uncomplicated.

4.27 [Mrs A] was reviewed by [Dr I] on 20/06/00. She recorded significant improvement in her level of pain, particularly her night pain. She was discharged to the care of her medical practitioner.

4.28 [Mrs A] requested further review by [Dr I] on 17.05.01. She complained of some catching and pain to the medial aspect of the right knee. [Dr I] felt this was secondary to a small cartilaginous flap or tear catching over the medial femoral condyle. He did not recommend any further surgical intervention and prescribed Neoprene knee support.

4.29 [Dr I] reports to the Health and Disability Commissioner on 17.05.01 'C' *'…with respect to the left knee, this did not seem to be causing her any undue discomfort when I saw her on 17.05.01, again I have not specifically questioned her about this.'*

4.30 Radiographs of [Mrs A's] right knee performed at … Radiology 26/06/01, including weight bearing views, confirm significant joint space loss consistent with progressive medical compartment osteoarthritis. This change has progressed since films performed 23/09/33.

5.0 Opinion:

5.1 [Dr C's] assessment of 08/10/99 of [Mrs A's] right knee condition was of a standard that complies with orthopaedic professional standards in New Zealand. His assessment, investigations and recommendation that she undergo surgery was appropriate. In reaching this decision I believe that [Dr C] followed the accepted guidelines in providing [Mrs A] an informed choice as to which treatment was in her best interests. From the records provided I feel that [Mrs A] was given a clear understanding of the nature of her condition and the proposed treatment along with a probable outcome for her and complications relevant to her situation. [Dr C] did make [Mrs A] aware of a probable degenerate component of the condition in her right knee, which may have a bearing on the ongoing outcome.

5.2 [Dr C] acted appropriately in the immediate pre-operative period by obtaining written informed consent to proceed with surgery on [Mrs A's] right leg.

5.3 [Dr C] failed in a duty of care to [Mrs A] 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 A's] care to ensure that the correct operation and site of surgery was performed on 03/11/99. At the time of [Mrs A's] surgery in 1999, there did not appear to be a clear protocol for correct site surgery at the [hospital]. 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 A's] case was completed diligently. However, at the commencement of surgery a double check was not performed to confirm that the correct site was to be operated on.

5.4 Routine marking of the surgical site by a surgeon pre-operatively was not standard practice in New Zealand at the time of [Mrs A's] first surgery. Since then the New Zealand Health Department and the New Zealand Orthopaedic Association have endorsed a policy to lessen the chance of wrong site surgery. Essential features of this policy are:

(i) That all patients have a mark placed on the effective limb and the operating field by the surgeon prior to surgery using an indelible marker. This marker must be visible when the patient is draped and surgery ready to commence.

(ii) The patient should not be admitted to the operating theatre unless this mark is present.

(iii) The surgery does not commence until the surgeon and scrub nurse have verified that the mark is visible. This information is to be relayed to the circulating nurse who will initial the theatre records in the appropriate place.

Site identification is thus a shared responsibility between the nursing staff and surgeon along the same lines as the swab count.

5.5 [The private hospital] nurse manager's memo for 11/09/99, A/1 does not entirely comply with the current site of surgery protocol. The limb must be marked prior to the patient entering the theatre. The presence of the mark must be confirmed with the surgeon and the scrub nurse prior to surgery commencing.

5.6 [Dr C's] recommendations to the Health Commissioner in his letter of 21/09/01 'J' do comply with the current recommendation although I again, should emphasise the importance of the nurses and surgeon confirming the presence of the mark at the correct site of surgery and that this should be documented contemporaneously.

5.7 The pre-operative checks for surgery, which include the confirmation of consent, nature of operation and operative site should be conducted in a quiet and restrained environment – it would be inappropriate for such activities to occur with loud music playing or an 'informal atmosphere'. The pre-operative preparation of the patient should be conducted only by those staff directly involved in the patient's care.

5.8 [Dr C's] decision to proceed to operate on [Mrs A's] right knee following inadvertent surgery on the left knee was appropriate and professionally sound. The error in operating on the left knee was quickly identified. [Mrs A] was stable under her anaesthesia. The procedure to the left knee involved two small arthroscopic portals and saline lavage of the joint. Such procedure was unlikely to cause the patient any immediate post-operative problems with mobility and would be unlikely to cause any long-term morbidity.

The alternative was for [Dr C] to have the patient wakened from anaesthesia and to leave the condition of her right knee untreated. This would have required further surgery and further induction of anaesthesia, putting [Mrs A] at greater risk.

[Dr C's] surgery to [Mrs A's] right knee was appropriate and of an adequate standard. His operative records were good. [Dr C's] decision making in proceeding to surgery on both knees on 03/11/99, I feel was in [Mrs A's] best interest and appropriate.

5.9 The records confirm that [Dr C] was extremely remorseful and apologetic following the erroneous surgery.

5.10 [Dr C's] assessment, record keeping and clinical care of [Mrs A] in the post-operative period was sound and of an acceptable standard. His decision to proceed to further surgery in January 2000 was appropriate.

5.11 [Mrs A] presented initially to [Dr C] with a degenerative tear of the medical meniscus of her right knee. This was accompanied by early osteoarthritic change to the medial compartment of the knee. [Mrs A's] medial meniscus at the first surgery was shredded and degenerate in appearance. The inner margin and unstable fragments of the meniscus were removed at the initial surgery. A further unstable fragment of the meniscus was removed at the second surgery by [Dr C]. It is possible this fragment of the meniscus could have occurred in the intervening period between the surgery. It is not an unlikely scenario in a fragile degenerate meniscus.

Subsequent surgeries and radiographs of [Mrs A's] right knee have confirmed a progression of the osteoarthritic process in the medial compartment of the joint

immediately adjacent to the damaged medial meniscus. It is this underlying process that is the cause of [Mrs A's] ongoing symptoms.

It was appropriate for [Dr C] and [Dr I] to trim the unstable fragments of the meniscus in the hope that this would protect the adjacent articular surfaces.

5.12 [Dr C's] statements of 20/05/00 *'… how much meniscus to resect is a technical balance between too much, which then exposes damage to articular cartilage to subsequent wear changes and the inevitable osteoarthritic change but clearly loose fragments of cartilage have to be removed … the failure to recover from the two arthroscopies that I performed on the right leg and I suspect the third too, is a result of suffering intra-articular damage. This is early arthritic change within the medial compartment of the right knee …'* is correct and a fair summary of events.

5.13 Arthroscopic meniscal surgery in the degenerate knee has an unpredictable outcome. Arthroscopic treatment of a degenerate meniscus may give short term relief of mechanical symptoms but underlying osteoarthritic changes are likely to cause progressive pain in the medium term. Arthroscopic intervention in these circumstances may fail to improve in up to 30% of cases.

5.14 [Dr I's] correspondence of 20/05/01 confirmed [Mrs A] was not troubled by significant left knee symptoms. The erroneously placed arthroscope has left a soft tissue bulge in the left knee, which is unsightly. Arthroscopy of the left knee confirmed early osteoarthritis in the medial compartment. I do not feel the arthroscopy per se will leave [Mrs A] with significant morbidity in the left knee long term.

5.15 I consider [Dr C's] record keeping and correspondence in relation to [Mrs A's] condition to be of a high professional standard.

6.0 SUMMARY

6.1 [Dr C] has provided a reasonable and skilled standard of care for the degenerative condition of [Mrs A's] right knee.

6.2 [Dr C] failed to provide [Mrs A] a reasonable and skilled standard of care by erroneously operating on her left knee on 03/11/99.

6.3 Identification of site and procedure in surgery is a collective responsibility of the operating surgeon and nursing staff. Strict adherence to current Health Department protocols should help minimise the complication of wrong site surgery.

APPENDIX 2

Full Report by Dr Malcolm Futter – Expert Advisor – Anaesthetist

Report on the anaesthesia care provided to [Mrs A] at [a private hospital] on 3rd November 1999.

This report is based upon documentation provided by the Health and Disability Commissioner's office. … Where specific documents are referred to in this report the Commissioner's 'labelling' system is used.

The principal purpose of this report is to advise the Commissioner on the responsibilities of the anaesthetist in ensuring that the correct surgery was performed. Contrary to what is stated in the documentation provided, it appears from discussion with the Commissioner's staff that no complaint was laid against the anaesthetist by the consumer, [Mrs A].

Before reviewing the particulars of this case certain principles, which in discussion appear to be supported by many colleagues, need to be stated:

- Along with all of those involved in an individual's healthcare, the anaesthetist is responsible, as far as circumstances allow, for ensuring optimal outcomes.

- If it becomes apparent to an anaesthetist that care, by whomever it is provided, is not of an appropriate standard it is the responsibility of the anaesthetist to draw attention to this.

- An anaesthetist's primary responsibility is to provide anaesthesia and perioperative care of an appropriate standard. Few anaesthetists possess qualifications that would allow them to assume responsibility for surgical care.

- A surgeon's primary responsibility is to ensure surgery of an appropriate standard is performed. Identification of the site of surgery is part of this responsibility, something recognised in many hospitals ([attached] [public hospitals] Policies on identification of patients for appropriate procedures in the main theatre and day stay suite).

- In many instances anaesthetists take a close interest in the care provided by medical and nursing colleagues, not because they are necessarily 'responsible' for doing so, but in order to be better able to integrate their own care with that of the parties. It is in this way that anaesthetists are sometimes in a position to notice whether others fulfil their responsibilities.

…

Dealing with the points raised under the heading 'Your Decision Required' in the request for advice:

- [Dr D] provided [Mrs A] with anaesthesia care that complied with professional standards. His involvement in the provision of surgical care is discussed more fully below.

- [Dr D] was not required to take any active steps to ensure the correct knee was operated on. Had the site of surgery required some particular consideration being given to the performance of anaesthesia, for example in the siting of intravenous access or injecting local anaesthesia, then [Dr D] would have been required to demonstrate an awareness of the details of the surgery, particularly its location. Such awareness appears not to have been required in this case. Not withstanding the previous comments, had [Dr D] noticed the wrong knee was about to be operated on he would have been required to immediately draw attention to this mistake. Following the commencement of anaesthesia it is not uncommon for the anaesthetist to be so busy that they do not witness the immediate preoperative preparation of a patient nor even the commencement of surgery. In such circumstances they are not in a position to 'supervise' the surgeon.

- As noted above, there appears to have been no allegation made by the consumer regarding [Dr D's] care. Regardless of that, it is not possible to sustain the suggestion that [Dr D] did not provide care of an appropriate professional standard unless it can be shown that he was in a position to observe the practice of other members of the team, without detriment to the anaesthesia care he was primarily responsible for providing.

- [Dr D] is correct in stating in his response (labelled B) that the anaesthetist is not responsible for consenting a patient for surgery nor for marking the surgical site (final paragraphs on pages 1 & 2 respectively). As noted above the anaesthetist's primary responsibility in orthopaedic (or any type of surgery) is to provide anaesthesia and perioperative care of an appropriate standard. If they are aware of any other aspect of care that they believe is not of an appropriate standard they are responsible for drawing attention to this. These responsibilities would be the same at [the private hospital] as elsewhere. The College documents TE6 and PS7 (labelled PY/1 and PY/2) are correctly cited.

- The process that is gone through by an anaesthetist in preparing to anaesthetise a patient for orthopaedic surgery is covered in a variety of College documents, including PS7. It must be noted the anaesthetist is not preparing for surgery. Where the site or type of surgery has some direct bearing on the conduct of anaesthesia the anaesthetist must be aware of this and prepare accordingly. In this case there would have been no particular anaesthetic preparation related to the site of surgery required.

- It is not uncommon practice for the atmosphere in operating theatres to be as described. It is the author's opinion, shared by many colleagues, that attempts to provide a relaxed and stress free workplace may have lost sight of the more important goal of providing an environment that is conducive to provision of quality health care. Although some patients might appreciate an informal atmosphere the majority would rather the atmosphere conveyed an air of interest and concern for their wellbeing, even when they are undergoing surgery that is quite routine (for the staff!). No patients want to be given the impression that staff are disinterested or not concentrating.

- Opinions apart there is a considerable amount published concerning music in the operating theatre ([attached] – Medline search – music operating rooms). From an anaesthetist's perspective a simple risk benefit analysis would tend to suggest risks outweigh benefits (see highlighted articles).

- It is interesting to note that on the occasion of [Mrs A's] second visit to [the hospital], which was before her complaint was notified to the Commissioner, the operating theatre atmosphere is alleged to have changed. It is possible to suppose that staff were more conscious of the need to create an appropriate atmosphere which implies that they were aware the atmosphere on the first occasion was inappropriate.

- In his letter of 9.5.01 (labelled B), page 1, paragraph 2, [Dr D] notes that he entered further information regarding the surgery onto the consent form. Whilst his action is not unusual, given the circumstances he describes, he may unwittingly have assumed more responsibility for the conduct of surgery than he intended or is appropriate. Similarly if [Dr C's] comment in his letter of 21/09/01 (my labelling J2) Page 1, paragraph 3, is correct and 'his anaesthetist' occasionally marked the leg then there was an inappropriate assumption of responsibility by the anaesthetist.

In Summary
[The hospital] and all relevant health professionals had some responsibility in ensuring the overall provision of care was of an appropriate standard.

Practices should have followed agreed policies and guidelines.

Primary responsibility for ensuring the correct surgery was performed lay with the surgeon.

