Medical Practitioners Disciplinary Tribunal

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NOTE: PUBLICATION OF THE NAMES OF AND ANY PARTICULARS WHICH MIGHT TEND TO IDENTIFY THE COMPLAINANT, HER SISTER, HER HUSBAND OR THE TWO FORMER PATIENTS OF DR STUBBS IS PROHIBITED. PUBLICATION OF THE STATEMENTS OF SUCH PATIENTS IS ALSO PROHIBITED.	**DECISION NO:**	116/99/54C
	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 **RICHARD STRAWSON STUBBS** medical practitioner of Wellington

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mr T F Fookes (Chair)

Dr I D S Civil, Professor W Gillett, Dr J W Gleisner,

Mrs H White (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Wellington on Monday 27, Tuesday 28 and Wednesday 29 March 2000

APPEARANCES: Ms K P McDonald and Ms J Daniell for a Complaints Assessment Committee ("the CAC").

Mr C W James for Dr R S Stubbs.

1. THE CHARGE:

1.1 The Complaints Assessment Committee pursuant to Section 93(1)(b) of the Medical Practitioners Act 1995 charges that Dr Richard Strawson Stubbs, Registered Medical Practitioner of Wellington in providing treatment to A prior to performing a revision gastric by-pass by way of gastric transection on 8 December 1993 failed to obtain the informed consent of the said A in that he failed to adequately inform her of the possible risks and adverse effects of the surgery so that she was unable to make an informed choice whether to undertake the surgery.

Being professional misconduct or being conduct unbecoming a medical practitioner and that conduct reflects adversely on the practitioner's fitness to practise medicine.

1.2 **THE** charge was denied.

2. THE TASK FACING THE TRIBUNAL:

2.1 **IN** this case the Tribunal is in the position of having to attempt to determine, from evidence put before it at the end of March 2000, what information was verbally conveyed by a

medical practitioner to his patient about the possible risks and adverse effects of certain proposed surgery in consultations which took place in October and November 1993. The patient asserts that there was no discussion about risks or serious complications in either of the consultations. The practitioner says that such matters were the subject of advice from him and discussion on both occasions. No record of such matters having been discussed was made by the practitioner during, or shortly after, either consultation.

2.2 **THE** patient's concern that the practitioner had (in the patient's view) not fully advised her of the risks first arose towards the end of 1994. During the year prior to that time she had been very ill, and in hospital, for many months. For his part, the matter of informed consent did not become a live issue for the practitioner until a considerable time after the consultations. Despite these matters, both the patient and the practitioner were definite in their evidence about what was and was not said about risk in consultations which took place more than six years ago.

2.3 **THE** delay between the consultations and the Tribunal's hearing, the relatively dogmatic positions adopted by the patient and the practitioner and the absence of any contemporaneous record of discussions about risks have contributed to the Tribunal having found this to be a case which has required detailed consideration of the evidence and lengthy deliberations.

3. ONUS OF PROOF:

3.1 **THE** onus of proving the charge against the practitioner (referred to herein as "Mr Stubbs") lies entirely on the Complaints Assessment Committee which laid the charge. Mr Stubbs does not have to prove anything.

4. STANDARD OF PROOF:

4.1 **THE** CAC must prove the charge to the satisfaction of the Tribunal on the balance of probabilities. The degree of satisfaction which is called for will vary according to the gravity of the allegation. Thus, the more serious the charge the higher the degree of satisfaction which is required. In this case the charge alleged professional misconduct or alternatively conduct unbecoming a medical practitioner and that conduct reflects adversely on the practitioner's fitness to practise medicine. A finding of professional misconduct is, as McGechan J said in *Cullen v Preliminary Proceedings Committee* (High Court, Wellington, AP 225/1992, 15 August 1994), *"a severe label"*. As the allegation made against Mr Stubbs was serious the CAC accepted that it must present a case that satisfies the Tribunal to a high degree that the charge has been proved and the Tribunal considers that the CAC was right to do so.

5. INFORMED CONSENT:

5.1 **THE** CAC's allegation is that, prior to performing a revision gastric by-pass by way of gastric transection, Mr Stubbs failed to obtain the *"informed consent"* of the complainant in that he failed to adequately inform her of the possible risks and adverse effects of the surgery so that she was unable to make an informed choice whether to undertake the surgery. In *Sutherland v Accident Compensation Corporation* (Decision No. 34/97)

the Appeal Authority referred to the following definition of informed consent by Justice Kirby in (1983) 9 Journal of Medical Ethics, 69:

"An informed consent is that consent which is obtained after the patient has been adequately instructed about the ratio of risk and benefit included in the procedure as compared to alternative procedures or no treatment at all."

5.2 **SINCE** 1983, when that definition was promulgated, there have been a number of pronouncements in relation to informed consent. The requirement that a patient's informed consent to a proposed form of treatment be obtained by a medical practitioner now has, in this country, at least three sources:

5.2.1 Case law.

5.2.2 The Code of Health and Disability Consumers' Rights (which was not in force in October and November 1993).

5.2.3 A pronouncement by the Medical Council of New Zealand.

5.3 **A** leading case on informed consent is *Rogers v Whittaker* (1992) 175 CLR 479, a judgment of the High Court of Australia. In that case the patient had had to make a decision as to whether to undergo an elective operation on her eye. She was blind in the eye which was to be operated on and was concerned not to lose her sight in her *"good eye"*. The surgeon considered that the risk that she might develop sympathetic opthalmia in her *"good eye"* was so small that he did not warn the patient that it was a potential complication.

5.4 **THE** Court held that there is a fundamental difference between diagnosis and treatment on the one hand and the provision of advice or information to a patient on the other.

"Whether a medical practitioner carries out a particular form of treatment in accordance with the appropriate standard of care is a question in the resolution of which responsible professional opinion will have an influential, often decisive role to play; whether the patient has been given the relevant information to choose between undergoing the treatment is a question of a different order. Generally speaking, it is not a question the answer to which depends upon medical standards or practices. ... Rather, the skill is in communicating the relevant information to the patient in terms which are reasonably adequate for that purpose having regard to the patient's apprehended capacity to understand that information." (p 489 - 490)".

5.5 **AS** the Tribunal noted in Decision No. 94/99/39C the concept of informed consent is based upon the patient's right to self determination. The Supreme Court of Canada has rejected a test of the adequacy of information imparted being based on the standards of medical practitioners. It said that that was inconsistent with the patient's *"right to self-determination on particular therapy"*. In considering whether a doctor had disclosed risks which were material to the patient the test is based NOT on the assessment of a reasonable doctor but on the view of a reasonable person in the patient's position: *Reibl v Hughes* [1980] 2 SCR 980:

"[a] risk is thus material when a reasonable person in what the physician knows or should know to be the patient's position , would be likely to attach significance to the risk or cluster of risks in determining whether or not to forego the proposed therapy."

5.6 ***ROGERS** v Whittaker* was followed and applied in New Zealand by Elias J (as she then was) in *B v The Medical Council of New Zealand* (High Court, Auckland, 11/96, 8 July 1996). At pp 17-18 Her Honour said:

"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. In the case of adequacy of communication of information to the patient, however, wider considerations are relevant. In particular, the communication must be such as to adequately inform the patient, taking into account the patient's capacity to understand it and the purposes for which the information is relevant. What needs to be communicated may depend upon whether the information is provided pursuant to the patient's general right to know about his or her condition, or whether it is required to inform the patient's own conduct in matters such as consent to medical

procedures, or co-operation with investigational treatment. These seem to me to be considerations which are relevant in assessing the conduct of a medical practitioner. Those standards to be met are, as already indicated, a question of degree; the practitioner is not a guarantor of the effectiveness of communication any more than he or she is a guarantor of the effectiveness of treatment. 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."

5.7 **THE** Tribunal notes the following additional points which were made in a paper presented, at the Brookfields Medical Law Symposium held in Auckland in June 1999, by Elias CJ and entitled *"Informed Consent - Should We Follow Rogers v Whittaker?"*

5.7.1 (Page 4) *"... given the truism that ultimately any decision about medical treatment is for the patient, it seems to me that the doctor's obligation to inform the patient about matters material to that decision (and in particular questions of risk), do not depend upon the patient having enough knowledge to ask the right questions. Risks which are inherent in treatment competently performed and which are not insignificant must be disclosed unless perhaps obvious to the patient. So too must any particular risks which affect the particular patient. ...... The duty is to disclose all circumstances which are material to the decision the patient has to take."*

5.7.2 (Page 11) *"(Where there is risk acknowledged by reasonable medical practice which the medical practitioner knows would be material to the patient either because it is inherently significant or because of the particular circumstances of the patient, known to the doctor, then it is hard to disagree with the view expressed by Gaudron J., that it should be disclosed, irrespective of professional practice in such disclosure.)"*

5.7.3 (Page 13) *"It is clear that where proposed treatment, even if skilfully performed, carries a "material" risk, a patient has a right to be informed of those risks. Expert medical opinion is relevant to the question of materiality of risk ..... Since the patient's decision whether or not to accept the treatment proffered may well be based upon considerations other than reasons which are clinically sound ..... reasonable clinical judgement cannot pre-empt patient choice ...... it seems to me that the reality is that the Courts will not defer to clinical judgment of medical practitioners as to what a patient should be told. Informed consent to treatment is a pre-condition of such treatment. The patient's right imposes a concomitant duty on the medical practitioner to inform. Such duty necessarily arises out of the relationship between a health professional and patient. Whether that duty has been performed in the particular case depends upon all the circumstances and is not determined by medical practice."*

5.7.4 (Page 15) *"It is open to the Court to disbelieve evidence which it finds to be tainted by hindsight."*

5.7.5 (Page 16) *"There is scope for debate, too, on the distinctions drawn in* Sidaway *between risks which are inherent in a medical procedure and risks which are particular to the patient. Lord Scarman was of the view that inherent risks, if material, would need to be disclosed. Lord Templeman considered that general risk, if generally understood to be inherent in a procedure, did not require further disclosure in the absence of questioning by a patient but that doctor should draw to the attention of a patient "any danger special in kind or magnitude or special to the patient". .... It may be possible to infer knowledge of a risk which is notorious, but in principle, once it is accepted there is a duty to inform for the purposes of a patient's choice of treatment exists, it is difficult to see that the duty should not include both inherent risks, if material and risks special to the patient or of special magnitude or kind in the circumstances of the patient."*

5.7.6 (Page 17) *"It is nowhere suggested that a medical practitioner is obliged to give full information about every possible eventuality, no matter how insignificant or remote from the circumstances of the patient."*

5.7.7 (Page 17) *"As a number of the Judges in the cases already cited recognise, the duty imposed upon a medical practitioner to disclose risk is a duty to communicate in an appropriately effective way. There is something of a tightrope here. A medical practitioner cannot be made a guarantor of the patient's comprehension, any more than he can be a guarantor of effectiveness in treatment. This was an issue of some difficulty in* ***B. v. The Medical Council****. It is not an easy matter to assess, particularly with the hindsight of the realisation of risk. Communication however, is central to the relationship between medical practitioner and patient. The question of adequacy in communication is not able to be evaded."*

5.7.8 (Page 19) *"As already discussed, the duty is to provide the patient with the information necessary to enable the patient to exercise informed choice about treatment. That will require disclosure of risks material to a reasonable patient in the position of the actual patient (an objective test which recognises the particular circumstances of the actual patient)."*

5.7.9 (Page 21) *"The question of materiality is not one of assessment of clinical risk alone. These are themes discussed in* ***Tai v Saxon*** *[SC (Full Court) WA 1/3/1996, 960113], by Ipp J. He suggested that the significance likely to be attached to risk is dependent upon the magnitude of the risk, the nature of the potential harm, the need for the treatment itself and the circumstances of the particular patient. There is nothing unfamiliar to a lawyer in this. Assessment of materiality in cases of disclosure is always undertaken against the register of the facts."*

5.8 **VARIOUS** rights set out in the Code of Health and Disability Services Consumers' Rights are relevant to any discussion in the year 2000 of what *"consumers"* are entitled to receive from practitioners but that Code had not been promulgated by the time of the events involved in this case.

Similarly the Medical Council's statement that it takes the view that (except in an emergency or a related circumstance) the proper sharing of information and the offering of suitable advice to patients is a mandatory pre-requisite to any medical procedure instituted by a medical practitioner (which has been referred to in a number of decisions of the Tribunal in *"informed consent"* cases) was not published until September 1995.

6. THE EVIDENCE:

6.1 **THE** CAC called evidence from the complainant, her sister and Professor John Collins. A bundle of documents was also produced. Mr Stubbs gave evidence and produced various documents and articles. His counsel also called evidence from an anaesthetist, Dr Sharpe, and a surgical specialist, Mr Sorrell. The statements of two witnesses who had consulted Mr Stubbs were produced to the Tribunal without the witnesses being called. This was on the basis that the statements were to be verified by affidavit (as they subsequently have been) and that Ms McDonald's decision not to require those witnesses to be called for cross-examination was not to be taken as an indication that she necessarily accepted the contents of the affidavits.

6.2 **PRIOR** to the hearing the Tribunal made an order prohibiting publication of the names of, or any particulars or information which might tend to identify, the complainant, her sister or

her husband. At the hearing it made an order prohibiting publication of the names and any of the affairs of the two former patients of Mr Stubbs and also made an order prohibiting the publication of the whole or any part of the statements of either or both of those two persons.

7. THE COMPLAINANT:

7.1 **IN** January 1986 the complainant, Mrs A ("the complainant") suffered a back injury. At that time she was carrying excess weight which was detrimental to her recovery from that injury.

7.2 **FOR** years she had been attempting to effect weight loss but had had little or no success.

7.3 **AFTER** medical examination and counselling she was accepted as a candidate for the procedure of gastric by-pass operation. Before the operation was carried out (in 1986) the risks involved were fully explained to her by the operating surgeon, Mr Richard Stewart (now deceased).

7.4 **POST-OPERATIVELY** she developed a deep vein thrombosis and a pulmonary embolus and was in hospital for something like 20 days at that time.

7.5 **AS** a result of the surgery she achieved a significant weight loss.

7.6 **IN** 1987 she had surgery for varicose veins. In April 1987 she was admitted to xx public hospital with acute abdominal pain caused by a bowel blockage. This required surgery

which was performed by Mr Stubbs (the defendant in this proceeding) and was completely successful.

7.7 **IN** 1989 she had a laminectomy and in 1990 a dilatation and curettage.

7.8 **ALSO** in 1990, she began to experience epigastric pain. As it happened she was admitted to xx public hospital in September 1990 with a urinary tract infection. During that admission her epigastric pain, which was accompanied by indigestion, was also investigated. She was referred back to Mr Stubbs. He performed a gastroscopy (an examination of the stomach with a gastroscope). He established that she had a peptic (or stomach) ulcer which he treated with medication. Initially the condition appeared to settle and the symptoms subsided. She continued to see Mr Stubbs on an out-patient basis until he resigned from xx public hospital and was appointed to a position at xx Hospital.

7.9 **DURING** 1993 she had a hysterectomy.

7.10 **IN** the latter half of 1993 she again experienced epigastric pain and discomfort. She also developed an unpleasant reflux (or belching) problem. Medication which she was taking at the time did not alleviate the problem and her general practitioner suggested that she make an appointment to see Mr Stubbs at xx Hospital. She did so. What transpired will be discussed later in this Decision but following two consultations she was admitted to xx Hospital and on 8 December 1993 she underwent the procedure of gastric revision surgery by transection.

7.11 **AS** a result of the development of post-operative complications she underwent further surgery on 21 December 1993. On 27 December 1993 she was transferred by ambulance to xx public hospital. She spent the next nine months in that hospital. During that time she had several surgical interventions. She was then discharged only to be readmitted a fortnight later for what proved to be a further stay in hospital of three months. Since the operation carried out by Mr Stubbs in December 1993 she has had numerous further operations and has had many distressing physical and emotional episodes. She has had a very difficult and painful time over many years and was still in pain, and requiring relief through morphine, at the time of the hearing.

7.12 **AS** will be obvious from that narrative the complainant is thoroughly familiar with surgery. The Tribunal is satisfied that she has a good understanding of medical procedures, that she is an intelligent person and that she is well capable of understanding advice which is clearly communicated.

7.13 **THE** Tribunal found the complainant to be a witness who did her best to recall what happened in the consultations which she had with Mr Stubbs in October and November 1993. There were, however, some aspects of her evidence about which she was incorrect. For example she did not recall a barium meal being mentioned at the first consultation. Mr Stubbs' clinical notes however clearly record that she was to have a barium meal. She also did not recall having had a barium meal between the consultation on 22 October and the surgery on 8 December 1993. There is, however, no doubt that such a procedure did take place and the Tribunal has seen the report which was prepared

following it. The Tribunal also thought that occasionally in the course of her evidence she demonstrated bitterness towards Mr Stubbs.

