Medical Practitioners Disciplinary Tribunal

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DECISION NO: 55/98/30C

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

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

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mr P J Cartwright (Chair)

Dr J C Cullen, Dr M-J P Reid, Mr G Searancke,

Dr B J Trenwith (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Napier on Monday 2 November 1998

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

Mr C J Hodson QC for Dr G M Curtis.

1. THE CHARGE:

THE Particulars of the charge are that Mr Curtis:

1. Failed to make appropriate arrangements for the aftercare of the complainant, Mr A, following the operation on the 10 September 1993.

2. Failed to take appropriate care at the time of the removal of the complainant's splint on 12 October 1993.

3. Failed to consider whether further investigation or a second opinion should have been sought before proceeding with further operations on the complainant,

being conduct unbecoming a medical practitioner which reflects adversely on his fitness to practise medicine.

2. BACKGROUND:

2.1 **IN** March 1993 Mr A, then aged 69, suffered an accident by falling onto a pile of logs.

2.2 **HE** was referred to Mr Curtis who first saw him on 16 August 1993. Mr Curtis had previously carried out a successful operation on Mr A’s right shoulder.

2.3 **ON** 10 September 1993 Mr A was admitted to xx Hospital where he underwent a left rotator cuff tendon repair.

2.4 **IN** the opinion of Mr Brett Krause, an orthopaedic surgeon practising in Lower Hutt, Mr A's left shoulder presented a difficult problem, first because of his age, and secondly, because of the time between the injury and the surgery (six months). In Mr Krause's view both of these factors were adverse prognostic indicators.

2.5 **MR** A was told by a nurse at the hospital that his left arm and shoulder would remain in an aeroplane splint for three weeks at which time he was to make contact with Mr Curtis to have the frame removed. Mr A understood that the nurse was acting on Mr Curtis' instructions. When Mr A's daughter, B, picked her father up from xx Hospital, he told her then that he had to ring Mr Curtis in three weeks time.

2.6 **MR** A rang Mr Curtis after three weeks but was told by his Secretary that Mr Curtis was out of the country for a fortnight, and that he would have to wait for another two weeks until Mr Curtis returned before the aeroplane splint could be removed.

2.7 **ON** 12 October 1993, after some five weeks of being in this frame, Mr A and his wife, C, went to Mr Curtis to have the frame removed. They all went into Mr Curtis' examination room. Mr A claims that Mr Curtis removed the frame very quickly, and once it was removed, simply let his left arm drop. In the Background Summary of Facts Mr McClelland explained *"At no time did he [Mr Curtis] hold Mr A's arm, lower it gently or ask how it was or whether he could*

move it". Apparently the pain was extreme and although Mr A did not cry out, Mr McClelland said *"He very obviously had tears in his eyes"*.

2.8 **AFTER** letting the arm drop Mr Curtis returned to his desk in his consultation room. Mrs A helped her husband get dressed and then went out to the car to get the sling which they had brought with them. Ms B was waiting in the car and she recalled at the time her mother rushing out, panicking and saying that her father was in pain because Mr Curtis had just let his arm drop. In Mr Krause's view, five or six weeks of immobilisation in the aeroplane splint would have made the shoulder stiff, in that any time after immobilisation in such a splint, gradual reduction in the degree of abduction was advisable prior to eventual removal.

2.9 **AFTER** the operation, Mr A's left shoulder was very painful and had a very limited range of movement.

2.10 **MR** Curtis referred Mr A to xx Hospital for physiotherapy but this was not successful as the shoulder was too stiff.

2.11 **ON** 31 January 1994, Mr A was admitted to xx Hospital for manipulation of the shoulder. However shortly after this the pain and stiffness returned.

2.12 **FURTHER** physiotherapy and an arthrogram followed noting:

"On this occasion it has not been possible to demonstrate any rotator cuff tendon tear, even with weight bearing views. There is an impression that the rotator cuff tendon may be thinned."

2.13 **ON** 31 May 1994 Mr Curtis performed an acromioplasty and darned a small rent in the tendon repair at xx Hospital.

2.14 **MR** A felt no improvement and the severe pain and stiffness continued despite further physiotherapy.

2.15 **ON** 27 September 1994 a further manipulation under anaesthetic was carried out at xx Hospital.

2.16 **ON** 28 November 1994 Mr Curtis carried out a revision acromioplasty and repair of rotator cuff at xx Hospital. It is implicit from the Registrar's operation note that the rotator cuff at this time was not intact.