The anaesthetist's primary responsibility was to provide anaesthesia and perioperative care and secondarily, if it was apparent to him, to advise others when aspects of the patient's care for which they in turn were responsible, were not of an acceptable standard.

APPENDIX 3

Full Report by Ms Gill Raven – Expert Adviser – Theatre Nurse

I am a Registered General and Obstetric Nurse. I hold post-graduate qualifications in Nursing, Midwifery and Medical Law.

Postgraduately I have worked in main operating theatres for approximately eight years and in day stay type settings for a further five years.

As a manager of theatre I have been responsible for cardiothoracic, orthopaedic, general theatres and recovery room, in the United Kingdom. In New Zealand I was the manager of gynaecology and obstetric theatres. Currently I am employed as a nurse consultant to acute surgical services. Within my area of responsibility is a five theatre operating suite, plus recovery room, covering the specialities, general and endoscopy, orthopaedics, gynaecology, ENT, ophthalmic and dental.

Incident Form AS/2

The documentation on the form adequately describes the events preoperatively, and postoperatively. No direct mention is made to the actual holding of the limb during the intraoperative set-up phase.

Statement of [Ms E], Registered Nurse (Exhibit E)

Point 3 — [Ms E] states that she has been employed at the [private hospital] since 1985, holding staff nurse and team leader positions. She does not state whether she is employed only in the operating theatres.

Point 4 — [Ms E] was the circulating nurse in Theatre Two at the time of [Mrs A's] surgery.

Point 6 — [Ms E] states that she checked the consent form and the operating list to make sure that she had the correct patient and the correct operation. She stated that she noticed that the limb was not marked.

COMMENT

Document AS/3

"The role of the Circulating Nurse, [the private hospital] Reference: ACCRED: KS: JM: APR 1998.

Duties Prior to Surgery

(8) Check Consent Form with the Scrub Nurse, note if any allergies, operation site marked, x-rays available.

Point 7 [Ms E] states that she informed [Dr C] that [Mrs A's] limb was not marked and confirmed that the right leg was to be operated on. From her statement it appears that [Ms E] followed the directives of [the hospital]. She notified the surgeon that the limb was not marked.

COMMENT

- [Ms E] acted in accordance with the policies/directives of [the private hospital], for checking the consent form, checking that the operation site is marked, allergies noted and x-rays available.

- It is not a nursing responsibility to mark an operation site, however as in this case I would expect a senior nurse to bring the omission to the attention of the surgeon and ask that he comply with the clinic policies and those of good clinical practice. Had correct procedures been followed the series of risks that occurred, culminating in the patient having the wrong surgery, would have been averted.

- Notably, there is no reference as to who held the patent's leg while the tourniquet was being applied or to who held the limb while it was painted and draped ready for the surgery.

- There is no reference made to the patient's x-rays being available in theatre.

- X-rays are routinely taken to theatre to enable the surgeon to refer to them as required. They are often placed in the X-ray illuminator at the start of the procedure, certainly for major orthopaedic cases.

Point 8 The circulating nurse and the scrub nurse would be working together to prepare the sterile trolley and instruments ready for commencement of the case. During the set up period, if it takes place with the patient present in the theatre, the patient would be under the care of the anaesthetist and his/her anaesthetic assistant.

Point 9 [Ms E] states that she recalls Enrolled Nurse [Ms H] being asked by [Dr C] to apply the tourniquet to [Mrs A's] limb.

The Perioperative Association of the New Zealand Nurses Organisation Guidelines states:

'Tourniquets are the responsibility of the medical staff, but the perioperative team has a collective responsibility.' (Section 5/3 Tourniquets.)

COMMENT

- As an Enrolled Nurse, [Ms H] will work under the direction of a medical practitioner or a Registered Nurse (Nurse Act 1977). In this instance she took her directions from [Dr C].

Point 11 [Ms E] states that she did not see the exposed leg or the draping up or painting of it.

COMMENT

- It is usual practice for the circulating nurse (or anaesthetic assistance) to assist with holding a limb while a tourniquet is being applied and while the surgeon paints and drapes it ready for surgery.

Point 12 [Ms E] states that she was completing her paperwork, writing up the Theatre Register. She states that she saw the theatre staff sitting on the left side of the patient and alerted the surgeon immediately.

COMMENT

- It is usual practice for the circulating nurse to remain in theatre, unless there is a strong reason necessitating her leaving. [Ms E] knew that they were proceeding without the limb marked yet she left the theatre to attend to other issues.

Point 15 [Ms E] states that [Dr C] was aware of a meeting that was to take place to discuss the incident – but he did not attend.

COMMENT

Document AS/3

'The Role of the Circulating Nurse's, [the private hospital] Reference: ACCREDTH: KS: JM: APR 1998:

Responsibilities

Part three states: To remain in theatre at all times during surgery. Should it be necessary to need relieving from the O.R., ensure the Scrub Nurse is notified. The relieving nurse …'

Duties

During Surgery:

1 Remain in theatre throughout

End of Surgery:

6 Complete operation register…

COMMENT

The role and functions of a circulating nurse includes but is not limited to:

- To co-ordinate the safe and efficient running of theatre session, in consultation with the surgeon and anaesthetist.
- To ensure patient safety is maintained at all times.
- To be aware of the order and makeup of the theatre list.
- To sight the patient's consent form and show this to the scrub nurse.
- To act as a patient advocate.
- To ensure sterility is maintained at all times.
- To maintain standards of infection control.
- To undertake the swab and instrument count with the scrub nurse.
- To be aware of any allergies or medical conditions that the patient may have.
- To ensure correct documentation of patient's intraoperative experience, noting the following:
- Swab and needle and instrument count is correct at the end of the procedure.
- To note blood loss intraoperatively.

- Placement of diathermy.
- Any specimens taken from the patient and sent to the laboratory.

Statement of [Ms H], Enrolled Nurse (Exhibit F)

[Ms H] is an Enrolled Nurse. She states that she has worked in the Operating Theatres at [the private hospital] for eight years.

Point 3 — [Ms H] was assigned to work in Theatre One on November 3rd 1999.

Point 4&7 — [Ms H] states that she was in Theatre two collecting some equipment when asked by [Dr C] to place the tourniquet on the patient's leg.

Point 8 — [Ms H] states that the patient's left leg was exposed; she touched the leg and said 'this leg?' She states that [Dr C] nodded and said 'yes'.

Point 10 — [Ms H] states that she 'held up the exposed leg and applied the tourniquet'. 'This took about one minute.' Limbs, especially legs are heavy, it is unusual for one person to hold a limb and apply a tourniquet without assistance.

Point 11 — [Ms H] acknowledges that the usual procedure is for the surgeon to apply the tourniquet, but in this instance she did as she was asked. [Ms H] further states that 'it is accepted practice that Theatre Nurses follow a Surgeon's instructions'.

COMMENT

- [Ms H] was not a member of the team on duty in Theatre Two. She states that she entered the theatre to collect some equipment. She acknowledges that it is the surgeon's responsibility to apply a tourniquet, yet she followed [Dr C's] instructions and applied the tourniquet. She does not state whether she informed the surgeon or the registered nurses that the limb was not marked. [Ms H] did not know the patient. Acting in good faith, by complying with [Dr C's] instructions [Ms H] increased the risk to the patient by applying the tourniquet to an unmarked limb. It is usual for a second person to hold the limb while the tourniquet is applied; no mention is made as to who held the leg. In this case there were three registered nurses and the anaesthetist in the theatre, none of them noticed that [Ms H] was applying the tourniquet to the wrong leg and that she appears to have been doing this without assistance. An accumulation of procedural errors resulted in the patient, [Mrs A] having an arthroscopy performed on the wrong leg without her consent.

Statement of [Ms G], Registered Nurse (Exhibit H)

[Ms G] is a Registered Nurse who has worked in the Operating Theatres at [the private hospital] for five years. [Ms G] was the scrub nurse for [Dr C's] list on November 3rd 1999.

Point 4&5 [Ms G] states that she and [Ms E] checked [Mrs A's] consent form. She recalls [Ms E] informing the surgeon that the limb wasn't marked.

Point 7 [Ms G] states that she recalls Enrolled Nurse [Ms G] entering the theatre and [Dr C] saying he had not put the tourniquet on.

Point 8 [Ms G] states that she did not see the tourniquet being applied.

Point 9 [Ms G] states that after the surgery had commenced she recalls [Ms E] stating that the incorrect limb was being operated on.

COMMENT

- [Ms G] does not mention whether she informed [Dr C] that the patient's leg was not marked.
- [Ms G] does not mention who held the patient's limb while the leg was painted and draped. Further clarification may be required.

The role and function of the Scrub Nurse includes but is not limited to:

- To maintain a sterile environment at all times.
- To act as a patient advocate.
- To ensure patient safety.
- To sight the consent form prior to commencement of surgery.
- To assist the surgeon by anticipating his/her needs for equipment required during the surgical procedure.
- To keep an accurate count of equipment used on the sterile trolley and sterile field.

COMMENT

- [Ms G] has acted within the prescribed role of a scrub nurse. [Ms G] would have been working with [Ms E] to count her instruments and prepare them for the arthroscopy and tenotomy. It is possible that she had her back to the patient and did not see the application of the tourniquet. Setting up for a case in the presence

of a patient, and a surgeon waiting to start a procedure, leaves limited time to observe the patient. Once she has set up her instruments it is usual practice for the scrub nurse to stand to one side of the operating table while the patient is positioned. Although a scrub nurse has a shared responsibility to care for the patient, and act as a patient advocate her primary function is to ensure the sterility of her trolley. However, it is usual for the scrub nurse to be in the vicinity of the operating table during the painting of the patient as she passes the sterile linen to the surgeon for draping of the sterile field. Depending on the type of procedure, and whether the surgeon has an assistant, she will assist with painting and draping the patient. Once the patient has been painted and draped the scrub nurse moves her trolley to the opposite side of the surgeon; the surgeon stands on the side on which he is going to operate. The circulating and or anaesthetic nurses will move non-sterile equipment into place, near the sterile field.

- It appears unusual that the scrub and circulating nurses had sighted [Mrs A's] consent form and yet neither noticed that the positioning of the scrub nurse, surgeon and equipment in the theatre lent itself to an operation on the patient's left side. Despite knowing that the limb was not marked [Ms G] contributed to the risk by not asking the surgeon to stop scrubbing and to mark the limb.

[MS F], Registered Nurse (Exhibit G)

[Ms F] is a Registered Nurse who had been employed in the operating theatres at [the private hospital] for ten months when the incident occurred.

Point 3 — She states that she was the anaesthetic nurse on November 3rd 1999. [Ms F] states that she 'had to make sure that the consent form had been signed and that the operation consented to on the consent form was the same operation that was written up on the theatre check list'. She complied with this duty (point 6).

Point 4 — [Ms F] states that she was not aware of any protocol or policy that stated that she was to check the operation site was correctly marked.

Note AS/5. 'The Role of the Anaesthetic Nurse's, [the private hospital] Reference: ACCREDTH: JM: APR 1998.

4 … ensure that the patient's details and consent are correct (see Protocol for 'checking in the patient').

Point 5 — [Ms F] states that once the patient was anaesthetised her role was then to help with patient positioning if necessary and moving equipment to the correct place.

COMMENT

- It is customary for the anaesthetic assistant/nurse to help reposition the patient and move equipment into the correct place. This could include moving the tourniquet machine into position, although it is not clear from the statements who moved the (tourniquet) machine; or if it was moved into its position for this operation. Further clarification would be required before objective comment can be made.

Point 9 [Ms F] states that she did not see [Mrs A's] leg exposed; she did recall [Dr C] asking Enrolled Nurse [Ms H] to apply a tourniquet. She did not hear which leg was being referred to.

Point 10 [Ms F] states that she did not hear any mention of either right or left leg mentioned by anyone in theatre.

[Ms F] has acted in the prescribed role of anaesthetic nurse. In her role [Ms F] may have been involved in the positioning and holding of [Mrs A's] limb during the application of the tourniquet and during the painting and draping of the limb. She makes no reference to her role in the preparation of the limb. She states that she sighted [Mrs A's] consent form yet she did not notice that the wrong leg was being prepared for surgery. She does not state whether she informed her senior nursing colleagues that the limb was not marked.

[Dr C] Exhibit C

Letter dated 25 October 2000

[Dr C] states that he 'invited the theatre nurse to place a tourniquet on the leg, which is common practice'.

COMMENT

Exhibit # AS/2 Incident/Accident Complaint Response

The incident form states: 'consultant surgeon should apply own tourniquet, only consultant not to do so'.

[Dr C's] letter dated 13 November 2000

Point 2 'Prior to this date an informal policy of marking limbs has existed for many years.'

COMMENT

Exhibit AS/4 'Sending for – receiving of – the surgical patient'

Section five

Point 14 'ensure the correct site has been marked'. [Dr C's] comment appears contradictory to the policy.

The footer of the policy is dated 1998.

Exhibit AS/5 'The role of the circulating nurse'

Duties

Point 8 … operation site marked.

- The footer of this policy is dated 1998.

[Dr C] is correct in saying 'that the limb has been marked is not routinely documented in the pre-operative checks'.

COMMENT

Exhibit AS/8 'For Hospital Use Only' – 'To be completed by the admitting nurse'

There is no provision on this form to tick that the (correct) site has been marked.

RECOMMENDATION

That this form is altered to include wording regarding the marking of the operation site.

