

**IN THE DISTRICT COURT OF
NEW SOUTH WALES**

MEDICAL TRIBUNAL

Deputy Chairperson: Judge D J Freeman DCJ

Tribunal Members: Dr Matthew Vukasovic
Dr Joanna Hely
Dr Maureen Gleeson PhD

No: 40008 of 2005

Date of Determination: 19 December 2005

Dr W AND THE MEDICAL PRACTICE ACT OF NEW SOUTH WALES

REASONS FOR DETERMINATION AND ORDERS

Suppression order pursuant to Clause 6 of Schedule 2 of the *Medical Practice Act 1992*

THE TRIBUNAL ORDERS THAT THE NAME OF THE PATIENT OR ANY MATERIAL CAPABLE OF IDENTIFYING THE PATIENT BE NOT PUBLISHED

1. This is an enquiry into a complaint by the Commissioner of the Health Care Complaints Commission (“the Complainant”) against Dr W (“the respondent”). The complaint was originally brought in the following terms:

COMPLAINT

Has been guilty of unsatisfactory professional conduct and/or professional misconduct within the meaning of s.36 and s.37 of the Act in that the practitioner has demonstrated a lack of adequate knowledge, skill, judgement or care in the practice of medicine.

PARTICULARS

On 25 August 2001, from around 1745 hours until around 2400 hours, the practitioner was the Medical Officer primarily responsible for the care and treatment of XXXXXX (“the patient”) in the Emergency Department of Campbelltown Hospital. At this time, the practitioner:

1. Failed to ensure that the patient’s vital observations were recorded regularly between 1745 and 2200 hours, despite abnormal BP and

RR readings at 1745 hours and despite confirmation of marked metabolic acidosis at about 1930.

2. Failed to commence urgently required resuscitation measures including intravenous fluids until 2230 despite evidence that the patient was critically ill and in circulatory shock as from 1745 hours at which time the patient's condition was reversible.
3. Failed to initiate contact with a VMO, until around 2200 hours, despite evidence that the patient was critically ill with a life-threatening condition as at 1745 hours, and despite having received the patient's ABG result confirming severe metabolic acidosis at around 1930 hours at which time the patient's condition was reversible.
4. Failed to commence intravenous antibiotics until 2245 despite having been instructed to do so by the VMO, Dr Rajaratnam at around 2200 hours.
5. Failed to commence inotropic support until 2355 hours, despite having been instructed to do so by the VMO, Dr Rajaratnam at 2200 hours.
6. Failed to adequately investigate the underlying causes of the patient's circulatory shock following initial assessment at 1745 hours.
7. Failed to order at least half-hourly observations of the patient over the period from 1745 until 2230 when she was critically ill and requiring resuscitation.

2. During the course of the hearing evidence was adduced concerning the timing of certain telephone calls, the time at which certain test results were available and so on, which caused the Complainant to amend the particulars. In addition Dr Lewis Macken gave evidence that it could not be positively established that the condition of the patient was in fact reversible at any stage while she was at the hospital. His evidence was that the stage at which her condition could have been reversed may have passed before she arrived at the hospital. The Tribunal and indeed the parties have, however, proceeded on the basis that early and appropriate intervention at the hospital may have enabled the patient to survive. In other words, whatever chance she had had was lost by the absence of such early and appropriate intervention. In its final form the complaint was in these terms:-

COMPLAINT

Has been guilty of unsatisfactory professional conduct and/or professional misconduct within the meaning of s.36 and s.37 of the Act in that the practitioner has demonstrated a lack of adequate knowledge, skill, judgement or care in the practice of medicine.

AMENDED PARTICULARS

On 25 August 2001, from around 1745 hours until around 2400 hours, the practitioner was the Medical Officer primarily responsible for the care and treatment of XXXXXX (“the patient”) in the Emergency Department of Campbelltown Hospital. At this time, the practitioner:

1. Failed to ensure that the patient’s vital observations were recorded regularly between 1745 hours and 2200 hours, despite abnormal BP and RR readings at 1745 hours and despite confirmation of marked metabolic acidosis at about 1930.
2. Failed to commence urgently required resuscitation measures including intravenous fluids until 2200 despite evidence that the patient was critically ill and in circulatory shock as from 1930 hours.
3. Failed to initiate contact with a VMO, until around 2052 hours, despite evidence that the patient was critically ill with a life-threatening condition as at around 1930 hours, and despite having received the patient’s ABG result confirming severe metabolic acidosis at around 1930 hours.
4. Failed to commence intravenous antibiotics until 2245 despite having been instructed to do so by the VMO, Dr Rajaratnam at around 2052 hours.
5. Failed to commence inotropic support until 2355 hours, despite having been instructed to do so by the VMO, Dr Rajaratnam at 2052 hours.
6. Failed to adequately investigate the underlying causes of the patient’s circulatory shock following initial assessment at 1745 hours.
7. Failed to order at least half-hourly observations of the patient over the period from 1745 until 2230 when she was critically ill and requiring resuscitation.

THE SCOPE OF THE EVIDENCE

3. The Tribunal heard evidence from Dr R Rajaratnam, a specialist cardiologist who had treated the patient before and after the surgery she had undergone on 7 August 2001 for the replacement of a mitral valve. Dr Rajaratnam was contacted on the evening of 25 August 2001 and ultimately made his way from Pymble to Campbelltown Hospital arriving there some time after 11.00pm or 2300 hours. Evidence was also given by Ms V Bragg, a registered nurse who was in charge of the ICU at Campbelltown Hospital on

the night of 25 August 2001 and from Ms Keys, a registered nurse who attended to the patient when she was in the emergency ward during the evening hours of 25 August 2001. The Complainant also called Dr A J Bezzina who is the Area Director of Emergency Medicine in the Illawarra, based at Wollongong Base Hospital, who reviewed the professional performance of the respondent. In addition Dr J Pelichowski, also in attendance at the hospital on this night, gave evidence.

4. In reply the respondent himself gave evidence and called Dr Y Shehabi who is the Program Director (Medical) and Director of Intensive Care Services at Prince of Wales Hospital, to testify as to the respondent's present employment and capacities. Dr Shehabi also made some comment on the circumstances which obtained at Campbelltown Hospital (and at other hospitals) at the relevant times. Dr L J Macken, a specialist in emergency medicine and currently Director of the Emergency Department at Royal North Shore Hospital, was also called to give evidence in support of the report which he had written concerning his review of the respondent's performance on 25 August 2001 and also to offer some observations about the arrangements which were in place at Campbelltown Hospital on this night. Similarly a review report from Professor Fulde was received and a number of references concerning the respondent's professional capacity and standing.

THE FACTS

5. Patient A was a 55 year old woman who was referred to the Emergency Department of Campbelltown Hospital by the Macarthur Area Community Nursing Service at 1713 on 25 August 2001. The triage sheet reports that her presenting problem was shortness of breath. Relevantly her past history included the mitral valve replacement on 7 August 2001. Her complaint was that she felt as she had previously felt (when she was suffering from

congestive cardiac failure prior to the operation). The examination findings at that time included blood pressure of 104/53, respiration rate of 30, pulse 84 and temperature of 35.2.

6. According to Ms Keys, she attempted to obtain a further blood pressure reading on Patient A at 1720 and 1730. On the first occasion, using the automatic device, she obtained readings of 70/40 or 69/49 which she regarded as unreliable. At 1730 using the manual equipment she obtained and recorded a reading of 98/50. This is consistent with the reading of 95/55 obtained by the respondent in the course of his assessment of the patient. This assessment had started at 1745.

7. Amongst the investigations ordered by the respondent was an ECG (which disclosed atrial fibrillation at a rate of 78, a chest x-ray which was reported as showing an enlarged heart and some pleural effusion but the lungs were basically clear. Venous blood was taken for testing but was not marked as urgent so that the results from these tests were not known until about 2030 or shortly before that time. The respondent was unable initially to obtain arterial blood for gas analysis but he did succeed later, at 1930, and by 1935 the blood gases were reported as markedly abnormal. The patient was in metabolic acidosis. The results demonstrated a high anion gap metabolic acidosis. It is asserted by the Complainant that the blood gas results should have established to a practitioner at least of the respondent's experience that the patient was in circulatory shock.