7.14 **SHE** did not start to make notes of what she considered relevant events until about a year after those events had occurred. When she prepared those notes she did not have access to her hospital records and was thus forced to rely on her recollection. The hospital notes, which the Tribunal has seen, do not always accord with her recollection. Given how ill she was at the relevant time, and the many concerns which she then had, it is entirely understandable that there should be some variation between her recollection and the records but the Tribunal noted a tendency on her part to be dogmatic about the correctness of the dates on which she said certain events occurred when the hospital notes suggest otherwise.

7.15 **IN** summary, and despite the occasional signs of bitterness on her part, the Tribunal regarded the complainant as an honest witness, doing her best to recall what was said in consultations which occurred approximately 6½years before the Tribunal's hearing, but who was capable of being - and in fact was - wrong in some aspects of her evidence.

8. MR STUBBS' RECOLLECTION:

8.1 **AS** noted in 7.3 above, the complainant had a gastric by-pass operation in 1986. That procedure involved placing a row of staples across the stomach to divide it into a small upper stomach and a much larger lower stomach. This was to limit the amount of food which the upper stomach could hold. The procedure also involved making a small opening along the upper stomach so that the emptying of that stomach would be slowed and a

feeling of fullness would remain for some time after the patient had eaten. In gastric by-pass surgery the upper stomach was opened into a length of small intestine so that the food then by-passed the remainder of the stomach and the duodenum.

The complainant acknowledged that in connection with that surgery she had received, from a support group, a booklet entitled "A GUIDE TO GASTRIC STAPLING OPERATIONS". It included the following passage:

<u>WHAT ARE THE RISKS?</u>

"The gastric stapling is a major operation and because of your weight, you will clearly be at risk of suffering a complication post-operatively. There is a small but very real risk of death from post-operative complications. Problems which may arise are infection of the wound or failure of the wound to heal properly, chest infection, or clots forming in the leg. Special measures will be taken to attempt to avoid any of these problems, but in spite of these measures a significant complication will probably occur in 10 to 20% of all patients.

The risk of death is less than two percent."

As noted in 7.8 above, the complainant was admitted to hospital in September 1990 with a urinary tract infection. During this admission, epigastric pain from which she was suffering resulted in her being referred back to Mr Stubbs and his performing a gastroscopy. He diagnosed that she had a peptic ulcer which was treated with medication. On 27 December 1993, Mr Stubbs wrote to Mr xx, a consultant surgeon at xx Hospital who had agreed to take the complainant for further management. In his letter Mr Stubbs said:

"Richard Stewart performed a gastric by-pass on her in July 1986 at which time she was 146.5 kg. She suffered a DVT/PE post operatively as well as having a minor anastomotic leak which settled spontaneously. A year or so later I saw her after an admission to WPH with a GI bleed."

In fact, this admission was not "a year or so" after July 1986. It was approximately 4 years and 2 months later.

8.2 **IN** his written evidence to the Tribunal, Mr Stubbs said of the September 1990 admission to xx Public Hospital:

"My recollection is that she was admitted with upper abdominal pain and vomiting of some blood."

In fact, according to the complainant, she was admitted because of a urinary tract infection but the opportunity was taken to investigate her epigastric pain. She firmly denied that she had been vomiting blood and that she was admitted to Hospital for that reason. In oral evidence Mr Stubbs said that most of those with an ulcer after gastric by-pass will (a) vomit, and (b) very frequently have blood in what they vomit. He said that that is not to say that this is major bleeding but it is blood stained vomiting. He said that his recollection is that that was the event but that it is simply a recollection and perhaps connected with his expectation that that would have been the case.

8.3 **THE** complainant was seen by Mr Stubbs on 22 October 1993. In his written evidence he said that she was referred to him and he saw her on that date because of on-going abdominal pain, foul-tasting and smelling vomiting, and weight gain. In fact the Tribunal is satisfied that weight gain was not the purpose of the referral by the complainant's general practitioner. It accepts the complainant's evidence on this point and during the hearing Mr Stubbs accepted that her weight gain appeared not to have been the purpose of referral.

8.4. **IN** the matters already canvassed in 8.1 to 8.3, the Tribunal finds clear evidence that after six years it is not only the complainant's recollection which is from time to time faulty. Mr Stubbs' recollection has also let him down on a number of occasions of which these three are but examples.

8.5 **OTHER** matters calling into question the reliability of Mr Stubbs' recollection will be dealt with later in this Decision.

9. THE FIRST CONSULTATION - MR STUBBS' INFORMATION BOOKLET:

9.1 **THE** complainant said in her written evidence that she met with Mr Stubbs on 22 October 1993 and explained her symptoms to him. She said that after a preliminary examination it was agreed that another gastroscopy was necessary to determine the extent of the problems. In oral evidence, the complainant estimated that the consultation would not have exceeded 30 to 35 minutes in duration. She said that during this time she met with Mr Stubbs, she explained what the problem was, she was examined on an examination table, there was a mass in her lower left quadrant that Mr Stubbs was concerned about and he also decided to do an ultrasound examination.

She said that there was no discussion about a gastric transection at the first consultation (that of 22 October 1993). Nor, she said, was there any discussion about revision of the original by-pass. She assumed that Mr Stubbs was going to investigate the problem before he made any diagnosis. Her recollection was that the investigations which were discussed at the first consultation were that she was to go and have an ultrasound, initially

to find out what the mass was, and the gastroscopy to find out what was causing the belching. She said that there was no mention of a barium meal at that consultation.

She said that she was not given any booklet by Mr Stubbs about revision surgery or transection. Referred to a statement in Mr Stubbs' written evidence about his "information booklet" she said she did not know what that is. In cross examination she denied that it was possible that Mr Stubbs had said something to her along the lines that he was considering a procedure, re-stapling, which was more dangerous than her first operation. She said that no diagnosis was offered on that occasion.

9.2 **MR** Stubbs' version of what took place at the first consultation was significantly different. He said in his written evidence:

"We discussed the difficulties of revision surgery, and how this was more difficult and dangerous than the initial surgery, because of adhesions and the difficulty of mobilising and defining structures without damaging them. I indicated that I could see no other answer for her. She had already had symptoms for at least two years, and anti ulcer medication during that time had failed to resolve the matter. Her weight gain (June 1990, 71 kg; June 1991, 75 kg; October 1993, 90 kg) could only be resolved by revision surgery.

At that time I spoke of re-stapling the stomach, as up till that time, that was the method known to me and most widely employed by obesity surgeons around the world. I was aware from my knowledge of the medical literature and from my own experience (then 82 obesity operations of which six were revision gastric by-passes) that such surgery was much more difficult than the initial surgery, which itself was difficult enough. It was on this basis that I indicated the risks would be higher than the 1-2% chance of dying and 5-10% chance of major complications (particularly leakage) which I normally quoted for the initial surgery. (See my information booklet – which I give to all prospective patients undergoing obesity surgery. I would expect that Mrs A received a copy.)

I also indicated that my research records indicated she had had a minor leak, but which had not required re-operation, following the first operation and a pulmonary embolus (PE). These facts meant she would be at increased risk of both these events if revision surgery was undertaken, and I pointed this out.

I indicated I should confirm my diagnosis of ulceration and staple line dehiscence by barium meal and gastroscopy. In addition, I needed to perform an ultrasound examination to investigate a tender mass in the left iliac fossa (which turned out to be a low lying normal kidney.)

I did indicate that surgery was the only way to resolve her problem in all its aspects, i.e. pain, ulcer, reflux, weight gain."

9.3 **MR** Stubbs' information booklet, which he said in paragraph 8 of his evidence he gives to all prospective patients undergoing obesity surgery, was produced. It includes the following passage:

"What are the risks?

Gastric stapling is a major operation and because of your weight and the possibility of pre-existing hypertension and diabetes the risks of complications after surgery are slightly greater than normal. There is a small but very risk of death from post-operative complications. When the surgery is performed by surgeons experienced with the technique, this risk should be no more than one or two percent. Other problems which may arise are infection of the wound or failure of the wound to heal properly, chest infection or the development of clots in the legs. Special measures are taken at the time of surgery and in the few days after surgery to avoid these problems but in spite of these measures some complication may occur in up to ten percent of patients."

9.4 **IT** will be noted that the passage in question deals with gastric stapling. This was the procedure which the complainant had undergone in 1986. The passage in the booklet does not deal with revision surgery (by which the Tribunal means further surgery carried out in the same area of the body as that on which the original surgery was performed). It therefore does not deal with revision surgery by transection.

9.5 **IN** oral evidence Mr Stubbs said that 500 copies of the booklet were produced in 1992 with the intention that they would be distributed to all of his patients undergoing that surgery (i.e. gastric stapling). He said that in 1993 distribution to patients was made by him personally. The booklets sat behind his desk and he reached for one and gave it to a

patient. The only alternative method was if patients telephoned in which case, in response to an inquiry, a copy of the booklet was sent out to them. Questioned about the complainant having said that she did not receive a copy of the booklet he said that if she did not that was an oversight and that it was a matter of some pride to him that he had produced the booklet at that time and at some expense and that he was endeavouring to distribute it to see that people knew his current thinking on the subject.

9.6 **IN** cross-examination Mr Stubbs said that he was surprised that Mrs A had not received his standard booklet. He said that he did not accept that she had not seen it. Asked whether he had any recollection of giving it to her he said that he gave it to all patients but it was remarkable that she did not get it. Questioned by Dr Gleisner he said that while he did not understand why she did not receive a booklet he could say that he intended that everyone who had gastric by-pass surgery with him, whether primary or revision, should receive the booklet. Questioned by Professor Gillett he accepted that she may not have received his booklet.

9.7 **THE** Tribunal finds on the balance of probabilities that the complainant did not receive Mr Stubbs' information booklet. She thus did not receive the information as to risks which is contained in that booklet and was set out in 9.3 of this Decision. It is to be noted that although the complainant had read in or about 1986 about the risks of death, infection of the wound, chest infection or clots forming in the leg it was common ground - at the hearing before the Tribunal - that this did not in any way absolve Mr Stubbs from having to give her all appropriate warnings and advice, and obtain her informed consent, before operating in 1993.

The First Consultation - Revision Surgery and Risks:

9.8 **THERE** was a substantial conflict of evidence between the complainant and Mr Stubbs as to whether, at the first consultation, there was:

(a) any discussion about revision surgery;

(b) any discussion about the risks involved in revision surgery

9.9 **THE** complainant's position was clear and has already been detailed (see paragraph 9.1 above). Mr Stubbs' position was originally clear (see the extract from his written evidence quoted in paragraph 9.2 above). When these two topics were further explored, however, his position became less clear.

Was Revision Surgery Discussed During the First Consultation?

9.10. **THE** complainant says that it was not. Mr Stubbs says that it was. Mr Stubbs' clinical notes relating to the first consultation were produced. They contained no evidence that revision surgery was discussed by him with the complainant on that date. What they do show is that the complainant was to have a barium meal, plus or minus a gastroscopy, an ultrasound examination in respect of the left iliac fossa, and blood tests. With the exception of the barium meal, which she did not recall being ordered at or as a result of the first consultation, these notes contain nothing which casts doubt on the complainant's evidence of what was discussed at the first consultation.

9.11 **ON** 28 October 1993 (six days after the first consultation) Mr Stubbs wrote to the complainant's general practitioner. (Mr Stubbs said that he generally dictated letters to a referring general practitioner on the same day as the consultation took place but it could be a little later.) In that letter Mr Stubbs recorded of the complainant that:

(a) Clearly her weight was increasing slightly and she was concerned about that.

(b) In addition she now had epigastric pain and the nature of her vomiting had changed somewhat to suggest that she may have a partial staple line disruption with communication to the originally by-passed body of the stomach.

(c) The other problem was that she had some left iliac fossa pain. On clinical examination there was a mass evident in the left iliac fossa. Her bowels were relatively unremarkable and at that point Mr Stubbs was not sure what to make of the mass, particularly given the fact that she had had a hysterectomy in April 1993.

(d) He thought it likely that there was a partial staple line disruption which was resulting in her weight gain and also regurgitation of acid with consequent production of gastro-oesophageal reflux and probable ulceration in her little gastric pouch.

He said that in the first instance he planned to investigate this with a barium meal but if necessary would follow on with a gastroscopy. The barium meal tends, he said, to demonstrate the staple line problem more readily than the gastroscopy but may not show an ulcer. In addition, he said, he had organised an ultrasound of the lower abdomen in order to *"give us more information about the mass in the left iliac fossa"*.

The letter concluded: *" I shall keep you informed of our findings and plans."*

9.12 **THE** letter contained no reference to revision surgery being necessary, nor to any possibility of revision surgery having been discussed with the complainant.

9.13 **IN** cross examination Mr Stubbs said that he believed that as at 22 October 1993 he had in his mind that the likely diagnosis was staple line disruption and he recorded that in his letter to the general practitioner following the first consultation. He accepted that he had not at that stage confirmed the diagnosis and that he would have been in no position to have confirmed to the complainant on 22 October that she had staple line disruption. He said, however, that he raised it. He said that the fact that he discussed it at that time was merely a reflection of his confidence that when the investigations were done it would confirm the staple line disruption. When it was put to him that he would not unnecessarily worry a patient before being in a position to confirm his diagnosis and give her advice as to what to do next, he said that he would still worry the patient on the basis that when one does major surgery people are better to be brought around to the idea of what is required and what the risks will be and not merely confronted with it on the last occasion and brought in for it. He said that it would be his standard practice to begin to discuss what is likely to be required and what that might entail and the likely risks on the first suitable occasion and that might well be before confirmation of a diagnosis.

9.14 **IT** was put to him that he was relying on what he expected he would have done on 22 October rather than on a specific memory. He said that though he did not have such a specific memory of that occasion he knew that on an occasion before he knew about

transection he spent some time talking about revision surgery generally. He said that there was only one occasion on which that conversation could have taken place and that is how he knew it was on 22 October.

9.15 **IN** further cross-examination he conceded that the first consultation could have lasted for 35 or 40 minutes and said that he did not wish to insist he knew how long the consultation took. He simply wished to say that what had to be discussed could not possibly have been discussed in a short time. He said that he knew that he had mentioned revision surgery at that consultation and began discussing how her symptoms would come about, that the likely solution would be revision surgery and what that would entail. He said that other than discussing revision surgery he did not have a clear recollection of that consultation in terms of the specifics.

In further cross-examination he said that while he had not confirmed his diagnosis as at 28 October (the date of the letter to the general practitioner) he knew what was going to happen. It was put to him that that letter was by and large entirely consistent with what the complainant had told the Tribunal in that (in that letter) he was not identifying, in the same way that he did not identify to the complainant on 22 October, any complications or risks or the mention of revision surgery but had told the general practitioner, in the same way that he had told the complainant, that he would get back to them with findings and plans. He agreed that the letter did not indicate that he had discussed risks. He did not agree that he did not discuss them.

9.16 **QUESTIONED** by the Tribunal he said that he recalled discussing revision surgery at the consultation on 22 October 1993. He maintained that he discussed then the issue of revision and what that entailed.

9.17 **IT** is impossible to reconcile the two accounts. The evidence of one of the witnesses is incorrect. Each witness relies solely on recollection. Three members of the Tribunal, having heard and seen both witnesses give evidence about the first consultation and having observed their demeanour while doing so, prefer the evidence of the complainant that there was no discussion of revision surgery at the first consultation. This should not be interpreted as indicating that those members consider Mr Stubbs deliberately misled the Tribunal on this point. Rather they consider that his recollection is (not for the first time) at fault and that the complainant is correct in saying that at the first consultation Mr Stubbs outlined the steps he would take by way of investigation of her symptoms and that there was not at that stage any discussion of revision surgery. One member of the Tribunal firmly believes, on the basis of the evidence and the manner in which it was presented, that the issue of a revision operation was raised at this consultation. The other member considers that Mr Stubbs had a good enough idea of the basis of the problem to discuss the likely treatment and that it is probable that revision surgery was then discussed.

Were risks attaching to revision surgery discussed at the first consultation?

9.18 **ONCE** again there is a clear conflict in the evidence. The complainant's position is that since revision surgery itself was not discussed there was no discussion at the first consultation about the risks that it might involve.

The starting point for consideration of Mr Stubbs' response to the complainant's evidence on this point is paragraph 8 of his written evidence. Referring to the first consultation he said:

"It was on this basis that I indicated the risks to be higher than the 1 – 2% chance of dying and 5 – 10% chance of major complications (particularly leakage) which I normally quoted for the initial surgery."

