PROFESSIONAL STANDARDS COMMITTEE INQUIRY

Constituted under Part 8 of *the Health Practitioner Regulation National Law (NSW)*
to hold an Inquiry into a Complaint in relation to:

Dr Anantha Kumarasamy Ramanathan

MED0001528572

506332

Date/s of Inquiry:	27 - 30 November 2017
Committee members:	Mr Robin Handley (Chair) Dr Anthony John Grabs (Vascular surgeon) Dr Upeksha Irani De Silva (Vascular surgeon) Dr Catherine Berglund, PhD (Lay member)
Appearance for Health Care Complaints Commission:	Ms Angela Petrie, instructed by Mr Feneil Shah, Legal Officer of the HCCC
Appearance for Dr Ramanathan:	Mr Stephen Barnes, instructed by Mr David Brown, of Browns Legal & Consulting
Date of decision:	20 December 2017
Decision	The Committee found unsatisfactory professional conduct in respect of particulars 7(c) and (d), 8 and 9(a) of Complaint 2 and, therefore, determined to impose conditions on Dr Ramanathan's registration, set out below, should he apply to be re-registered in Australia. The Committee did not find unsatisfactory professional conduct in respect of Complaints 1, 3 and 4.
Publication of decision:	Refer to paragraph 98 of this decision for details of non-publication directions.

1. Dr Ramanathan, who qualified as a doctor in Sri Lanka, was first registered to practise medicine in Australia in 2010. He has practised as a vascular surgeon in Queensland and on the Central Coast of New South Wales. In April 2014, the Medical Council of NSW received notification that, following a review by the Royal Australasian College of Surgeons (RACS) at the request of the Central Coast Local Health District, restrictions had been placed on the scope of Dr Ramanathan's practice as a vascular surgeon. The RACS report identified concerns with Dr Ramanathan's surgical approach, skills and techniques, and with his communication with other team members.

2. On 16 September 2014, the Medical Council convened proceedings under s 150 of *the Health Practitioner Regulation National Law (NSW)* (the National Law). These proceedings resulted in conditions being placed on Dr Ramanathan's registration limiting his performing aortic surgery or endoluminal aortic surgery and requiring that his practice be subject to supervision and monthly reporting to the Medical Council. On 23 September 2014, the Council also referred the matter to the Health Care Complaints Commission (HCCC) for investigation as a complaint. On 18 November 2014, after a review, the conditions imposed on Dr Ramanathan's registration were varied to reporting on a quarterly rather than a monthly basis. In June 2015, the restrictions on his performing surgery were relaxed.

3. On 28 January 2016, the Medical Council received a further report detailing complications arising from surgery performed by Dr Ramanathan. On 18 April 2016, the Council received a mandatory notification from Dr Brian Bourke, the Head of the Department of Vascular Surgery at Gosford and Wyong Hospitals, raising concerns about Dr Ramanathan's clinical performance following surgery performed by him in February 2016. The Council therefore again convened s 150 proceedings and, following a hearing on 11 May 2016, Dr Ramanathan's registration was suspended. On 13 May 2016, the Council referred this further matter to the HCCC for investigation as a complaint. In September 2016, Dr Ramanathan sought a review of the decision to suspend his registration and, following a hearing on 28 October 2016, the suspension was lifted and conditions imposed on Dr Ramanathan's registration. The principal conditions limited his practice to working as a surgical assistant and only under the direct supervision of a consultant surgeon.

4. On 3 May 2017, following its investigation of the 2016 incident, and with reference to its investigation of the other incidents which had been the subject of the earlier s150 proceedings, the HCCC lodged four complaints with the Medical Council alleging that Dr Ramanathan was guilty of unsatisfactory professional conduct. On 15 August 2017, the Council convened this Professional Standards Committee to inquire into those complaints which, prior to the hearing, were the subject of further minor amendments.

5. Having examined the evidence, the Committee found that Dr Ramanathan's conduct in respect of one of the four complaints constituted unsatisfactory professional conduct and made orders for the protection of the health and safety of the public.

BACKGROUND

6. Dr Ramanathan, who is now aged 55, graduated with the degrees MBBS from the University of Colombo in 1990. He became a fellow of the Royal

College of Surgeons in 1995 and of the RACS in May 2010, having worked in Sri Lanka, England and New Zealand. He was first registered as a medical practitioner in Australia on 23 September 2010. From October 2010, Dr Ramanathan practised as a vascular and general surgeon at Cairns Base Hospital in Queensland and, from January 2012 until May 2016, when his registration was suspended, as a vascular surgeon on the Central Coast of NSW. He did not practise between then and September 2017, although between April and September 2017 he was an "observer" at the East Tremont Vascular Centre in the Bronx, New York. Since 2 October 2017, he has been employed as a vascular surgeon at Nassau University Medical Center in New York.

7. The four complaints which are the subject of this inquiry arise from Dr Ramanathan's treatment of six patients, referred to here as Patients A to F, at Wyong and Gosford Hospitals.