Informal Atmosphere of the Operating Theatre on November 3rd 1999

It is commonplace to have music played in theatres. That music played is usually done in consultation with the surgeon and anaesthetist. Nursing staff are aware which Doctors allow music to be played and take note accordingly.

[Dr C] stated in his letter dated 25 October 2000 that 'although I don't personally much like this, it is rarely very loud'. [Dr C] should make the staff aware that he does not like background music playing during his theatre sessions.

The feeling of a MASH-like atmosphere as described by [Mrs A] may have some explainable basis. When theatre trolleys and instruments are set up, either in a set up bay or in front of the patient, there is a degree of noise. This is because the instruments

are made of metal/stainless steel and when taken out of crates they make a fairly loud noise. There is a lot of movement in the theatre during the set up phase as each team member attends to their assigned role.

The anaesthetic nurse will be helping position the patient on the table and moving equipment, such as arm boards, drip poles into place. He/she will be helping place monitor cables and other anaesthetic related equipment.

The scrub nurse and circulating nurse will be working together to prepare the sterile trolley ready for surgery. They would be attending to the surgical count of swabs, instruments and other equipment on the sterile trolley. Either the circulating nurse or the anaesthetic nurse will place the diathermy, as required, and other ancillary equipment.

As described above there would have been a reasonable amount of movement and noise within the theatre in preparation for the surgery.

It is possible that [Mrs A] had not realised that she would be in theatre and awake during the setting up of the trolleys and equipment. This should have been brought to her attention prior to taking her straight into theatre.

Other Issues

Exhibit J – letter from [Ms J], dated 3 April 2001

[Ms J] states that '1998 saw us increasing our staff of which one new member …'

This sentence does not appear to make sense. I presume she meant that an experienced staff member drew up the two-week roster. In my opinion two weeks is a grossly inadequate time frame to teach any inexperienced nurse the intricacies of the operating theatres. This includes teaching registered nurses with some years postgraduate experience, yet new to theatre.

In 1999 [the hospital] increased their staffing again; teaching took place 'when and where' able. Taking a new graduate without adequate support/mentorship is unacceptable. It exposes the new graduate to situations she will have little knowledge of, thus increasing the risk to staff member and the patients.

No mention is made of orientating the new graduate to the circulating role. The circulating role is by far the most challenging, as the circulating nurse is in control of the theatre and the safe running of the session.

At a minimum it would take at least six months before a new graduate could safely manage the most basic of theatre nursing, realistically one year, and then they would need assistance for complex cases/situations.

Memo dated 4.11.99 Exhibit # AS/1

Given the serious nature of the incident I find that this memo lacks instruction. [The hospital] had policies in place for the marking of limbs and checking consent forms. This memo states 'it would be appreciated if …' The purpose of the memo should have been instructive and not passive. It appears at face value to be conciliatory.

Should abbreviations be used on any consent form?

Response to further information supplied in the case of [Mrs A].

- Copy of [Dr C's] letter – labelled C

[Dr C] 'suspects' that one of the nurses walked into the operating room and that upon his asking 'one of the nurses' applied the tourniquet. He further suggests that the nurse 'assumed' which leg was to be operated on. He also states that 'he did not spot the trap set'. It is my submission that the unnamed nurse did not set a trap for [Dr C] but that she acted in good faith and applied the tourniquet without knowing which leg was to be operated upon if she was expected to apply the tourniquet.

In his letter [Dr C] states that sometimes his anaesthetist may choose to mark the leg in advance of him. Thus it appears that there is no clearly defined system of accountability for the responsibility of marking the limb prior to surgery. This has been corrected with the implementation of policies at [the hospital].

- Copy of [Ms E's] letter – labelled E 2

Point 2 [Ms E] mentions that Dr D (anaesthetist) normally applies the tourniquet; however, she makes no mention as to who usually marks the limb.

Point 6 [Ms E] acknowledges that it is not usual practice to enter another theatre and carry out tasks. I agree with this assertion, although this practice could occur during an emergency event.

Point 7 The orientation of new staff is usually undertaken by a designated preceptor/mentor or where the position exists, by a nurse educator. From my readings it appears that there is not a nurse educator in the theatres at [the hospital]. Education in nursing is a life long experience and one that is shared by all nurses individually and collectively.

Point 8 [Ms E] states that she was not in charge of other nurses during [Mrs A's] operation. It is my experience that the circulating nurse is in charge of the theatre during the course of a list to which he/she is assigned. The circulating nurse has an overall view of the needs of the staff and

the needs related to the surgery being undertaken. [Ms E] discusses the role of the circulating nurse at [the hospital] at point number seven.

- Copy of [Ms H's] letter – labelled F2

Point 3 [Ms H] acknowledges that she applied the tourniquet, and that she carried out this task without assistance. She responded to the surgeon's request and although acting in good faith she did not know, nor was she told which leg was to be operated on.

A prudent practitioner should clearly establish the site of surgery before undertaking a task such as the application of a tourniquet. As an Enrolled Nurse [Ms H] works under the instructions of a Registered Nurse or Medical Practitioner.

- Copy of [Ms F's] letter – labelled G2

Point 1 [Ms F] states that she did not assist in the preparation of [Mrs A's] leg for surgery.

Point 2 [Ms F] cannot recall who carried out the painting and draping of [Mrs A's] leg.

Although [Ms F] sighted [Mrs A's] consent form it remains unclear as to whether she informed her senior colleagues of the surgeon's omission to mark the limb.

- Copy of [Ms G's] letter – labelled H2

Point 1 [Ms G] acknowledges that she assisted [Dr C] in draping [Mrs A's] leg. It appears that she did not notice that they were preparing the wrong leg; neither did any of her colleagues in theatre.

- Theatre List dated 3rd November 1999 (labelled PF/4)

The theatre list is in my opinion suitable for the time frame that has been allowed.

- Procedure for use of pneumatic tourniquet (labelled PF/7)

'Rule of thumb' Given the error in the case under investigation and in the interest of any new employee orientating to the theatre suite I would suggest that the words 'rule of thumb' be altered or removed. It is suggested that a statement be made that the Orthopaedic Consultant will inform the staff member of the pressures that he/she wants in each individual case.

CONCLUSION

Having read the statements of the nursing staff in theatre on the 3rd November 1999 it remains unclear as to who held the leg while the painting and draping of [Mrs A's] leg took place. This person along with the scrub nurse should have noticed that they were preparing the wrong leg for surgery, given that they checked the patient's consent form and the printed operating theatre list. The three staff members assigned to [Mrs A's] case state that they checked the consent form but all failed to notice that the wrong leg was prepared and subsequently operated on. It is my assertion that both the scrub nurse and the circulating nurse have a duty to check the consent form, equally the anaesthetic nurse should have this knowledge.

[The hospital's] policy for checking in patients clearly states that one component of the anaesthetic nurse's role is to check the consent form and to pass on appropriate information to the Anaesthetist and Circulating Nurse. The policy for the circulating nurse similarly states that this person is responsible for checking the consent form.

Individually the Registered Nurses are responsible for checking the patient's consent form, checking this against the printed theatre list, and informing the surgeon of the omission to mark the limb. They are under a duty to safeguard the welfare of the patients in their care. Individually and collectively they have omitted to alert the surgeon to his error, however [Dr C] too has a duty to care for his patient as he has overall responsibility to undertake the correct surgery."

APPENDIX 4

Response to Provisional Opinion on behalf of the private hospital

… Barristers and Solicitors:

"We have been instructed to reply to your provisional opinion for the [the private hospital]. It is very concerned at the criticism you have expressed towards it.

The [hospital's] primary objective is to provide high quality care to its patients. It has a team of experienced and dedicated management and staff. They took this incident seriously and reviewed their policies and procedures to reduce the risk that it might be repeated. The [hospital] has also made a determined effort to develop open and transparent systems consistent with current best practice principles in all aspects of its business.

The provisional opinion is critical of [the hospital] in a number of areas. It appears you have come to a number of conclusions without the benefit of having the full information available. This may have occurred because the legal advisers were concentrating on the issue of vicarious liability. The [hospital] regrets that this has occurred. It requests that you consider the further information provided in this letter. It is also available to provide any additional information required.

You have stated that there has been reluctance on the part of [the hospital] to accept the mistake was anything other than the responsibility of [Dr C] (at page 23). This is not correct. [The hospital] has always accepted that this incident was a surgeon and a team error. However, it was provided with a preliminary view from your Office that it was vicariously liable for the actions of [Dr C]. It did not agree and made submissions on the point.

It is [the hospital's] view that the primary responsibility for the surgery remained with [Dr C]. However, the other members of the team were also responsible and had separate obligations to [Mrs A] to ensure the surgery went ahead at the correct site. In a similar way, [the hospital] accepts that it is part of that same team and is required to have appropriate policies and protocols in place to assist the delivery of quality surgical care. It believes your provisional opinion also reflects this approach.

The issue of vicarious liability diverted [the hospital's] attention in responding to your investigation away from considering the additional responsibilities for the error on the part of other individuals and [the hospital] itself. As a result, it did not provide a detailed response concerning its procedures and protocols and the action taken after the incident. We also note that your office did not focus on these aspects in its correspondence with [the hospital] during the investigation. As a result the provisional opinion proceeds on the basis that [the hospital] took little action in response to the incident. We provide the necessary detail later in this response so that you might reconsider this conclusion.

You also state that [the hospital] did not undertake an investigation and that it was left to [Dr C] to follow up the sentinel event (page 24). Again, [the hospital] does not accept this conclusion. It did undertake an investigation and took a number of specific steps after this incident. [Dr C] was not involved in that investigation or the steps taken to reduce the risk of this mistake being repeated. In particular, [Dr C] did not spend time developing a protocol that was later adopted by [the hospital]. In fact, [the hospital] developed the protocol without [Dr C's] input. It understands [Dr C] supported its conclusions and that he did promote [the hospital's] protocol to the ACC Medical Misadventure Unit.

We have set out the actions taken by [the hospital] in some detail and then responded to particulars of the breach you have indicated.

Actions taken by [the hospital]
[The hospital] acknowledged the error had occurred immediately. A debriefing meeting of the theatre staff was held straight after the incident on 3 November 1999. All members of the surgical team attended except [Dr C]. An incident report was completed. The report noted that this was a 'team error'. The report included a plan detailing the action to occur in the future.

The error was acknowledged to Mr and [Mrs A]. Drs [C] and [D], and [the hospital's] principal nurse apologised to the couple.

After the debriefing, [the hospital] drafted and circulated a memorandum to all consultants. This formalised the general practice in place before the incident. The memo reinforced the requirement for the surgeon to mark the site of the surgery prior to the patient arriving in theatre.

A memorandum was entered in the theatre communication book for theatre staff.

A staff meeting held a few days later discussed the incident and the new policy at some length. The discussion centred on the action nurses might take if procedures were not followed by surgeons involved.

The pre-operative check form was changed to capture the fact that the surgical site needed to be marked with a pen. Question 3 of the new form asks if the correct limb has been marked for surgery by the consultant.

[The hospital] then developed policies on the marking of the limb, application of tourniquet and updated checking-in of patients to theatre. [Dr C] was not involved in the process. In fact, the clinic took the initiative and developed the policies.

The policies have been reviewed on a number of occasions since 1999.

The role descriptions for each nurse have been reviewed and the scope of service for the Perioperative Unit developed.

[The hospital] is committed to the development and implementations of quality systems. These systems have been developed to the level where [the hospital] achieved accreditation through Quality Health New Zealand 2001.

Breach by [the hospital]
You have described the breach of the Code by [the hospital] at page 21 of the provisional opinion. The breach involves two parts, the training of theatre nursing staff and the requirement for policies to prevent wrong site surgery.

Training of theatre staff
The training and orientation of nursing staff has changed and developed since [the hospital] was first opened. Staff Nurse [Ms E] began at [the hospital] in August 1985. Even at that time she was already an experienced theatre nurse. She had previously been a charge nurse at a large public hospital. Staff Nurse [Ms G] joined [the hospital] in March 1994. She was also an experienced theatre nurse having trained at a tertiary facility and practised in the private health sector. In addition, she also acted as theatre manager for a 12 month period. Both these two nurses have been involved in the development of many of [the hospital's] protocols and procedures. As a result these two nurses knew their roles and the expectations asked of them by [the hospital].

Nurse [Ms F] joined [the hospital] as one of the first new graduate nurses to the Periopertive Unit at the end of January 1999. [The hospital] does not believe her statement provides sufficient detail as to her training and orientation. It is accepted that Nurse [F] did not receive a formal orientation in the sense of a dedicated program of introductions to [the hospital] and its work-areas. But a less formal introduction did occur. She was also 'buddied' by an experienced mentor until she was considered competent. Nurse [F] spent 3 months in the anaesthetic nurse role before moving to the recovery nurse position for 4 months and finally the scrub nurse position for 4 months. She did not advance to become a circulating nurse as she was not considered experienced enough. Instead she spent the next 5 months in each of the other roles. Nurse [F] left in early June 2000.

The Nursing Co-Ordinator provided Nurse [F] with copies of the protocols for each of the roles involved. [The hospital] believes Nurse [F] was familiar with the policies and procedures because staff recall her feedback on several aspects which was of assistance.

The increased size and development of [the hospital] meant that a formal orientation package could be developed and introduced in 1998 and 1999. There is now an organisations wide orientation package for all new employees who must complete this prior to commencing area specific orientation. There are also formal job descriptions and role descriptions as well as organisation wide manuals of policies and procedures. These have been upgraded to achieve accreditation with Quality Health New Zealand.