2.17 **THE** pain and stiffness continued until on 6 March 1995 Mr Curtis told Mr A that he could do nothing further and that Mr A would have to learn to live with the pain and lack of movement. Over the two year period Mr Curtis had never before suggested that he could do nothing for Mr A. Mr Curtis never discussed with Mr A his options or other alternatives including obtaining a second opinion.

2.18 **ON** 17 August 1995 Mr A was again admitted to xx Hospital and had a left deltoid dehiscence repaired together with an operation on his toe.

2.19 **SUBSEQUENTLY** Mr A was referred to Mr Steven Bentall, an orthopaedic surgeon practising in Napier and Hastings. His sub-speciality is the upper limb. At the time Mr A was still suffering

from severe shoulder pain, which was on-going despite the previous four operations and two manipulations under anaesthetic.

2.20 **MR** Bentall considered the problem to be complex, particularly as the pain continued after the operations and manipulations. Clinical and ultrasound examination showed marked thinning of the rotator cuff tendons and dehiscence of the middle third of the deltoid muscle.

2.21 **MR** Bentall sought advice from numerous colleagues both nationally and internationally. Two options emerged. First, the most certain procedure proposed was fusion of the shoulder; secondly a procedure to maintain movement was suggested, being the excision of the lateral end of the left clavicle with transfer of the anterior third of the deltoid under the acromium.

2.22 **AFTER** discussion with Mr A, the second option was carried out by Mr Bentall on 7 May 1998. The surgery was very successful. Mr A has regained a functional range of movement. The pain ceased immediately after the operation.

3. MANNER IN WHICH CHARGE FRAMED:

3.1 **MR** Hodson, by reference to the way the charge had been framed, with a number of particulars listed, submitted there was an obligation on the CAC of making out each particular cumulatively before any adverse finding could be made against Mr Curtis.

3.2 **THE** Tribunal prefers Mr McClelland's submission, that the manner in which charges are drafted against medical practitioners can vary considerably as between or among Complaints Assessment Committees. There is certainly a practice which alludes to the fact that one or more particular,

or each one separately, may amount to conduct unbecoming as statutorily qualified. It is not necessary that all particulars be taken together, cumulatively, to consequentially amount to conduct unbecoming. It follows that the Tribunal is entitled to consider each particular of the charge separately as it has done on previous occasions. This practice will be adopted again in this case.

4. FIRST PARTICULAR:

"Failed to make appropriate arrangements for the after care of the complainant following the operation on 10 September 1993."

4.1 **IN** respect of this particular, Mr A's evidence, as supported by the evidence of his daughter, is that a nurse told him, while still in xx Hospital after the first operation on 10 September 1993, that he would remain in the aeroplane splint for three weeks. It was Mr A's evidence that Mr Curtis at no stage told him that he was required to remain in the splint for six weeks. Consistent with the nurse's advice, Mr A rang Mr Curtis after three weeks, but was told that he was out of the country.

4.2 **HOWEVER** Mr Curtis maintains that Mr A is confused over this, as he had never intended to leave the splint on for less than five or six weeks. Mr Curtis relies on the entry in his notes where he made a special point of notifying the family doctor that the splint was to be on for six weeks. Mr McClelland submitted there could be no guarantee that Mr Curtis had any way of knowing whether the family doctor would pass this information on to Mr A, and as it happened, he did not, Mr McClelland observed.

4.3 **AT** the time of the operation, Mr Curtis was the person primarily responsible for Mr A's care and management. As such he was obliged to ensure that Mr A was fully informed of the outcome of the operation, including the period he was expected to remain in the splint.

4.4 **IN** Mr McClelland's view the fact that Mr A had a different understanding from Mr Curtis, would certainly indicate that Mr Curtis had failed to communicate, or effectively communicate with his patient. Writing to the family doctor does not discharge his obligation to his patient, in the view of Mr McClelland.

4.5 **WITH** respect to this first particular of the charge, the Tribunal is satisfied, due to misinformation which to some extent was contributed to by incorrect information being given by nursing staff to Mr A, that a misunderstanding did occur as to the length of time during which the aeroplane splint would be in place.

4.6 **MR** Curtis explained he does not normally use abduction frames, very seldom in fact. He said he finds them clumsy. As a rule he does not get good patient compliance with them, and normally can get good fixation of the repair without resorting to them. However in Mr A's case he was afraid that without the use of a splint, the repair site would be at risk, and consequently he made a point of notifying Mr A's family doctor that it would be removed in five - six weeks. It seems unfortunate that Mr A was given a different version of the length of time it would be necessary for the aeroplane splint to remain in place.

4.7 **THE** Tribunal is satisfied it was always Mr Curtis' intention to leave the splint on for between five and six weeks. Although Mr Curtis said in evidence it had nothing to do with whether he was

on holiday or not, we think the point should be made that it was unlikely Mr Curtis would have been on holiday beyond a time when it could reasonably be expected that the splint would have been removed.

