MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

PO Box 5249, Wellington • New Zealand
Ground Floor, NZMA Building • 28 The Terrace, Wellington
Telephone (04) 499 2044 • Fax (04) 499 2045
E-mail mpdt@mpdt.org.nz

**DECISION NO:** 206/01/82D

**IN THE MATTER** of the Medical Practitioners Act 1995

-AND-

**IN THE MATTER** of a charge laid by the Director of Proceedings pursuant to Section 102 of the Act against **THIRUNAVUKARASU RAJASINGHAM** medical practitioner of Rotorua

**BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL**

**TRIBUNAL:** Ms P Kapua (Chair)

Dr F E Bennett, Dr L Henneveld, Dr C P Malpass, Mrs H White (Members)

Ms G J Fraser (Secretary)

Ms H Gibbons/Ms P Dunn (Stenographer)

Hearing held at Rotorua on Wednesday 3 and Thursday 4 April 2002

**APPEARANCES:** Mr M F McClelland and Ms T Baker for the Director of Proceedings

Mr C J Hodson QC and Ms R Scott for Dr T Rajasingham.

**The Charge**

1. The Director of Proceedings of the Health and Disability Commissioner pursuant to sections 102 and 109 of the Medical Practitioners Act 1995 charged that Dr Thirunavukarasu Rajasingham, Medical Practitioner, of Rotorua, in the course of his anaesthetic management of Mrs Patricia Ross during the course of surgery at Lakeland Health on 11 and 12 December 1996, acted in such a way that amounted to professional misconduct in that he failed in one or more of the following particulars:

    1.1 To monitor or adequately monitor the patient, Mrs Patricia Ross, while she was under anaesthetic and in particular failed to monitor urine, blood pressure and temperature.

    1.2 To ascertain whether the central line was correctly placed or sited and/or was functioning appropriately.

    1.3 To communicate adequately to the orthopaedic surgeons and/or radiographer that he was concerned about the wellbeing and safety of the patient when there were indications by at least 4.30am on 12 December 1996 that her wellbeing and safety was being compromised.

    1.4 At any time to discuss with the orthopaedic surgeons the need for a catheter to be inserted to enable him to monitor the urine output of the patient.

    1.5 To review at any time the decision not to insert a catheter despite a continuous need to monitor IV fluid replacement and the instability of vital signs including those related to cardiac output.

1.6 To take appropriate steps when he became concerned or ought to have become concerned about the patient's wellbeing.

1.7 That the conduct in particulars 1.1 to 1.6 separately or cumulatively amount to professional misconduct.

**Background**

2. Mrs Ross was involved in a motor vehicle accident near Edgecumbe late in the afternoon of 11 December 1996. She was trapped in the car for approximately 40 minutes before she was cut out of the car and flown by rescue helicopter to Rotorua Hospital. She was initially received into the Emergency Department of Rotorua Public Hospital around 5.50pm. She was later transferred to the Intensive Care Unit.

3. Mrs Ross had at least 13 fractures largely confined to her legs although there were some fractures to her hands. The Emergency Department reports indicate that, upon admission, her vital signs were stable and that she was orientated and alert. At 11.20pm she was transferred to the Operating Theatre where she was operated on by the orthopaedic surgeon, Dr Moorcroft assisted by Dr Lowden. The anaesthetist for the operation was Dr Rajasingham.

4. The operation was intensive and continued throughout the night. Around 4.30am Dr Rajasingham became concerned about Mrs Ross's condition. He asked the surgeons to hurry and at the end of the operation asked Dr Moorcroft, to percuss the chest. It is clear that Dr Rajasingham had some concerns about Mrs Ross's condition and was suspicious that the CV line that had been changed to enable the surgeons to operate on Mrs Ross's hands may have been in the wrong place and that her condition was related to that. Dr Rajasingham had asked the radiographer to take an x-ray of Mrs Ross's chest in theatre but was advised that that was not possible. The Tribunal is still not clear as to why that was not possible, although Dr Moorcroft's response was that there was not enough room in the theatre for the x-ray equipment as well as the equipment that the surgeons required to operate on Mrs Ross's legs.