8. The first complaint relates to Dr Ramanathan's surgical planning and decision making for Patients A, E and F, alleging that Dr Ramanathan is guilty of unsatisfactory professional conduct as defined in s 139B(1)(a) of the National Law in that he:

> *"engaged in conduct that demonstrates the judgment possessed or care exercised, by the practitioner in the practice of medicine is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience".*

9. The second complaint relates to Dr Ramanathan's clinical decision making and surgical technique for Patients B, C, D, E and F and alleges that Dr Ramanathan is guilty of unsatisfactory professional conduct as defined in s 139B(1)(a) of the National Law in that he:

> *"engaged in conduct that demonstrates the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of medicine is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience".*

10. The third complaint relates to Dr Ramanathan's post-operative care and management for Patients C and F and alleges that Dr Ramanathan is guilty of unsatisfactory professional conduct as defined in s 139B(1)(a) of the National Law in that he:

> *"engaged in conduct that demonstrates the judgment possessed, or care exercised, by the practitioner in the practice of medicine is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience".*

11. The fourth complaint alleges that Dr Ramanathan is guilty of unsatisfactory professional conduct pursuant to s 139(1)(b) of the National Law in that he failed to ensure the operation report for Patient B's surgery contained sufficient detail regarding the quality of the vessels in the region of the aortic bifurcation, and failed to document adequate directions for hospital staff to follow for Patient A's post-operative care and management, thereby

contravening clause 7 of the *Health Practitioner Regulation (NSW) Regulation 2010* (now repealed) (the 2010 Regulation).

12. The relevant provisions of the National Law and the 2010 Regulation are set out in **Attachment 1**.

13. In reaching our decision, the Committee had regard to oral evidence given in person by Dr Ramanathan, and by Dr John Crozier and Professor John Fletcher (the HCCC's expert witnesses), and by telephone by Professor Sir Peter Bell and Dr Ammanulla Bolio (Dr Ramanathan's expert witnesses). The Committee also had regard to the documents produced by the parties. We applied the standard of proof of reasonable satisfaction and in doing so we were mindful of the gravity of the allegations and the consequences for Dr Ramanathan if we were to find them proven.

ISSUES

14. The four complaints and particulars or details of the complaints are set out in full at **Attachment 2**. The allegations raised in the complaints raise a number of issues that we will consider in turn with reference to the particulars, stating our findings based on the evidence before us and having heard submissions on the evidence from the parties.

15. The issues in respect of each complaint are as follows:

> **Complaint 1**. Did Dr Ramanathan's surgical planning and decision making for Patients A, E and F demonstrate that his judgment or the care he exercised in the practice of medicine were significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience?
>
> **Complaint 2.** Did Dr Ramanathan's clinical decision making and the surgical technique he exercised during vascular surgery for Patients B, C, D, E and F demonstrate that his knowledge, skill or judgment, or the care he exercised in the practice of medicine were significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience?
>
> **Complaint 3.** Did Dr Ramanathan's post-operative care and management of Patients C and F demonstrate that his judgment, or the care he exercised in the practice of medicine were significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience?
>
> **Complaint 4**. Did the operation report completed by Dr Ramanathan in respect of Patient B's surgery on 24 February 2013 - in particular, detail in respect of the quality of vessels in the region of the aortic bifurcation - and the directions to hospital staff for Patient A's post-operative care and management meet the required standard for medical record keeping?

16. Having made our findings on these issues, we will consider whether Dr Ramanathan's conduct amounts to unsatisfactory professional conduct and, if so, what orders or directions we should make.

Complaint 1. The First Issue

Did Dr Ramanathan's surgical planning and decision making for Patients A, E and F demonstrate that his judgment or the care he exercised in the practice of medicine were significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience?

PATIENT A

17. Patient A was a 32 year old man who had cardiothoracic surgery at the Royal North Shore Hospital (RNSH) on 4 March 2013. Patient A was referred to Dr Ramanathan by Dr Gabrielle O'Kane, an Infectious Diseases consultant on the Central Coast. In his statement dated 23 August 2017, Dr Ramanathan said that his understanding was that the vascular surgeons at the RNSH had requested that the patient's mycotic aneurysm be managed on the Central Coast. Dr Ramanathan was concerned that the aneurysm had doubled in size within a short period of time, that the patient had presented to Gosford Hospital on multiple occasions complaining of abdominal pain, and that delaying the required surgery would result in a burst aneurysm and catastrophioc bleeding, given that the patient was on Warfarin. Although his preference was to operate at Gosford Hospital, no emergency operating time was available and staff at Gosford offered to arrange for the operation to be conducted at Wyong Hospital. Dr Ramanathan also requested that an experienced general surgeon, Dr Adrian Cohen, be present throughout the operation.

Particulars:

1. On 3 April 2013, Patient A consulted the practitioner in his rooms for his infective aneurysm. On 3 April 2013, the practitioner inappropriately planned to operate on Patient A's aneurysm at Wyong Hospital on 5 April 2013 in circumstances where:

a. the practitioner had limited time for a perioperative workup of Patient A's medical and surgical history.

18. The Committee found that the perioperative workup was adequate. There was an echocardiogram in the Perioperative Chart (exhibit 8) and computed tomography angiography (CTA) images showing the position of the Patient's mycotic aneurysm (Attachment B to Dr Ramanathan's statement dated 23 August 2017). We reject Dr Crozier's opinion, noting Dr Ramanathan's evidence of his concern that the aneurysm had doubled in size since the patient's cardiothoracic surgery at the RNSH (as shown in a CT scan arranged by Dr O'Kane) and therefore might rupture. He considered the situation an emergency. We note Professor Bell's evidence that given this concern, the investigations carried out by Dr Ramanathan were adequate.

b. the practitioner was uncertain of the exact location of the presumed infective aneurysm and he considered it may have involved paraduodenal arteries.

19. The Committee is satisfied, as Professor Bell recognised, that the CT images available to Dr Ramanathan and examined by the Committee show the location of the aneurysm in a distal branch of the superior mysenteric artery.