In paragraph 9 he said:

"I also indicated that my research records indicated she had had a minor leak, but which had not required re-operation, following the first operation and a pulmonary embolus (PE). These facts meant that she would be at increased risk of both these events if revision surgery was undertaken, and I pointed this out."

Mr Stubbs was thoroughly cross-examined on this issue. Having agreed that on 22 October he had not confirmed a diagnosis he faced a suggestion from Ms McDonald that even if it were in his mind he would hardly be in a position of advising the complainant of risks associated with gastric revision surgery before he had confirmed the diagnosis. He said that he did not accept that. He said that he was sufficiently confident in his own mind that in what was always a good amount of time he would begin to discuss where we go from here and the fact that he did discuss that at that time was merely a reflection of his confidence that when he did the investigations he would confirm that to be the case. Ms McDonald asked him why, before he had confirmed his diagnosis, he would be outlining to the complainant all of the risks and complications associated with a procedure which she might not have. He replied, *"I can just say that in my own mind I knew where she was going, and it was time to begin, make use of consultation time, and begin the process of discussing what was likely to be the solution."*

To a suggestion that, even accepting that it might have been in his mind, he would not unnecessarily worry a patient before being in a position to confirm his diagnosis and give her advice as to what to do next, he gave the answer noted in 9.13 above.

Asked what he told the complainant on 22 October about risks he replied that he told her she was likely to need a revision operation which would have entailed a re-stapling and that operation was a more hazardous one than the first time around because of the presence of adhesions that made access more difficult. He said that he indicated to her that he knew she had had a minor leak the first time and that meant that things would be additionally difficult and that the prospect of a leak occurring again was present. He said that he indicated that she had had a pulmonary embolus on the previous occasion and that anybody who had had one pulmonary embolus and deep vein thrombosis at surgery was at risk of having another. He said that certainly those were the two points on which he was very clear other than the general statement he makes to all patients undergoing this sort of surgery that the risk of dying is somewhere between 1 and 2% *"though a little greater in this context"* and the overall risk of complications is somewhere between 5 and 10%. Asked:

"So you gave that all to her on 22 October did you?" he replied *"Yes I did"*.

9.19 **A** little later he was asked *"Is it the position that that is what you expect you would have done rather than a specific memory of it?"* He answered *"There are aspects of which I have a specific memory."* Ms McDonald asked *"What are those aspects?"* He replied: *"Those are of Mr/Mrs A sitting before me and my describing transection to them, explaining why that was a better procedure, explaining the conference I*

had just attended and explaining my concerns about that as a potentially more difficult procedure." (The answer continued with further detail).

9.20 **THIS** answer must in fact have related to the consultation on 18 November since the complainant's husband was not present at the first consultation on 22 October and it is common ground that transection was not discussed until the second consultation.

9.21 **MS** McDonald continued: *"So that's what you say you have a specific memory of as opposed to your expectation of what your general practice is?"*

Mr Stubbs replied: "Yes, I can see them before me before today."

Ms McDonald: *"And that is all on 18 November?"*

Answer: *"That particular conversation was on the 18th"*

9.22 **THE** cross-examination continued:

"So you are relying on what you would expect you would have done on 22 rather than on a specific memory?" ... "I know also, though I don't have such a specific memory of the occasion, but I know also that I spent some time talking about revision surgery generally and that I did that on an occasion before I knew about transection. There is only one occasion on which that conversation could have taken place. That is how I know it was on 22 October." "So your actual memory of 22 October is based on a recollection that you have of discussing revision surgery generally and that must have been at that consultation because that was the one before 18 November consultation?" ... "That's correct". "Other than that you don't have a specific memory and you are relying on your notes?" ... "That's correct"

9.23 **LATER** Ms McDonald returned to the subject of the first consultation and the cross-examination continued as follows:

"What you mean by that I take it from what you've said in answer to my earlier questions is what you now expect you would have said from your usual practice to have been discussed?" ... "No, I said before there are some points on which I have

a clear recollection, there are some on which I simply discussed them with all patients." "And what you said to me of what you know you discussed on 22nd was that you mentioned revision surgery?" "... Yes." "And the matters covered in your notes?" ... "I began discussing how her symptoms would have come about and the likely solution would be revision surgery. And what that would entail." "But you have no specific memory of discussing the specific risks that you say you remember talking about on the 18th?" ... "I think that's probably fair, that other than discussing revision surgery and then I don't have a clear recollection of that consultation in terms of the specifics, no."

9.24 **SUBSEQUENTLY** Mr Stubbs confirmed that the letter dated 28 October to Dr B did not refer to any risks or complications associated with revision surgery. He disputed Ms McDonald's suggestion that what he conveyed to Dr B in that letter was likely to be what he conveyed to the complainant on 22 October with maybe a little more technical information in it. Ms McDonald put it to him that if he were advising the patient of possible risks, complications and dangers associated with revision surgery, and he was going to the trouble of writing to her general practitioner, he would mention the possibility of associated risks to the general practitioner. He replied that today he thought you would find that that is almost invariably the case but in 1993 issues about documentation of the informed consent process - not of conducting the process but of documenting it - were less universal than today. He accepted that his notes and letters did not document his discussion of risks but said that at that time that was not an uncommon practice. He agreed that his letter did not indicate that he discussed risks. He did not agree that that meant he did not discuss them.

9.25 **AT** a later stage in the cross-examination Ms McDonald asked Mr Stubbs:

"What did you tell (the complainant)?" ... "I told her the risk of dying from gastric by-pass is 1-2% and that in revision surgery it might be somewhat greater than that, and the risk of serious complications in first time surgery is 5 to 10% and the risk of that in revision surgery is likely to be somewhat greater. I have no recollection of anything more specific in terms of figures or percentages than that." "Are you

saying you would have said that because that's what you expect you would have said or you have a specific recollection of that?" ... "I know that is what I always say and I don't believe there are patients who won't be told that. In terms of (the complainant) I have a clear recollection of discussing the risks of dying/leakage and those are the figures so I know I discussed the risk of death, I know I discussed the risk of complications, and those are the only figures I really ever talk about in this context."

9.26 **THE** Chair then asked Mr Stubbs:

"You have just told Ms McDonald what you say you said on that topic. For my edification did you say that on the first 1993 consultation, the second 1993 consultation or both?"

Mr Stubbs replied:

"I know I discussed it on the second with (the complainant and her husband) present. I believe I would have also discussed it at the first because I began discussing revision surgery and I cannot conceive that I would do that in the absence of a discussion of the risks."

The Chair asked:

"But is your position, to put it fairly and if I don't correct me, that you have no specific recollection of saying that on the occasion of the first consultation?"

Mr Stubbs replied:

"I think that's fair. I think that's fair, yes."

On this topic there was further discussion (recorded at pages 189-191 of the notes of evidence). Mr Stubbs told the Chair, in relation to the first consultation, that he recalled discussing revision surgery and the general risks and increased risks of that. He said that he did discuss at that time the issue of revision and what that entailed and that there were specific risks associated with it. He said he was much more specific about those risks at the second occasion (the consultation on 18 November 1993). With reference to the first consultation he said:

"So, I think I cannot specifically recall discussing those figures, though I imagine I would have done so because it was my usual practice, but I do not specifically recall discussing those figures at the first occasion, though I did discuss the risks, meaning generically what could happen - death, clots in the lung etc, but I quantified those risks as well as I was able on the second occasion when we honed in on transection ...."

The Chair asked:

"So you did not - you have no specific recollection of discussing the figures on the first consultation, is that correct?" The answer was: *"Yes."*

The Chair then referred Mr Stubbs to his statement in paragraph 8 of his written evidence that (at the first consultation) he indicated the risks would be higher than the 1-2% chance of dying and the 5-10% chance of major complications which he normally quoted for the initial surgery and asked Mr Stubbs whether he still adhered to that statement. The answer was: *"Can I say yes, but by way of explanation, there are two levels on which I have considered what I told her. What I believe I recall being discussed and what I imagine I discussed because I always did so. I believed that she received the booklet and the general - my expectation would have been that it would have been on the first occasion. That being the case, I believed I would have discussed those figures but I believe I would have discussed. That falls into the category of what I expect I did, but I think I must acknowledge that on that first occasion my memory is not so clear for me to be able to say "I said 1 to 2% risk of dying, 5 to 10", but I know that when I talk about the risk of dying, and of complications, I always put the figure to it. So there is a blurring of what I clearly recall saying and what I always associate myself as saying with a particular, in a particular context."*

9.27 **THE** Chair then asked him to look at the sentence in paragraph 9 of his written evidence in which he had said (with reference to the first consultation) that these facts meant *"she would be at increased risk of both these events if revision surgery was undertaken, and I pointed this out"*. The Chair asked him whether he still adhered to the contents of that sentence. He replied *"Yes, but I'm not sure at which consultation that might have occurred ...."*.

9.28 **HAVING** seen and heard the witnesses give evidence on this point and having noted what Mr Stubbs said when questioned about it the same three members of the Tribunal have a clear preference for the complainant's evidence on this point and find on the balance of probabilities that at the first consultation there was no discussion of the risks, complications or dangers associated with any revision surgery which might later be recommended. The other two members of the Tribunal are not satisfied that no discussion of risks occurred but accept that there was certainly no adequate discussion of the risks and complications of revision surgery at that time.

9.29 **THE** Tribunal's findings so far in the case are thus that:

(a) Prior to the consultation on 18 November 1993 the complainant did not receive Mr Stubbs' information booklet (which, of course, referred to the risks of gastric stapling and not the risks of revision surgery);

(b) She also was not warned at the first consultation of any risks, adverse effects and complications of revision surgery.

9.30 **THERE** was a further telephone call between Mr Stubbs and the complainant before the consultation on 18 November but there is no suggestion by Mr Stubbs that there was any discussion about risks etc during it. Accordingly, and since the consultation on 18 November represented the last contact between the complainant and Mr Stubbs prior to the date of the surgery, that consultation is the only remaining time at which Mr Stubbs could have given the complainant sufficient advice to ensure that any consent which she gave to the proposed surgery was indeed informed consent.

10. THE SECOND CONSULTATION - THE CAC'S EVIDENCE:

10.1 **THE** complainant's evidence in relation to the second consultation will be dealt with in Section 13 of this Decision.

10.2 **IN** her opening address Ms McDonald indicated that it was intended to call evidence from the complainant's husband who was present at the second consultation. For reasons which were made known to the Tribunal in private the complainant's husband did not give evidence at the hearing. A written statement of his proposed evidence, which had previously been lodged with the Tribunal, was therefore returned to counsel for the CAC along with all copies which had been made of it and the contents of that statement were not able to, and did not, play any further part in the hearing.

10.3 **EVIDENCE** was called from the complainant's older sister who was familiar with the complainant's ongoing difficulties and had been involved in them over a number of years. Her evidence was that she and the complainant had always been close and that they have often discussed medical problems.

10.4 **SHE** gave evidence that, shortly after the complainant and her husband had met Mr Stubbs (on 18 November 1993) the complainant telephoned her, on that same day, to discuss what Mr Stubbs had told her. She said that when the complainant spoke to her the complainant was *"wavering"* about whether or not she should have the operation in case it would interfere with her studies at the xx. She said that the complainant decided, however, to have the operation because she had been assured by Mr Stubbs that she would be in and out of hospital in a maximum of ten days and the surgery would improve the way she had been feeling for some time prior to the operation.

10.5 **THE** complainant's sister said that she herself was aware that there were always risks with any kind of surgery but that she could not recall that, at any time during her conversations with her sister prior to the operation, her sister had ever mentioned that the surgery could be life-threatening or involve severe complications. The sister said that because of the closeness of her relationship with the complainant she was positive that the complainant would have mentioned such a thing to her when they were discussing whether or not the complainant should go ahead with the surgery.

10.6 **THE** sister said that she is convinced that if the complainant had learned that there was a chance that she would have to spend many months in hospital recuperating from the operation then she would not have considered having the surgery at the time she did. This was because the complainant was very close to finishing her four year course at the xx. As far as the complainant was concerned, however, she would be able to recover from the operation over the Christmas period and then continue and complete her studies the

following year. The sister gave evidence that the complainant had since said to her that, although she would have been a bit uncomfortable because of the pain she was in she would have completed the xx course and simply put up with the pain.

10.7 **HER** evidence was that knowing the complainant as she does, and knowing the complainant's desire to finish her xx course, she believed that if the complainant had known of the risks of serious complications that she would face after the operation, she would not have gone ahead with the operation. She knew that the complainant wanted to try to stem the pain caused by the peptic ulcer but she also knew that the complainant would not have risked her own life to do this and would not have had the operation at that time because of her xx course.

10.8 **IN** cross examination the sister said that she thought that if Mr Stubbs had mentioned to the complainant that there was a large risk, or a risk, that she was not going to be able to complete her course the complainant would have told her.

10.9 **THE** Tribunal considered the sister to be a good witness whose evidence was not in any way shaken by cross examination. She was not, of course, present at the consultation on 18 November and the weight to be given to her evidence depends substantially on the closeness of her relationship with her sister. The Tribunal accepts that they are close. It also accepts the sincerity of her belief that if the complainant had understood that there was a risk of a prolonged stay in hospital which would or might interfere with her ability to complete the course she would certainly have mentioned it to her sister and have given consideration to at least delaying the surgery. The sister's evidence may therefore well be a pointer to the complainant not having understood, as a result of the second consultation,

that there was such a risk but it cannot be determinative of whether Mr Stubbs warned the complainant that there was such a risk.

11. EXPERT EVIDENCE

11.1 **THE** CAC called evidence from Professor Collins, Associate Professor in general surgery at the University of Auckland. Based at South Auckland Health he was head of General Surgical Services there between 1993 and 1997 and has since then been head of the South Auckland clinical school. He is the incoming Senior Examiner in General Surgery for New Zealand. He told the Tribunal that candidates who are sitting their graduation examination in surgery are often asked what they understand by informed consent and issues surrounding that. He believed, and the Tribunal accepts, that he was adequately qualified to comment in relation to informed consent, in 1993 and now.

11.2 **MR** Stubbs proposed to the complainant at the second consultation that she should undergo the surgical procedure known as gastric transection. That procedure needs to be distinguished from gastric revision. In the latter the staple line created at the time of the original gastric by-pass surgery is re-done. A new row of staples is placed across the stomach to stop food leaking into the distal part of the stomach. It was the common way of dealing with a staple line which had broken down. In gastric transection the top pouch is, by surgery, completely separated from the bottom part of the stomach so that they are not in contact. Mr Stubbs learned about the transection procedure at a conference in Australia which he attended between the first and second consultations with the complainant and, at the second consultation, indicated his belief that the revision surgery should include transection rather than re-stapling if possible.

11.3 **PROFESSOR** Collins' evidence was in substance that, in relation to the proposed gastric transection, the complainant was at an increased risk of complications of that major surgery (as he described it) for the following reasons:

1. The two previous abdominal operations which she had had would make access to the site of her proposed gastric surgery difficult due to adhesions.
2. The leak from the previous gastric by-pass would make her surgery even more difficult and hazardous.
3. Because of her previous leak (at the time of the original gastric by-pass surgery), the likelihood of another leak after the proposed surgery would be increased.
4. If a leak did occur then the consequence for the complainant would be *"enormous"* in terms of a threat to her health and involving a prolonged stay in hospital.

Professor Collins said that against that background it would be normal in clinical practice to inform that patient of those risks.

11.4 **HE** said that informed consent would then be based upon providing the patient with;

1. An outline of the problem, why surgery was necessary and whether any alternative treatment was possible.
2. An outline of the proposed operation in understandable terms.
3. An outline of the risks involved with the surgery and the reasons for those risks.
4. An outline of the possible consequences of these risks.
5. Confirmation that the patient understood the above four.

11.5 **PROFESSOR** Collins said that there was a significantly increased risk to the complainant involved in the transection surgery. He said that a surgeon, having made the diagnosis, would normally explain why the surgery was necessary, outline the proposed surgery and then go through what are the most important risks because in clinical practice you cannot go through every tiny risk. So you would cover the major risks. In this kind of surgery, he said, it is very easy to puncture the bowel or the intestine and so a patient may have a leak from that. He thought that was probably the most significant one. The other would be the possibility of haemorrhage during the surgery which is a risk in all surgery but particularly in difficult surgery. Because this was such major surgery, and death could be a possibility, albeit a small one, one would cover that also. Asked how he would seek confirmation from a patient that they have understood an explanation of risks he said that he thought that in clinical practice it was the most difficult to achieve but that he would ask the patient to explain back to him first of all if they understood the risks could they understand what the surgery was about and the outcome of the risks. He thought that was particularly important when you have time in an elective, booked, operation.