8. The respondent agrees that he understood that to be the situation. However there remained a question as to the cause of this circulatory shock. If it was cardiogenic in origin then the administration of a large volume of intravenous fluid posed the risk of plunging the patient into pulmonary oedema. If, on the other hand, the circulatory shock was the result of

sepsis then the appropriate course was clearly the administration of intravenous fluids and antibiotics. It is accepted by all of the practitioners who gave evidence that the patient presented a very difficult diagnostic problem. Even after Dr Rajaratnam arrived late on the evening of 25 August and performed further diagnostic tests such as an echocardiogram, the cause was uncertain. Indeed, regrettably, the patient died at 0630 on 27 August in Liverpool Hospital to which she had been transferred and even at post mortem the cause of death could not be confidently established.

9. That the respondent was unable to resolve this diagnostic question is not a ground for criticism of him. The basis of most criticism is that, if he realised (as he should have) that the patient was critically ill, then he should have taken some action to resuscitate her even if the diagnosis of her underlying condition remained uncertain.

10. At this stage, of course, shortly after 1930 on 25 August the probabilities still favoured cardiogenic shock because of:-

1. The patient's description of her symptoms as being similar to those she had previously experienced during earlier episodes of congestive cardiac failure;
2. Her history of mitral valve replacement;
3. The absence of fluids in the chest examination did not entirely exclude left sided heart failure. Right sided heart failure was indicated by the swelling of her legs, etc.

11. It was not until the results of the blood studies became available at about 2030 that an infection began to hold sway as a more likely diagnosis. This was because of the elevated white cell count (23.8) and high percentage of neutrophils.

12. In the meantime, at 1955 or thereabouts, Dr J Pelichowski had examined the patient. Dr Pelichowski was a career medical officer who had been in charge of the intensive care unit at Campbelltown Hospital on 25 August and whose shift had been scheduled to finish at 1930. There is a dispute as to how Dr Pelichowski became involved in this matter. The respondent claims that he paged Dr Pelichowski who rang him back and, when apprised of the patient's condition, came down to assess her. Dr Pelichowski testified that his involvement was fortuitous, coming about as a result of a nurse seeking his assistance as he was passing through the emergency department on his way home, having completed his shift in the ICU.

13. It is a little surprising that Dr Pelichowski gave evidence in these proceedings because he is, himself, facing a complaint relating to this patient and this is to be heard by the Medical Tribunal early next year. In the circumstances the members of the Tribunal as presently constituted are reluctant to express any concluded view about the role played by Dr Pelichowski or to make any express findings as to his credit. The Tribunal believes that Dr Pelichowski may have been confused in some of his recollections and some of the actions in which he described himself as being involved may have become transposed in his mind, for example, the administration of 500ccs of haemaccel which was not necessarily charted and so on. The Tribunal differently constituted will separately consider the evidence relating to Dr Pelichowski's performance. For this Tribunal it is necessary to concentrate upon the evidence relevant to the respondent, Dr W. For the purpose of this hearing the Tribunal accepts that the respondent requested the consultation with Dr Pelichowski.

14. It appears from the respondent's evidence (supported by his contemporaneous note) that there was a conversation with Dr Pelichowski at about 2015 during which the suggestion

of a GTN or “Tridil” infusion was made. Although no formal order was written up for this infusion, Nurse Keys’ evidence was to the effect that the GTN was administered, at least for a short time, until stopped on the orders of Dr Pelichowski at about 2055. She estimates that only a small amount, perhaps 10ml, would have been infused. Presumably Dr Pelichowski’s order to stop this procedure would have been brought about on his part by the patient’s low blood pressure. Unfortunately there is no record of the patient’s blood pressure, either before or after this Tridil infusion and indeed Dr Pelichowski’s recollection was that no such procedure was in fact undertaken.

15. On the subject of record keeping, it must be observed that the recording of the patient’s blood pressure is lamentable. The nursing staff made no entries on this aspect of the patient’s condition between 1730 and 2230 on the evening of 25 August 2001. The respondent noted in his records only the initial reading at 1745 and, at 2200, the pressure of 60/30 on palpation. His recollection is that he had checked the patient’s blood pressure at 2030 when he extracted more blood for lactate testing and blood culture. He is not confident about what reading he obtained although he believed that it would have “stayed lower” but (apparently) not so alarmingly low as that registered at about 2200. Dr Pelichowski has made no record of blood pressure readings on his examinations until very late in the piece, being 80/40 before resuscitation started, improving into 105/60 after one litre of haemaccel had been administered but this is well after 2200.