We reject Dr Crozier's evidence on this issue. In our view, the particular is not made out.

c. an operation on the vessels in the region of Patient A's infected aneurysm was likely to be very challenging;

20. Given Dr Ramanathan's knowledge of the location of the aneurysm, the Committee disagrees with this statement and the opinion expressed by Dr Crozier. Dr Ramanathan said that on viewing the images from the CT scan at Wyong Hospital, he concluded that the aneurysm was located in a teriary jejunal branch of the superior mesenteric artery. He said the surgical repair, undertaken on 5 April 2013, was uneventful, the aneurysm proving to be in the exact location he had identified. Professor Bell's oral evidence was that since the aneurysm was in a branch of the artery, this was "not too big a procedure and the chances of it going wrong were relatively small".

d. Patient A underwent surgery at Royal North Shore Hospital on 4 March 2013. Post-operatively, Patient A's cardiothoracic surgeons made arrangements for Royal North Shore Hospital vascular surgeons to further manage Patient A's infective aneurysm involving the superior mesenteric artery;

21. The Committee noted that the RNSH discharge paperwork (exhibit 9, pp 12-13) shows the follow up identified was with cardiothoracic surgeons and not vascular surgeons. Dr Ramanathan said Dr O'Kane, who referred the patient to Dr Ramanathan because she was concerned at the doubling of the patient's aneurysm shown in the CT scan, told him that the patient had been discharged into the care of the Central Coast Local Health District vascular surgeons. Dr Ramanathan thought the patient's aneurysm needed urgent attention. Given the degree of difficulty of the surgery, Professor Bell considered it reasonable for Dr Ramanathan to undertake the surgery at Wyong Hospital. The Committee is not satisfied on the evidence that Dr Ramanathan's conduct was below the required standard.

e. the practitioner should have referred Patient A back to Royal North Shore Hospital.

22. In hindsight, Dr Ramanathan agreed that he should have referred the patient back to the RNSH. The Committee is of the same view. However, given the referral from Dr O'Kane, and the fact that the patient had a growing mycotic aneurysm, the Committee is satisfied that expedient surgery was not unreasonable and Dr Ramanathan's conduct in operating on the patient without reference to the RNSH was not significantly below the required standard.

23. The Committee also notes that in his report dated 8 September 2017, Professor Bell said that because the aneurysm was in a branch of the artery and not the main artery itself, "it was perfectly reasonable to do it [to operate] at Wyong Hospital". The CT angiogram indicated that the main mesenteric artery was normal and there was enough room between the aneurysm and the main SMA to ligate it safely. He said the sutures used were those used by vascular surgeons.

24. The Committee concludes that none of the particulars relating to Patient A discussed above establish that Dr Ramanathan's conduct was significantly below the required standard.

PATIENT E

25. Patient E, an 82 year old man, was admitted to Gosford Hospital for repair of a 100mm abdominal aortic aneurysm. Dr Ramanathan performed an endovascular aortic repair on 2 December 2013.

Particulars

2. On 3 December 2013 at the angiography room at Gosford Hospital, the practitioner inappropriately planned to perform surgery on Patient E in circumstances where:

a. the practitioner performed Patient E's surgery with the assistance of a junior nurse who had not assisted with this type of procedure before.

26. The Committee accepts Dr Ramanathan's evidence that two senior nurses also assisted with the surgery. He said it was unfortunate that a junior nurse, who happened to be nearest to the table where the Lunderquist wire was located, dropped it in the course of passing it to him.

b. the practitioner performed Patient E's surgery in a poorly lit radiology facility which required him to wear a head lamp.

27. The Committee notes Dr Ramanathan's evidence that elective endovascular aortic repairs were performed in the radiology room at Gosford Hospital. He said that lighting in the room was adequate but it was his practice to wear a head lamp. While Dr Crozier was critical of Dr Ramanathan operating with the assistance of a junior nurse in a poorly lit radiology facility, Professor Bell disagreed. He said in oral evidence that in a radiology suite the lighting is often not as good as in an operating theatre but it is only if things go wrong that additional lighting is required.

28. The Committee is not satisfied that the particulars in either paragraph (a) or (b) establish that Dr Ramanathan's conduct was significantly below the required standard. We note that the circumstances in which he operated on patient E were largely outside his control.

PATIENT F

29. Patient F was a 73 year old man when Dr Ramanathan performed varicose veins surgery on Patient F in November 2015. His plan was also to perform a "minimally invasive arterial procedure" in February 2016 to address an arterial blockage in the patient's right leg. Prior to the surgery on 25 February 2016, Dr Ramanathan said he warned the patient that there was a risk that the arterial clearance might not be successful and could lead to problems such as compromise of distal circulation. Ultimately, the surgery was unsuccessful because, after several attempts, "re-entry back into the lumen could not be achieved". Dr Ramanathan therefore decided to stop the procedure. He said

"The patient followed routine angiogram post-operatve care and was discharged home."

30. Approximately three weeks after the operation, when the patient's post-operative pain had subsided, Dr Ramanathan planned to perform a scan of the ectatic aorta. He said that on 2 March 2016, he saw the patient in his rooms, and did not find him to be unwell. While the patient had some pain in his right thigh, he said it was getting better on Panadol. However, in the evening of the next day – 3 March 2016 - having first attended his GP, the patient presented at Wyong Hospital Emergency Department (ED) "very unwell". The ED doctor phoned Dr Ramanathan that evening and Dr Ramanathan explained the treatment the patient had undergone, that he had seen him the previous day, and that he could not visit him at Wyong Hospital because he had no privileges there. Dr Ramanathan told the ED doctor he was planning to see the patient the following week. The ED doctor "did not raise any degree of concern that would have necessitated an earlier review". Dr Ramanathan said his understanding at that time was that the main concern under consideration at Wyong Hospital was gastroenteritis and that, subject to addressing that issue, the patient would be sent home.