In summary, [the hospital] did have training and orientation in place for its nurses at the time of this incident. It has continued to develop and formalise those procedures over the last few years.

Policies to prevent wrong site surgery
You have stated that [the hospital] should have had a dedicated policy to prevent wrong site surgery in place for all medical and nursing staff prior to this incident occurring.

This is accepted. In hindsight such a policy may have assisted the staff in clarifying their respective roles and responsibilities. The importance in requiring the surgeon to mark and tourniquet the limb needed to be underlined.

However, we consider [the hospital's] policies at the time were consistent with those in place in other hospitals at the same time. The expert advice from Dr Atkinson confirms that routine marking of the surgical site by a surgeon pre-operatively was not standard practice in New Zealand at the time of [Mrs A's] operation. Immediately after the incident, the theatre manager tried to obtain information and policies from the College of Surgeons and the Orthopaedic Association. Both organisations did not have standard policies or information available. It was after this incident that the Health Department and Orthopaedic Association endorsed a policy on this point. This is reinforced by the fact that the Royston Hospital protocol was circulated in late 1999.

Other comments
You have made a number of other observations in the section headed 'Other Comments'. [The hospital] does not accept it was reluctant to accept the mistake was anything other than the responsibility of the surgeon. Again, the incident report recorded this was a 'team error'. [The hospital] took actions to remedy and prevent a repeat occurrence. It has re-evaluated its policies and set new standards.

[The hospital] did provide information when it was requested. Copies of the protocols for the role of scrub nurse are attached together with the pre-operative check forms mentioned earlier. Please advise if we can assist with any further information.

Summary
In summary, [the hospital] accepts this was a surgeon and team error. It took appropriate immediate action including putting in place a written policy reflecting the current best practice. It also took a number of other remedial steps.

[The hospital] believes it has provided appropriate training and orientation to its nurses. It accepts it did not have a formal policy in place to prevent wrong-site surgery before this incident but says that this was a common failing amongst hospitals at this time.

We request you review your opinion to take account of these comments.

[The hospital] is happy to provide a letter of apology to [Mrs A] at the appropriate time. It has also reviewed its practices in relation to internal investigations based on the Sentinel Events Workshop you have mentioned on page 24. [The hospital] would welcome any additional audit believed to be appropriate in the circumstances.

Please advise whether we can clarify any aspect of this response. We look forward to a copy of the final opinion in due course."

APPENDIX 5

Response to provisional opinion on behalf of Ms F

New Zealand Nurses Organisation

"Please find **enclosed** in response to your provisional opinion a letter from Staff Nurse [Ms F]. …

I wish to make the following submissions on Staff Nurse [F's] behalf.

1. You have found Staff Nurse [F] to be in breach of Right 4(5) of the Code along with [Dr C], [Dr D], Staff Nurse [G] and Staff Nurse [E]. You have stated at page 21 *'yet for some reason it seems everyone assumed that someone else had the matter under control'*. It is unclear from your opinion what you mean by *'the matter'*.

2. You go on to say *'each individual member of the team had an opportunity to identify the mistake that was being made'*. There was not one mistake made, there were a number of mistakes made and these were made by [Dr C] (See my submissions on behalf of Staff Nurses [E] and [G] enclosed with my letter to you dated 14 June 2002). Staff Nurse [F] had no opportunity to identify these mistakes because she was focussed on her duties assisting the anaesthetist.

3. Your finding that Staff Nurse [F] was in breach of the Code finds that Staff Nurse [F] did not co-operate with the rest of the theatre team to ensure quality and continuity of service.

4. There is no evidence that Staff Nurse [F] did not co-operate. Staff Nurse [F] did co-operate with the rest of the team. There was nothing whatsoever that *she* could have done in terms of co-operation that would have minimised the risk of the incorrect limb being operated on.

5. It was one of the other team members, [Dr C], that did not co-operate with the rest of the team. He created numerous risks that were unforeseeable in the circumstances. A reasonably prudent anaesthetic nurse in Staff Nurse [F]'s position would not have been able to do anything else in terms of her co-operating with other team members. It was not her fault her team member, [Dr C], breached the trust that the rest of the team were reasonably entitled to have in him.

6. It is unfair that Staff Nurse [F] should be found in breach of the Code for lack of co-operation in a situation where an error occurred due to another team member's numerous mistakes and his lack of co-operation with the rest of the team.

7. There is nothing else that Staff Nurse [F] could have done in terms of co-operation that would have changed the outcome in this case.

8. She should not be found in breach of the Code."

APPENDIX 6

Response to provisional opinion on behalf of Ms [E] and Ms [G]

New Zealand Nurses Organisation

Case 00/06857 – Submissions on the Commissioner's Provisional Opinion on behalf of Staff Nurse [E] and Staff Nurse [G]

"1. You have found both staff nurses in breach of Right 4(1) of the Code and [Dr C] in breach of this Right as well. You find (at page 16) in relation to [Dr C's] breach of Right 4(1) that *'Although* [he] *bears primary responsibility for this serious error, he does not bear sole responsibility.'* When this sentence is viewed in the light of the findings relating to breaches of Right 4(1) by the two staff nurses, the whole tenor of the provisional opinion suggests that the two staff nurses are as equally to blame for the error as [Dr C].

2. My submission is that Staff Nurses [E] and [G] are not equally to blame with [Dr C]. [Dr C's] contribution to the error was significantly greater than either of the two nurses and this should be clearly stated in your final opinion.

3. In my submission, neither Staff Nurse [E] nor Staff Nurse [G] should be found in breach of Right 4(1). Alternatively if this submission is not accepted your opinion should clearly find that the nurses' contribution to the error was nowhere near as great as that of [Dr C].

Comments on Ms Gill Raven's evidence

4. Ms Raven is mistaken on two matters. The first is regarding Staff Nurse [E] and Ms Raven's mistaken belief that she left the operating theatre (see page 40). Her belief is not supported by any evidence. Staff Nurse [E] definitely did not leave the theatre at any time during the operation (see Staff Nurse [E]'s letter enclosed at page 1).

5. The second matter is that in page 49 Ms Raven states

'… it is my assertion that both the scrub nurse and the circulating nurse have a duty to check the consent form … [I]ndividually the Registered Nurses are responsible for checking the patient's consent form, checking this against the printed theatre list and informing the surgeon of the omission to mark the limb. They are under a duty to safeguard the welfare and safety of the patient in their care. Individually and collectively they have omitted to alert the surgeon to his error.'

6. This is not correct. Both Staff Nurse [E] and Staff Nurse [G] checked the consent form and checked this against the printed theatre list (see original statements of Staff Nurse [E]'s at paragraph 24 and Staff Nurse [G]'s at paragraph 5).

7. Staff Nurse [E] informed [Dr C] of the omission to mark the limb and this appears to have been acknowledged by Ms Raven on page 39: *'It is not a nursing responsibility to mark the limb, however as in the case I would expect a senior nurse to bring the omission to the attention of the surgeon.'* It is unclear therefore why Ms Raven at page 49 expresses herself as she does and her comments on page 49, being incorrect should be disregarded by you.

Staff Nurse [E]

8. Your opinion is that once Ms [E] had informed [Dr C] that the limb was not marked she *'was not simply entitled to rely on [Dr C's] knowledge of the omission, nor to assume that [Dr C] would ensure the omission was corrected'*. There is nothing whatsoever in the evidence including the expert opinion of Ms Gill Raven to support this finding.

9. [Dr C] and Staff Nurse [E] were part of a team. [Dr C] was clearly in breach of his obligation to mark the limb or to check that the anaesthetist had marked it. In either case, as Ms Gill Raven states at page 39 *it is not a nursing responsibility to mark the limb.* At the point she advised him that the limb was not marked, Staff Nurse [E] provided an opportunity for [Dr C] to remedy his error and thus eliminate the risk he created. At the point she advised him that the limb was not marked, the responsibility for marking it became that of [Dr C]. [Dr C] is a health professional and member of the operating theatre team. You have yourself stated at page 21 that *'a team is called a team for a very good reason; there is an expectation that there will be sufficient co-operation and communication amongst its members to minimise the risk of harm to the patient … Each individual member of the team had an opportunity to identify the mistake that was being made.'* Your finding that Staff Nurse [E] was not entitled to rely on [Dr C's] knowledge of the omission, nor to assume that he would ensure the omission was corrected, is contrary to your opinion that a team is called a team for a very good reason, that there is an expectation of sufficient co-operation. She should have reasonably been able to expect he would acknowledge his responsibility to mark it. The anaesthetist was busy. It was therefore [Dr C] that should have marked it at that point. If he chose not to, as he did, then he should take responsibility for the flow on consequences of his choice.

10. A circulating nurse should only be able to rely upon the fact that once she has advised another senior team member of an omission, that team members, whose responsibility it was in the first place not to make the omission, will correct it. As a team member [Dr C] should have listened to Staff Nurse [E]'s advice and acted on it. In my submission, Staff Nurse [E] should have been reasonably entitled to assume that

another team member would listen to her and act on her advice. This is part of co-operation amongst the team. It was also reasonable for her to assume that [Dr C] would act on her advice, because on past occasions other surgeons, including [Dr C], had done so (see her enclosed letter at page 2, lines 2-6).

11. After advising [Dr C] that the limb was not marked and reminding him which limb was to be operated on, Staff Nurse [E] attended to her duties in relation to opening packs and assisting the scrub nurse. (See the duties set out by Ms Raven at page 41, in particular the duty to undertake swab and instrument count with the scrub nurse.) She was therefore legitimately focussed on other matters and it was not foreseeable in the circumstances that [Dr C] would create a further risk that the wrong limb would be operated on by choosing to ignore her advice.

12. In my submission, it is unreasonable of you to find that Staff Nurse [E] was responsible on this occasion for failing to '*prevent surgery commencing on the incorrect leg'* (page 19). She had taken steps to prevent this by informing [Dr C] that the leg was not marked and reminding him which leg was to be operated on.

13. Her omission, if there was one, was not checking with him that he acted on her advice. In my submission it was reasonable of her not to have done so in the circumstances. She and [Dr C] had worked together for a long time. He was a senior specialist. He was a member of the theatre team. As he was a member of that team she could reasonably expect that he *should* act on her advice. In this case she also could reasonably expect that he *would* act on her advice as he had done so in the past.

14. At page 19 you have found that *'Ms [E] heard [Dr C] ask Ms [H] to apply the tourniquet to [Mrs A]'s leg. Ms [E] knew that Ms [H] was not part of the theatre team, that [Dr C] had not specifically mentioned the right leg to Ms [H].'* Staff Nurse [E]'s evidence was that she heard Nurse [H] ask [Dr C] if this was the leg to which to apply the tourniquet (see her original statement paragraph dated 24 January at paragraph 10). This evidence appears to have been disregarded by you. Also as you will see from Staff Nurse [E]'s enclosed letter (at page 2 paragraph 2 line 10) she states that she heard Nurse [H] ask [Dr C] if the limb she was tapping was the correct one. She goes on to state that she distinctly heard [Dr C] say yes to Enrolled Nurse [H]. This shows that she knew that [Dr C] had indicated one of the legs.

15. It was reasonable of Staff Nurse [E] to assume that [Dr C] would have indicated the correct leg and would not tell Enrolled Nurse [H] to tourniquet the wrong leg. This is because
    (a) Staff Nurse [E] had on other occasions advised surgeons, including [Dr C], of matters including omissions and they had acted on her advice, and
    (b) She had advised [Dr C] not only that the limb was not marked but also which limb was to be operated on, and

(c) After she had advised [Dr C] that the leg was not marked and reminded him which leg was to be operated on, she heard [Dr C] speak with [Mrs A] and ask her if this was the leg to be operated on and she heard [Mrs A] say yes, and
(d) She heard Enrolled Nurse [H] ask him if the leg she was tapping was the correct one and she heard [Dr C] say yes, and
(e) [Dr C] was part of the theatre team and it was reasonable to expect that he would act upon his circulating nurse's advice.

16. A reasonable circulating nurse in the circumstances would assume that [Dr C] would not tell Enrolled Nurse [H] to apply the tourniquet to the wrong limb.

17. While Enrolled Nurse [H] was applying the tourniquet to the limb, Staff Nurse [E] was busy, again carrying out legitimate and necessary tasks. She was also aware that Enrolled Nurse [H]
(a) was familiar with the procedure she was being asked to carry out, and
(b) had actually asked [Dr C] if the leg she tapped was the correct one, and
(c) that [Dr C] had said yes, that the leg she tapped was the correct one.

18. Staff Nurse [E] was also not simply standing around in the theatre when [Dr C] asked Enrolled Nurse [H] to tourniquet the limb. She was attending to other duties which she was expected to focus on. It is reasonable that she should have been able to rely on her team member, [Dr C], to not create further risks by ignoring her advice and by telling Enrolled Nurse [H] to apply the tourniquet to the wrong limb.

19. In this case [Dr C] by-passed the usual procedure by asking Enrolled Nurse [H] to apply the tourniquet. He should have waited until Staff Nurse [E] finished her tasks with Staff Nurse [G] and then asked her to assist him to apply it. Your expert adviser Ms Gill Raven (at page 40) refers to the Perioperative Association of the New Zealand Nurses Organisation Guidelines that states that tourniquets are the responsibility of the medical staff. [Dr C] should take sole responsibility for the tourniquet being applied to the wrong leg. He should have either put it on himself or asked a nurse to assist him. He did neither. He was obviously in such a rush to finish his list that day that he disregarded his obligations in relation to the marking of the limb and the tourniquet. This had consequences both for the patient and for the rest of the team.