16. Of course the respondent is not responsible for the recording of Dr Pelichowski’s findings but he is responsible for recording his own findings and for ensuring that the nursing staff were making the observation and recording their findings at regular and, in the case of this patient, relatively short intervals.

17. In this regard the respondent was entitled to believe that the nursing staff would do their duty [*Elliott v Bickerstaff* (2000) 48 NSWLR 214] but he nonetheless carried the obligation of observing whether they had and, of course, a history of the patient's haemodynamics was important to him in the management of her condition.

18. To return to the chronology of the night, it is recorded in the respondent's notes that at 2015 he had conferred with Dr Pelichowski. Sometime after that, between 2015 and 2030, the results of the blood tests became available and it is clear that the respondent here set out in the form of six numbered points his observations and thoughts on the condition of the patient. His notes headed at that time "Problems" are as follows:-

1. Cardiac failure
Hypotension, peripheral oedema
Peripherally shut down
2. Acute renal failure
Cr 50s \Rightarrow 104 K 5.2
3. ? sepsis
WCC 23.8 hypotension
4. Metabolic acidosis (with) resp compensation
High anion gap
Lactate sent
5. L pleural effusion
6. Diarrhoea now
Blood culture taken.

19. At the time Dr Pelichowski was terminating the Tridil infusion the respondent rang Dr Rohan Rajaratnam. The records reveal a conversation commencing at 2052 and lasting for seven or eight minutes. Dr Rajaratnam does not recall the telephone conversation occurring at this relatively early hour nor does he recall that there were three telephone connections

between his mobile phone and Campbelltown Hospital on the night of 25 August 2001. This is not a criticism of Dr Rajaratnam who was first asked to recall this conversation some years after the event. The records disclose, however, that there was a second connection between Campbelltown Hospital and Dr Rajaratnam at 2144 – a conversation which lasted a little over a minute and a further conversation (again lasting seven or eight minutes) commencing at 2219.

20. Although the respondent does not note the time on his records the Tribunal accepts that it was following the conversation commencing at 2052 that the respondent, as a result of his discussion with Dr Rajaratnam recorded the following directions:

- ⇒ small amt of fluid challenge ~ 250 colloid
- ⇒ Gentamicin / Ceftriaxone
- ⇒ ICU. He will R/V tomorrow
- ⇒ Ceased Verapamil
- ⇒ ICU reg informed

21. The act of conveying these instructions from Dr Rajaratnam to Dr Pelichowski did not relieve the respondent of his obligations as the physician in charge of the patient's treatment. He had, at the very least, equal responsibility whilever the patient remained within his department.

22. The directions of Dr Rajaratnam were not carried out.

23. It is perhaps convenient to make some observations here about the respondent's perceptions of Dr Pelichowski and the position which that doctor occupied, namely, "ICU Registrar".

24. The respondent regarded Dr Pelichowski as his senior because of his apparent age, because of the title of the position he occupied and because Dr Pelichowski had, in the past, made himself available to assist the respondent and other doctors in the emergency department with problems of diagnosis, management and the like. The respondent said that in his mind Dr Pelichowski was in the role of a consultant.

25. In truth the position was that Dr Pelichowski was only some three years more experienced than the respondent. He was not in a training position. He was not in truth a registrar. He was a career medical officer. Dr Pelichowski regarded himself as equal to the respondent and did not consider that he had any authority to direct the respondent. In this he was probably correct. The misunderstanding on the part of the respondent of their respective positions undoubtedly contributed to the decision of the respondent to “defer” to the ideas of Dr Pelichowski.

26. It was observed by Dr Macken that in the circumstances of that night “it requires significant clinical leadership and some experience to be able to actually communicate adequately to the treating doctors who actually has responsibility for the patient”.

27. Later Dr Macken said, “whilst the patient is in emergency department the geography suggests that it is the emergency department’s responsibility to care for that patient unless it’s been arranged otherwise”.

28. Later, Dr Macken, when asked this question, gave this answer:

“Q. To what extent do you think that criticism is a reflection on [Dr W] having regard to his seniority and experience at the time, and to what extent is it a reflection on the system, if I can put it that way, and the structures that were in place at Campbelltown at the time?”