31. The following morning – 4 March 2016, another doctor from the Hospital phoned to say the patient had been kept in overnight. Dr Ramanathan discussed the patient's condition and treatment with the doctor. That evening, Dr Ramanathan received a series of calls from the Hospital, the first from the ED consultant who said there had been a sudden increase in the swelling of the patient's right leg. Dr Ramanathan suggested review by a general or vascular surgeon. The general surgical registrar subsequently phoned Dr Ramanathan several times and he endeavoured to assist her, again recommending that the patient should be seen by another consultant given his inability to see the patient in Wyong Hospital. Later, an ICU doctor phoned about the possibility of transferring the patient to Gosford Private Hospital. Dr Ramanathan considered this unsatisfactory, given that it was a Friday evening, Gosford Private Hospital's Intensive Care Unit was small and the supporting staff limited. The patient was later transferred to Gosford Public Hospital.

32. Dr Ramanathan said he then recieved a phone call from Dr Bourke's registrar, Dr Chandra, enquiring about the patient, which Dr Ramanathan understood to be at Dr Bourke's request, Dr Chandra finishing the call saying Dr Bourke would call him if he needed further information. It appears the patient underwent further surgery, a CT angiogram having revealed an infected pseudoaneurysm. Dr Ramanathan said he was in touch with Dr Chandra by phone both before and after the surgery and also tried to contact Dr Bourke both by phoning his rooms and sending him an email, receiving no response. Dr Ramanathan said he very much regretted this outcome for the patient and it was regrettable that he was unable to visit him as he would have liked.

Particulars

3. In January 2016, the practitioner inappropriately planned to perform arterial revascularisation surgery on Patient F on 25 February 2016 in circumstances where:

a. Patient F's peripheral arterial disease was asymptomatic;

b. *Patient F was experiencing no symptoms suggestive of intermittent claudication;*

c. *Patient F had no evidence of critical limb ischemia;*

d. *the practitioner's surgical plan was to attempt to revascularise Patient E's right superficial femoral artery using a contralateral approach passing an access sheaf from the left common femoral artery over the aortic bifurcation to the right common femoral artery. The practitioner's contralateral approach carried an increased risk of procedural complications;*

e. *the practitioner had not arranged scans pre-operatively to assess Patient F's abdominal aortic aneurysm;*

f. *the practitioner failed to first trial compression stockings for management of the venous insufficiency.*

33. Dr Ramanathan said he did not accept that planning to perform arterial revascularisation on Patient F on 25 February 2016 was inappropriate. However, he agreed with the statements in paragraphs (a), (b), (c), (e) and the first sentence of paragraph (d). With regard to paragraph (e), as Professor Bell indicated, not all vascular surgeons arrange for such scans pre-operatively. Professor Bell said that while a scan is prudent, not all specialists would arrange one. With regard to the second sentence of paragraph (d), Professor Fletcher gave oral evidence that the contralateral approach is standard practice for Australian vascular surgeons. With regard to paragraph (f), the Committee accepts Dr Ramanathan's evidence that he had trialled (TED) compression stockings on the Patient who was obese and could not tolerate them.

34. The Committee concludes that none of the particulars relating to Patient F discussed above establish that Dr Ramanathan's conduct was significantly below the required standard.

35. In summary, the Committee is not satisfied on the balance of probabilities that the particulars for Complaint 1 establish that Dr Ramanathan's surgical planning and decision making demonstrate that his judgment or the care he exercised in the practice of medicine were significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.

Complaint 2. The Second Issue

Did Dr Ramanathan's clinical decision making and the surgical technique he exercised during vascular surgery for Patients B, C, D, E and F demonstrate that his knowledge, skill or judgment, or the care he exercised in the practice of medicine were significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience?

PATIENT B

36. Dr Ramanathan stated that Patient B, a 77 year old man, presented as an emergency at Gosford District Hospital on 24 February 2013 with a ruptured abdominal aortic aneurysm. Dr Ramanathan was on call and therefore

undertook the repair. He said he achieved safe and timely clamping of the aorta in spite of the presence of significant adhesions in the upper abdomen. However, he encountered difficulties in completing the proximal anastomosis.

Particulars

1. The practitioner exercised poor clinical decision making and surgical technique during Patient B's surgery on 24 February 2013 in circumstances where:

a. the practitioner did not adequately suture the infra-renal aortic anastomosis on his first two attempts.

37. Dr Ramanathan acknowledged this. He called another vascular surgeon, Dr Alan Meek for assistance who completed the anastomosis. Dr Crozier, while stating in his report dated 19 October 2015 that Dr Ramanathan's failure to achieve the anastomosis after two attempts was significantly below the required standard, stated in oral evidence that while not common, such problems do occur especially in emergency situations. In his report dated 8 September 2017, Professor Bell also indicated that a failure on the first two attempts was unusual. In the Committee's view, Dr Ramanathan's surgical technique was, in this regard, below the required standard but not significantly below.

b. the practitioner did not achieve aortic cross clamping in a timely manner, ideally within minutes, during Patient B's surgery on 24 February 2013.

38. Dr Ramanathan said there were adhesions in the patient's upper abdomen which had to be dealt with first in order to achieve safe clamping. He had the aorta pinched between the thumb and index finger of his right hand and control was achieved within a few minutes of commencing the operation. Once he was satisfied that the line of sight was clear, clamping was achieved and he called out "aorta clamped". Unfortunately the time taken was not recorded.