11.6 **PROFESSOR** Collins said that based on what the complainant had said in her evidence she was not in a life-threatening situation (at the time of her referral to Mr Stubbs in 1993) and therefore the timing of her surgery could be altered but the only way to manage her symptoms would be revision. Directed to a form which the complainant had signed before the surgery he agreed that it did not give any legal or other guarantee that the patient had been informed about the various points he made concerning informed consent. What the patient was asked to sign was that they had received reasonable explanation of the procedure and that the patient accepts the advice of the caregiver. He said that in 1993 it

might not have been universal but may have been common for a surgeon to make some sort of record that advice about risks, alternatives and so on was given. Asked whether it was common practice to his knowledge he said that he thought the Medical Defence Union and the Medical Protection Society, right from probably 1990, and documents which had been sent from the College of Surgeons, had requested practitioners to record what they had told the patient and that they had discussed the risks. He said it was probably in the last seven to eight years that that had become a major issue for the College of Surgeons and as a reflection of that young surgical trainees were asked in examinations about that.

11.7 **HE** told the Tribunal that his current practice was to involve the patient in reading back to him or communicating what they understood and that he had done that for probably five years. He said that it was not his practice seven years ago. He indicated that it was over the last seven or eight years that there had been a recommendation that informed consent aspects be put in writing by surgeons.

11.8 **IN** his written evidence Mr Stubbs said: "W*ith regard to the statement of Mr John Collins, I agree with the points he raises and confirm that they were all addressed by me with (the complainant) in the course of my two consultations with her".* He told the Tribunal that those words meant that Mr Collins' points were covered in one or other of the consultations - in the course of the two rather than in each. He said that the only point of Mr Collins' which he had some reservation about was point 5 as to how it was to be achieved. Asked whether he thought it was actually in the interests of both the patient and practitioner for the practitioner to ask something like *"What risks do you, having heard me, understand are involved?"* he said that having been through this process he

could see that that is so. He said he would not have thought of that in such clear terms prior to this sort of experience.

11.9 **COUNSEL** for Mr Stubbs called evidence from Mr Sorrell, a General Surgical Specialist recently retired from the position of Clinical Head of General Surgery for South Auckland Health. Since 1968 part of his practice had involved surgery for morbid obesity which he described as a small sub-speciality of general surgery. Since 1974 his practice had involved both primary gastric procedures and a much smaller number of revision procedures.

11.10 **MR** Sorrell told the Tribunal that the operation of gastric by-pass performed in 1986 would be regarded as a drastic form of treatment. It was only performed after the possibilities of conservative treatment had been completely exhausted. He said that one of the main sequelae of that operation was breakdown of the staple line, allowing food to pass between the two gastric pouches. The result was often weight gain and, because of the altered gastric physiology, ulceration at that point. Bleeding from that could be fatal. Sometimes it might settle with conservative treatment but often recur. The proposed surgery to correct it involved separating the two gastric pouches either by re-stapling or by stapling and dividing between the staple lines.

11.11 **MR** Sorrell said that this might sound simple in theory as there would be no need to join up the small bowel again. However in practice he said it was known to be hazardous. He referred to a report on revisionary gastric surgery and quoted a series with an increased

morbidity (serious complications) and mortality (death) of revisionary surgery of respectively 71.8% and 12.5%.

11.12 **MR** Sorrell indicated that early complications of the revision surgery included prolonged surgery time with re-dissecting the stomach, damage to adjacent organs including the spleen, small bowel obstruction, free leak from the stomach into the abdomen as well as pulmonary embolus and other respiratory complaints. He said that the result might be death and that for those reasons the surgery was usually only undertaken by very experienced surgeons in the field and only after full discussion of the risks.

11.13 **MR** Sorrell also said in his evidence in chief that he would have expected that in 1993 at the consultations prior to the revision operation Mr Stubbs would have:

(a) discussed with his patient the reasons for revisionary surgery;

(b) discussed the basic technical details of the proposed operation, what he intended and how he would go about it;

(c) advised his patient of the risks of the procedure to the extent that they were known to surgeons in 1993;

(d) assured himself that the patient actually knew what the risks of primary surgery had been and what the risks of revisionary surgery were and of the possible outcome from those risks.

Mr Sorrell said that knowing Mr Stubbs as he did he would be extremely surprised, and extremely disappointed, if Mr Stubbs had not explained the risks sufficient for informed consent.

11.14 **IN** oral evidence in chief, Mr Sorrell said that he would have thought Mr Stubbs would have been thinking and talking of the most likely course which would have been a reasonable stay in hospital and not a prolonged stay with excessive complications. It would have been reasonable for Mr Stubbs to be thinking and talking in those terms. The most likely course was that with the transection operation on 8 December the patient would have recuperated and be up and about by February some eight to ten weeks down the track. He said that what had in fact happened was that the patient had developed a complication and a series of events which followed on from that which would be quite unusual in his experience. There would certainly be a small percentage chance of that sort of thing happening. The chance of a complication going on into a series of repeated operations and the length of time involved here would be unusual in his experience and from his reading of the literature and discussion with colleagues at meetings.

11.15 **MR** Sorrell said that he would have expected a surgeon of Mr Stubbs' experience to point out, to a patient about to embark on re-section gastric by-pass, that this was the most likely way of correcting her problem both in the short and long term but there would be a risk involved – a known risk for primary and more for revision surgery which could involve death and other significant complications. Those were the two main things he would expect Mr Stubbs to be telling this patient.

11.16 **COMMENTING** on articles produced by Mr Stubbs and relating to the recall, or lack of recall, of patients who, following pre-operative consultations, were subsequently interviewed to determine the extent of their recall of risks of which they had been warned,

Mr Sorrell said that he had not previously seen them but that they would be in line with his general experience of patients, particularly in this field and possibly more so in this field than other areas of more simple surgery. He said that patients presenting for these operations, both primary and secondary, have a number of slightly different problems from some of the patients with simpler operations. Most of them have had a life-long battle with their problem of obesity and there are a number of difficulties they have encountered over the years so when they come for discussion they are really looking for a quick answer which is "*yes you can have an operation*" and they tend to blot out a lot of information and he thought that carried on later on in terms of what they recall from the detailed discussion at interview. He thought they were a set of patients that have slightly different problems in relation particularly to recall.

11.17 **CROSS-EXAMINED** Mr Sorrell said that the transection procedure had significant increased risk. He said that gastric revision by re-stapling carried an increased risk over and above the original gastric by-pass and that transection carried an increased risk again over and above general revision. He would certainly have expected that to be made clear to the patient and he would have done that.

11.18 **QUESTIONED** about the articles on recall he said that the uniqueness of the surgery and the different problems which such patients have would make him more aware than ever to ensure the patient had well and truly understood his explanation of risks/complications and consequences. He also said that that was the reason why the patient always had more than one consultation and that that was also the reason why you always include a partner or a very good friend in the discussion and do everything you can to ensure that the partner

or very good friend is understanding what you are saying. He said that he would want the patient to go away from the first consultation well and truly understanding that there were significant risks they need to think about and that he would mention them at consultation one so that there was an interval to think about it before consultation two occurred. In the context of this case he said that if nothing was mentioned at the first consultation about risks/complications and consequences he would probably have had another consultation, in other words two involving discussion about the actual operation.

11.19 **HE** said that his view about revisionary surgery was that it's a risky business which has to be done at times. There are different views from different surgeons about the best way of going about it. Transection is only one view. He had not himself done a revisionary transection. He accepted that there is a slightly increased risk with transection. He said that he had included in his written evidence reference to the paper alluded to in paragraph 11.11 of this Decision to say there was a greatly increased risk with revisionary surgery and that this was widely accepted. He also said that he had included that reference in his evidence to demonstrate the increased risk associated with revisionary surgery but also to make it clear that it wasn't just his impression that there was increased risk; there were facts to back that up.

11.20 **ASKED** by Professor Gillett for his best estimate of the serious complication risk, he said that morbidity covering everything, all risks, could be as high as 15% or 20%. Asked what he would now estimate as the risk of serious complications given transection revisionary surgery he said that he would put that up another 5% on what he had described. It was put to him by Dr Gleisner that in paragraph 24 of his written evidence

Mr Stubbs had said "*the risks as I stated before (being something more than 1-2% chance of dying and 5-10% chance of serious complications).*" Dr Gleisner suggested that there was a significant difference between that and the figures which Mr Sorrell had quoted. Mr Sorrell said that there are different ways of describing morbidity and it could include relatively minor things like wound infection and you would not necessarily include that in significant serious risk so slightly different things were being talked about there. Asked whether the sentence in Mr Stubbs' evidence accurately reflected the risk or understated it, Mr Sorrell replied *"I think that's reasonably accurate, the 1-2% from the primary and 5-10% of significant, that is serious risks and we go up on that. It doesn't say how much it goes up but that's a reasonable comment to make."* Asked whether "*something more*" was reasonable Mr Sorrell said yes but he could not say how much more.

11.21 **REFERRED** to Professor Collins' written evidence and in particular his list of "*important points in informed consent in this situation*" and his list of five points upon which informed consent would be based he said that in general he agreed with the points but he had a problem with point 5 of what informed consent would be based upon namely "*confirmation that the patient understood the above four*" and how he actually ascertained that. Asked whether it would be possible for him to state all the risks and possible adverse effects to a particular patient and for that patient not to have understood a word that he said that is why you have the safeguard of two consultations normally and why you have another person to back that up. Asked whether his aim was to reduce the risk of the patient failing to understand fully the risks which had been outlined he said that it was a matter of failing to understand and failing to accept because they did not necessarily

take in or want to accept some of the things (the surgeon) was telling them. Asked how, if you do not ask the patient to tell you what risks you have just outlined to them, you know that they have (a) understood and (b) accepted the risks he said that he did not think you do. Again this was the point of having the other person (present at the consultation). He did not think there was any way of being absolutely sure everything you have told the patient has been understood and accepted. Asked whether there was not a way in the form of asking the patient to state what his/her understanding of the risks involved was he agreed. Asked whether he accepted that the obligation on him was not only to explain the risks but to ensure that they had been comprehended and accepted by the patient he said "*yes I think that's the counsel of perfection*". Asked whether it was only a counsel of perfection or whether he would think that that was an obligation which he as a reasonably competent medical practitioner should accept he said that he thought one makes every effort one could but that to achieve what the question was putting to him was really only something you could obtain by an exam, as it were, with the patient filling in the questions. He said that he would accept that the surgeon should ask the patient '*have you fully understood the risks which I have tried to explain to you?*" or words to that effect. He said that during the to and fro of a consultation you normally ask them to indicate whether they've understood and that this occurs at various points in the consultation.

11.22 **HE** accepted that it was not just a matter of the medical practitioner saying what the risks were and that the process of obtaining informed consent involves more than that. He said that except for the reservations he expressed as to point 5 of Professor Collins' evidence (the point relating to confirmation that the patient understood the above 4 points) he had no other quarrel with what was on that page.

11.23 **ASKED** by the Chair whether he thought it was adequate to say to the patient *"this revisionary surgery involves a risk which is somewhat higher, or something more, than 1-2% and 5-10%"* and leave it at that he said *"No, I don't think you would normally leave it at that because usually you would expect the patient to respond to that and you go on to talk about what those percentages mean." They would say "what do you mean, I might die, what from?"* and you go through a list of things, embolism, cardiac episode, leak etc, and there is this dialogue over that. Asked whether he would make some attempt, however difficult it might be, to quantify the increase in risk arising from it being revisionary surgery he said that it was very difficult to put a figure on it because there are not good publications in the area except to stress there is increased risk. As to whether, given the difficulty of quantifying it, that meant that in practice what was really important was to ensure that the nature of the risks was fully understood by the patient he said that the nature of the risks is a difficult one. You are talking about the most common risks and a series of other things that might happen and that it was difficult during any consultation to outline that. He agreed that it was reasonable to expect that material risks would be identified by the practitioner and explained to the patient in a way that could readily be understood and said that he would expect that to be the basis of the consultation.

11.24 **HE** said that if he had been quantifying the risk he would put the percentage for morbidity at 15-20% and 25% with the transection but repeated that he was talking about major and minor complications which was different from the serious risks. When it was put to him that if talking to a patient he would want to talk about informed consent risks both major

and minor he said that it was actually very difficult to cover all the rare possibilities as well as the main ones. When Ms McDonald put it to him that the position was that this was a very risky procedure with a patient who had had a history of problems and that he would want to make sure that she had a very clear understanding that this may not be plain sailing and that he would not want her to be left feeling that this was going to be straight forward, he said *"exactly, that is what happens, you put this before the patient and they say they want the operation given what you've told them"*.

11.25 **TO** further questions he said that whereas Professor Collins had said that if a leak did occur the consequences for the complainant would be *"enormous"*, he would have used the word *"considerable"*. Asked about whether a prolonged stay in hospital was a material risk, he said that was difficult to quantify. *"You can have a serious risk dealt with quite quickly which does not result in a prolonged stay and some that do result in a prolonged stay so it would be a maybe rather than a must be."*

11.26 **ALTHOUGH** the evidence of the experts was lengthy the Tribunal's view is that there was substantial agreement, from both Mr Sorrell and Mr Stubbs, with Professor Collins' *"important points in informed consent in this situation"* and at least most of what he said *"informed consent could be then be based upon providing the patient with"*. The Tribunal generally accepts Professor Collins' evidence, regards it as a commonsense and reasonable approach to what the circumstances called for and considers that it provides the Tribunal with clear guidance as to the risks which were both inherent in the proposed surgery and material to the complainant and therefore needed to be appropriately canvassed in the consultation on 18 November 1993.

11.27 **IT** should however be noted that the Tribunal does not unhesitatingly adopt the opinions expressed by practitioners who give *"expert evidence"*. Thus, while expert medical opinion is relevant to the question of materiality of risk, evidence of what other doctors would have said, or currently say, or as to how they assess the requirements which the particular circumstances imposed on Mr Stubbs, will not be determinative of whether a particular practitioner has sufficiently informed a particular patient. Neither the Courts nor this Tribunal will defer to the clinical judgment of medical practitioners as to what a patient should be told. Whether the duty on a doctor has been performed in a particular case depends on all the circumstances and is not determined by medical practice.

12. WHAT DID THE CIRCUMSTANCES REQUIRE OF MR STUBBS?

12.1 **THE** Tribunal has already found on the balance of probabilities:

12.1.1 that the complainant was not given Mr Stubbs' booklet (not that it dealt with revisionary surgery, or the risks associated therewith, in any event);

12.1.2 (by a majority) that at the consultation on 22 October Mr Stubbs gave no advice to the complainant about the risks associated with revisionary surgery (and certainly gave none about the risks associated with revisionary transection surgery because the question of transection could not have been and was not discussed between him and the complainant until after he returned from the conference in Australia and raised the matter with the complainant, in an enthusiastic and positive way, during the second consultation).

12.2 **SINCE** the second consultation was intended to be the only remaining consultation before the surgery (if the complainant agreed to it) it was essential that at that consultation Mr Stubbs adequately explained to the complainant not only the risks which were inherent in the procedure, even if skilfully carried out, but also any risks which were material to a reasonable patient in this particular patient's circumstances (see the legal principles quoted in paragraphs 5.5 and 5.7 above). The possible consequences of those risks also needed to be explained to the complainant (as both Professor Collins and Mr Sorrell said).

12.3 **IT** was common ground between the parties that a practitioner is not entitled to rely on advice as to risks, complications and consequences which he gave on an earlier occasion or which he knows or assumes another practitioner may earlier have given to the same patient. He must accept a fresh obligation of ensuring that he imparts sufficient information to his patient to enable him/her to make an informed choice as to whether to undergo the surgery which is being recommended.

12.4 **ASKED** by the Chair to specify the *"possible risks and adverse effects of the surgery"* (the words used in the charge) which the CAC alleged Mr Stubbs failed to adequately inform the complainant of Ms McDonald said that the first issue was the risk of death, the second (taken principally from Mr Sorrell's evidence) was major complications of the surgery including leakage, pulmonary embolus, infection, damage to adjacent organs, respiratory complaints and other major complications and the third was that the consequence of those major complications would need to be explained. In particular there would need to be explained to this complainant the possibility of a prolonged stay in hospital, the need for further surgery and the need for transfer to the public system.