5. Once the operation was completed Mrs Ross was moved into intensive care and an x-ray was taken which showed there was bleeding occurring into the chest cavity. Dr Rajasingham inserted a chest drain and the blood was drained. By 8.15am it was thought that Mrs Ross had improved, but within an hour, she required further resuscitation. More intrathoracic drains were inserted but Mrs Ross did not respond to the resuscitation.

6. The Tribunal found during the course of the evidence that management of a severe trauma patient such as Mrs Ross was below what would be an acceptable standard from a Level 4 Hospital. While the charge before the Tribunal relates to the anaesthetic management of Mrs Ross by Dr Rajasingham, there are matters that arise that reflect on the operation of the Emergency Department and the pre-operative team management of a patient such as Mrs Ross that have raised with the Tribunal serious questions as to the standard of care that Mrs Ross received on arrival at Rotorua Hospital in 1996.

7. Having made that observation however, it is not for this Tribunal to look at the actions of other individuals, but rather to assess the charge against Dr Rajasingham.

**Failure to Monitor Urinary Output**

8. Dr Rajasingham has stated that he accepted the pre-operative team's decision not to insert a catheter for Mrs Ross. Dr Moorcroft, in his evidence, stated that he was surprised that a catheter had not been inserted. It would appear that the issue of the catheter was not discussed by the doctors operating on Mrs Ross. Mrs Ross had been managed by a preoperative team for almost six hours prior to her operation and that team had prepared her for theatre. She was presented to the doctors in theatre without a urinary catheter. The Tribunal accepts that monitoring urinary output is a good practice and would expect that practice to be followed as a matter of course. As to whether the catheter should have been inserted once Mrs Ross was in theatre, Dr Rajasingham considered that there was an increased chance of infection. While that may have been a consideration, it is relevant that in this instance inserting a catheter would have been appropriate, but it would not have changed the outcome.

**Failure to Monitor Blood Pressure**

9. It is clear from the evidence and was appropriately accepted by counsel for the Director of Proceedings that Dr Rajasingham did monitor blood pressure.

**Failure to Monitor Temperature**

10. With regard to temperature, Dr Rajasingham stated that he had little or no confidence in the temperature probes available in theatre and in the past had been outspoken in his opposition to the state of the equipment for recording temperature. This was confirmed by Mr France who is an anaesthetic technician at Rotorua Hospital. It is clear however from the evidence that Dr Rajasingham was aware throughout the operation of Mrs Ross's temperature and did what he could with the equipment available, including thermal blankets, to ensure that she was kept warm.

**The Central Line Placement**

11. Dr Rajasingham put the first CV line in and had difficulty as the guide wire kinked. He withdrew it and replaced it. The second line went in with no such problems. Dr Rajasingham tested it by aspirating blood and was confident that the line was in the right place.

12. At around 4.30am when Mrs Ross's condition began to deteriorate, Dr Rajasingham was concerned that perhaps the CV line was in the wrong place and he took steps at that time by asking the surgeon to hurry up and complete the operation. He also asked for an x-ray to be taken but as already outlined he was told by the radiographer that that was not possible.

**Evidence**

13. The Tribunal was greatly assisted in hearing evidence from Dr Malcom Futter, a specialist anaesthetist at Starship Childrens Hospital in Auckland, called by the Director of Proceedings, and Professor Alan Merry (called on behalf of Dr Rajasingham). Professor

Merry is a specialist anaesthetist who is Clinical Director of the Department of Anaesthesia at Greenlane Hospital and is Professor of Anaesthesia at the University of Auckland.

14. Both Dr Futter and Professor Merry are agreed that the preoperative processes were important in ensuring Mrs Ross was ready for surgery. Both agreed that once in theatre monitoring was Dr Rajasingham's responsibility.