Staff Nurse [G]

20. Staff Nurse [G] was aware the limb was not marked because she had checked this with Staff Nurse [E]. She knew that Staff Nurse [E] advised [Dr C] of the omission (see her original statement at paragraph 5).

21. In between her knowing this and her draping the limb [Dr C] effectively marked the limb by telling Enrolled Nurse [H] to apply the tourniquet. Staff Nurse [G] had her back to the table and did not see this.

22. In my submission, once a tourniquet has been applied it can reasonably be expected (because of the previous checks that should have taken place when applying the tourniquet by the surgeon) that it is on the correct limb. The dynamics of an operating theatre would then be such that painting and draping would automatically flow on without question because the presence of the tourniquet 'marks' the limb. Thus those procedures would be carried out on the limb that had the tourniquet on it.

23. Also when Staff Nurse [G] assisted [Dr C] to drape the limb not only had the tourniquet been applied but the leg had already been painted by [Dr C]. Staff Nurse [G] had no part in the painting of the limb. Ms Gill Raven states at page 43 that it is *'usual for the scrub nurse to be in the vicinity of the operating table during the painting, depending on the type of procedure she will assist with the painting'*. In this case Staff Nurse [G] did not assist with the painting. Given that [Dr C] assisted with draping the limb that he had already painted and indicated that the tourniquet should be applied to, he should bear greater responsibility for draping the wrong limb than Staff Nurse [G].

24. She could reasonably in the circumstances rely upon the two 'marks' of the tourniquet and of the painting carried out by [Dr C].

25. The fact that [Dr C] painted the limb with the tourniquet applied to it is evidence that my submission, at paragraph 22, that the tourniquet 'marks' the limb, is correct. If this submission is not accepted, then Staff Nurse [G] should reasonably have been able to trust that [Dr C], being a senior member of the team and having been told which leg was to be operated on, would not paint the incorrect limb.

26. Staff Nurse [G] had her back to the patient and to the surgeon when the tourniquet was being applied and the limb was painted. She did not hold the limb whilst it was being painted. She was attending to other necessary matters. She had a good reason for having her back to the table and therefore not seeing what was going on. [Mrs A] came in to the theatre awake and was awake on the table until the anaesthetic took effect. Staff Nurse [G] did not want to cause [Mrs A] fear and anxiety by having her seeing the instruments that would be used on her. Staff Nurse [G] was focussed on her tasks and it was reasonable of her to rely on [Dr C] as a team member to carry out his task of painting the correct limb so that the correct limb would be the one that was draped by both of them.

27. A reasonably prudent scrub nurse in Staff Nurse [G]'s position would not foresee that the surgeon would make **four** major errors behind her back (not acting on his circulating nurse's advice, telling Enrolled Nurse [H] to apply the tourniquet, indicating her to apply it to the wrong limb and painting the wrong limb). A reasonably prudent scrub nurse would expect to be able to trust him not to create such significant risks. … They were not simple mistakes. Two of them were deliberately highhanded,

at the very least they were reckless acts (ignoring the circulating nurse's advice and asking Enrolled Nurse [H] to apply the tourniquet instead of doing so himself, knowing he had chosen to ignore the circulating nurse's advice). Indicating to Enrolled Nurse [H] to apply the tourniquet to the wrong limb and painting the wrong limb were consequences of his recklessness.

28. Any omission by Staff Nurse [G] to notice which leg was being operated on was a direct consequence of [Dr C's] … reckless risk taking.

29. In relation to your finding that Staff Nurse [G] failed to notice that operation was being performed on the incorrect leg, it was not unreasonable in the circumstances that Staff Nurse [G] did not notice this. Ms Gill Raven states that *the surgeon stands on the side on which he is going to operate.* [Dr C] stood on [Mrs A]'s left (see evidence of Staff Nurse [E]) thus misleading Staff Nurse [G]. His standing on the left followed his earlier active errors of indicating to Enrolled Nurse [H] to apply the tourniquet to the wrong limb, painting the wrong limb and assisting Staff Nurse [G] to drape the wrong limb. In short, [Dr C] had 'set up' Staff Nurse [G]. Only one limb was exposed for the operation and this was the painted, draped one.

30. In my submission, it would be difficult to tell whether an exposed limb is the left one or the right one, especially when the patient is in the prone position. All [Dr C's] errors misled Staff Nurse [G] unconsciously into a mind-set such that as she was handing him the instruments she was, reasonably in my submission, unaware that the wrong limb was being operated on. Staff Nurse [G]'s primary function was to ensure the sterility of her trolley and focus on her instrumentation (see opinion of Ms Gill Raven at page 43). This was what she was doing.

Analysis of the error (operating on the wrong limb) please refer to attached copy of 'swiss cheese' model:

31. I refer you to the works of Professor James Reason (James Reason *Human Error* (New York: Cambridge University Press, 1990) 173 and J Reason, *Managing the Risks of Organisational Accidents* (Aldershot: Ashgate, 1997) 126, 127.).

32. Professor Reason's work, though focussing on errors in contexts other than in the health area, can be of assistance in this case. He analyses errors by identifying conditions that result in error. He uses what he terms the 'Swiss cheese model' to identify these conditions. He considers that all errors are consequential on a number of conditions, which may be latent defects or active errors, all of which contribute to the error occurring.

33. To analyse this particular error I have used a combination of two diagrams created by Professor Reason, which have been put together and adapted by me. Once the error is analysed it can be seen that almost all the conditions that resulted in the error were

active errors rather than latent defects. It can also be seen that [Dr C] created these active errors.

(Please refer to attached copy of diagram with reference to this section of appendix.)

34. Referring to the … diagram, it can be seen that the incorrect leg was operated on as a consequence of a number of failures, only some of which were latent defects in the system, such as 'swiss cheese' 1, lack of clear theatre policies about marking the limb and 'swiss cheese' 2, the practice of a scrub nurse setting up her trolley with her back to the patient due to the absence of an anaesthetic room and the need for the patient to be anaesthetised in theatre and thus being frightened by the sight of the instruments. It can also be seen that most of the conditions that resulted in the error weren't latent defects on the system but active errors. The majority of these were made or set up by [Dr C].

    a) [Dr C] set up the risk of error in the first place by not marking the limb. ('swiss cheese' 3).
    b) [Dr C] ignored Staff Nurse [E]'s advice that the limb was not marked. ('swiss cheese' 5).
    c) [Dr C], apparently wanting to rush through his list asked a nurse who was not involved in that operation to apply the tourniquet, a task normally undertaken by himself. ('swiss cheese' 6).
    d) [Dr C] told Enrolled Nurse [H] which limb to tourniquet ('swiss cheese' 7). By telling her which limb to tourniquet [Dr C] in effect 'marked the limb'. At this point [Dr C] knew he had not marked the limb and knew which site the tourniquet should have been applied to because he had just been reminded.
    e) [Dr C] painted the incorrect limb, knowing which limb should be operated on and knowing he had advised Enrolled Nurse [H] which limb to tourniquet ('swiss cheese' 98).
    f) [Dr C] assisted Staff Nurse [G] to drape the limb, knowing which limb should be operated on and knowing he had just pained the limb, ('swiss cheese' 9). This was an inevitable consequence of his active errors at 7 and 8.
    g) [Dr C] stood on the left side of the patient after having been advised the right side was the side to be operated on, ('swiss cheese' 10).

Staff Nurse [E]

35. In your provisional opinion you state that in relation to Staff Nurse [E] there were at least two occasions on which the risk was made evident. Also you consider that Staff Nurse [E] failed to act with reasonable care by a) assuming that [Dr C] would act on her advice and by b) not checking that Enrolled Nurse [H] was applying the tourniquet to the correct limb.

36. In your opinion Staff Nurse [E] failed to prevent the wrong limb being operated on by failing to act where risks were evident. The risks of the error occurring were multiple and as demonstrated above were mostly created by [Dr C]. A finding of failing to act where risks were evident implies that you found that a reasonable circulating nurse would have known the risks were evident and that it was reasonable able to act on them. My submission is that a reasonable circulating nurse would have not known that some of the risks were evident and of those that were, it would have been reasonable in the circumstances for a prudent circulating nurse not to act.

37. In my submission a reasonable circulating nurse would be expected to identify none of the latent defects and only the following active errors.

The omission by [Dr C] to mark the limb ('swiss cheese' 3). This was identified by Staff Nurses [E] and [G] and acted on by Staff Nurse [E]. She advised [Dr C].

The asking by [Dr C] of Nurse [H] to tourniquet the limb ('swiss cheese' 6).
It was reasonable that Staff Nurse [E] should have identified this as a risk. However it was not unreasonable in the circumstances that Staff Nurse [E] did not act on it. Enrolled Nurse [H] was not a stranger to either [Dr C], or to the type of operation, or to applying a tourniquet to a limb. Staff Nurse [E]'s evidence is that had she been a stranger, she would have been more concerned. This comment implies that she identified the risk, but felt there was no reason to act on it in this situation. This was not unreasonable in the circumstances. She was focussed on other legitimate duties and reasonably believed that [Dr C] would advise Enrolled Nurse [H] to tourniquet the correct limb. This was because he was a senior member of the team and had been advised he had not marked the limb and had been reminded which limb was to be operated on and was heard by her discussing with [Mrs A] which leg he was to operate on.

38. There were other active errors created by [Dr C]. These errors created risks that a reasonable circulating nurse <u>in the circumstances</u> would <u>not</u> be expected to identify. These were:
The failure by [Dr C] to act on his circulating nurses advice ('swiss cheese' 4).
It was entirely reasonable for a circulating nurse in Staff Nurse [E]'s position to expect the surgeon to listen to and act on his circulating nurse's advice. Surgeons are members of the theatre team. In this case [Dr C] was a specialist surgeon and he had ultimate clinical responsibility for the patients. He was a senior surgeon, not a junior and he and Staff Nurse [E] had worked together for a long time. He had in the past acted upon Staff Nurse [E]'s advice, as had other surgeons. It was therefore reasonable for Staff Nurse [E] to assume that on this occasion he would act on her advice.

39. In the … diagram 'swiss cheese' 5 is the condition of Staff Nurse [E] not checking that [Dr C] had followed her advice. This was one of the conditions that led to the serious

error of operating on the wrong limb and I have put it in the diagram as an active error ('swiss cheese' 5) on the basis that had she checked with [Dr C] then the wrong limb might not have been operated on. However, this cannot be conclusive. Even if she had stood over [Dr C] until he marked the right leg he could still have gone on to advise Enrolled Nurse [H] to apply the tourniquet to the left leg or painted the left leg.

40. Although I have put it in the diagram as an active error, my submission is that Staff Nurse [E] should not be found to be in breach of the Code for not checking with [Dr C] because in the circumstances it was reasonable of her not to check. She was reasonably entitled in the circumstances to rely on this knowledge of his omission and to trust that he would ensure the omission was corrected. Had Staff Nurse [E] just advised a junior doctor that he had forgotten to mark the limb, or had she no experience of working with [Dr C] previously, or had he a habit of ignoring her advice then she should have checked he was acting on her advice. In the circumstances of having worked for a long time with [Dr C], having had him act on her advice in the past and with him being a senior member of the team it was reasonable of her to assume she could trust him and that she need not check up on him.

41. I have not put into the diagram your opinion that Staff Nurse [E] should have ensured that the tourniquet was applied to the correct limb. This is because I do not consider that this was an active error in the circumstances. If Staff Nurse [E] had less reason than she had to trust that [Dr C] would act on her advice and had Enrolled Nurse [H] been unfamiliar to the theatre, then in those circumstances a reasonably prudent circulating nurse would have checked that Enrolled Nurse [H] was properly applying the tourniquet to the correct limb. However a reasonably prudent circulating nurse in Staff Nurse [E]'s position would not check. This is because she would have known as Staff Nurse [E] did, that she had just advised a senior surgeon, whom she had no cause to suspect would ignore her advice, which was the limb to be operated on and had just heard him discuss the leg with the patient and indicate to Enrolled Nurse [H] which was the correct limb. She would also be, as Staff Nurse [E] was, confident in the Enrolled Nurse's familiarity with [Dr C] and the theatre and the type of operation and her ability to apply the tourniquet.

42. Staff Nurse [E] should not be found in breach of Right 4(1) of the Code.

Staff Nurse [G]

43. You have stated that *'The fact that the surgeon mistook the leg to be operated on is no excuse for Ms [G] assisting in procedures that she should have known were wrong.'* You have found that she failed to exercise reasonable care in performing her duties in theatre, especially in assisting the draping of the incorrect leg then failing to notice that the operation was being performed on the incorrect leg.

44. [Dr C] did not simply mistake the leg to be operated on. He made more than five active errors that led to the wrong leg being operated on and in my submission these misled Staff Nurse [G] so much that it is unreasonable of you to find that she should have known that procedures she was assisting in were wrong. A reasonable scrub nurse in Staff Nurse [G]'s position in the particular circumstances would have not known she was assisting in procedures that were wrong. This is because any failure on her part to notice that she was draping the wrong limb and that the operation was being carried out on the wrong limb was a consequence of active errors made by [Dr C] that were very misleading. These were 'swiss cheeses' 4, [Dr C's] failure to act on Staff Nurse [E]'s advice that the limb was not marked and which limb was to be operated on, 7, [Dr C] indicating to Enrolled Nurse [H] to tourniquet the wrong limb and 8, [Dr C] painting the wrong limb.