12.5 **THE** Tribunal needs to be careful not to impose standards which are determined with the advantage of hindsight. Nor should it impose standards which require medical practitioners to give full information about every possible eventuality, no matter how insignificant or remote it may be from the circumstances of the patient. Risks which are far-fetched or fanciful need not be disclosed. The duty is to provide the patient with the information necessary to enable the patient to exercise informed choice about whether or not to undergo treatment. All circumstances which are material to the decision the patient has to take should be disclosed (as the Chief Justice said in her paper in June 1999) and - as she also said - that requires disclosure of risks material to a reasonable patient in the position of the actual patient. The duty imposed on a medical practitioner to disclose risk is a duty to communicate it in an appropriately effective way. The right to effective communication in a form, language and manner which enables the patient to understand the information provided is now recognised in Right 5 of the Code of Health and Disability Services Consumers' Rights.

12.6 **THE** question of materiality is not one of assessment of clinical risk alone. The significance likely to be attached to risk is dependent upon the magnitude of the risk, the nature of the potential harm, the need for the treatment itself and the circumstances of the particular patient. Assessment of materiality in cases of disclosure is always undertaken against the backdrop of the facts of each case. Thus a risk which may be of little or no materiality in one case could be highly material in another.

12.7 **FINALLY** it may be noted that in her paper the Chief Justice expressed the view that the doctor's obligation to inform the patient about matters material to the patient's decision about medical treatment (and in particular questions of risk) does not depend upon the patient having enough knowledge to ask the right questions. Risks which are inherent in treatment competently performed, and which are not insignificant, must be disclosed unless perhaps obvious to the patient. So too must any particular risks which affect the particular patient.

12.8 **IN** the circumstances of this case the Tribunal considers that:

(a) The revision surgery by transection which Mr Stubbs was recommending was plainly going to be difficult, hazardous and dangerous surgery.

(b) Any revision surgery carried greater risks than the original 1986 by-pass surgery and the 1990 operation.

(c) The two previous abdominal operations would make access to the site of the proposed transection surgery difficult due to adhesions.

(d) The leak which the complainant suffered at the time of the gastric by-pass was capable of making her 1993 surgery even more difficult and hazardous.

(e) There was a risk of a further leak, or damage to adjacent organs, arising in the course of or as a result of the transection surgery. (The risk of damage to adjacent organs materialised and the complainant's spleen had to be removed by Mr Stubbs in the course of the December 1993 surgery. The matter is not, however, being judged with the advantage of that hindsight. The risk of damage to adjacent organs during the proposed surgery was always foreseeable.)

(f) There was a risk of death and that risk was probably of the order of double the risk of mortality attaching to the original gastric by-pass surgery.

(g) There was a risk of serious complications developing; that risk was probably of the order of (and perhaps even higher than) double the risk of serious complications attaching to the original gastric by-pass surgery and was further increased due to the fact that what was proposed was not merely a re-stapling operation but involved transection.

(h) In the particular circumstances of the complainant, involving her being a relatively young woman with children, her studying for and passing examinations and her having to resume her xx course in February so as to be able to complete it and become qualified as a xx, (circumstances which were known to Mr Stubbs) there was a risk that if a leak or other serious complication occurred, could not promptly be remedied and persisted she might require longer hospitalisation than would be the case if everything went smoothly and might not be able to resume her course early in 1994.

(i) The risks set out in (e) to (g) above were material risks which were inherent in the proposed surgery, even if skilfully performed.

(j) The risk set out in (h) above was highly material to a reasonable person in the circumstances of the complainant.

(k) All of the risks in (e) to (h) needed to be disclosed to the complainant in an appropriately effective way so that she could understand them and decide either to accept them and undergo the surgery or that she did not wish to accept them, at least at that stage.

12.9 **THE** Tribunal considers that on the evidence it was not imperative that the complainant undergo the surgery in December. Certainly she had pain and unpleasant symptoms but, as she pointed out, she had coped with those well enough to pass examinations between the first and second consultations. Mr Stubbs, in one of his letters, himself said that she had been coping. She was, the Tribunal considers, entitled to be fully informed about the nature of the surgery which was proposed and the risks identified by the Tribunal and set out in 12.8 above. Without requiring far-fetched and fanciful risks, or those which were so remote as to be regarded as practically immaterial, to be disclosed the circumstances nevertheless called for an assessment of the risks identified in 12.8 above, and the consequences if any of those risks materialised, to be explained to the patient in a manner which enabled them to be readily understood by her. Finally it behoved Mr Stubbs, both as part of his duty to the patient and in his own interests, to do what he reasonably could to ensure that the risks which the Tribunal has identified were not only explained by him but understood and, if she decided to have the recommended surgery, accepted by the patient.

13. DID MR STUBBS ADEQUATELY INFORM THE COMPLAINANT?

13.1 **ONCE** again there is a conflict of evidence.

13.2 **THE** complainant said that on the occasion of the first consultation it was agreed that another gastroscopy was necessary to determine the extent of her problems and that this was arranged for and performed on 18 November 1993 at xx Hospital. Her husband remained in the waiting room while the procedure was being performed (by Mr Stubbs). After the gastroscopy had been performed she joined Mr Stubbs in his office and, after her

husband was called into the room to join them, Mr Stubbs discussed what the gastroscopy had shown. She told the Tribunal that Mr Stubbs explained to her husband and to her that:

(a) During his examination he had seen that her stomach ulcer seemed to be aggravated and that she had staple line dehiscence (meaning that the staple line from her original by-pass surgery had perforated).

(b) This dehiscence was causing food to pass down into the unused part of her stomach, to lie there and rot until such time as there was enough gaseous material built up to *"reflux"* back into the part of her stomach that she used.

(c) This in turn aggravated the ulcer and resulted in the foul smelling belches which she was troubled by.

(d) The problem could be fixed by surgery.

(e) He had attended a recent medical conference where weight reduction surgery had been discussed at length and at the conference he had learned that the most successful method of weight reduction surgery was now thought to be a total gastric transection (total separation of the stomach into two sections), rather than the gastric stapling used in the past, because of the very problem she was then experiencing.

(f) The staples and staple gun used in her first operation were now known to be inferior and this would have contributed to this problem.

(g) A gastric transection could be the way to prevent any recurrence of her condition.

(h) He would make a decision about whether or not to carry out a gastric transection at the time of surgery and that procedure would only be performed if there were no problems and the surgery was proceeding smoothly.

(i) He could refer her back to the public hospital system which, with waiting lists as they were, could take approximately 11 months (before she was operated on) but if she waited this long her condition would deteriorate significantly.

(j) In his opinion there was no-one in the public system at present as qualified as him to perform the surgery and she would be advantaged by using him because he was familiar with her case and anatomy.

(k) He could schedule the surgery in a few weeks and definitely before Christmas 1993.

13.3 **SHE** was adamant that this was the full extent of her discussion of the revision gastric by-pass operation with Mr Stubbs. She said she could recall the consultation with him very clearly. She said that there was never any discussion by Mr Stubbs of the post operative risk of complications or of the potential risk of death as a result of the operation. She said that in her view Mr Stubbs conducted the conversation in quite a casual way and led her to believe that a gastric transection, though major surgery, was a relatively straight forward procedure.

13.4 **SHE** said that the discussion with Mr Stubbs about the operation then changed to the costs involved. He estimated that her stay in hospital would be approximately 5 to 7 days and at the very outside 10 days. She reiterated that at no time was there any discussion by Mr Stubbs about the risks associated with this surgery. She said that the consultation would have been no more than 15 to 20 minutes in duration. She said that there was no discussion at all about the chance of any further leakage, or of any leakage because of her previous by-pass. She also suggested that she would certainly remember if death had been mentioned to her by Mr Stubbs (as a possible outcome). She said she had no

appreciation at the time that there were increased risks associated with this procedure from her 1986 procedure. She said she was very reassured by Mr Stubbs that (the proposed transection surgery) was a procedure that was very safe, that was perfectly within his expertise and that he was very sure about the fact that this was going to be what would fix her, that this would be a very good procedure for her and she was going to be fine.

13.5 **SHE** told the Tribunal that prior to seeking help about her problem she was studying full-time. The problem was an intrusion but certainly was not dominating her life. The symptoms were very unpleasant but she was able to function quite normally. Because she was involved in full-time study and in the third part of her degree, the most important thing for her was to enable her to be able to finish her studies and if that meant she had to wait to have the problem fixed then she was prepared to do that. She had 12 weeks of theory that she was going back to complete. After that 12 weeks she was to sit an examination and that would have completed her degree, or all of the theory part of it, as the practical time which she had to complete to finish the degree could have been done at any time. Those 12 weeks in which she had to finish her theory to complete the theory part of her degree were very important to her. Her evidence was that if anything had been said to her by Mr Stubbs about death or life threatening situations she had at the very least to consider her xx children and what she was going through at the time as she was in employment as well as studying. If she were going to be put in a life threatening situation she would take that in and consider it very seriously. She had her career to think about and if there were going to be any serious problems requiring long recovery she would have taken that into consideration as well and would either have had the surgery at a more appropriate time or certainly have weighed that option up very heavily. Questioned about a sentence in Mr

Stubbs' written evidence in which he said (with reference to the second consultation) *"I explained that there were reasons why this might be more difficult than re-stapling, and might entail a slightly greater risk – again principally of leakage"* the complainant said that that was not made known to her by Mr Stubbs on 18 November. As to the next sentence in Mr Stubbs' evidence namely *"(The complainant) was quite definite that she did not want to have a recurrence of the staple line problem, with return to experiencing pain and weight regain, and for that reason was very keen to have the transection if at all possible*." she said she recalled saying that she did not want this to happen again and Mr Stubbs was going into quite some detail about the gastric transection and this would mean this could not happen again. Asked what her comment would be if it were suggested to her that she was hell bent on having the surgery at this time, no matter what, she said that that was not true. She had other priorities, her career being the principal one, but certainly family were also a major consideration.

13.6 **SHE** said that her career was the principal consideration. It was important to her that nothing would jeopardise the completion of her course. Asked whether it would have been an option to have deferred any surgery until after that, she said certainly 12 weeks would not have made an awful lot of difference.

13.7 **THE** complainant said that at the second consultation it was almost as though Mr Stubbs was on a high about the conference. He was full of it, and was very confident *"very, you know, yeah, we will go and get this done, this will fix you and you'll be right"*.

13.8 **AS** to Mr Stubbs' evidence that he did not believe the complainant considered she had a choice to proceed with revision surgery or not she said that she thought we all have choices. She was in study and work and was coping with a family, was still walking around and studying, which she said was very stressful, and had sat examinations as well, which were also very stressful. She felt that if things were so bad that she didn't have choices she would have been admitted to public hospital as an emergency.

13.9 **ASKED** when her concern that Mr Stubbs did not fully advise her of the risks/complications of the transection procedure first arose she said that that was when she was in a position to think of it more clearly. She said that she was very very ill for a good year after the initial surgery so when the clouds began to part (approaching the end of 1994) she began thinking *"if I had known any of this might occur things might have been different"*.

13.10 **ASKED** about her ability as at 18 November 1993 to understand medical or technical matters which related to her particular medical condition she said that she did not think she was the brightest person in the world but could certainly understand if someone said *"you could lose your life over this or there are some severe things that could go wrong and these are what they are"*.

13.11 **SHE** also said that if Mr Stubbs had said to her *"do you think you understand or fully comprehend what you are about to go through?"* she would then have been able to say either a simple *"yes"* or *"no I have more questions"* but that was not put to her and she thought it would have been useful for it to have been put to her.

13.12 **IN** cross-examination she agreed that she was saying that Mr Stubbs told her virtually nothing about the risks and down sides of the transection procedure. Asked whether her position was that he had told her the *"whys and wherefores"* about how it would be done but nothing of the *"ifs and the problems"* she agreed.

13.13 **SHE** said that at the second consultation nothing was said about transection being a more serious operation with greater leakage prospects than before. Mr Stubbs had given her the impression that she would have recovered from the procedure that he was undertaking within the holiday period for her tertiary break. She agreed that she had had quite considerable major surgery prior to the revisionary transection. She said that she had had enough surgery to realise that there could be a number of post-operative risks and had experienced some but was certainly not prepared for what happened to her (following this operation) by which she meant the leakage and the consequent sepsis. She accepted that she had had a pulmonary embolus following the 1986 gastric by-pass operation but said that Mr Stubbs had not indicated to her that there was a greater risk of this for this next (gastric) operation because she had already had one. Mr James put it to her that she was being very selective in the evidence about risks that she was giving because she pitched it on the basis that she was not told she would have such a terrible time, therefore she was told nothing. She said that that was not correct, that she was told of the procedure and what the procedure involved and of the conference that Mr Stubbs had been to. She reiterated that her estimate was that the second consultation took about 20 minutes.

13.14 **MR** Stubbs' position was diametrically opposed to that taken by the complainant. Once again he found himself in the position of deriving no support, from his consultation notes or his letter to the complainant's general practitioner, for his claim that he had discussed with the complainant the risks of the proposed transection surgery. The consultation notes for the second consultation contained no record of risks having been explained to and accepted by the patient. In the letter of 19 November 1993 to the general practitioner Mr Stubbs said that the mass about which he had been concerned on 22 October was a low lying kidney, that the barium meal revealed staple line disruption at the side of the gastric by-pass and that the gastroscopy had confirmed superficial ulceration. He said that the way to solve ulceration was to close the staple line dehiscence which would prevent acid reflux back from the distal stomach. He said that she would do well to have a revision of her gastric by-pass both in order to achieve control of her ulceration and also to get control once again of her weight. The letter said that she would like to proceed with that.

The letter was written in a very matter of fact tone (tending to support what the complainant said was his approach at the second consultation). It contained no indication that there were increased risks and none that he had warned her about risks. A short letter which he wrote to the general practitioner on 3 December 1993 does not assist on this issue. The same applies to the letter of 27 December 1993 which he wrote to Mr xx when the complainant was transferred to xx Public Hospital because she and her husband were not in a position to go on meeting the costs of further care at xx Hospital. Some features of that letter are nevertheless worthy of mention:

(a) After referring to her gastric by-pass in July 1986 Mr Stubbs said that a year or so later he saw her after an admission to xx Public Hospital with a GI bleed. In fact the

admission when he saw her for epigastric pain was in September 1990 and was therefore more than 4 years after the 1986 surgery. This is evidence that without notes to support him Mr Stubbs' recollection can be faulty. In addition, and as already noted by the Tribunal, the complainant maintains that that admission was on account of a urinary tract infection and that she had not been vomiting blood prior to that admission.

(b) Having referred to the September 1990 admission he said:

"She has coped with her ulcer since that time and represented to me at xx on 22 October 1993 with epigastric pain, foul vomiting and weight gain". The Tribunal considers that this sentence supports the complainant's position that she was, despite her pain and vomiting, coping with her situation when she was referred to Mr Stubbs in 1993 and that her surgery could have been delayed until after the completion of her course.

(c) He said that he performed revision surgery which proved extremely difficult. In essence he transected the stomach between staple lines and over sewed cut ends. A splenectomy (removal of the spleen) was required for bleeding and a gastrostomy tube was placed distally to decompress the by-passed stomach. Mr Stubbs was extensively cross examined as to whether he should have proceeded with transection given that the surgery proved extremely difficult and that he had conveyed to the complainant that he would proceed with transection only if the surgery was proceeding smoothly. His position was in essence that although the surgery was difficult it did proceed satisfactorily from his point of view. Mr Stubbs is not charged with proceeding when he should not have and it is not necessary for the Tribunal to make any specific determination on that issue.

(d) A laporotomy was performed on the evening of 21 December. The peritoneal cavity was largely obliterated by adhesions (from 1986 and the recent surgery) but four litres of pus were evacuated from the pelvis, left paracolic gutter and the LUQ. (This confirms the complainant's evidence on that point.)

(e) No obvious leak was then identified but it was now apparent that she did have an ongoing leak. In addition her gastrostomy site was probably leaking and fistulating to the lower end of her wound.

13.15 **ON** 27 October 1994 Mr Stubbs sent a report to the Medical Misadventure Unit of the ACC. It is important that at that time the issue was not, on the face of it, whether Mr Stubbs had given any or sufficient warning in relation to risks, possible adverse effects and complications (although that seems later to have become an issue). The issue in 1994 appears to have been whether the consequence of the surgery was sufficiently rare to qualify the complainant for cover by ACC.