4.8 **EVIDENCE** was given by Brett Lee Krause, a Lower Hutt orthopaedic surgeon, for the CAC, and by Timothy Malcolm Astley, an Auckland orthopaedic surgeon whose speciality is shoulder injuries.

4.9 **IN** his evidence Mr Krause noted the fact that Mr Curtis had made it clear in his notes that the splint was to be left on for a six week period. Mr Krause acknowledged it seemed likely that the confusion arose from misinformation being given to the patient. Although Mr Krause noted the period of time in the aeroplane splint seemed rather long, he also acknowledged it as being used by other practitioners.

4.10 **IN** cross-examination Mr Krause indicated that the use of an aeroplane splint was not to be criticised and if used, that there was a range of duration times from three to eight weeks, again by reference to certain preference.

4.11 **BRIEFLY** evidence was also given by Stephen James Bentall, the orthopaedic surgeon who operated on Mr A's shoulder with such conspicuous success. Mr Bentall said he was not in the habit of using an aeroplane splint, that he used a padded abduction pillow instead, which would be retained in place anywhere from three to six weeks.

4.12 **ALTHOUGH** obviously there was some confusion in the mind of both Mr A and members of his family as to how long his shoulder would remain in the aeroplane splint, it is clear from the evidence of Mr Curtis that the intended duration of the splint was some five to six weeks. And also it is clear from the evidence of Messrs Krause, Bentall and Astley, that for a patient to remain in an aeroplane splint for a period of some five to six weeks, is not excessive, and principally is a matter of surgical preference.

4.13 **A** second aspect of the first particular of the charge for which Mr Curtis has been criticised, is failure on his part to arrange for any appropriate cover from a colleague for Mr A during the period that he was out of the country, or at the very least to advise Mr A that he would be away on holiday, and who he should contact, or what he should do in his absence, should the need arise. In Mr McClelland's view this was also a significant gap in what arrangements were put in place for Mr A's after care.

4.14 **IN** cross-examination by Mr McClelland Mr Curtis explained that when he went overseas briefly, before removing the aeroplane splint, he did not make any cover arrangements in particular in his absence. Mr Curtis explained *".... we have an arrangement amongst the six of us, that if one or more of us are away, we cover for one another. It is passive, not in writing."* Mr Curtis explained further that this cover arrangement was for private patients. He said although he did not specifically inform Mr A that such a cover arrangement existed, that his staff were there and would be able to relay that information, if necessary.

4.15 **THE** evidence of Messrs Krause, Bentall and Astley did not contain any comment which was adverse or critical of a failure on the part of Mr Curtis to make cover arrangements in respect of

Mr A during his short absence overseas towards expiry of the five to six weeks period when the aeroplane splint was due to be removed.

4.16 **A** third aspect of criticism levelled at Mr Curtis by reference to the first particular, is his failure to gradually reduce the angle of the splint. There is no dispute that over the six week period that Mr A was in the aeroplane splint, Mr Curtis did not reduce the angle of the splint at any time, but rather kept it at the same angle throughout the period. Given the difficulty of the operation and the length of time that Mr A was in a splint without reduction of the angle, it is not surprising that his shoulder was very stiff. Mr McClelland invited the Tribunal to determine whether this was appropriate aftercare, or whether as was suggested by Mr Krause, it would have been more advisable to lower the splint in stages over the six week period.

4.17 **IN** his evidence in chief Mr Curtis explained his staff had been able to inform him that he conducted between 23 and 27 rotator cuffs per year and has done so for approximately 30 years, a remarkably constant number. Overall Mr Curtis said he has found his results reasonably good, particularly with what is considered to be a somewhat chronic degenerative disorder in the elderly. Unhappily this particular case he believes, did not go well at all, but under normal circumstances, some 80% of those which are repaired seem to do reasonably well, and people are reasonably happy with the results.

4.18 **IN** cross-examination by Mr Hodson it was acknowledged by Mr Krause that whether one embarks on some kind of gradual reduction before complete removal of the splint, would be a matter of opinion. In so acknowledging, Mr Krause said the point had to be made that a gradual reduction in abduction would have been preferable. But in any event, Mr Krause also agreed that

management in this case by continued support from collar and cuff or sling, sounded reasonable, because the patient's arm would have to be supported by some method, as in fact it was in this case.