A. Look there is no doubt to be able to actually take an overview such as that and therefore being able to communicate an issue such as who is responsible takes a certain amount of experience, leadership and familiarity with the place where one is working. There is no doubt that that requires senior staff to be able to do that. And as we know in this instance there wasn't an emergency physician working on the shift, there wasn't an emergency physician on call, or a senior doctor who was available to be able to help oversee or drive that process and there is no doubt that contributed to the problematic care that this patient received."

29. Dr Macken maintained his criticism of the respondent however, in saying that it was the time-frame that was important. "Treatment needed to occur". He suggested that the respondent should have recognised the significance of the blood gases and instituted some form of treatment immediately.

30. Thus his evidence reinforced the report which he had originally provided in which he viewed with mild to moderate disapproval the fact that the respondent "did not act on his clinical and investigation findings or begin treatment of this listed possible diagnosis (sepsis) with the urgency that was required". (Emphasis added).

31. There are, to this point, two demonstrated failures to act on the part of the respondent. Firstly, when his own clinical judgment dictated, or should have dictated, the need for urgent resuscitation, and secondly, when he was directly advised by Dr Rajaratnam to take such steps.

32. Consultation with Dr Pelichowski, whilst perhaps in all the circumstances as perceived by the respondent a reasonable step to take, was not, however, a substitute for the action he, as the treating physician, should have initiated.

33. An attempt is made to excuse his failure to act when so instructed by Dr Rajaratnam by saying that, at that time, Dr Pelichowski was involved and (probably) physically present with the patient. It was reasonable, so this argument runs, to expect Dr Pelichowski to administer treatment in accordance with the instructions of Dr Rajaratnam. It was not. While there may have been some uncertainty in the respondent's mind, this represents a lack of knowledge on his part of his obligations both as the physician who had primary care for his patient and his obligations under the protocols of the Macarthur Health Service Clinical Manual which governed his employment. His obligation in the Department of Emergency Medicine was to stabilise (emphasis added), diagnose and treat.

34. To return, again, to the chronology of that night, there were further calls to Dr Rajaratnam. At least the second of these, at 2144, is the subject of some dispute. This dispute occurs because Nurse Bragg testified that, having been told by Dr Pelichowski that the patient was to be admitted to ICU at Campbelltown, Nurse Bragg went down, herself, to assess the patient's condition. She did so because of fears she had earlier formed about the seriousness of the patient's condition. On arrival in the emergency ward, she said, she could see immediately that the patient was in dire straits. Nurse Bragg said that she examined the observation chart and noted that there were no blood pressure readings recorded since 1730. She then made enquiries both of the nurse, presumably Nurse Keys and the team leader, Nurse Henderson, and was told neither had been able to obtain a result. She then checked the patient's blood pressure and discovered it was barely discernable on palpation at 60 systolic. Alarmed, she returned to ICU and rang Dr Rajaratnam. She then returned, she said, to the emergency ward, and found the respondent on the phone. From his presentation it was clear, she said, that the respondent was talking to Dr Rajaratnam. Nurse Bragg contributed to this conversation by calling out that the blood pressure was barely palpable with a reading of

60 systolic. The respondent, at the end of the call, said “he said to transfer her out” meaning that Dr Rajaratnam had ordered the patient to be taken to Liverpool Hospital.

35. Dr Rajaratnam says he has no recollection of telephone contact with Nurse Bragg on that night. He recalls only two telephone conversations. The respondent claims that he made all three telephone calls but he is clearly struggling to explain the content of the second and third calls. Why did he ring at 2144? He says because Nurse Bragg had told him the patient’s blood pressure was low. If that is so how can he and Dr Rajaratnam have a recollection that the blood pressure reading was unknown at this time? Perhaps the respondent was not told the reading (unlikely) or was not prepared to rely upon it sufficiently to relay it to Dr Rajaratnam (unlikely) or perhaps the contents of the phone calls has become jumbled in his recollection. This is the more likely answer. It is likely that Nurse Bragg did make a call to Dr Rajaratnam but it is difficult to resolve this conflict with any degree of confidence. It is also unnecessary because nothing turns on the second conversation or the identity of the caller.