13.16 **IN** his letter Mr Stubbs again repeated his erroneous statement that he had seen the complainant, for a gastro-intestinal bleed, approximately a year after the 1986 surgery. Referring to the consultation on 18 November 1993 he said that:

"We discussed in detail her options. In a sense, medical therapy for her peptic ulceration had already failed in spite of significant attempts and she had had at least one previous GI bleed and what was perhaps of equal importance to her at the time was that her weight was beginning to increase and the prospects for further weight gain were very real. Together, after thorough discussion of the risks related to revision gastric by-pass surgery, we agreed to proceed. (The complainant) was thoroughly aware that not only was gastric by-pass surgery potentially hazardous on the first occasion, but I made it quite clear to her that the risks were somewhat greater in the setting of revision surgery. In particular these related to the possibility of leak from the stomach and/or new anastomosis because of the difficulties in mobilising the previously operated stomach. In her case it was likely to be additionally difficult because of the previous anastomotic leak. We discussed that

the ideal way to manage things would be to perform a gastric transection at the site of the new staple line. I indicated that I would only be prepared to do this in the event the procedure was proceeding reasonably smoothly because the risks were certainly somewhat greater. In my own mind I would have thought of anything up to a 10% chance or conceivably greater of leakage from the stomach staple line and/or new anastomosis. Both she and her husband were well acquainted with the possibility of this risk at the time and chose to proceed. ..... As outlined in this report the possibility of a leak and problems related to that was thoroughly discussed prior to her surgery and is certainly an accepted complication of this sort of surgery. Both she and her husband were well aware of that though they may not have fully appreciated the precise extent of trouble she might have been in. Nevertheless the risk of leakage was explained and it was also explained that this could lead to a life threatening situation and the possibility of death.

The risk of leakage from this sort of surgery in experienced surgical hands at the first time of operating should be small and indeed less than 5% but even in the hands of very experienced gastric by-pass surgeons, the risks of such an event in revision surgery is accepted to be a good deal higher."

While I, and all those concerned, might feel very much for (the complainant), I regret to say that the nature of the possible complications were discussed and accepted by all concerned at the time of surgery. I do not believe therefore that she has a claim under ACC for these events."

13.17 **IN** that report Mr Stubbs said that she was admitted to xx Hospital with an upper GI bleed. In fact, the complainant maintains, she was admitted for urinary tract infection but while she was there asked for her epigastric pain to be investigated, that was why she was referred to Mr Stubbs and the presence of an ulcer was then established.

13.18 **THE** complainant gave evidence that when she first received a copy of that report she was amazed at what it contained. She said that in her view Mr Stubbs' assertions that he explained the risk of leakage and the potential risk of death were simply not true. She said that she could clearly recall the discussion with Mr Stubbs regarding the operation and that she was adamant that the risks of the surgery were not made known to her husband and her and were, in fact, not discussed with them at all. She said she believed that Mr Stubbs

had overstated what he claimed he told them in his report. She said that if Mr Stubbs had told them that there was a possibility that she could die as a result of the operation she was of the view that this would definitely have been something that they would have remembered. She would have seriously considered not going through with the operation if she had known that it was life-threatening. While she was aware that the surgery would be major she expected that she would be in and out of hospital in 10 days and Mr Stubbs assured her that this would be the case. She intended to use the Christmas period to recover from the operation and would then return to her course at the xx.

13.19 **IN** a letter dated 21 April 1998 which he wrote to the complainant after he was aware that ACC had accepted a claim from her on the basis of medical error on his part (based on lack of informed consent) he said that he could not accept that he did not give (sic) proper informed consent.

"While I did not, and indeed could not, have foreseen the set of circumstances that developed, we did talk about the risk of leakage, we did talk about the risk of dying, and we spent a great deal of time discussing the possible problems related to the revision gastric by-pass. No matter how experienced a surgeon, revision gastric by-pass poses particular problems and I was very conscious of these, though equally conscious that you had no other way of resolving your problems as they presented at that time."

As to that it is to be remembered that the complainant said that this consultation took 15 to 20 minutes. Mr Stubbs said that it took nearer to 30 minutes. He said in the letter that *"a great deal of time"* was spent discussing the possible problems related to the revision gastric by-pass. It needs to be remembered that at the same consultation there were a lot of other matters dealt with. These included the results of the gastroscopy, and of the ultrasound examination, the conference which Mr Stubbs had attended since the first consultation, what he had learned at that conference, the fact that he was now proposing

revision by transection, what transection meant in technical terms and what the procedure involved, what the costs of the hospitalisation were likely to be and how the complainant and her husband had limited resources, what should be said to the insurance company about the nature of the surgery, the particular difficulties which the revision surgery was likely to present (because of adhesions from previous surgery and the probable difficulty of mobilising the stomach) and how Mr Stubbs would only proceed with transection if things were proceeding satisfactorily. Given that all of these matters were discussed and that on Mr Stubbs' own evidence *"a great deal of time"* was spent discussing the possible problems related to the gastric revision by-pass there is a real question as to how much time was left in a 20 to 30 minute consultation for a thorough discussion of the material risks which the Tribunal identified in 12.8 above. The Tribunal returns to this issue in 13.37 below.

13.20 **ON** 3 May 1999 Mr Stubbs sent a letter to the convenor of the CAC about the allegation relating to the complainant. In that letter he said that when the complainant returned to see him in October 1993 he was well aware that she had already suffered complications from her original operation and he discussed these with her. He also said that he was well aware that the risks of revision surgery are greater than those of first time surgery and he was certainly careful to point this out to her. If that sentence was intended to relate to the first consultation it will already be apparent that the Tribunal does not accept it as correct. As already noted its majority finding is that risks were not discussed at the first consultation.

13.21 **LATER** in his letter to the convenor Mr Stubbs said:

"While I do not have precise recollection of all that I told her at that time prior to the revision surgery, there are certain points about which I am very clear. In November of 1993 I attended an international meeting of an Obesity Surgery Society in Australia and came away from that meeting with the knowledge that the most reliable way of dealing with staple line dehiscence was not to do as we had done in the past, merely re-apply staples, but to divide the stomach between staple lines, thus isolating the stomach pouch completely. This surgery however entailed a somewhat greater risk than simply re-stapling itself. ..... For this reason I was anxious to discuss the option of complete gastric transection with (the complainant) and her husband, and did so. I do have a clear recollection however of discussing that this might be inordinately difficult if things were particularly stuck as a result of her previous surgery and the minor anastomotic leak she had had at that time. I indicated that to transect the stomach would add some risk to an already difficult procedure. The risks we spoke of were of death and of a leak leading to intra-abdominal sepsis as well as other more general risks, such as the DVT and pulmonary embolus which she had previously experienced. (The complainant) herself made it clear that if at all possible she wished to have an operation that gave no chance for further staple line disruption and failure. I indicated that providing I was comfortable with doing the transection at the time, I would proceed along those lines. ..... There is no question I would not have indicated that her original surgery could have led to such problems as to require multiple re-operations over several years. Such an outcome has never been seen by me before and could certainly not have been envisaged. Instead, she would have known from me of the risk of dying and of the risk of a leak which unfortunately occurred."

13.22 **BEFORE** the Tribunal Mr Stubbs referred, in paragraph 13 of his written evidence, to the second consultation. He said that at it he indicated his belief that the revision surgery should include gastric transection if possible. He explained why this might be more difficult than re-stapling and might entail a *"slightly"* greater risk - principally of leakage. He said that his recollection was clear that he discussed this point of potential leakage not just because he invariably does spell out risks but specifically because this was the first of the revision gastric by-passes undertaken by him where gastric transection was planned. It is stating the obvious to note that the fact that he claims that he invariably spells out risks does not in any way contribute to whether his recollection that he discussed potential leakage is clear.

In paragraph 16 of that evidence he said that despite the technical advantage of transection it still posed the same or greater risks of leakage and infection as a revision operation without transection. The risks from the surgery itself are also there - *"even more so"* - and all this was made clear to the complainant. He did not believe that the new technique lessened risks and he not belittle them.

In paragraph 19 he said that to say (as the complainant did) that there was never any discussion of the post-operative risk of complications or of the potential risk of death as a result of the operation was quite preposterous and he emphatically denied it.

13.23 **AS** to what he claimed he said about risks he said in paragraph 24 of his written evidence:

"The risks as I stated to her (being something more than 1-2% chance of dying and 5-10% chance of serious complications) were regarded as acceptable to her at that time."

In paragraph 32 he said that he had not been kept informed of the subsequent events at xx Hospital and that while he expected her course to be a difficult one he would never have expected her to require so many re-operations. He said that he had never known a patient in a similar, or even not so similar, situation to require so many re-operations and be disabled for such a period of time following an internal leak from a staple line, suture line, or anastomosis. Generally, the result is either uncontrolled infection leading to death (possibly after one or two re-operations) or resolution of the problem in a few months.

In paragraph 33 he claimed that the complainant was either not capable of or not willing to confront the risks and realities of revision surgery or that she was ready to mislead, *"no doubt because of her bitterness over what has been an extremely devastating series of events since December 1993 and a real need to gain cover from ACC, however*

that might be achieved". He reiterated that he did give the complainant a *"realistic indication"* of the risks and complications of her operation in 1993.

In paragraph 37 he said *"The risks were outlined as being something more than 1-2% of dying and 5-10% of major complications"*.

At paragraph 45 he observed that it can be very difficult to ascertain whether a patient has fully understood all that has been said and that they retain memory of that discussion. He said that nothing was said by the complainant in the course of the two consultations to suggest to him that she did not understand the issues he was addressing. If he had detected some lack of understanding, or was not comfortable that she had understood, he would have taken additional steps with her. He said it was important to him to have his patients understand what he is doing, what they are faced with and what the risks are. He said he believes in the whole concept of informed consent, especially in this field where there can be overlays of emotional and psychological issues.

13.24 **IN** oral evidence in chief he said that he was aware that patients may not take in all the information over 1 hour. In this case the Tribunal has already found that any information about risks which Mr Stubbs conveyed to the complainant was conveyed solely at the second consultation. On the evidence this consultation took between 20 and 30 minutes.

Later in his evidence in chief Mr Stubbs said:

"Revision surgery is difficult, is dangerous, as evidenced by what has happened with these very unfortunate sequence of events to (the complainant). There is every reason to attempt to never have the requirement for a revision operation, and today,

all of my gastric by-passes from their first operation have a transection in the hope that no-one will need a revision in the future."

13.25 **MR** Stubbs said that he was aware of the complainant's need to be back at her xx course and that it was the expectation that she could recuperate within a 2 to 3 month period even in the presence of some of the sorts of complications that might have existed. He said, however, that he could not have foreseen the series of events which occurred. He said that, in general, he would have expected that *"almost"* regardless of the complication she would be fit enough to resume a position as a student within a three month period.

13.26 **ASKED** to comment on the fact that nowhere in his clinical notes and nowhere in his correspondence to the complainant's general practitioner was there any reference to risk factors he said that he could only say that in 1993 it was not his practice routinely to do that and clearly on this occasion he did not record what he had said. Subsequent to that, and probably spurred considerably by this particular case, he was now very careful – and had been for some years – to document both in his notes and in his first letter to the General Practitioner that that discussion had taken place. He believed that in 1993 that was not usual practice though obviously it would have been good practice.

13.27 **IT** is now necessary to see how Mr Stubbs' evidence as to what he said about risks at the second consultation stood up to cross-examination. First the Tribunal notes that, in the claim that he made that he had discussed risks at the first consultation, Mr Stubbs said that the general statement which he makes to all patients undergoing this sort of surgery is that the risk of dying is somewhere between 1 and 2%, *"though perhaps a little greater in*

this context" and that the overall risk of complications is somewhere between 5 and 10%.

13.28 **AT** page 107 he said that revision surgery was known by everyone who does it to have a significantly higher risk, meaning mortality might even be doubled, and the risk of leakage again doubled, so that would be what might be covered by the term *"significantly increased risk"*. For revision surgery that is the order of magnitude of additional risk over first time surgery. To do a transection in the context of revision surgery does not double that again, it would add perhaps. He came back to saying that inherently he thought it (revision) was a more risky procedure so one needed to take that into account.

13.29 **MS** McDonald asked him what he said to the complainant about the risk generally of revision surgery and specifically, or inherently, about transection on 18 November. This was a very important question. His answer was:

"I said - well, ... the specific - I spoke of the transection on the 18th, that is the only day on which I can be absolutely clear that I spoke of transection, but in this context I related the risks of revision surgery to the risks of the initial surgery because that was the area in which I had a bigger experience and better feel for the specific risks. I could have said I've done six operations and no-one has died and no-one has leaked. Therefore there is no risk. But no, that is not sensible when you're talking about such a small experience, and that is why it's better to relate the risk of that procedure to the risk of a much larger number of patients better described in the literature and of whom I had a better experience. My reference point is 1-2% risk of dying for the original surgery and 5-10% chance of serious complications. What I discussed with (the complainant) is that her risks at revision would be somewhat higher than those because revision surgery is more difficult and I did certainly indicate that transection, although highly desirable for her, because it would be a more reliable procedure over time, there was a penalty potentially to be paid in that it was inherently a little more risky and because it was not something that I had personal experience of at that time. I worked on the basis that it might add incrementally an additional small risk, hence my saying to her I will do this if I believe things are proceeding satisfactorily."

13.30 **IN** further cross-examination Mr Stubbs told Ms McDonald that the published series of risks for revision surgery would have mortality (death) varying from nothing through to probably 10%. Shortly thereafter he conceded that the upper limit of that range should be 12.5%. He also said *"there is great difficulty quantifying the actual risk but we can simply say this is a risky procedure and it is probably ideal that each of us when we quote to patients the risk we do so on the basis of our own experience. That is only appropriate when that experience is large enough to be meaningful. It would be inappropriate for me to quote a 12% mortality when I have not had a patient die from this and I've done 40 odd revision procedures."* Referring to revision surgery he said that he always made the point that the risk was going to be higher *"and I don't put a figure necessarily unless asked I would just refer to it being potentially higher than the 1-2% and I think that's reasonable"*. (The Tribunal notes that informed consent does not depend upon the patient having sufficient knowledge to ask the right questions. There is a considerable difference between saying that there is a *"somewhat higher"* risk of death than 1-2% and saying that that risk is probably doubled. Material risks should be disclosed by the practitioner in such a manner that they can be readily understood by the patient. If they are not understood they cannot be accepted and if they are not accepted consent which is given to a recommended procedure cannot be regarded as informed.). Asked by Ms McDonald what he had told the complainant he said he told her the risk of dying from gastric by-pass was 1-2% and that in revision surgery it might be *"somewhat greater"* than that. He told her that the risk of serious complications in first time surgery was 5-10% and the risk of that in revision surgery *"is likely to be somewhat greater"*. He said that he had no recollection of anything more specific in terms of figures or percentages than that. Asked whether he was saying that he said that because that's what

he expected he would have said or because he had specific recollection he said he knew that that is what he always said and he did not believe there were patients that would not be told that. In terms of the complainant he said he had a clear recollection of discussing the risks of dying/leakage and those were the figures so he knew he discussed the risk of death, knew he discussed the risk of complications and those were the only figures he ever really talked about in this context.

13.31 **REFERRING** to the second consultation Mr Stubbs told Ms McDonald that he explained what revision gastric by-pass was and then went on to talk about the Australian conference and what he believed he had learned there. To Ms McDonald's suggestion that the complainant was adamant that he had never mentioned the risk of dying he agreed that he would think that that was something she would be particularly concerned about if he had mentioned it. He said that he had a specific recollection of saying there was a risk of death. Asked what her response to that was he said that he did not consider she responded badly at all. He said he had no clear recollection of a specific response but he knew that he discussed that the risk of dying from this sort of surgery began at 1-2% and to do a revision and a transection conferred potentially a *"somewhat greater"* risk. He said *"That is what I know I said. That is what I always say and that is what I know I said because this was a turning point, if you like, in my obesity surgery – in my understanding, and it represented a departure, so its clear in my mind"*. Ms McDonald asked *"So you have a specific clear recollection that you mentioned dying but no clear recollection of how she reacted to that?"* He replied *"That is correct."* and later said it was not remarkable to him that he did not remember her specific reaction.

13.32 **MR** Stubbs maintained that there was no way in which the risk of death could be fixed accurately. He said that what he believed was reasonable was to say that the risk of revision surgery is greater than the risk first time around, the risk of dying and the risk of major complications and to put a figure to it. He said that is why he sticks to the figures and does not change this. Ms McDonald put it to him that he did not put a figure to the complainant and did not want to put a figure to it now. He said that was not correct. He said he used the figures 1-2% of dying and 5-10% of serious complications and with all patients undergoing revision he indicated that it was likely to be in excess of that and possibly even in the order of double. He said that that was what he had said to the complainant.

