Surgeon, theatre nurses and hospital failed to prevent wrong-site surgery (00HDC06857, 21 August 2002)

Surgeon ~ Anaesthetist ~ Nurses ~ Private hospital ~ Standard of care ~ Co-operation among providers ~ Orthopaedic surgery ~ Wrong-site surgery ~ Rights 4(1), 4(5)

A 67-year-old woman was admitted to hospital with a torn medial meniscus in her right knee. The surgery was mistakenly performed on her left knee. The responsibilities of the orthopaedic surgeon, the anaesthetist, the anaesthetic nurse, the scrub nurse, and the theatre nurse were considered.

The Commissioner held that it was primarily incumbent on the orthopaedic surgeon to ensure he was operating on the correct knee. Anything less than the correct operation, performed on the correct site, prima facie amounts to negligence and is a breach of Right 4(1) of the Code.

The circulating theatre nurse, who noticed that the operation site was not marked prior to surgery and brought this to the surgeon's attention, was held to have breached Right 4(1) in failing to prevent surgery on the incorrect leg. She was not entitled to rely on the surgeon's knowledge of the omission, nor to assume the omission had been corrected.

The scrub nurse noticed preoperatively that the surgical site was not marked and was aware that this had been brought to the surgeon's attention. When she assisted with the draping of the leg she failed to notice that the operation was being performed on the incorrect leg. She had an independent professional responsibility to recognise the situation and to do what was reasonably within her power to ensure the patient's safety. Individuals cannot disassociate themselves from their own involvement in major errors simply because they incorrectly take their lead from the mistakes of another.

The anaesthetist, who involved himself in the consent process, and was specifically aware that the surgery was to be performed on the right knee, was considered to have unwittingly assumed more responsibility than was appropriate. However, he was not obliged to mark the operation site and at critical times had other key anaesthetic responsibilities. Likewise, as part of her preoperative duties, the anaesthetic nurse confirmed that the right knee was to be operated on, but had duties to attend to other than ensuring the correct progression of the surgery.

While each member of the theatre team had individual responsibilities, the theatre team is not itself a legal entity and did not breach Right 4(5).

The private hospital breached Right 4(1). As wrong-site surgery is a well-recognised potential problem, the failure to specifically acknowledge and attempt to minimise the risk by providing dedicated policies amounted to an omission to provide surgical services with reasonable care. The Commissioner is not bound by medical practice prevailing at the relevant time but is entitled to demand stricter, patient-focused standards. A common practice may still breach the Code.

The Commissioner referred the matter to the Director of Proceedings, who prosecuted the surgeon before the Medical Practitioners Disciplinary Tribunal. The Tribunal dismissed the charge of professional misconduct 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.