39. The Committee disagrees with the statement in particular (b), which is based on Dr Crozier's report, because the patient was having CPR at the commencement of the surgery, clamping did occur, and the fact that the patient survived indicates, according to Professor Bell, that clamping occurred in a timely fashion.

c. the practitioner failed to advocate for the performance of the embolectomy after Patient B's aneurysm repair in a timely manner.

40. Dr Ramanathan said "it was noticed that the right leg was ischaemic necessitating right femoral embolectomy". The theatre staff insisted on a staff changeover before he could commence this procedure, resulting in a wait of at least an hour. Dr Ramanathan said he did not want to create controversy by insisting that the embolectomy be done immediately. In the interim, the patient was ventilated, kept warm and was monitored in the operating theatre. Dr Crozier criticised Dr Ramanathan's failure to advocate on behalf of the patient for the embolectomy to proceed immediately. Professor Bell

commented that insistence by the staff on a changeover suggested a poor relationship between the theatre staff and Dr Ramanathan. Dr Ramanathan accepts that he could have dealt better with the situation.

41. The Committee is of the view that the situation could have been avoided had Dr Ramanathan exercised better leadership skills, but is satisfied that while his decision making was below the required standard it is not significantly below.

    2. *The practitioner's operating time for Patient B's surgery on 24 February 2013 was approximately seven hours which was excessive and not in Patient B's best interests.*

42. In the Committee's view, given the delay in waiting for Dr Meek to arrive to assist in the aortic anastomosis, and the wait of at least an hour between the two operations, the total operating time of approximately seven hours was not so excessive as to be below the required standard. Professor Bell commented that seven hours would not, if the anaesthesia was properly conducted, be harmful to the patient. Without delays, the two operations would have taken about five hours, which, he indicated, was still within the ball park for such surgery.

43. The Committee concludes that none of the particulars relating to Patient B discussed above establish that Dr Ramanathan's conduct was significantly below the required standard.

PATIENT C

44. Patient C, who was aged 53, had been scheduled to undergo a right femoropopliteal bypass under Dr David Robinson but had failed to attend on three occasions. Additionally, she had been scheduled to undergo an aortabifemoral bypass under Dr Ramanathan on 24 April 2012, but once again did not attend. She was subsequently admitted to Wyong Hospital on 18 July 2012 suffering from deteriorating gangrene and cellulitis of the right leg. Dr Ramanathan said when he discussed the urgent need for revascularisation of her leg with her, she would only agree to undergo the two operations if they were performed on the same occasion. Dr Ramanathan balanced the risks associated with multilevel bypass against the risk of further harm from delaying the revascularisation due to the patient's declining to co-operate, and decided to proceed with the two operations on 14 August 2012. After completion of the aortabifemoral bypass, he asked the anaesthetist whether it was safe to continue and, on being told that it was, the patient having been stable throughout the first operation, he decided to proceed with the femoropopliteal bypass.

45. Dr Ramanathan said the patient recovered well and went home after 10 days. However, six months later, the patient suffered complications with the left limb graft thrombosis and required further surgery, which Dr Ramanathan performed on 5 February 2013. He said that widespread vascular disease, ongoing smoking and a background of severe diabetes were important factors in her condition.

Particulars

3. The practitioner inappropriately used a transverse infra umbilical abdominal incision to commence Patient C's surgery on 14 August 2012 in circumstances where:

a. the incision is more challenging than an incision superior to the umbilicus, risks transection of multiple collateral vessels in the abdominal wall and increases the risk of lower extremity ischaemia;

b. *the transverse infra umbilical abdominal incision used by the practitioner was not justified as Patient C was not morbidly obese and did not appear to have significant obstructive airway disease.*

46. The Committee is satisfied that transverse infra umbilical abdominal incision used by Dr Ramanathan during the course of this surgery was appropriate. Professor Bell's evidence is that this approach is standard practice for many surgeons.

4. The practitioner exercised poor clinical decision making and surgical technique during Patient C's surgery on 14 August 2012 in circumstances where:

a. the practitioner inappropriately performed the aortobifemoral bypass graft and right femoro popliteal bypass graft together;

47. The Committee is satisfied that in the particular circumstances of this patient, outlined above, it was appropriate to perform the two operations on the same occasion as Professor Bell stated. An endovascular approach could not be used as the patient had anaphylactic reaction to intravenous contrast. The Committee prefers Professor Bell's opinion that revascularisation was required to address tissue loss and gangrene in the right foot, rather than the contrary opinion of Dr Crozier that debridement could have been performed without revascularization.

b. the left sided component of the aortofemoral bypass graft presented greater risk to the patency of the previous left femoropopliteal bypass graft which added to the complexity of the operation;

48. The Committee acknowledges that this statement is correct. Professor Bell agreed with Dr Crozier that a unilateral bypass graft on the right would have been a better option. Professor Bell stated, nevertheless, that "it does not mean that such a procedure is unacceptable if the surgeon is properly trained".

c. the dissection of the left groin during Patient C's surgery was more technically demanding given the left sided component of the aortofemoral bypass graft;

49. The Committee acknowledges that this is correct. However, while Professor Bell accepted that the dissection would be more challenging, he said "it should not be a problem to a trained vascular surgeon".

d. the practitioner inappropriately harvested the great saphenous vein over its thigh length and undertook a valvulotome instead of using a reversed long saphenous vein, despite the distal anastomosis being performed to the below knee popliteal artery.