13.33 **WHEN** Mr Stubbs claimed that he had told the complainant that the risks were possibly even of the order of double Ms McDonald put to him: *"You said of all that to (the complainant)?"* He answered *"Yes"*. Ms McDonald asked *"And she didn't react?"* He replied *"I have no recollection. Her reaction was not an untoward one that has been memorable for 7 years"*. Shortly afterwards Ms McDonald asked *"How did (the complainant's husband) react when you mentioned death or dying?"* The answer was *"I don't have any clear recollection of that, and so I have no clear recollection."*

13.34 **ASKED** by Ms McDonald what he had said about leakage he said that he believed they spent a good deal of time talking about leakage. *"That is the bugbear of revision surgery. That is why people die of revision surgery. That is the major reason they die. So I was discussing leakage, and that was to my mind inherently there was a greater chance of leakage after transection, so I discussed with her that leakage*

with infection inside, peritonitis, abscess, perhaps the need for further surgery, that is what I discussed with her as leakage."

13.35 **ASKED** whether he had advised her of any consequences he said that he was less clear about what he would have said of the consequences and that he had no clear recollection of that but that he usually said that this can lead to infection inside, abscess, peritonitis and the possible need for further surgery. (As noted in 13.34 he had just said that he had discussed those matters with her. Now he said that he had no clear recollection of what he said to her about consequences and had to rely on what he usually said). He said that people often ask about that and he goes on to relate it to perforated appendicitis or the bowel or an ulcer. He said that he discussed leakage and that he had to say that he could only assume that the consequences of that were dealt with in the way that he usually did. Asked specifically *"you have no specific recollection of that"* he replied *"no"*.

13.36 **ASKED** whether one of the consequences would have been that complications would have necessitated a prolonged stay in hospital for the complainant and transfer to the public system he said that would have been unusual and she was the only gastric by-pass in now over 300 who had been transferred to the public system. Ms McDonald put it to him that it was also the first time he had done a transection and that this was a woman particularly concerned about being able to afford the private system and who told him she did not want a prolonged stay in hospital. He replied that that did not influence him greatly in terms of what he would/would not discuss in terms of risk. He said that it was his view that she would not need to be transferred to the public hospital. Asked whether this was because he did not see she could get into a situation with any complications that could require that

he said it was because the prospect, the chance, of that being required was very small indeed. He said that he talked about the risk of dying and of serious complications and he did not go into all of the ramifications of each of those potentially serious complications. He accepted that the complainant had made it clear that she wished to be fit to resume her course in the following year and said he believed she would be.

13.37 **MS** McDonald put it to him that in the 20 or 30 minutes he had dealt with the result of the gastroscopy and barium meal, he had talked about the need for revision surgery, he had talked about transection and what he had gained from the conference in Australia, about the insurance company, about costs, that the complainant and her husband had raised their concerns about being able to afford the private system, that the complainant had talked about wanting to finish her course at the xx and that this did not leave a lot of time to have discussion about risks, complications and consequences. Mr Stubbs accepted that it was a lot to talk about and that on any view it was not a lot of time for a patient to take all of that in, process it and make an informed decision. He said *"I accept that's a difficult one for them"*. He said that he did not send her away to think about it and come back and discuss things further with him (this contrasts with Mr Sorrell's practice of having two separate consultations about risk) but that he said she should ring him when her insurance company confirmed things. Ms McDonald put it to him that there really was no need to rush it and that the complainant could have been told to go away and think about these very real risks, discuss them with her family and get back to him. Mr Stubbs suggested that that's exactly what took place and said *"one doesn't have to discuss these things for weeks/months"*. Ms McDonald then put to him *"She made the decision to go ahead with surgery at the consultation on 18 November?"* He replied *"The*

confirmation that she would go ahead came after she had gone home, talked with whoever, talked with her insurance company, rung me and at that point we confirmed it on the phone. It was not confirmed on the 18th or the admission booklet with my signature and date would have recorded 18 December (sic). The decision to proceed was made on the date shown, which was 22 November, which was after she had gone home, talked with people, thought about it and talked with her insurance company". Ms McDonald: *"You suggested in your answer a couple of questions ago that all she had to do was to talk to the insurance company and confirm the insurance cover, otherwise she agreed to go ahead and it was going to be December when the surgery would be done?"* Answer: *"I can't begin to say what she does in the days after but I expect people to think carefully about what's happened - that is part of the process. I am sure I knew she would go away and reflect, but I also felt almost certain she would proceed."* Ms McDonald then asked: *"The reality is that your understanding at the end of the consultation on 18 November was she had decided to go ahead with the surgery?"* Answer: *"I don't know if I can really confirm that as you've put it, but I don't know that I can confirm it."* Ms McDonald then pointed out to him that on 19 November he had written to the general practitioner and finished his letter by saying: *"she would like to proceed with this and I am making arrangements to have her admitted to xx Hospital ...."* At that point Mr Stubbs conceded that it was likely that it had been decided. The Tribunal has no difficulty in concluding that in the course of a consultation which lasted for 20 to 30 minutes the complainant agreed to proceed with surgery after a statement by Mr Stubbs about risks which had to be and was fitted in among the numerous other topics, including a detailed discussion of the nature of the proposed surgery and the difficulties it was likely to involve,

which were discussed within that time. It is, in the Tribunal's view, an irresistible inference that the time spent by Mr Stubbs on any statement about risk was necessarily limited. (Whether informed consent was obtained in a particular case is not however to be judged solely by the time taken in discussion. If all material risks are communicated in an appropriately effective way the practitioner's duty will have been discharged irrespective of the time which the process took. (A particularly short time might, of course, call into serious question whether the communication was appropriately effective.) In this particular case it is relevant that the complainant was an intelligent person. Nor was she new to the issue of gastric surgery. For both of these reasons Mr Stubbs may have been able to explain to her the inherent risks of the procedure more easily and quickly than he could have to another patient.)

13.38 **ASKED** by Ms McDonald how he had ensured that the complainant had understood sufficiently well the risks that he said he had told her about, he said that there were no specific mechanisms by which he did that. He said *"In general terms I do that by allowing people and encouraging questions at the time of my consultation. At no time did I gain the impression from her that she was not clear about what was required and what that would entail and what the risks would be"*. He accepted that how much a patient understands about negative consequences, risks, and complications depends on how the clinician conveys the information to her. Asked whether he said to the complainant something like *"you need to understand that this procedure carries sufficient increased risks from your original gastric by-pass, that you could die as a result of this procedure, that you could have significant complications such as leakage and all of the other things we've talked about and you need to think*

seriously about this procedure and go away and think about it." he answered *"I said all of the first part, I doubt I would have said and you need to think about that, because that is not my style, but I said the rest"*.

13.39 **MS** McDonald reminded Mr Stubbs that in paragraph 32 of his written evidence he had said (of the consequences of an internal leak from a staple-line, suture line or anastomosis) "*Generally, the result is either uncontrolled infection leading to death (possibly after 1 or 2 re-operations) or resolution of the problem within a few months"*. Ms McDonald asked him whether he had put it that bluntly to the complainant when he saw her on 18 November. He initially replied *"I don't know that I can be so specific*". When the Chair directed him to give a yes or no answer he said *"No, I would think not likely."*

13.40 **IN** re-examination Mr Stubbs told Mr James that he specifically recalled that at the second consultation he said to the complainant that the complication or risk assessment was higher than 1-2% for death and 5-10% for serious complications. Asked why he did not indicate how much higher he said it was because it's really very difficult to quantify. He pointed out to the Tribunal that at that time he had performed 6 revision operations with no mortality and had had no major morbidity resulting in prolonged hospital stay. (None of these, however, involved transection.)

13.41 **QUESTIONED** by Professor Gillett as to his best estimate of a serious complication for a woman having a primary operation in his hands Mr Stubbs said that with risk of a serious complication defined as one which leads to significant extension of hospital stay or a need

for further surgery the risk is about 5%. If a transection operation were a primary event it would be approximately 5%. His estimate for revision with staples would be 10% (which is of course double). If it was a transection revision operation he would go to perhaps 15%. Asked whether it was possible that he had used qualitative terms, when speaking to the complainant (e.g. something like *"the revision that I am offering you has a little higher risk to it but not much)"* he said *"No, I am always very specific about figures and that is partly because I keep figures myself. I publish figures. I know the figures. My booklet, if (the complainant) had received it and I accept she may not have, my booklet details figures which I always mention in a consultation. So what I know I said to (the complainant) is that the risks were greater than the original risks. But I also know that when I discuss, that I use those figures as a base line. They are there for my patients to take away and look at and if for any reason they fail to get that, I'm sorry. But that is the information I give them and I appreciate the points you raise, and it is partly because I have figures, I believe in figures, and I think it helps people put some perspective to this, that I always use 1-2%, even though my own experience is less, and 5-10% which is still really a bit in excess of my own experience but I use those figures."* Asked by Professor Gillett *"Do you accept that the use of qualitative terms like something higher than 1-2% may be construed very, very differently?"* He replied *"certainly I accept that."*

13.42 **QUESTIONED** by Doctor Gleisner he said that the operation was *"unquestionably extremely more difficult"* - *"revision surgery in the upper abdomen is extremely difficult and the potential for things to go wrong is high."*

13.43 **QUESTIONED** by the Chair he accepted that in the absence of records it was possible to be definite about matters but also to be wrong. He also accepted that if one were reporting events from the past without records that was not likely to be as reliable as with records. He said that at the second consultation he used figures and demonstrated through the use of figures that what was being talked about was a greater risk than 1-2% for death and 5-10% for complications. He also said that he could specifically recall advising the complainant at the second consultation that she might die, that she might suffer major complications and that he told her what those major complications might be. Asked what he said he told her they might be he replied *"I told her the risk of the transection that we were discussing was likely to be greater than the risks of the original operation, which was a 1-2% of dying and a 5-10% chance of major complications. The two complications, the one I have the most clear recollection, because it was the one I feared most for her, was leakage. And the one that I had, if you will, the most trepidation in terms of embarking on, but which I did on the basis that it was now believed to be the right thing to do. So I discussed that 1-2% figure and 5-10% and indicated that what we were talking about was something more than that. If asked to quantify that, and I don't recall whether she did that or not, I generally talk about a doubling."*

13.44 **ASKED** by the Chair whether, having used the term *"major complications",* he proceeded to say what major complications he had in mind he said *"yes though it was not an exhaustive list. It was leakage, pulmonary embolus, those two at least, which is what she had had. I don't have the recollection that tells me I also told her of pneumonia, wound infections, but I imagine I would have, but of leak I am very*

clear because it was the whole issue for me and of pulmonary embolus because she had had a previous one. These were not issues that were just by the by."

13.45 **ASKED** whether his recollection that he said those things to her was clear he said it was. He said he could see the complainant and her husband sitting in front of him and he could hear the word leakage and the emphasis he was putting on that not to say you will get a leak, but to say that that is the problem; if we get a leak that is the thing we all need to be worried about. He could not recall the complainant's response to what he said on that topic. It did not strike him as a little odd that he should clearly recall what he said and not recall what she said. He said there was not a memorable response from most people and it did not surprise him that he did not have a memorable response from her. He said he did not think it was likely to have been much of a response because she was focused on what she needed to have done and the thing which was going to be the only way she would ever get there. Asked whether he recalled even whether she made any response, he said he did not.

13.46 **ASKED** what steps he had taken to confirm that she had fully understood what he said he said to her about the risks that were involved, he said *"only the steps which I normally take, which is that through a relaxed, in a course of a relaxed consultation, I ask are there any questions, is anything not clear, and it is a two way exchange."*

13.47 **THE** Tribunal heard evidence from Dr Sharpe. He had had nothing to do with the complainant or her surgery. His evidence was that he had observed Mr Stubbs' *"remarkable candour and honesty with patients and their families."* He had been

present at instances in the intensive care unit at xx Hospital where Mr Stubbs had sat with a family and discussed what could be done. He said that the discussions were very frank, almost to the point of what he thought was bluntness. Since 1990 he had worked with Mr Stubbs at xx Hospital and had since 1992 been Mr Stubbs' anaesthetist every second, fourth and (if applicable) fifth Tuesday of each month for his major cases. He said he could say without any hesitation that Mr Stubbs' patients are some of the best informed that he deals with. By the time he sees them they have what can only be described as exceptionally good understanding of what they face and the implications and risks of surgery and anaesthesia. He has attended some consultations with high risk patients when Mr Stubbs has been present. He has always been impressed at the lengths Mr Stubbs goes to to spell out the potential problems the patients may face and what it is planned to do to try and lessen any risks. He said that Mr Stubbs consistently invites them to ask questions and is very good at clarifying things in lay terms. He has never felt that Mr Stubbs has understated risk. At times he has thought Mr Stubbs was almost brutal in his frankness.

13.48 **THE** Tribunal, as noted earlier, has also received and considered affidavits from two former patients of Mr Stubbs. Both patients had revision gastric surgery carried out by Mr Stubbs. (Of Mr Stubbs' revision cases they were numbers 5 and 6 and the complainant number 7.)

13.49 **NEITHER** patient had transection surgery. Each patient had two consultations with Mr Stubbs before the revision surgery. Each deposed to what had been said about the

proposed surgery, and about risks, by Mr Stubbs. Each outlined the process which Mr Stubbs had followed in relation to those topics.

13.50 **EACH**, in different words, praised the outline of risks which Mr Stubbs had given them and the time and care he had taken in doing so.

13.51 **THE** Tribunal has no reason to doubt the evidence of Dr Sharpe or the former patients. While noting that that evidence relates to what happened between Mr Stubbs and other patients on other occasions, that the evidence cannot by itself determine what passed between Mr Stubbs and the complainant on 18 November 1993 and that neither of the former patients' revision surgery involved transection the Tribunal nevertheless considers that the evidence is of some probative value and should be considered along with the other evidence in the case.

14. SUBMISSIONS:

14.1 **MS** McDonald and Mr James made detailed final submissions (occupying 15 pages of transcript in one case and 11 in the other). Although these submissions are not here set out (the Decision is already long enough) the Tribunal wishes to record that the submissions were helpful, that they were listened to with care at the time and that the record of them has been further considered since the hearing.

15. RISKS INHERENT IN THE PROCEDURE:

15.1 **PARAGRAPHS** 15.2 to 15.10 relate only to the material risks which were inherent in the transection procedure.

15.2 **THE** Tribunal recorded in sub-paragraphs (e) to (g) of paragraph 12.8 the material risks which were inherent in the transection procedure and needed to be disclosed by Mr Stubbs to the complainant in an appropriately effective way.

15.3 **THE** Tribunal's findings in relation to the consultation on 22 October 1993 have already been recorded. The majority finds that the inherent risks were not disclosed on that occasion. The minority finds that there was no adequate discussion of risks at that time.

15.4 **THE** complainant, whose concern that Mr Stubbs had (in her view) not fully advised her of the risks and complications of the transection procedure did not arise until towards the end of 1994, addressed that issue after she had been very ill and in hospital for many months. She concluded that she had received detailed advice about what the transection procedure involved but no advice about its associated risks. Having arrived at that conclusion she has adhered to it since and the Tribunal is satisfied that she genuinely believes that she was not given any advice about risks by Mr Stubbs.

15.5 **FOR** his part Mr Stubbs on 27 October 1994 wrote the report to ACC which has already been referred to. He wrote it at a time when the issue was apparently not one of whether the complainant had given informed consent to the transection procedure but whether what had happened to the complainant was such a rare consequence that she should receive accident compensation. In that report he plainly averred that:

(a) There was thorough discussion of the risks related to revision gastric bypass surgery;

(b) He made it quite clear to her that the risks were somewhat greater in revision surgery than had applied to the original gastric surgery;

(c) There was anything up to a 10% chance, or conceivably greater, of a leak from the stomach and/or new anastomosis;

(d) Both the complainant and her husband were well acquainted with the possibility of this risk and chose to proceed;

(e) The risk of leakage was explained and it was also explained that this could lead to a life-threatening situation and the possibility of death.

For those reasons he said that he did not believe she had a claim under ACC.

15.6 **IT** is therefore the position that since about the last quarter of 1994 the complainant has been convinced that she was given no advice about the risks inherent in the proposed procedure and Mr Stubbs has maintained that there was thorough discussion thereof. Both parties have adhered to their respective positions over the subsequent years.

15.7 **NOW**, about six and a half years after the November 1993 consultation, in the absence of evidence from the complainant's husband or of any other evidence directly corroborating the account of the complainant or Mr Stubbs, the Tribunal is called on to make findings. To assist it to do so it has had to look at indirect, as well as direct, evidence to see what assistance it could derive therefrom.

15.8 **NEITHER** the complainant nor Mr Stubbs appeared to the Tribunal to be a witness whose evidence was demonstrably unreliable or even could be regarded as manifestly less likely to be correct than that of the other.