45. Added to that are the facts that Staff Nurse [G] knew [Dr C] knew [Mrs A] and which one of her legs was to be operated on and knew that he was reminded of this by Staff Nurse [E]. It is entirely reasonable in these circumstances that a scrub nurse with her back to the table, focussing on her instrumentation, would not consider that [Dr C] would commence operating on the wrong limb.

46. [Dr C] made another active error ('swiss cheese' 10) by standing on the left side of the patient and operating on the wrong limb (see evidence of Staff Nurse [E]). It was not unreasonable in the circumstances that Staff Nurse [G] did not identify that the incorrect leg was being operated on. This is because she was focussed on her trolley and because she was 'set up' by [Dr C] to believe the leg he was operating on was the correct leg. Ms [G]'s primary function, as identified by Ms Gill Raven, was to ensure the sterility of her trolley. Ms [G] was focussed on her trolley and her instruments.

47. [Dr C]'s two previous active errors (7 and 8) led directly to 'swiss cheese' 9. It was directly as a consequence of 7 and 8 that Staff Nurse [G] reasonably assumed that the limb she assisted to drape was the one to which the tourniquet was applied and the one that was painted. [Dr C] was responsible for the application of the tourniquet. He was responsible for painting the limb. These were tasks he should have carried out properly whilst Staff Nurse [G] was carrying out her task which was to ensure the sterility of her trolley and focus on the instruments. He was a senior member of the theatre team and she should have been able to trust him. He then misled her again by assisting her to drape the limb he had painted. All this was after he had been reminded which limb was to be operated on. It was reasonable of her to trust he would not have painted the wrong limb and thus reasonable of her to trust he would be draping the correct limb. He then stood on the wrong side of the patient. By standing on [Mrs A]'s left side he misled Staff Nurse [G] once again after already misleading her three times before that. It is not unreasonable in the circumstances that Staff Nurse [G] did not realise the wrong leg was being operated on.

48. In my submission Staff Nurse [G] did not fail to exercise reasonable care in performing her duties in theatre. She carried out all her duties appropriately and draped the limb correctly. It was not unreasonable in the circumstances that she assisted the draping of the incorrect limb because she had been misled and 'set up' by the active errors of [Dr C] that had in effect 'marked' the limb she draped. Any omission on her part to notice that she was draping the wrong limb is directly consequential on [Dr C]'s active errors and this should be taken into consideration by you.

49. It was also reasonable in the circumstances due to [Dr C]'s numerous active errors that she did not notice that the operation was being performed on the incorrect leg. Again any omission on her part in this regard is a direct consequence of [Dr C]'s active team errors and again I submit that this should be taken into account by you.

50. In the circumstances, Staff Nurse [G] should not be found in breach of Right 4(1) of the Code.

Conclusion

51. Whilst the Staff Nurses acknowledge a collective responsibility with [Dr C], it is clear that the far greater proportion of blame for the error lies with [Dr C]. The nurses acknowledge that they had collective responsibility to try to prevent the wrong limb being operated on. However any finding by you of the failure by Staff Nurses [E] and [G] to prevent this error should take into account that the risk of the error occurring, was created by [Dr C], not just once, but more than five times during the whole procedure.

52. This was not a situation in which the Staff Nurses failed to advise [Dr C] that the limb was not marked. They did advise him and it was his responsibility to have marked it or ensure it was marked. Once he was advised it was not marked, it was … arrogant and dangerous of him to totally disregard Nurse [E]'s advice. He then furthermore placed the patient at risk of having the wrong limb operated on, and Staff Nurse [G] at risk of assisting to drape the wrong limb, by recklessly asking Enrolled Nurse [H] to do that. Instead he carelessly indicated to her which limb to apply it to. He then did not even check when he painted the limb yet he knew he had ignored Staff Nurse [E]'s advice and he knew he had not applied the tourniquet himself. His actions were a major breach of the trust and level of co-operation that the rest of the theatre team were entitled to have in him.

53. Blame should not lie equally in this matter. Staff Nurses are not in theatre as surgeons' handmaids. They are there to carry out specific duties and tasks and although they are there to safeguard the safety and wellbeing of the patient, this is a team responsibility, not just the nurses' responsibility. The team have a responsibility to the patient but they also have a responsibility to each other *'In the operating theatre, all members of staff, as part of the team have their own area of responsibility … Hence each person has*

their individual duty of care towards the patient and towards other members of staff' (my emphasis added) (Wicker CP 1990 Legal Responsibilities of the Nurse 2 – Negligence. Surgical Nurse 20-22, cited in British Journal of Theatre Nursing Vol 4 No 2 May 1994).

54. [Dr C] was part of that team and he let the rest of the staff in the team down by recklessly creating significant risks.

55. As team members the nurses should be entitled to expect a surgeon to properly carry out his own tasks and not be reliant on the Staff Nurses to keep checking up on him. Checks are important, but also is trust in other team members. [Dr C] let the team down and the degree to which he did this was not foreseeable.

56. I submit that you should not find that Staff Nurses bear an equal responsibility with a senior surgeon where the surgeon is responsible for creating significant risks, unless that surgeon is not a junior doctor or unfamiliar to the nurses, or acting on their advice. [Dr C] is not a junior doctor; he is senior specialist who had worked with Staff Nurse [E] and Staff Nurse [G] for many years.

57. Also, your provisional opinion does not acknowledge that ultimate clinical responsibility for the wellbeing and safety of the patient lies with the surgeon, not the theatre nurses. This is acknowledged by Ms Raven. At page 49 final sentences she states … *[Dr C] … has overall responsibility to undertake the correct surgery.*

58. This is a private hospital. [Mrs A] was [Dr C]'s private patient. Overall or ultimate clinical responsibility for her safety and wellbeing is reflected on [Dr C]'s considerable fees in comparison to the nurses' pay.

59. The nurses were, in my submission, reasonably entitled to assume that as a senior specialist with clinical responsibility for his patient, [Dr C] would correct his error of not marking the limb and thus estimate the potential for risk that he created. They were not reasonably to know that instead [Dr C] would …, high handedly in my submission, totally ignore the nurses' advice and then create further significant errors that put at risk, not only the patient's safety and wellbeing, but also the liability of the rest of the theatre staff.

60. Nurses [E] and [G] are not seeking to absolve themselves from all responsibility but whilst it can fairly be said that the Staff Nurse [E] failed to identify some risks [Dr C] created them by making numerous active errors. Not all of these were reasonably evident and in the case of those that were, one was acted on by Staff Nurse [E] and it was not unreasonable of her that she did not act on the others.

61. Staff Nurse [G]'s omissions in not noticing she was assisting to drape the incorrect limb and not noticing that surgery was commencing on the incorrect limb were a direct consequence of [Dr C]'s numerous active errors and should not be seen as her errors.

62. I submit therefore that Staff Nurse [E] and Staff Nurse [G] should not be found to be in breach of Right 4(1) of the Code.

63. Alternatively, if you do not accept this submission, then I submit that you should adjust the weighting of accountability. Your provisional opinion places what the nurses did not do on equal footing with the considerable active errors made by [Dr C]. This is unfair on the nurses. Your final opinion should make it clear that [Dr C] not only bears primary responsibility for this error but that his contributions to it were significantly greater than those of Staff Nurses [E] and [G].

64. Your provisional opinion suggests that you intend to refer the whole matter to the Director of Proceedings. My submission is that none of the staff nurses have made a serious breach of the Code and none of them should be further investigated. They are willing to apologise to [Mrs A] and have all made changes to their practice. The only serious breach of the Code was made by [Dr C] who created numerous significant risks that let the rest of the theatre team down. It appears from your provisional opinion however that [Dr C] has taken steps to ensure he does not create such risks in the future. I therefore submit that there is no need to refer any part of this matter to the Director if Proceedings for further investigation."

APPENDIX 7

Response to provisional opinion from Staff Nurse [F]

"Dear Sir

Opinion – Case 00/06857
Ms [F] [The private hospital]

Thank you for your letter dated 9 May 2002.

I accept that as anaesthetic nurse I had a responsibility to ensure the safety and wellbeing of the patient. I accept that the team as a whole failed to prevent the wrong limb being operated on and I am willing to sign a letter of apology signed by the entire surgical team and written to [Mrs A].

I would, however like to make comment on your provisional opinion as follows:

I advised you that I had no orientation to the position of anaesthetic nurse and this is correct. I however received some 'on the job' training and was 'buddied' with another more senior nurse at times. However due to the work load of both of us and the rosters, we were working in different theatres at times. I want to make it clear therefore that I did receive some training though it was not a formal program of training or an orientation such as I received when I started work at [a public hospital].

I have already reviewed my practice to try to ensure that this sort of serious error does not occur in the future and have put in place the following changes.

(a) I will not take patients to theatre unless the correct limb/site is marked.

(b) If a patient arrives in theatre with the limb/site not marked I ask the surgeon to mark it after checking the correct site-/limb and I make the surgeon mark it in front of me.

(c) Whilst assisting the anaesthetist, I deliberately keep an eye on the whole team as much as I am able to whilst attending to the patient.

Yours faithfully

Staff Nurse [F]"

APPENDIX 8

Response to provisional opinion from Ms [G]

Submission from Staff Nurse [G]

"Dear Sir

Opinion – Case 00/06857
Ms [G] [The private hospital]

Thank you for your letter dated 9 May 2002.

…

I accept that as a scrub nurse I had a responsibility to ensure the safety and wellbeing of the patient. I accept that the team as a whole failed to prevent the wrong limb from being operated on and I am willing to sign a letter of apology signed by the entire surgical team and written to [Mrs A].

I would, however like to make comment on your provisional opinion as follows.

My role as a scrub nurse necessitates me setting up the trolley with the instruments on it for the operation. During this setting up process my back was always to the patient and therefore to the surgeon and so this was why I did not see the tourniqueting and painting of the limb during the operation. I turned towards the patient after the limb was painted to assist with draping the limb.

The reason for my back being turned was that in [the hospital], unlike some other hospitals, there is no anaesthetic room in which the patient is anaesthetised before being taken into theatre. At [the hospital] the patient is taken directly into theatre and anaesthetised on the operating table. I therefore had my back to the patients, as I did to [Mrs A], to try to screen them from seeing the instruments that are to be used. For example, one of the things I need to do is put the scalpel onto the blade. I did this with my back to the patients to prevent them seeing me doing it and becoming frightened or anxious.

Whilst I accept that I have some responsibility for the safety and welfare of the patient I also feel that I assisted draping a limb that had in fact been 'marked' by [Dr C]. [Dr C] instructed Enrolled Nurse [H] to tourniquet a limb that he should have checked was the correct one, especially given that he had been advised he had not marked it. Also [Dr C] painted the limb. I was therefore draping an already tourniqued painted limb. I accept I could have checked it was the correct one and now I do check, but I feel that I am not equally responsible with [Dr C] for the error of the wrong limb being operated on. I feel that I was 'set up' to drape the wrong limb because it was tourniqued and painted by the surgeon. Also I did not drape on my

own. I assisted [Dr C] to drape the limb. [Dr C] is a member of the theatre team and I reasonably expected him to have acted on Staff Nurse [E]'s advice that the limb was not marked and so have taken all precautions not to tourniquet and paint and drape the wrong limb. This is not an unreasonable expectation given that after scrubbing, the surgeon's role is to tourniquet, paint and drape, whereas the scrub nurse and circulating nurse have other roles they have to be very focussed on such as setting up the instruments and counting swabs etc. Also it is not unreasonable to assume that [Dr C] would have responded to Staff Nurse [E]'s advice, given that surgeons, including him, had done so in the past.

You have said that I am in breach of Right 4(1) of the Code because I failed to exercise reasonable care, especially in assisting the draping of the incorrect leg then failing to notice that the operation was being performed on the incorrect leg. You have found me equally in breach of the Code with [Dr C] yet the risk was created by [Dr C]. I would ask to consider this when reaching your final opinion.

I have already reviewed my practice to try to ensure that this does not occur in the future and have put in place the following changes:

(a) I never drape a limb that is not marked and I never drape a limb where I cannot visibly see the mark. If a mark is not visible because the limb is elevated, I either pull down the limb or ask for the limb to be lowered until I see the mark.

(b) I never drape a limb that I have not checked with my circulating nurse to be correctly marked. I am prepared to hold up an operation if the limb is not correctly marked. There is a new checklist that will shortly be in place on which the circulating nurse must tick a box to say that both she/he and the scrub nurse have sighted the correctly marked limb. This checklist is a policy updating and reviewing the policy that is already in place. I will not let the circulating nurse tick the box on this checklist until I have sighted the correctly marked limb and checked with my circulating nurse that she/he has done so also. This involves not only looking at the limb but at the consent form and notes as well.

(c) I now set up my trolley facing the patient, notwithstanding that there might be some distress involved in them seeing what I am doing. I set up facing the patient now so that I can check to see that the limb being tourniqued and painted is the correct limb. With my back to the patient I was reliant on the surgeon tourniqueting and painting the correct limb, but now I no longer rely on the surgeon to do this and I watch these procedures closely.

Yours faithfully

Staff Nurse [G]"

APPENDIX 9

Response to provisional opinion from Ms [E]

Submission from Staff Nurse [E]

"Dear Sir

Opinion – Case 00/06857
Ms [E] [The private hospital]

Thank you for your letter dated 9 May 2002.