36. What is important is that the respondent says that on his first call (the one at 2052) he was not given instructions by Dr Rajaratnam to use inotropic support for the patient. Dr Rajaratnam says that he did give that instruction. With respect to him the Tribunal is not satisfied that that direction was given at that time. The respondent, whose notes were careful, made no such record. The choice of inotrope, whilst not critical, was one to be made when some degree of satisfaction was reached as to the diagnosis of the underlying condition. Dobutamine, the inotrope instituted by Dr Rajaratnam after he had taken charge after 2300 or thereabouts is eminently suitable for cardiogenic shock. It is likely, as was demonstrated by

the treatment at Liverpool Hospital, that a diagnosis of septic shock would indicate the use not of Dobutamine but another inotrope such as adrenaline or noradrenaline.

37. In any event, the Tribunal is not satisfied that the use of inotropic support was ordered by Dr Rajaratnam at any time prior to his arrival, and consequently Particular 5 is not made out.

38. What is common ground in the evidence is that about 2200 whoever had been on the telephone and however it came about, it was noticed by the respondent amongst others that the patient's blood pressure had dropped and that urgent resuscitation was absolutely essential. Finally it was undertaken. The patient was transferred to the resuscitation room around the corner from the emergency ward and colloid was administered stat. It is entirely possible that the first 250 or 500 mls was pumped into the patient and not recorded on the fluid chart. All concerned were frantically involved in the transfer and her resuscitation, the lead role being played by Dr Pelichowski.

39. By 2330 she was being examined by Dr Rajaratnam who assumed control of her treatment. She had passed from the control of the respondent when she was removed by Dr Pelichowski into the resuscitation room about 2200.

40. Until that time when the patient passed from his responsibility at 2200, the respondent had not commenced resuscitation measures. He had not commenced intravenous antibiotics.

41. Mr Donaldson argued that no peer reviewed had specifically criticised the respondent for failing to introduce IV antibiotics. That argument is not persuasive. The quotation from

Dr Macken above to the effect that the respondent did not commence treatment of the listed possible diagnosis (in this case referring to sepsis) with the urgency that was required is indeed criticism of the failure to use intravenous antibiotics. More generally, Mr Donaldson argued that the absence of actual intervention on the part of the respondent is explained (and excused) by him:-

Waiting for the results of the quite proper investigatory tests he had ordered;

By seeking advice from his perceived senior;

Not being entirely happy with that advice (the Tridil) by seeking a consultation with the patient's VMO, Dr Rajaratnam;

He did not himself put into effect the orders of Dr Rajaratnam because he believed that Dr Pelichowski would take the necessary action;

Finally, being still involved, as he was required to be, he noted the deterioration some time around 2200 and contacted Dr Rajaratnam again. He assisted in the resuscitation efforts which followed.

42. Thus, it is said, his actions throughout the night can be seen as reasonable, not attracting criticism and certainly not demonstrating any lack of adequate care for his patient.

43. These arguments are not persuasive either because they do not really address the basic thrust of the complaint. The respondent had undertaken to perform a service in the Department of Emergency Medicine. His qualifications and experience befitted him to examine, stabilise, diagnose and treat. He should have recognised the seriousness of the patient's illness at his first assessment, that is by 1830 but without argument by 1930, when the blood gas results showed marked acidosis. His obligation was to stabilise – to treat her circulatory shock first and foremost. Consultation and further investigation to define the

underlying cause could wait. Resuscitation could not. His failure to recognise the priority is indicative of a lack of judgment.

44. However, the points made by Mr Donaldson do have some validity in terms of how harshly the respondent should be judged. The respondent was concerned at the obligation to “first do no harm”. This is often seen and is, indeed, the expected behaviour of a junior doctor (Dr Macken). The respondent, however, had undertaken obligations more onerous than those of a junior doctor with access to many levels of supervision. That he had done so, ie, placed himself in this position of responsibility, was basically his decision but it must be observed that the system which operated at Campbelltown (and apparently other hospitals) made a mismatch between a doctor’s level of skill and the problems with which he was required to deal almost an inevitability.

45. Dr Shehabi observed that there is an “unregulated industry” of career medical officers. These practitioners, with respect to them, are not required to have specialist training or even to undergo regular meaningful professional education. They operate without consultant supervision on site or even on call. This is a system fraught with danger. It is believed that this situation has been recognised and corrected at Campbelltown Hospital.

46. According to Dr Bezzina, the major part of the blame for this tragic outcome lies with “the system” as it then was; part lies with at least some of the nursing staff who do not appear to have been as vigilant as they should have been on behalf of the patient and, part, of course, is sheeted home to the respondent.