15.9 **THERE** is no doubt that Mr Stubbs did not inform the complainant of the possibility of the exact sequence of events which ultimately unfolded following the transection surgery. For most of the first year after that surgery the complainant's attention must have been focussed on her state of health and the serious complications she was suffering. When, late in 1994, she came to recall the conversations she had had with Mr Stubbs in October and November 1993 she faced a difficult task in view of all that she had gone through in the interim. She must have felt "under informed". She plainly did not recall having received advice about risks in either of the 1993 consultations. On the balance of probabilities the Tribunal considers (by a majority) that she is correct in relation to the first consultation. Although it accepts without question the sincerity of her belief that Mr Stubbs also gave her no information about risks at the second consultation, the Tribunal, after considering all the evidence in the case, is not satisfied that it has been proved that she is correct. All members think it more likely that during that consultation there was some discussion by Mr Stubbs about the risks which were inherent in the proposed revision surgery.

15.10 **THERE** are some inconsistencies and contradictions in Mr Stubbs' evidence about what he said concerning the inherent risks of the revision surgery. Such matters have caused the Tribunal to reflect carefully on the adequacy of what he said in this area. In the end, however, it is the CAC which alleges and the CAC which must prove. The Tribunal finds that at the second consultation there almost certainly was some discussion by Mr Stubbs about the risks inherent in the proposed surgery and that the CAC has failed to prove to the required standard that <u>those</u> risks were inadequately disclosed by Mr Stubbs to the complainant during the consultation on 18 November 1993. This is not, and should not be

interpreted as, a finding that there was adequate disclosure of those risks. It is a finding that in relation to the inherent risks the CAC has not met the required standard of proof.

16. PARTICULAR RISKS:

16.1 **THE** obligation on Mr Stubbs was to disclose to the complainant in an appropriately effective way not only the risks inherent in the procedure but also any risks which were material to a reasonable person in the circumstances of the complainant.

16.2 **SOME** of the circumstances of the complainant have already been recorded in 13.5 above. The complainant also told the Tribunal that her xx course was a priority for her and it was important that any medical treatment she was to undergo did not interfere with her training. If she had known that the complications of the surgery could be so serious as to jeopardise the completion of the course she would never have considered undergoing the surgery at the time.

16.3 **IN** fact because she was ill in hospital she was unable to resume the course. The completion of it is no longer feasible because that institution no longer offers the course. Cross-crediting to universities which do offer it is difficult but even if she could achieve it she would have to do a further three years of study. This situation leaves her with no qualifications after previously investing three years of hard work and financial outlay.

16.4 **IN** cross-examination the complainant said that Mr Stubbs gave her the impression that she would have recovered from the procedure within the holiday period for her tertiary

break and that there was adequate time for her to be up and about and back into her course in mid-February.

16.5 **THE** complainant also gave evidence that Mr Stubbs estimated her stay in hospital would be approximately 5 to 7 days and at the very outside ten days. The admission/consent form signed by Mr Stubbs and the complainant records the scheduled date of operation as 8 December 1993 and the anticipated date of discharge as 16 December.

16.6 **EVIDENCE** given by the complainant's sister which is relevant to this area of the case is recorded and commented upon in 10.3 to 10.9 above.

16.7 **IN** 12.4 above the Tribunal noted the CAC's contention that the consequence of the major complications which its counsel specified needed to be explained including the possibility of:

- a prolonged stay in hospital
- a need for further surgery
- a transfer to the public health system.

16.8 **IN** his evidence Professor Collins said that if a leak did occur the consequence for the complainant would be enormous in terms of a threat to her health and involving a prolonged stay in hospital. He also said that informed consent would be based on providing the patient with (among other things) an outline of the risks involved with this surgery and the possible consequences of those risks. As already noted Professor Collins' evidence as to what the circumstances required was not seriously challenged except on the

issue of how a practitioner can confirm the patient's understanding of what has been outlined by the practitioner.

16.9 **MR** Sorrell's evidence as recorded in 11.12 and 11.13 above is noted here and attention is particularly drawn to his expectation that in the consultations prior to the surgery in 1993 Mr Stubbs would have assured himself that the patient actually knew what the risks of primary surgery had been and what the risks of revisionary surgery were and of the possible outcome from those risks.

16.10 **IN** evidence in chief he said in relation to this case that he would have thought Mr Stubbs would have been thinking and talking of the most likely course which would have been a reasonable stay in hospital and not a prolonged stay with excessive complications. It would, he said, be reasonable for Mr Stubbs to be thinking and talking in those terms. In cross-examination he said that you are talking probabilities and you are going into an operation saying that the chances are you will have something sorted out within 10 days, there is a very small chance of things carrying on beyond that but you would not necessarily elaborate and say *"off to the public hospital"*.

16.11 **WHEN** questioned by the Tribunal Mr Sorrell said that it was reasonable to expect - and it would be the basis of a consultation - that material risks would be identified by the practitioner and explained in a way that can readily be understood by the patient.

16.12 **HE** told Mr James that he would have used the word *"considerable"* rather than *"enormous"* to describe the consequences of a leak. Asked whether that would be a

material risk he said *"Well I think it's the same saying that there is a serious risk and a threat to health"*. Mr James then asked *"What about the prolonged stay in hospital?"* Mr Sorrell replied *"That's a difficult one to quantify. You can have a serious risk dealt with quite quickly and does not result in a prolonged stay and some that result in a prolonged stay so it would be a may be rather than a must be"*. Mr James then asked *"You indicated in your earlier evidence that a stay in hospital longer than the period we talked about of 2 to 3 months would be most unusual. Would you consider something most unusual such that it is a material risk that you should inform the patient of?"* Mr Sorrell replied *"I think ideally if you cover everything you would, but you are talking of a situation where the expectation is whatever is happening they will get over it, be treated and be out in a reasonable time. Only if there is an exceptional series of events that there will be a prolonged stay in hospital"*.

16.13 **IN** relation to the issue now under discussion attention is drawn to that part of Mr Stubbs' evidence which is recorded in 13.41 above. He there said that, with the risk of serious complication defined as one which leads to significant extension of hospital stay or a need for further surgery, his best estimate of the risk of a serious complication for a woman having a primary operation in his hands is about 5%. If a transection operation were a primary event it would be approximately 5%. His estimate for revision with staples would be 10%. If it were a transection revision operation he would go to perhaps 15%. The Tribunal regards that as particularly important evidence.

16.14 **MR** Stubbs recorded in his notes that the complainant was a trainee xx. He gave the evidence recorded in 13.25 above. He did not claim that he had warned the complainant that there was a risk that the resumption of her course in mid-February could be jeopardised, or even prevented, if serious complications ensued. He said he believed that almost everybody who had major surgery is recovered within three months. He noted that the complainant had a summer vacation of three months and said the timing seemed perfect. (In fact the period from the date of the surgery to mid-February was only one week longer than two months).

16.15 **IN** cross-examination he accepted that the complainant made it clear that she wished to be fit to resume her course in the following year. He said he believed it was highly likely that with essentially a 2.5 to 3 month period she could accomplish the surgery in that time and recover sufficiently to return to her course.

16.16 **TO** Dr Gleisner he said that the operation is unquestionably extremely more difficult, revision surgery in the upper abdomen is extremely difficult and the potential for things to go wrong is high. To Mrs White he said that if the complainant had said to him *"I don't want an operation if anything can go wrong"* he would undoubtedly have responded *"I'm sorry, I cannot help you. If there is no room for negotiation on possible unpleasant complications, including early recuperation, I cannot help you"*. To the Chair he said that he did not believe the complainant had reason to seriously consider that she might not get back to the xx. His confident expectation was that she would be recovered well enough to resume her studies and the timing would simply have seemed perfect.

16.17 **THE** Tribunal has no doubt that the proposed transection surgery was difficult, dangerous and high risk surgery with a high potential for things to go wrong. While Mr Stubbs was positive and enthusiastic about this new procedure it carried with it a significant risk (on his own evidence about a 15% risk) that a serious complication (defined by him as one which leads to significant extension of hospital stay or a need for further surgery) could occur. In the case of a patient with no unusual circumstances that risk would have needed to be disclosed. In the case of a patient who had made it clear that she had to resume her course in mid-February and that that was important to her it was, the Tribunal finds, absolutely essential that Mr Stubbs warn her that:

(a) There was a significant risk of serious complications.

(b) If one or more of them materialised, could not promptly be remedied and persisted a prolonged stay in hospital and further surgery were possible and the scheduled resumption of her course in mid-February could be jeopardised or even prevented.

16.18 **MR** Stubbs could not in November 1993 have foreseen the exact sequence of events, affecting the complainant, which subsequently occurred. To hold that he should have foreseen them and warned the complainant that they might all occur in the way that they did would be to impose standards which were patently unrealistic and based on hindsight. The risk that serious complications might result from the difficult and dangerous surgery proposed was however not remote, far-fetched, insignificant or immaterial. It was a significant risk. The consequences for the complainant, if serious complications did occur and a significant extension of hospital stay and/or a need for further surgery resulted, plainly might have included her being unable to resume her course in mid-February as scheduled. In all the circumstances the Tribunal is satisfied that there was a significant risk of serious

complications and that if that risk materialised the complainant might be unable to resume her course as scheduled. This risk was material to the complainant because of her particular circumstances and would have been material to any reasonable person in the circumstances of the complainant.

16.19 **THE** Tribunal has no doubt that the complainant should have been told by Mr Stubbs, in a specific and clear way which she could readily understand, that the transection procedure involved a risk of serious complications one or more of which, if they materialised, could not be promptly remedied and persisted, could result in a prolonged stay in hospital and a need for further surgery and could jeopardise and even prevent her resuming her course in mid-February as scheduled. Had that advice been given the complainant would then have been able to make an informed choice as to whether she accepted and was prepared to run the risk that she might not be able to resume the course as scheduled or whether she preferred to put up with the symptoms, until she had completed the remaining twelve weeks of the course, and reconsider the issue of surgery thereafter.

16.20 **NO** doubt Mr Stubbs hoped that serious complications would not occur and that the complainant could resume the course on time. But that is not the issue. The issue is that there was a significant risk of serious complications which might result in an extension of hospital stay and/or need for further surgery. If the complications could not promptly be resolved her ability to resume her course in time would be in jeopardy. This risk was undoubtedly there; it was material to the complainant because of her particular circumstances which were known to Mr Stubbs; it was not a risk which was so

insignificant that it could be regarded as immaterial; it should have been - but was not - spelt out so that the complainant could make her own informed decision.

16.21 **THE** Tribunal refers again to what Mr Stubbs said in paragraph 32 of his written evidence namely that following an internal leak from a staple line, suture line or anastomosis the result is generally uncontrolled infection leading to death or resolution of the problem within a few months. When he saw the complainant on 18 November 1993 he knew this. He also knew that there was a real risk of a leak. He also knew that he was dealing with someone who wanted and needed to resume her xx course in mid-February 1994. While he obviously hoped that a leak would not occur it was plainly possible that one would. If it did then death, a prolonged stay in hospital and resolution over a period of months were possible outcomes. The risk that a leak (or other serious complication such as a pulmonary embolus) might result in a prolonged stay in hospital or need for further surgery or resolution over months and could jeopardise the scheduled resumption of the course needed to be made clear to the complainant because of her particular circumstances. It was not.

16.22 **FOR** the foregoing reasons the Tribunal finds that the CAC has proved to the necessary standard that Mr Stubbs failed to adequately inform the complainant of the possible risks and adverse effects of the surgery in that he failed to inform her of the material risk that the resumption of her course in mid-February 1994 could be jeopardised or even prevented if serious complications materialised, could not promptly be remedied and required a prolonged stay in hospital and/or further surgery. It has considered Mr Stubbs' reasons for not doing so but does not accept them as valid. His failure meant that her choice to

undergo the surgery was not informed and that he did not obtain her informed consent. In this area the CAC has proved its case.

16.23 **THE** decision of the Tribunal on this point is by a majority of four to one. The dissenting member (who was one of the minority in relation to the findings stated in paragraphs 9.17 and 9.28 above):

(a) does not agree with the Tribunal's finding in paragraph 16.20 that the risk, that serious complications might result in an extension of hospital stay and jeopardise the complainant's resumption of her course on time, was not spelt out;

(b) does not agree with the finding in the last sentence of paragraph 16.21 that the risk stated in the immediately preceding sentence was not spelt out to the complainant;

(c) in relation to both the risks inherent in the procedure and the risk material to the particular patient is not satisfied to the required standard that the risks were not adequately presented to the complainant by Mr Stubbs.

17. DOES THE PROVEN CONDUCT WARRANT SANCTION?

17.1 **THIS** point has been carefully considered. Informed consent is a cornerstone of the practice of medicine and the Tribunal has consistently made it clear that obtaining it before a procedure involving risk is undertaken is a matter of fundamental importance. The Tribunal is satisfied that the conduct in this case is sufficient to warrant the sanction of an adverse disciplinary finding.

18. PROFESSIONAL MISCONDUCT:

18.1 **IN** *Ongley v The Medical Council* 4 NZAR 369,375 Jefferies J indicated that whether there was professional misconduct was embodied in the answer to the following question:

"Has the practitioner so behaved in a professional capacity that the established acts under scrutiny would be reasonably regarded by his colleagues as constituting professional misconduct?"

18.2 **HAVING** carefully considered this issue the Tribunal is of the opinion that the conduct in question does not amount to professional misconduct. In arriving at this conclusion it has had particular regard to its view that it is likely that some advice was given about inherent risks and that this is not a case in which a practitioner failed to provide the patient with any advice in that area. The information imparted in the area of a risk particular to the complainant was not adequate but in all the circumstances the "severe label" of professional misconduct is not considered to be warranted. The allegation that Mr Stubbs is guilty of professional misconduct is therefore dismissed.

19. CONDUCT UNBECOMING:

19.1 **THE** CAC alleged in the alternative that the conduct amounted to conduct unbecoming a medical practitioner and that conduct reflects adversely on the practitioner's fitness to practise medicine.

19.2 **IN** *B v The Medical Council* (Auckland, HC 11/96, 8/7/96) Elias J (as she then was) said at p 15:

"There is little authority on what comprises conduct unbecoming. The classification requires assessment of degree. But it needs to be recognised that conduct which

attracts professional discipline, even at the lower end of the scale, must be conduct which departs from acceptable professional standards. That departure must be significant enough to attract sanction for the purpose of protecting the public. Such protection is the basis upon which registration under the Act, with its privileges, is available."

19.3 **THE** Tribunal is satisfied that the conduct which it has found proven departs from acceptable professional standards, that the departure is significant enough to attract sanction and that the proven conduct is conduct unbecoming a medical practitioner.

19.4 **FOR** the charge to be proved the CAC must establish not only that the conduct is conduct unbecoming a medical practitioner but that it reflects adversely on the practitioner's fitness to practise medicine. The CAC is not required to prove that the practitioner is unfit to practise medicine and no such suggestion could be entertained on the evidence. The section does not call for an assessment of an individual practitioner's fitness to practise. The focus of the inquiry is whether the conduct which has been proved is of such a kind that it puts in issue whether or not the particular practitioner is a fit person to practise medicine. The conduct needs to be of a kind that is inconsistent with what might be expected from a practitioner who acts in compliance with the standards normally observed by those who are fit to practise medicine. Not every divergence from recognised standards will reflect adversely on a practitioner's fitness to practise. It is a matter of degree. Whether the particular conduct reflects adversely on the practitioner's fitness to practise medicine is a matter of judgement to which the Tribunal applies its collective wisdom. The requirement that the conduct reflect adversely is as at the date of the hearing. Given the lengthy delay between the conduct and the hearing the Tribunal spent some time considering this issue. It finds that the proven conduct, involving as it does a failure to

obtain informed consent in relation to a major and hazardous surgical procedure, does reflect adversely on the particular practitioner's fitness to practise medicine.

20. SUPPRESSION ORDERS:

20.1 **THE** Tribunal reminds the parties of the orders prohibiting publication of the names of, and any particulars which might tend to identify, the complainant, her husband, her sister or the two former patients of Mr Stubbs who made affidavits in this proceeding.

20.2 **PUBLICATION** of the statements of the former patients remains prohibited but this does not preclude publication of paragraphs 13.48 to 13.50 of this Decision.

21. CONCLUSION:

21.1 **FOR** the foregoing reasons the Tribunal is satisfied that Mr Stubbs has been guilty of conduct unbecoming a medical practitioner and that conduct reflects adversely on his fitness to practise medicine.

21.2 **COUNSEL** are now invited to make submissions as to penalty. The CAC's submissions are to be lodged with the Tribunal, and a copy thereof is to be served, not later than 14 days after and exclusive of the date of this decision and those on behalf of Mr Stubbs not later than 14 days after receipt of a copy of the CAC's submissions.

DATED at Wellington this 13th day of June 2000

....

T F Fookes

Senior Deputy Chair

Medical Practitioners Disciplinary Tribunal