50. The Committee does not consider this an inappropriate practice. As Professor Bell acknowledged, this is a recognised approach which would be adopted by some vascular surgeons. The Committee is not satisfied that particular 4 establishes that Dr Ramanathan exercised poor clinical decision making and surgical technique during Patient C's surgery.

5. Anaesthetic in theatre commenced at about 1000 hours and continued until about 2130 hours. The practitioner's operating time for Patient C surgery was approximately eight to nine hours in length which was excessive and not in Patient C's best interests.

51. The Committee noted that the patient had three operations - an aorto-bifemoral bypass, a right femoro-popliteal bypass and a right transmetatarsal amputation - in the course of the surgery on 14 August 2012. While the surgery took many hours to complete, the Committee considers that the length of time was not excessive for a small regional hospital without senior vascular registrar assistance or fellow consultant assistance. The Committee accepts Dr Ramanathan's evidence that he asked the anaesthetist whether it was safe to continue with the right femoro-popliteal bypass and, it was on the basis of his being told that it was, that he decided to continue.

6. The practitioner exercised poor clinical decision making and surgical technique during Patient C's surgery on 5 February 2013 in circumstances where:

a. the practitioner delayed in obtaining suitable stenting for interventional treatment of the ruptured limb of the aortobifemoral graft;

52. The Committee did not consider the delay in obtaining a suitable stent to be unreasonable given that this was a regional hospital and that the large diameter stent required was unlikely to be held in stock by such a hospital. We note Dr Ramanathan's evidence that he arranged for a suitable stent to be delivered to Gosford Hospital.

b. the practitioner failed to seek surgical assistance from a more senior colleague or colleagues to assist with the bleeding complication, to achieve vascular control of the aortobifemoral graft or to assist generally at surgery.

53. The Committee agrees with Professor Bell's evidence that senior assistance was not required. Dr Ramanathan achieved vascular control by inserting a 8mm balloon. Professor Bell stated: "It is hard to know how another surgeon would have helped in this situation as access was limited and not all surgeons are trained in endovascular techniques."

54. The Committee concludes that none of the particulars relating to Patient C discussed above establish that Dr R's conduct was significantly below the required standard.

PATIENT D

55. Dr Ramanathan operated on Patient D, an 80 year old woman, on 4 September 2012 to effect an abdominal aortic aneurysm repair of a 52mm aneurysm. He said that early in the operation, an anterior branch of the inferior vena cava was avulsed and the tear was immediately repaired. There was no further bleeding from that site. Then, after completing the aneurysm repair, and whilst closing the abdomen, Dr Ramanathan noticed venuous blood pooling. At about the same time, the patient's blood pressure dropped. There was significant bleeding noted upon re-opening and no particular source could be found. The aorta had to be re-clamped to maintain blood pressure and the proximal anastomosis was reinforced. When the bleeding continued, it was clear to Dr Ramanathan that the patient had gone into Disseminated Intravascular Coagulation (DIC). With input from the anaesthetist, the massive transfusion protocol was implemented, but every time the clamp on the aorta was removed, the patient's blood pressure dropped precipitously. Dr Ramanathan arranged for Activated Factor VII to be delivered from Sydney, it not being stored locally on the Central Coast. Application of this led to some improvement, but the patient went into multi organ-failure and died during the night.

56. In his statement dated 23 August 2017, Dr Ramanathan said no post mortem or debriefing or root cause analysis was done despite his request. He asked the registrar who had assisted in the surgery, Dr Trevor Kwok, to complete the operating record for the surgery, as well as the CHASM (the Collaborating Hospitals' Audit of Surgical Mortality) report, so that there could be no question about a lack of transparency in the reporting of the surgery. The case was discussed at the morbidity and mortality meeting with Dr Bourke and no concerns were raised.

Particulars

7. The practitioner exercised poor clinical decision making and surgical technique during Patient D's surgery on 4 September 2012 in circumstances where:

a. [deleted in the revised Complaint]

b. the practitioner only recognised the accumulation of blood from an injury to a venous structure after approximately four hours of Patient D bleeding;

57. This particular accords with Dr Ramanathan's evidence, although it was not clear that the bleeding was from a venous structure. Dr Ramanathan said the bleeding was not from the tear repaired earlier in the operation. Dr Crozier's opinion was that Dr Ramanathan may not have checked for venous bleeding before closure of the abdomen and should have checked for this. Professor Bell thought the patient must have bled slowly during the course of the operation and blood must have accumulated somewhere, only becoming obvious on closure of the abdomen. We accept Dr Ramanathan's evidence that there was no significant bleeding noted until he started closing the

abdomen. The Committee is not satisfied that Dr R's surgical technique in this regard was significantly below the required standard.

c. the practitioner failed to seek additional surgical assistance to discern the site of bleeding and to determine the best method of definitive haemorrhage control after re-opening the abdomen;

58. Dr Crozier's opinion was that, in the circumstances, the assistance of another surgeon – "another set of eyes" - might have been helpful. Professor Bell agreed that if Dr Ramanathan could not locate the site of the bleeding, he should have called for help. The Committee agrees, as Dr Ramanathan conceded, that consulting a senior colleague might have been helpful. In our view, his not doing so was significantly below the required standard.

d. following achievement of immediate haemorrhage control, the practitioner failed to seek additional surgical assistance to reassess for a method of definitive haemorrhage control;

59. As with particular 7(c) above, the Committee agrees that consulting a senior colleague was warranted and that Dr Ramanathan's failure to do so was significantly below the required standard.

e. the practitioner did not initiate expedient haemorrhage control including by evacuating the abdominal cavity of blood and clots, and by using directed and immediate pressure to the point of presumed bleeding.