4.19 **IN** cross-examination by Mr McClelland it was acknowledged by Mr Curtis, having heard the evidence about stiffness of the shoulder and arm joint, that gradual lowering of the arm over the four to six week period "*.... would probably be one of the ideal ways of doing it but when you repair tendons elsewhere in the body you don't follow that routine.*"

4.20 **MR** Curtis said he followed Mr McClelland's argument, but he did not necessarily agree that gradual lowering of the arm was essential.

4.21 **MR** Curtis was asked by Mr McClelland whether had he lowered the arm gradually over a five week period, if the pain and associated problems would have been overcome. It was Mr Curtis' emphatic response in negative vein, that impingement had nothing to do with tightness, that the injury was tight because it had been repaired, which was nothing to do with impingement.

4.22 **MR** Astley said he was unable to make specific comments. However he made the general observation that removal of the splint would vary depending on the surgeon's concern about the security of the healing. He said there may be occasion when an arm might be lowered in a graduated fashion over a period of time. However in other circumstances Mr Astley said the splint might be removed and the arm allowed to come down to the side in the one movement. Mr Astley opined that it would always be a question of professional judgement on any particular occasion.

4.23 **IN** cross-examination Mr Astley was asked by Mr Hodson if removal of an aeroplane splint is a procedure which can be expected to cause pain to the patient. Mr Astley replied that depends, particularly because such a procedure in his opinion is an art, in an environment and culture which is a science, but an inexact science, so there is very considerable variation on what might be anticipated, depending on individual circumstances. But generally to answer the question, Mr Astley replied in the affirmative.

4.24 **WHILE** Mr Krause obviously favours a lowering of the shoulder and arm joint progressively and gradually, it was the evidence of Mr Curtis that this would depend on professional judgement in each individual case. In this case Mr Curtis concluded that gradual lowering was unnecessary. That the Tribunal should not make an adverse finding against Mr Curtis with respect to this third aspect of the first particular of the charge, is reinforced by answers given by Mr Astley to the Chair. He was asked to describe the occasions when an arm such as Mr A had might be lowered gradually. Mr Astley replied if there was concern that the tissues were friable and weak, or if the quality of the repair and the security of the fixation was such that there was a very bad wound which justified lowering in a gradual fashion. In this particular case Mr Astley explained, rightly or wrongly, that the rotator cuff was demonstrated to be intact subsequently. Accordingly Mr Astley said it would be reasonable to presume, from subjective descriptions of the way in which the arm was lowered, that however it was lowered, in fact did no harm other than to be associated with considerable pain.

4.25 **IN** respect of the first particular of the charge, the Tribunal is satisfied to the requisite standard, the balance of probabilities, that no adverse finding should be made against Mr Curtis.

5. SECOND PARTICULAR:

"Failure to take appropriate care at the time of the removal of the complainant's splint on 12 October 1993."

5.1 **THE** Tribunal is faced with a clear conflict on the evidence in respect of the removal of the splint on 12 October 1993.

5.2 **ON** the one hand, Mr A's evidence is that after the splint was removed, Mr Curtis simply let his arm drop. This evidence is supported directly by Mr A's wife who was in the examination room with her husband when Mr Curtis removed the splint. It is also supported by Ms B who described in her evidence how her mother rushed to the car saying that Mr A was in pain because Mr Curtis had just let his arm drop.

5.3 **THE** Tribunal agrees with Mr McClelland that the pain which Mr and Mrs A described could not be mistaken. Having had an opportunity to watch and assess the A family as witnesses, the Tribunal upholds Mr McClelland's submission that they are clearly witnesses telling the truth; they certainly had no reason to lie. Mr A's conduct subsequently is certainly consistent with his description of events: He made a complaint to the Chief Executive to the CHE and also a complaint to the Medical Council.

5.4 **ON** the other hand Mr Curtis denies that he let the arm drop. He is a busy surgeon performing over 20 similar operations a year, and has done so for the past 30 years, and presumably has continued to do so since 1993 when the operation on Mr A was carried out.

5.5 **MR** McClelland criticised Mr Curtis for not having any helpful notes to rely on. Indeed Mr McClelland submitted in respect of this consultation and for many of the other consultations, that Mr Curtis' notes were brief to the point of being non-existent.

5.6 **THE** Tribunal is unable to resolve the conflict in the evidence concerning the manner in which the arm was lowered following removal of the splint. The Tribunal accepts in whatever way the procedure was actually undertaken, that Mr A suffered pain so severe that tears came to his eyes. That evidence, from three witnesses, is accepted without reservation.

5.7 **QUESTIONED** by the Chair Mr Krause confirmed he knew of no protocol or similarly described method of abduction splint removal, either in the literature of his speciality or in the text books.