15. There appears to be a view among the medical witnesses giving evidence, based on a review of the procedures followed, that there was an underestimation of the injuries suffered by Mrs Ross and of the effects of the trauma she had suffered. Dr Laidlow, an anaesthetist at Rotorua Hospital who was head of the Intensive Care Unit in 1996 and two years ago headed the Department of Anaesthesia of Rotorua Hospital stated in cross examination:

*"Everyone seems to have trivialised the extent of her injuries. Here was a lady who had been in a car accident and had some broken bones, but they were major breaks, multiple fractures, with a lot of blood loss and as an anaesthetic department auditing this some weeks later we felt the whole way through that it had been assumed that there was nothing really wrong with this lady at all apart from a few fractures. We don't believe that's the case. We think that she was shocked, that there was a lot of blood loss and it was a lot more serious than people would appear to think."*

16. In response to a question as to who had trivialised Mrs Ross's injuries, Dr Laidlow replied:

*"By the process, by being seen by a junior house surgeon, by lying in ICU without any medical cover for four or five hours before coming to theatre. She came to theatre as a - you could almost say a routine case, that's my impression. I wasn't there but that's my impression."*

17. In his evidence, Professor Merry stated:

*"Reading the notes, it is my impression that the severity of Mrs Ross' injuries was somewhat worse than was fully appreciated."*

He further states

*"… it does suggest that all concerned underestimated the extent of the trauma" and "[i]t seems to me that none of the team associated with Mrs Ross' care fully appreciated the potential severity of the situation."*

18. In cross-examination Professor Merry elucidated further by stating:

*"I can't be completely sure but the impression I have is that Mrs Ross was admitted by a house surgeon, that a Registrar did take some role in evaluating her but then went off to theatre and was occupied doing cases with Dr Rajasingham, that Mrs Ross remained under the care of the house surgeon and that she was admittedly transferred to ICU but not as far as I've been led to – I've been informed to gain the benefit of any senior doctor as a result of that."*

19. Dr Futter agreed in stating in cross-examination:

*"Well I think the fact that we may hear otherwise but that no one thought of putting in a urinary catheter, and the ongoing – well, the fluid requirements to date and the ongoing fluid needs of the patient, there may well have been an underestimation by all parties of the severity of the injuries, the consequences of that and what lay ahead in undertaking, as you've said, hours of surgery."*

20. There was also during the course of the hearing concern raised about fatigue and the length of time operating staff had been working. Dr Rajasingham had commenced work on December 11, 1996 in his private capacity as an anaesthetist at the Southern Cross Private Hospital in Rotorua. During the day he was involved with approximately seven or eight relatively routine operations. He left the Hospital around 5pm and as he was on call he was paged by Lakeland Health around that time. He was the only anaesthetist on call from 5pm through until 8am on December 12. Dr Rajasingham was involved in two operations prior to Mrs Ross's surgery. However, it was accepted by all medical witnesses that on occasion such a long period of work was required. Professor Merry expressed concerns about how such a long period of work might affect a doctors' work but Mr Hodson made it clear that Dr Rajasingham does not argue fatigue was a factor in his management of Mrs Ross. He said:

*"Dr Rajasingham's position, and I'm sure not one of the doctors will disagree with it, is that on occasion doctors have to work for 24 hours and its expected that they're able to do so up to a reasonable standard."*

**The Law**

21. Dr Rajasingham has been charged with professional misconduct, the test for which is well established. As was stated in *Ongley* v *Medical Council of New Zealand* [1994] for NZAR 369. The test for professional misconduct is:

*"Has the practitioner so behaved in a professional capacity that the established acts under scrutiny would reasonably be regarded by his colleagues as constituting professional misconduct? With proper diffidence, it is suggested that the test is objective and seeks to gauge the given conduct by measurement against the judgment of professional brethren of acknowledged good repute and competency, bearing in mind the composition of the tribunals which examine the conduct. Instead of using synonyms for the two words the focus is on the given conduct which is judged by the application to it of reputable, experienced medical minds supported by a lay person at the committee stage."*

22. In *B v The Medical Council* (High Court, Auckland, 11/96, 8/7/96), and in the context of the charge of conduct unbecoming, Elias J stated:

*"In the case of diagnosis or treatment, conduct which falls short of the mark will be assessed substantially by reference to usual practice of comparable practitioners. …Those standards to be met are, as already indicated, a question of degree; …I accept that the burden of proof is on the balance of probabilities. Assessment of the probabilities rightly takes into account the significance of imposition of disciplinary sanction. I accept that the court must be satisfied on the balance of probabilities that the conduct of the practitioner is deserving of discipline."*

23. Both cases identify that the central issue for this Tribunal is to ascertain whether or not the practitioner's conduct and management of the case (at the relevant time) constituted an acceptable discharge of his or her professional and clinical obligations. Only if this Tribunal identifies shortcomings or error, may it then go on to determine if those shortcomings or errors are culpable and warrant the sanction of a finding against the practitioner. Essentially, the issue for this Tribunal is the issue of "*responsibility vs culpability.*"

**The Decision**

24. The Tribunal has carefully considered all of the evidence presented to it and the very helpful submissions made by both counsel. The Tribunal has determined that Dr Rajasingham is not guilty of professional misconduct in terms of section 109(1)(c) of the Act. The charge is dealt with in respect of each part.

25. The first part states that Dr Rajasingham failed to monitor or adequately monitor Mrs Ross whilst she was under anaesthetic and in particular failed to monitor urinary output, blood pressure and temperature.

26. The relevant issues relate to monitoring urinary output and temperature. There is general agreement that best practice would dictate that monitoring urinary output over this period of time is recommended. It is also accepted that a urinary catheter should have been inserted during the preoperative stage, particularly given that Mrs Ross waited six hours for surgery. Both Dr Futter and Professor Merry agree that for patient comfort, a catheter would have been preferred, but the Tribunal considers that monitoring urinary output would not have changed the outcome for Mrs Ross.

27. It is also the Tribunal's view that in respect of monitoring temperature, best practice would dictate that that should occur. Mention has already been made of the issue of confidence in the temperature probes and that was a view expressed by others working in Rotorua Hospital at this time. It was recognised that the main issue was in ensuring that Mrs Ross was kept warm and that Dr Rajasingham did that with the use of a K thermia water blanket and layers of covering for the body.

28. The Tribunal accepts that it would have been more desirable to have a urinary catheter inserted at the pre-operative stage, but that Dr Rajasingham's decision not to insert the catheter when Mrs Ross was presented in theatre was a reasonable decision based on the circumstances at the time and accordingly did not fall short of an acceptable standard. Further the Tribunal considers that Dr Rajasingham did monitor temperature to the extent that he used blankets and his actions given his lack of confidence in the temperature probes were of an adequate standard to discharge the obligation of monitoring temperature.

29. The next issue concerns the charge of a failure to ascertain whether the central line was correctly placed or sited and/or was functioning appropriately.

30. The evidence was that upon inserting the central line for the second time, Dr Rajasingham satisfied himself that it was correctly sited by aspirating blood and then filling a four lumen catheter with heparinized saline. By that action, Dr Rajasingham satisfied himself as to the appropriate placement of the CV line. It was only when he became concerned around 4.30am that he considered the possibility of the line being in the wrong place. At that stage, he did ask the surgeon to hurry up and finish, sought an x-ray and asked the surgeon to assist him to percuss the chest.

31. The Tribunal considers that those actions were appropriate in the circumstances. It is always more difficult in hindsight given the tragic outcome to wonder whether more could have been done, but given the circumstances at the time, it is clear that completing the operation as quickly as possible was a priority and that it was reasonable to expect that upon completion, Mrs Ross's condition would be able to be stabilised. In fact, her condition did stabilise for a short time prior to the final deterioration.

32. The next part concerns a failure to communicate adequately with the Orthopaedic surgeons and/or the radiographer about the safety and wellbeing of Mrs Ross following the indications around 4.30am, that her safety and wellbeing were being compromised.