"I accept that as circulating nurse I had a responsibility to ensure the safety and wellbeing of the patient. I accept that the team as a whole failed to prevent the wrong limb being operated on and I am willing to sign a letter of apology signed by the entire team and written to [Mrs A].

I would, however like to make comment on your provisional opinion as follows:

I did not leave the theatre at any time. In your opinion, Ms Gill Raven at page 40 in her evidence states that I left the theatre. She states *it is usual practice for the circulating nurse to remain in theatre, unless there is a strong reason for necessitating her leaving. Ms [E] knew that they were proceeding without the limb marked yet she left the theatre to attend to other issues.*

This is incorrect. I remained in theatre at all times. Ms Raven may well be mistakenly assuming that I had to leave to the theatre to fill in the register. In some hospitals filling in the register and other paperwork is carried out outside the theatre. This is not the case in the [hospital]. The paperwork is kept on a trolley inside the theatre. I definitely did not leave the theatre.

Whilst I accept that I have some responsibility for the safety and welfare of the patient I was the circulating nurse and had duties to perform once I had advised [Dr C] that the limb was not marked. I spoke to [Dr C] by the scrub bay and then went over to where Staff Nurse [G] was setting up her tray, she was already scrubbed and sterile. As circulating nurse I was not scrubbed and sterile. My role was to assist the scrub nurse by undertaking the non sterile part of the process of opening equipment packs and other matters. I therefore tied Staff Nurse [G]'s gown and opened her packs so that she could take out the sterile instruments. This was a process I needed to focus on. [Dr C] is a member of the theatre team and I expect that as a member of the team he accepts and acts upon my advice. This had always occurred in the past. I advised [Dr C] that the limb was not marked and fully expected him to do something about it as it was his responsibility to mark the limb. My expectation that he would listen to my advice and act on it was based upon my previous experience of advising surgeons including [Dr C] of various matters, including omissions by them, and having known them to act upon my advice

in the past. I accept that I could have followed through with him to check he had marked the limb, but I fully expected that my advice would be listened to and acted upon by him as it had been on previous occasions.

When Nurse [H] came into the operating theatre I was busy carrying out other duties and did not see her and [Dr C] and what they were doing in relation to tourniqueting the limb. I heard them talking and as I did not consider that Nurse [H] was a stranger to either [Dr C] or to the particular type of operation or to tourniqueting the limb I was not as concerned as I would have been if she had been a different nurse that I was not so confident about. Also I did not expect that [Dr C] would tell Nurse [H] to tourniquet the wrong limb especially as I had only just informed him that the limb was not marked and which leg was being operated on. My expectation of him as a member of the team and the person with clinical responsibility for the patient was that he would be extra careful that the correct limb was tourniqued and given that he had not carried out his responsibility to mark it initially. Although [Dr C] did not specifically mention the right leg to Staff Nurse [H] I heard Staff Nurse [H] ask him if the leg she was tapping was the correct one and distinctly heard him say yes. I realise now that [Dr C] ignored my advice and had I thought that he would do that, I would have prevented Staff Nurse [H] applying the tourniquet. Unfortunately I relied on [Dr C] acting on my advice just as any other surgeon would, and indeed as he himself had done on previous occasions. As stated above I have since modified my practice and now do not expect a surgeon to take my advice, although as a team member I consider that they should.

You have said that I am in breach of Right 4(1) of the Code because I failed to take reasonable care to prevent surgery commencing on the incorrect leg despite at least two occasions on which the risk was made evident. You have found me equally in breach of the Code with [Dr C] yet the two occasions on which the risk was made evidence were occasions where the risk was created by [Dr C]. [Dr C] failed to mark the limb in the first place thus creating a risk which I remedied by advising him the limb was not marked. He then created a further risk by asking Staff Nurse [H] to tourniquet the limb by advising her to tourniquet the wrong limb. You have found me in breach of Right 4(1) for not preventing the wrong limb from being operated on, by not following through with him after I advised him that the limb was not marked and for not stopping him from telling Staff Nurse [H] which limb to tourniquet. I would not have had to follow through if [Dr C] had listened to my advice as a reasonable surgeon should have done as a member of the theatre team. I would not have had to stop Staff Nurse [H] applying the tourniquet to the wrong limb if [Dr C] had complied with usual theatre procedure and tourniqued the limb himself. Whilst I am not trying to avoid responsibility on my part I feel that my responsibility for this serious error is much less than [Dr C]'s. You say there were at least two occasions on which the risk was made evident to me, yet you have not acknowledged that the risk was created by [Dr C] on those two occasions ((i) Not acting on my advice and (ii) Departing from usual procedure by asking Staff Nurse [H] not only to tourniquet but telling her to tourniquet the wrong limb).

I feel that far more responsibility for this serious error should be [Dr C]'s than mine and I feel that he created the risk of the error occurring on more than one occasion. I would ask that

this be reflected in your opinion and the weight of responsibility be more fairly adjusted to take into account his creation of the risks that you consider I should have prevented.

I have already reviewed my practice to try to ensure that this does not occur in the future and have put in place the followed changes:

(a) I will not permit any procedure to commence without the limb being checked between the scrub nurse and the circulating nurse (as was correctly carried out on the day).
(b) If a patient arrived in theatre with the limb/site not marked I ensure that the patient is not anaesthetised until the limb is marked by the surgeon after discussion with the patient as well as checking the consent form and clinical notes.
(c) I will not permit the operation to commence if the correct limb is not marked by the surgeon.
(d) I personally check that the correct limb is marked.
(e) I do not permit any visiting nurse to take part in any part of the team procedure. If a surgeon asks a visiting nurse to take part, I advise the surgeon that the visiting nurse cannot take part.
(f) No nurse now tourniqets a limb. I would stop a nurse from doing it if he/she was asked by a surgeon to do so.
(g) I ensure that marking pens are kept in the theatre and in the other area that they might be needed.
(h) Whilst assisting a scrub nurse opening packs, I deliberately keep an eye on the whole team as well as the patient.

Yours faithfully

Staff Nurse [E]”

APPENDIX 10

Response to provisional opinion on behalf of [Dr C]

Ms N, Barrister

"As you are aware, I act for [Dr C]. The above case concerns an unfortunate error that has previously occurred in theatres and will again unless looked at with a prevention rather than blame focus.

An error has been made and we could, in a simplistic way, say that the surgeon – a captain of the ship – should be held responsible. That is, one assumes, reflected in the highlighting on your provisional opinion that: *'In her deliberations the Director of Proceedings will no doubt consider the role that [Dr C] played in the incident and determine whether further action against him personally is required.'*

It is respected that your opinion is intending to highlight individual as well as collective responsibility. The issue is whether referral as proposed would

(a) achieve the aim of preventing a recurrence of this type of error, and

(b) be constructive or be destructive in the functioning of a team that works regularly together.

It is respectfully submitted that it would be destructive, and in all the circumstances the referral is an inappropriate decision.

An extension of time was sought so that your Office could be provided with and have the benefit of expert opinion from one of the USA's (and internationally) most recognised experts in the prevention and investigation of iatrogenic injury. Preliminary reviews received suggested that it would be most constructive to have had the input of that opinion before a final decision was made and the matter referred to the Director of Proceedings. It is therefore unfortunate that an extension of time was not provided in order to enable this to occur, particularly as [Dr C]'s response has been praised as being commendable and given that this matter has not been treated with urgency during the two years of its investigation.

With respect, if the intention is to be prevention-focused, then the present recommendation of referral to the Director of Proceedings (an Office which has more limited functions than that of the Commissioner) would be counter productive and indeed destructive. You are therefore asked to reconsider the referral.

I enclose a letter that [Dr C] has drafted for your information."

Letter from [Dr C] – Orthopaedic Surgeon

"Dear Mr Paterson

Re: Mrs [A] (age 68) …

Since receipt of the provisional judgement of the Health and Disability Commissioner on the above case my legal adviser and I have sought to obtain an expert opinion from a suitably respected expert. Despite an extension of time beyond the original period, we simply cannot secure such a review. Further requests for an extension to allow such a review have been denied and I am fearful that unnecessary hardship may result.

This case had caused great personal stress and has been protracted over two years during which time the Health and Disability Commissioner has requested many reports and clarification from me which have been promptly responded to.

The Health and Disability Commissioner's conclusion that a system error took place at a number of levels is not in question.

To further submit my name to the Director of Proceedings can only add further hardship and threaten to repeat a process which has seen not just a Health and Disability Commissioner enquiry but also an ACC investigation and indeed a summons to the District Court.

We have earnestly sought to support this view with independent opinion but such opinions are available only from busy clinical doctors who necessarily have only their personal time to give to such matters, and cannot do so in a short time frame. I fear that a less than robust judgement may be made without such a review.

Yours sincerely

[Dr C]"

APPENDIX 11

Response to provisional opinion on behalf of [Dr D]

Ms O, Barrister

"Dear Mr Paterson

Mrs [A] – Your Ref: 00/06857/AM

"I have been instructed by Dr [D] to reply to your provisional opinion. [Dr D] is very concerned at the criticisms you have levelled at his practice in this case.

I am concerned at the emphasis and reiteration throughout the report on [Dr C] having 'assisted' the Commissioner's office 'greatly' throughout this investigation stage, to the exclusion of other parties.

In particular, it appears you have come to a number of conclusions without the benefit of having full information, particularly the incorrect information contained in the *Information Gathered During Investigation* section. [Dr D] regrets that you have clearly placed weight on this incorrect information and request that you consider the further information provided in this letter.

In terms of process, it is, of course, important that all parties feel that the investigation stage has been conducted in a fair, balanced and impartial manner.

Information Gathered During Investigation

There are a number of errors within the report which relate to this section, of which [Dr D] has first hand knowledge.

1. *Protocols – p.23, para.1: p.6, para 3, etc*
   There is a clear impression through the report that [Dr C] was left to investigate this incident and develop preventative measures to reduce the risk of such an incident re-occurring.

   I am instructed the investigation and incident report leading to the development of protocols adopted by [the hospital] were primarily completed by [the hospital's] own staff.

2. *P.5, para.2*
   At a debriefing meeting of theatre staff held straight after the incident on 3 November 1992, all members of the surgical team, apart from [Dr C], were present. An incident report was completed. In your report, you state:

'[Dr C] sent a copy of that report to me.'

[Dr C] may have sent a copy of this report at some time later, but [Dr D] is aware of the fact that [Dr C] had no knowledge of the existence of this report until August 2001 when [Dr D] pointed out its existence to him personally. [Dr D] also enclosed a copy of this report to you in May 2001 and considers the statements of the nurses involved would have also referred to this report, if not enclosed it also.

3. *P.4, para.4*
You state in your report that:

'… [Dr D] … agree in their responses to me…that the operation site had not been marked.'

The underlined words to do not appear in [Dr D]'s statement to you dated May 2001. [Dr D] cannot recall being specifically aware that the operation site had not been marked. He was aware, as was [Dr C] and the nursing staff, that the patient had consented to the surgery to her right knee. Please amend this fact to reflect [Dr D]'s response to you.

4. *P.5, para.1*
In the report you state:

'… This was added to the consent form and signed by [Mrs A] and [Dr D].'

This statement is not correct. [Dr D] did write the additional operation on the consent form in the presence of [Dr C] and [Mrs A] after they had just completed discussing it.

[Dr D] did not sign the form. There could be no way that this action might lead anyone (let alone [Mrs A] or [Dr C]) to believe that [Dr D] was involved with the surgery or had any responsibility for the surgery itself. This point will be discussed in greater detail.

5. *P.5, para.5*

'… [Dr C] apologised for the incorrect operation and [Dr C] and [Dr D] offered to waive their fees.'

My instructions are that this statement is misleading. The offer to waive the fees did not occur in the recovery room as implied, but later in the ward after the doctors had had the opportunity to apologise and then reassure [Mrs A]. Your statement as written gives the impression that monetary matters were foremost in the doctors' minds, which is far from correct.

6. *P.6, para.1*
You state:

> *'However, Drs [C] and [D] both comment on the importance of working as a team in a theatre to ensure the correct site for surgery is conducted.'*

This first part of your comment is correctly inferred from [Dr D]'s statement of May 2001. However, it has been taken out of context and the underlined words are not part of this context and do not appear in his statement.

The actual words from his statement are:

> *'Of course, I accept that we do work as a team and if any of the team had noticed anything untoward occurring (even if it was in someone else's area of responsibility) there would be an obligation to speak out promptly.'*

Enclosed for your consideration [Dr D]'s further submissions in respect of the report."

APPENDIX 12

Response to provisional opinion from [Dr D]

Letter from Dr [D]

"Dear Mr Paterson

[Mrs A] …

Thank you for the copy of your provisional report and the opportunity to make comments.

You have found me not in breach of the Code of Health and Disability Services Consumers' Right 4(1) which is appropriate and in keeping with the details of this case. Despite your conclusion, you have spent considerable time discussing and criticising my actions – this I wish to comment upon. You have found me in breach of Right 4(5) with regard to the 'team responsibility' for the error that occurred to [Mrs A]. I dispute your findings on this matter.