5.8 **WHAT** is clear to us is that pain of the severe degree suffered was unexpected. There was no evidence Mr A had been warned to expect such pain. While both Mr and Mrs A say the arm was dropped, Mr Curtis states Mr A did not indicate to him and nor did he perceive Mr A felt he had dropped his arm during the procedure. It is this absence of any reported dialogue between the parties at the relevant time, which has made it impossible for the Tribunal to determine this particular of the charge.

5.9 **MR** Curtis denies that he dropped the arm, either intentionally or unintentionally. We tend to agree with Mr Curtis that it would surely be the most counter-productive manoeuvre he could ever carry out on any patient, having taken so much trouble to secure a satisfactory repair.

5.10 **OUR** decision to give Mr Curtis the benefit of any doubt, has been influenced by the fact that the dehiscence of deltoid did not become obvious until some 23 months after the initial surgery. Certainly it did not occur contemporaneously with release of the abduction splint. Also the fact that the ultrasound study on 1 March 1996 demonstrated an intact rotator cuff, without evidence of re-rupture, is further evidence that Mr Curtis was not intentionally rough when he removed the splint.

5.11 **FINALLY** there is the fact that no medical misadventure claim was made by Mr A to ACC for medical error on the part of Mr Curtis. Although this should not be taken as being in any way determinative, it is but one aspect which has been taken into account by us.

5.12 **THE** Tribunal is obliged to conclude that the second particular of the charge has not been established.

6. THIRD PARTICULAR:

"Failure to consider whether further investigation or a second opinion should have been sought before proceeding with further operations on the complainant."

6.1 **FOR** this particular to be established there would need to be some evidence of a specialist nature that Mr Curtis was remiss in the manner charged.

6.2 **IN** the Tribunal's view the evidence falls far short of establishing this particular.

6.3 **MR** Krause acknowledged there was evidence from Mr Curtis' notes that further investigations were indeed done, and he thought appropriately so. However over the course of the two year

period in which Mr A was being treated and clearly not making progress as Mr Curtis had anticipated or hoped, Mr Krause went no further than to say he felt further opinion from colleagues may have been helpful in reducing the pain suffered by Mr A.

6.4 **ASKED** by Dr Trenwith whose responsibility it is to obtain a second opinion when a problem becomes insoluble, Mr Krause said he believed it would be his as the specialist. However Mr Krause conceded it is important in the GP/patient relationship at primary level, that the patient may prefer to discuss some matters with the GP rather than with the secondary provider.

6.5 **SO** far as the potential for procurement of a second opinion is concerned, Mr Krause explained to the Chair it is probably dependent on an expressed desire on the part of the patient in combination with whoever the health professional happens to be when the subject of a second opinion is raised, whether that be by the GP or the secondary provider.

6.6 **UNDER** cross-examination by Mr McClelland it was put to Mr Curtis that he did not make a referral for a second opinion because Mr A did not request one. In replying that was only part of it, Mr Curtis explained an important factor was on the information he had, that the repeat arthrogram demonstrated an intact rotator cuff. This led him to believe that in the fullness of time his expectation of improvement would be realised.

6.7 **ALTHOUGH** Mr Curtis conceded he could have given Mr A the option of seeking a second opinion, he said he did not because his expectation was that the situation would improve over time.

6.8 **UNDER** cross-examination by Mr McClelland Mr Astley explained that the issue of who should initiate procurement of a second opinion tends to be a mutual accommodation, that if the patient does not raise the subject, that as the specialist he *"might do that"*.

6.9 **QUESTIONED** by Dr Reid Mr Astley clarified why he thought Mr Curtis continued the treatments regime instead of seeking a second opinion. He explained *"It wasn't as though he did an operation and the operation failed so he did it again, and did the same operation four times. It was a different procedure each of those times. The patient will forgive you once but not twice, but each time it seemed to be new or a different problem or a variation on the theme culminating in the deltoid dehiscence, and I am sure when you get to that point you think, "Oh heck why didn't I bail out long ago." In retrospect, but given that each circumstance that led to the procedures was different to the one before, I can understand how one would keep going ....."*

7. CONCLUSION:

7.1 **AS** was submitted by Mr Hodson, the CAC has not established error on the part of Mr Curtis to the extent that any adverse findings should be made. However it was a most appropriate acknowledgement for Mr Hodson to make, that nothing said by him was designed to detract from the sincerity of the case put forward by and on behalf of Mr and Mrs A. There is nothing but complete sympathy for the long period of pain and discomfort suffered by Mr A.

7.2 **THE** charge is dismissed.

DATED at Auckland this 2nd day of December 1998

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P J Cartwright

Chair

Medical Practitioners Disciplinary Tribunal