60. Professor Bell noted that it is not clear from the information available whether the patient's loss of blood had given rise to tachycardia and hypotension and whether the anaesthetist had alerted Dr Ramanathan to this, in which case he would have looked for a bleeding point. Dr Crozier noted that what was required was the evacuation of the pooled blood and the application of pressure. Professor Bell thought the application of pressure would not have stopped the bleeding. The Committee accepts Dr Ramanathan's evidence that he could not locate a particular point of bleeding in the abdomen. In our view, Dr Ramanathan's surgical technique in this regard was not significantly below the required standard.

8. The practitioner's operating time for Patient D's surgery was approximately 12 hours which was excessive and not in Patient D's best interests.

61. The evidence indicates that the prolonged duration of the surgery was largely a reflection of the time spent in trying to stop the abdominal bleeding. Dr Crozier pointed to "target fixation, loss of situational awareness and absence of adequate surgical assistance". Professor Bell noted that the surgery took longer than it should have done, although he pointed out that the speed with which surgeons operate varies. The Committee is satisfied that the operating time was excessive, noting that this may have been a consequence of Dr

Ramanathan's failure to call for surgical assistance. In our view, this was significantly below the required standard.

PATIENT E
Particulars

9. The practitioner exercised poor clinical decision making and surgical technique during Patient E's surgery on 3 December 2013 in circumstances where:

a. the practitioner failed to achieve percutaneous closure of the right common femoral artery puncture in his first four attempts;

62. The Committee notes that Dr Ramanathan recognised his deficiency in using Proglide percutaneous closure devices and has subsequently undertaken further training to address this. The Committee established that nine Proglide devices failed between the two groins: four devices were placed pre-closure and five post-closure (four of these being in the right groin). We are satisfied that this is indicative of poor device knowledge and practitioner inexperience and that Dr Ramanathan's persistence in trying to apply the devices indicates a failure of judgment. We agree with Dr Crozier that this was significantly below the required standard.

a2. the practitioner failed to achieve rapid haemorrhage control during Patient E's surgery;

63. The Committee accepts Dr Ramanathan's evidence that he achieved control once he had made the decision to open the groin. In our view, this particular is not made out.

b. the practitioner inappropriately used a Coda balloon in the aortic graft with 20 minutes of inflation which risked thrombosis within the body of the graft and would not prevent retrograde bleeding from the more distal common vessels;

64. The Committee disagrees with this statement, which is based on Dr Crozier's opinion, and relies on Professor Bell's evidence that it was reasonable to achieve proximal arterial control in this way during a cut down to the femoral artery.

c. the practitioner inappropriately inserted a dilator over a soft (Glide) wire which is of an inferior standard to a stiff (Lunderquist) wire;

65. The Committee accepts Dr Ramanathan's evidence that he felt he had enough purchase with the wire in the patient's chest to attempt this manoevre. We are not satisfied that his conduct in this regard was significantly below the required standard.

d. the practitioner failed to call for senior surgical assistance despite his multiple attempts at using the percutaneous closure device and technical device failures.

66. The Committee accepts Dr Ramanathan's evidence that once he realised his attempts at percutaneous closure had failed, he addressed this through open surgery. We are not satisfied that his conduct in this regard was significantly below the required standard.

PATIENT F
Particulars

10. The practitioner exercised poor clinical decision making and surgical technique during Patient F's surgery on 25 February 2016 in circumstances where:

a. the practitioner inappropriately persisted with multiple attempts to enter the right superficial formal artery occlusion for between 60 minutes and two hours;

67. Dr Ramanathan's procedure involved 68 minutes fluoroscopy time. According to the Guidelines of the American College of Cardiology (ACC.16), the mean time for this procedure in 47.07 minutes plus or minus 30.47 minutes. Dr Ramanathan's procedure was, therefore, within this time frame. This particular is not made out.

b. the practitioner ought to have been aware that Patient F did not have critical limb ischemia and would not require amputation if the revascularisation surgery was unsuccessful.

68. In his statement, Dr Ramanathan said he was aware of this. The Committee notes that this is a true statement and does not reflect on Dr Ramanathan's clinical decision making or surgical technique. This particular is, therefore, not made out.

69. The Committee concludes with regard to Complaint 2 that particulars 7(c) and (d), 8 and 9(a) discussed above establish that Dr Ramanathan's conduct was below the required standard, namely that the knowledge, skill or judgment possessed by him identified in those particulars was significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.

Complaint 3. The Third Issue

Did Dr Ramanathan's post-operative care and management of Patients C and F demonstrate that his judgment, or the care he exercised in the practice of medicine were significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience?

PATIENT A
Particulars

1. [deleted when the Complaint was revised]

PATIENT C

70. Dr Ramanathan said that on the day following the operation - 6 February 2013 - he noted that the patient's left foot was not well perfused, but Dr Ramanathan had to leave to travel overseas that day due to a family emergency. He arranged with Dr Alan Meek to look after his patients and, before leaving, he both told the registrar of the arrangement and sent Dr Meeks an email with information about his treatment of the patient and spoke with him by phone. The medical records show that Dr Meeks reviewed the patient the same day and then again on 9 February 2013.