Right 4(1)

As has been pointed out by your expert, Mr Malcolm Futter, the performance of my duties as the anaesthetist was entirely appropriate. However, you have laid some serious criticisms on me regarding my 'involvement in the consent process'. It needs to be pointed out firmly and unambiguously that as far as [Mrs A], [Dr C] and myself were and are concerned there was no suggestion, either directly or inferred, that I was involved in the surgery per se. I did not discuss the surgery specifically with [Mrs A]. [Dr C] did that. I merely 'acted in a spirit of co-operation' to pen the additional operation to the consent form, which [Mrs A] then countersigned. I did not sign the form myself to indicate any involvement in the consent process. [Dr C] was present throughout this time and [Mrs A], I am sure, had no other impression other than that [Dr C] was responsible for her surgery.

I note Dr Futter's comment that I 'may unwittingly have assumed more responsibility for the conduct of surgery than he intended or was appropriate' (p.37, para.4). I do not believe this is supported by the context of this case. As I stated above, neither [Mrs A], [Dr C] nor myself had any confusion with respect to the consent process and the areas of responsibility. One could say that I was acting in the innocent role of the scribe for [Dr C] and that there was no assumption of 'inappropriate responsibility for the conduct of surgery'. In fact, I believe I was acting with a professional, co-operative, collegial spirit that generally makes for a smooth, efficient and friendly service. To interpret my actions differently is both erroneous and somewhat mischievous.

Similarly your conclusion that my marking the operative site on occasions is an 'inappropriate assumption of responsibility' is erroneous. There was no assumption of responsibility. I had, in the **past**, occasionally marked the limb after [Dr C] had confirmed the site with the patient

and at [Dr C's] express request. This was never done independent of the surgeon's request and it would be difficult to imagine any situation where this would be necessary. [Dr C] has stated this himself. I refer you to your decision at p.7 where you state:

> *'[Dr C] added that in the past, on some occasions, [Dr D], his anaesthetist, had occasionally marked the site for surgery with the pen AT HIS REQUEST.'*

[Dr C] would agree with me that on these previous occasions I was doing nothing more than helping with the process. There was no assumption of responsibility for the conduct of the surgery.

If I had had the opportunity to respond earlier to this point, I would have emphasised that following [a previous] incident (wrong side hip operation) that had occurred several months prior to [Mrs A]'s case, I had already ceased any occasional markings of the operative site. Therefore, by the time [Mrs A] came to surgery, the surgeon was the only person involved and responsible for marking the limb. Although [Dr C] may not have specifically stated this, he certainly implied that I no longer marked limbs when he stated:

> *'IN THE PAST on some occasions, [Dr D], his anaesthetist, had occasionally marked the site for surgery with the pen at his request'.*

Right 4(5)

As stated in my original statement, I accept that we are part of a team but I do not believe that as far as my participation in this particular team is concerned there was any breach of Right 4(5). In fact, I would say that in general my level of co-operation and communication was good and not at all deficient. I communicated effectively with the patient and the surgeon at the appropriate times and I believe that my actions show a high level of co-operation.

It is essential at this point to make an important distinction that is not clear in your report. The point is clearly enunciated ion the surgical expert, Mr Atkinson's report, where he says:

> *'Identification of site and procedure in surgery is always a collective responsibility of the operating surgeon and the nursing staff.'*

Whilst I am part of the whole surgical team, I am not part of the surgical team in respect of effective communication relating to specifically the site of the surgery.

Dr Futter stated that:

> *'Along with all of those involved in an individual's health care, the anaesthetist is responsible, as far as circumstances allow, for ensuring optimal outcomes'* (p.35, para.5, Dr Futter).

The underlined words are pivotal. I have demonstrated that I have done all the appropriate pre-operative checks to ensure there was no confusion regarding the site of surgery, even though as stated by myself and affirmed by Dr Futter that I:

> *'Was not required to take <u>any</u> active steps to ensure the correct knee was operated on'* (p.36, para.2).

In my opinion, the crucial error occurred when [Dr C], for whatever reason, ignored the warning by the circulating nurse that *'no mark to identify the operative site was present'* (p.28, para.4.8, your report).

I repeat Dr Futter's advice to you:

> *'Following the commencement of anaesthesia it is not uncommon to be so busy that they do not witness the immediate preoperative preparation of a patient nor even the commencement of surgery. In such circumstances, they are not in a position to "supervise" the surgeon'* (p.36, para.2 your report).

Dr Futter's comments reinforce my view that as far as my actions were concerned, there was no breach of co-operation. In his summary, Dr Futter states:

> *'The clinic and all relevant health professionals had **<u>some</u>*** (my emphasis) *responsibility in ensuring the overall provision of care of an appropriate standard.'*

But he qualifies this with his further comment that the:

> *'Primary responsibility for ensuring the correct surgery was performed lay with <u>the surgeon</u>.'*

As well as the earlier comment already mentioned above:

> *'… the anaesthetist is responsible, <u>as far as circumstances allow</u>, for ensuring optimal outcome.'*

I repeat Mr Atkinson's advice to you:

> *'Identification of site and procedure in surgery is always the collective responsibility **of the operating surgeon and the nursing staff**' (my emphasis).*

I do not believe that Dr Futter is suggesting every member of an operating team should be held responsible for the specific actions, inactions or errors of each other, especially when they fall outside recognised areas of responsibility.

Conclusion

I acknowledge your conclusion that I was not in breach of Right 4(1). However, I find your criticisms of my action with regard to the consent form and past marking of operative site erroneous and unfounded.

I do not concur with your finding that as part of the operating team in [Mrs A]'s case I was in breach of Right 4(5). My co-operation and communication in this case was not deficient and as your expert witnesses have attested, I did not reasonably have the responsibility nor the opportunity to identify the unfortunate error. On the basis of what I and your expert witnesses have said, it is unfair to therefore hold me accountable and in breach of Right 4(5)."

APPENDIX 13

Joint Commission on Accreditation of Healthcare Organizations

Sentinel Event Alert • Issue 24 - December 5, 2001

Sentinel Event ALERT

A follow-up review of wrong site surgery

In August 1998, the Joint Commission issued a *Sentinel Event Alert* examining the problem of wrong site surgery, including a review of 15 cases that had been reported to JCAHO. Today, the sentinel event database includes 150 reported cases of wrong site, wrong person or wrong procedure surgery, of which 126 have root cause analysis information. Of the 126 cases, 41 percent relate to orthopedic/podiatric surgery; 20 percent relate to general surgery; 14 percent to neurosurgery; 11 percent to urologic surgery; and the remaining to dental/oral maxillofacial, cardiovascular-thoracic, ear-nose-throat, and ophthalmologic surgery. Fifty-eight percent of the cases occurred in either a hospital-based ambulatory surgery unit or freestanding ambulatory setting, with 29 percent occurring in the inpatient operating room and 13 percent in other inpatient sites such as the Emergency Department or ICU. Seventy-six percent involved surgery on the wrong body part or site; 13 percent involved surgery on the wrong patient; and 11 percent involved the wrong surgical procedure.

Eighty-one percent of the cases were self-reported, with the remaining cases coming from patient complaints, media stories and other sources. However, wrong site surgery data collected by other organizations, including the New York Department of Health and the Board of Medicine in Florida, suggest a significant amount of under-reporting to JCAHO by health care organizations. Most organizations reporting wrong site surgery cases to JCAHO indicated they were aware of the previous *Sentinel Event Alert* recommendations.

Risk factors and root causes

JCAHO identified a number of factors contributing to the increased risk for wrong site, wrong person, or wrong procedure surgery, including: emergency cases (19 percent); unusual physical characteristics, including morbid obesity or physical deformity (16 percent); unusual time pressures to start or complete the procedure (13 percent); unusual equipment or set-up in the operating room (13 percent); multiple surgeons involved in the case (13 percent); and multiple procedures being performed during a single surgical visit (10 percent).

The root causes identified by the hospitals usually involved more than one factor; however, the majority involved a breakdown in communication between surgical team members and the patient and family. Other contributing causes included: policy issues such as marking of the surgical site was not required; verification in the operating room and a verification checklist were not required; and patient assessment was incomplete, including an incomplete pre-operative assessment. Staffing issues, distraction factors, availability of pertinent information in the operating room, and organizational cultural issues were also cited as contributing risk factors.

Carrots and sticks

While professional organizations, associations and regulatory bodies continue to address the problem of wrong site surgery, and despite widespread media attention, wrong site surgery remains a significant concern across the nation. In February 1997, the American Academy of Orthopaedic Surgeons (AAOS) issued a revised *Advisory Statement* highlighting recommendations and methods for eliminating wrong site surgery, as well as the appropriate management following the discovery of wrong site surgery.[1] "Although the wrong site surgery

"The American Academy of Orthopaedic Surgeons believes that a unified effort among surgeons, hospitals and other health

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Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

problem has been addressed on a local level in many areas of the country, there has been no organized national effort to eliminate wrong site surgery," says **S. Terry Canale, M.D.**, immediate past president, AAOS. "The American Academy of Orthopaedic Surgeons believes that a unified effort among surgeons, hospitals and other health care providers to initiate preoperative and other institutional regulations can effectively eliminate wrong site surgery in the United States. The AAOS urges other surgical and health care practitioner groups to join the effort in implementing effective controls to eliminate this system problem."

care providers to initiate preoperative and other institutional regulations can effectively eliminate wrong site surgery in the United States. The AAOS urges other surgical and health care practitioner groups to join the effort in implementing effective controls to eliminate this system problem."
–S. Terry Canale, M.D., *immediate past president, American Academy of Orthopaedic Surgeons*

In February 2001, the New York State Department of Health released the final report of its Preoperative Protocols Panel, outlining steps for preventing wrong site surgery, wrong procedures, and procedures on the wrong patient.[2] The guidelines, applicable to all settings, are considered baselines that hospitals, surgery centers and practitioners can build upon and tailor to their settings. Shared with all New York State hospitals and ambulatory care centers, the guidelines emphasize enhanced communication among surgical team members, three independent verifications including marking or identifying the correct site, and having the surgeon see and speak with the patient while in the peri-operative area.

Clearly, the public will no longer tolerate injuries involving wrong site, wrong person or wrong procedure surgery and is forcing action through state agencies and other regulatory bodies. For example, in Florida, the Board of Medicine in June 2001 instituted stiff penalties for physicians and organizations experiencing wrong site surgery. Penalties include fines up to $10,000, five hours of risk management education, 50 hours of community service, and a one hour lecture to the medical community on wrong site surgery.

The American College of Surgeons stresses the importance of teamwork in any surgical situation. "It is most important that there be cooperative openness between the surgeon and the nurses," says **Tom Russell, M.D.**, executive director, American College of Surgeons. "The two groups must both take responsibility, and if there are questions, they should stop and clarify to be sure everyone is on the same page. No one should make assumptions."

As the first line of defense in reducing the risk of medical errors including wrong site surgery, JCAHO advises patients and family members to make sure that there is total agreement between themselves, their primary care doctor and the surgeon about exactly what will be done and where. A good resource is the Agency for Healthcare Research and Quality's *Patient Fact Sheet–20 Tips to Help Prevent Medical Errors*, which provides tips to patients to help prevent medical errors, including wrong site surgery.[3]

Recommendations

JCAHO reiterates the importance of implementing risk reduction strategies as stated in the earlier issue of *Sentinel Event Alert* and suggests developing processes to assure the correct surgical site, patient and procedure by: 1) marking the surgical site and involving the patient in the marking process; 2) creating and using a verification checklist including appropriate documents, for example, medical records, X-rays and/or imaging studies; 3) obtaining oral verification of the patient, surgical site, and procedure in the operating room by each member of the surgical team; and 4) monitoring compliance with these procedures. Additionally, JCAHO recommends that 5) surgical teams consider taking a "time out" in the operating room to verify the correct patient, procedure and site, using active--not passive–communication techniques.

Resources

[1]American Academy of Orthopaedic Surgeons, http://www.aaos.org/wordhtml/papers/advistmt/wrong.htm

[2]New York State Department of Health, http://www.health.state.ny.us/nysdoh/commish/2001/preop.htm

[3]Agency for Healthcare Research and Quality, http://www.ahrq.gov/consumer/20tips.htm

Published for Joint Commission accredited organizations and interested health care professionals, Sentinel Event Alert *identifies specific sentinel events, describes their common underlying causes, and suggests steps to prevent occurrences in the future.*

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During the on-site survey of accredited organizations, JCAHO surveyors assess, for consultative purposes, the organization's familiarity with and use of Sentinel Event Alert *information. Accredited organizations are expected to:*

- *Review and consider relevant information, if appropriate to the organization's services, from each* Sentinel Event Alert.
- *Consider information in an alert when designing or redesigning relevant processes.*
- *Evaluate systems in light of information in an alert.*
- *Consider standard-specific concerns.*
- *Implement relevant suggestions or reasonable alternatives or provide a reasonable explanation for not implementing relevant changes.*

At this time, JCAHO has placed a moratorium on using the organization's response to Sentinel Event Alert *recommendations as the basis for scoring standards.*

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Setting the Standard for Quality in Health Care
Joint Commission on Accreditation of Healthcare Organizations
Sentinel Event Hotline (630) 792-3700

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Addendum

The Director of Proceedings laid before the Medical Practitioners Disciplinary Tribunal a charge alleging professional misconduct. On 11 August 2003 the Tribunal dismissed the charge on the grounds that although the consultant surgeon must bear primary responsibility for the error that occurred, it was a chain of events involving a team of providers that culminated in the adverse outcome. The Tribunal ordered permanent name suppression of the anaesthetist, nurses and hospital involved.