47. The Tribunal did consider whether, in these circumstances, the failures of the respondent might be seen to be just an isolated act of poor judgment and not demonstrative of a lack of adequate judgment. Such a distinction was described by Hodgson JA in *Daskalopoulos v Health Care Complaints Commission* (2002) NSWCA 200 [59].

48. However the aggregation of the respondent's missed opportunities persuades the Tribunal that, in conformity with the unanimous views of the peer reviewers, the respondent's conduct fell below an acceptable level.

49. The remarks of AJA Rolfe in *HCCC v A Medical Practitioner* (2001) NSWCA 158 [56] are apposite:-

However for the overall good and protection of patients, the *Medical Practice Act* 1992 has laid down standards with which medical practitioners must comply. The standards, no doubt, recognise that medical practitioners will, probably, frequently, work under conditions of pressure, stress and urgency of the type this medical practitioner encountered in this case. It is against such a background, at least in part, that the standards for "unsatisfactory professional conduct" have been given statutory formulation. It is with that demanding standard that medical practitioners must comply.

50. In summary, for the foregoing reasons, the complaint is made out in that the respondent has been guilty of unsatisfactory professional conduct because he demonstrated a lack of judgment in the following particulars: 2, 3 and 4.

51. As to particulars 1 and 7, being dealt with together, the Tribunal is not satisfied that it was an act of unsatisfactory conduct to fail to write an order for 30 minute observations. As a doctor the respondent was entitled to rely on the nurses experienced in the Department of Emergency Medicine to make and record timely observations. The failure to ensure that this was done, however, does represent a lack of care on his part.

52. As to Particulars 5 and 6, these are not made out. The Tribunal is not satisfied that inotropic support was ordered by Dr Rajaratnam before his arrival and the Tribunal is satisfied that the respondent's investigation, as distinct from his intervention, was quite appropriate.

53. Having made this finding of unsatisfactory professional conduct the Tribunal is also satisfied that the lack of confidence in his own abilities displayed by the respondent on this occasion no longer provides a proper description of his capacities.

54. It is noted that he returned without complaint and served as the medical officer in charge of the ICU at Campbelltown Hospital after these events. He was regarded as the medical practitioner to whom others could turn with confidence for help because of his superior skills (Dr Goolam). His knowledge and skills are regarded as superior to the general (run of) locums/registrar (Dr Doan). His skills are praised by registered nurses with whom he has worked. Most significantly, in his present employment and proposed future training as established by Mr Nanavadi and Dr Shehabi, the respondent is performing well and is expected to perform at even higher levels as his expertise is increased and honed in appropriate training positions with clear lines of responsibility together with easily available supervision. There is, then, no need to impose any conditions on the respondent's registration.

55. Indeed, the Tribunal briefly contemplated whether, having regard to the extenuating circumstances, it was desirable or even possible to make the finding of unsatisfactory conduct and yet impose no sanctions. Such a course is not, however, open. [*HCCC v a Medical Practitioner* (2001) NSWCA (158)]. Selecting from the options prescribed by ss 61 to 64 the

Tribunal has determined that the facts of this case, as established, require the respondent be reprimanded for his failure to act positively on this occasion.

56. Finally, the shortcomings of the respondent are at the lowest end of the scale of seriousness. The outcome was tragic, the respondent may have contributed by failing to act, but his failure to act was in no way a gross dereliction of duty. In those circumstances it is somewhat surprising that a complaint was made to bring him before the Medical Tribunal.

57. In the ordinary course, a complaint having been found established, costs would follow the event. In these circumstances it seems to the members of the Tribunal that an appropriate and just way of dealing with these proceedings is to make no order as to costs.

ORDERS

1. The complaint is made out in particulars 1, 2, 3 and 4.
2. Dr W is guilty of demonstrating a lack of judgment and care.
3. Dr W is reprimanded for his actions on 25 August 2001.
4. No order as to costs.

(Signed)
Judge D J Freeman DCJ

(Signed)
Dr Matthew Vukasovic

(Signed)
Dr Joanna Hely

(signed)
Dr Maureen Gleeson PhD

Further Order: 5. Temporary order preventing the name of the practitioner being published, subject to any further application which may be made.