33. It is clear that there was little communication about the management of Mrs Ross between Dr Moorcroft and Dr Rajasingham. It is the Tribunal's view and it was acknowledged by Dr Moorcroft that as the surgeon, Dr Moorcroft was ultimately responsible for Mrs Ross's care. Dr Rajasingham had visited Mrs Ross in the Emergency Department to discuss issues relating to her breathing but Dr Moorcroft did not see Mrs Ross until she was brought into theatre. There was little communication between the pre-operative team and the surgeons and anaesthetist and this is certainly not, in the Tribunal's opinion, an ideal situation.

34. Dr Futter referred to "*The need for communication and co-operation in the management of such patients*" and that *"[N]ormally, a surgeon and anaesthetist*

*would be expected to communicate to each other their respective plan for management.*"

35. The arrangement in theatre was such that the orthopaedic surgeons were clearly concentrating on operating on the fractures and did so in a way that separated them from Dr Rajasingham. Dr Moorcroft described it as "*An enormous plastic sheet…which goes from one end of the operating table to the other, and it is suspended from a pole which is about seven foot high.*" Dr Moorcroft went on to say:

*"Basically at that point, the anaesthetist is fairly well excluded from the whole procedure, we get them right out of the way."*

36. Dr Moorcroft acknowledged that any communication in theatre was essentially between the orthopaedic surgeons. In response to a question from the Tribunal as to how an anaesthetist could attract his attention when he was concentrating on the operation at hand, Dr Moorcroft stated:

*"Probably they'd have to kick us I think, shout at us."*

37. In response to the request to the radiographer for an x-ray, it would appear that the main reason for an x-ray not being able to be taken is that there was very little room available in theatre with the plastic sheet and the imaging machine. Dr Rajasingham accepted the advice given to him that an x-ray was unable to be done and he waited until the operation was complete.

38. Lack of team management of Mrs Ross is indicative in respect of the communication between those responsible for her care at different times. It is accepted by the medical witnesses and by Dr Laidlow, who is experienced in this Hospital, that stopping the operation around 4.30am was not particularly feasible and that the emphasis should have been on completing it as soon as possible. The Tribunal is satisfied that Dr Rajasingham did attempt to communicate with the surgeons and with the radiographer to assist in the management of Mrs Ross and it is difficult to see how, without the co-operation of the surgeons and radiographer, Dr Rajasingham could have done any more.

39. The parts of the charge relating to the discussions concerning the need for a urinary catheter and the review of the decision concerning the urinary catheter are matters that are an extension of the specific charge of failing to monitor urine. It is however, noted that there does not appear to have been a discussion between Dr Moorcroft and Dr Rajasingham about the catheter and the comments made during the course of the hearing by Dr Moorcroft concerning the catheter were his thoughts in retrospect rather than any recollection of discussions had at the time.

40. Bearing these matters in mind, it is the Tribunal's view that Dr Rajasingham did take appropriate steps when he became concerned about Mrs Ross including inserting a chest drain. The Tribunal is therefore of the view that the charge of professional misconduct against Dr Rajasingham has not been made out. It is hoped that the reviews that have taken place in respect of the tragic death of Mrs Ross has resulted in internal changes to the procedure and a recognition of the need to have in place procedures to deal with trauma patients. The management of Mrs Ross on arrival in the Emergency Department at Rotorua Hospital appears to have been characterised by an underestimation of both her state and her injuries – and that was an underestimation that permeated her management throughout. To single out Dr Rajasingham as playing the major role in the tragic outcome for Mrs Ross and her family is not, in the Tribunal's view, borne out by the circumstances at the time or the opinions of the medical witnesses who reviewed Dr Rajasingham's actions. It is noted that Dr Rajasingham has identified himself matters that he feels may have resulted in more information being available, such as urinary output monitoring and temperature monitoring with reliable instruments.

41. The charge not having been made out in respect of the individual particulars and there being no further matters put forward, the Tribunal does not consider a cumulative charge has been made out.

**Orders**

42. The charge of professional misconduct against Dr Rajasingham is dismissed.

**DATED** at Auckland this 23rd day of July 2002

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P Kapua

Deputy Chair

Medical Practitioners Disciplinary Tribunal