Particulars

2. The practitioner failed prior [sic] 6 February 2013 to prepare a formal and documented transfer of care to a vascular surgical colleague in circumstances where:

a. following Patient C's surgery on 5 February 2013, the practitioner left to go overseas on 6 February 2013;

71. The Committee is satisfied from Dr Ramanathan's evidence that he contacted his colleague, Dr Alan Meek, both by email (exhibit 14) and phone and gave a comprehensive handover. Dr Ramanathan produced an email sent to Dr Meek at 12.28am on 6 February 2013 in which he described the surgery performed on Patient C, and Dr Ramanathan's evidence is that he also phoned Dr Meek from Sydney Airport before departing overseas. Moreover, Dr Ramanathan said he told his registrar, Dr Manjuka Raj, that he would speak to Dr Meek about Patient C and that Dr Raj should follow up with Dr Meek.

b. the practitioner was aware prior to leaving that Patient C's left foot was not well perfused.

72. Dr Ramanathan agrees with this statement: he thought the femoral-popliteal graft had failed. The Committee is not satisfied that the particulars with regard to Patient C establish conduct by Dr Ramanathan that was significantly below the required standard.

PATIENT F
Particulars

3. After Patient F's operation on 25 February 2016, the practitioner failed to make arrangements with a vascular surgeon with appropriate admitting rights to be able to take over the management of Patient F (at any time) if urgent admission to a public hospital facility was required.

73. The Committee notes that once the patient was admitted to Wyong Public Hospital on 3 March 2016, the duty of care for the patient lay with the Hospital and not Dr Ramanathan, who had no privileges there. The Committee accepts Dr Ramanathan's evidence that he provided Hospital staff, with whom he had a number of telephone conversations on 3 and 4 March 2016, with as much information as he could given the circumstances. We accept Dr Ramanathan's evidence that it would not have been appropriate, given the patient's condition and the more limited facilities at Gosford Private Hospital, for the patient to have been transferred there. This particular is not made out.

4. *After Patient F's operation on 25 February 2016, Patient F consulted with the practitioner on 2 March 2016. The practitioner inappropriately advised Patient F on 2 March 2016 to return to see him in 3 months or earlier if his leg pain did not improve in circumstances where at the consultation on 2 March 2016, Patient F presented to the practitioner complaining of severe pain in the right groin and profuse sweating.*

74. Dr Ramanathan's evidence is that when he saw the patient in his rooms at around 9.00 am on 2 March 2016, the patient had some pain in his right thigh but said it was getting better with his taking Panadol. Dr Ramanathan said he examined the patient, who was wearing shorts, and there was no evidence of any lumps or cellulitis. Moreover, the leg was well perfused. Dr Ramanathan said the patient was not sweating and he did not observe him to be using a towel for this at the time he saw him, contrary to statements made later by the patient and his wife. Had he seemed unwell with a fever and sweating, Dr Ramanathan said he would have arranged for a review by a physician, conducted further testing himself and/or referred him to hospital for review.

75. As it was, Dr Ramanathan said he told the patient that if his condition got worse, the patient should come back and see him. He had arranged to see the patient in three months time, but the patient was also to come in for an ultrasound scan of his aneurysm at Dr Ramanathan's rooms in a few weeks time and Dr Ramanathan said he would have seen the patient then. In his statement dated 4 July 2016, the patient said Dr Ramanathan told him to come back and see him in a week if the pain was no better.

76. The Committee is unable to make a finding as to whether the patient was sweating when he saw Dr Ramanathan on 2 March 2016 given the contradictory accounts of Dr Ramanathan and the patient and his wife as to the patient's condition and what occurred on that day.

77. In conclusion with regard to complaint 3, the Committee is not satisfied that the particulars above establish conduct by Dr Ramanathan significantly below the required standard.

Complaint 4. The Fourth Issue

Did the operation report completed by Dr Ramanathan in respect of Patient B's surgery on 24 February 2013 - in particular, detail in respect of the quality of vessels in the region of the aortic bifurcation - and the directions to hospital staff for Patient A's post-operative care and management meet the required standard for medical record keeping?

Particulars

1. *The practitioner failed to ensure that the operation report for Patient B's surgery on 24 February 2013 contained sufficient detail regarding the quality of the vessels in the region of the aortic bifurcation.*
2. *By reason of Particular 1, the practitioner acted contrary to:*
    a. *clause 7 of the Regulation;*
    b. *Schedule 2, clauses 2(1) and/or 2(2) of the Regulation.*

78. The Committee finds, relying on Professor Bell's evidence, that it is not common practice to record details of the quality of the vessels in the region of the aortic bifurcation in an operation report. Dr Crozier's evidence about this level of detail is merely that it would have been helpful. Particulars 1 and 2 are therefore not made out. We note Dr Ramanathan's evidence that he has, nevertheless, now addressed this issue recognising that such detail is useful for other staff.

    3. *On 5 April 2013, the practitioner failed to document adequate directions for hospital staff to follow for Patient A's post-operative care and management.*
    4. *By reason of Particular 3, the practitioner acted contrary to:*
        a. *clause 7 of the Regulation;*
        b. *Schedule 2, clauses 2(1) and/or 2(2) of the Regulation.*

79. Dr Ramanathan's instructions for Patient A's post-operative care, which were examined by the Committee, were recorded in the operation report by the registrar, according to Dr Ramanathan, at his direction. The Committee is not satisfied, therefore, that particulars 3 and 4 are made out.

80. Thus, in conclusion with regard to Complaint 4, the Committee is not satisfied that the particulars establish unsatisfactory professional conduct by Dr Ramanathan.

DOES DR RAMANATHAN'S CONDUCT AMOUNT TO UNSATISFACTORY PROFESSIONAL CONDUCT?

81. It is necessary for the relevant provisions of the National Law and their application to be briefly explained. Section 139B of the National Law states relevantly:

Meaning of "unsatisfactory professional conduct" of registered health Practitioner generally

1) Unsatisfactory professional conduct of a registered medical practitioner includes each of the following:

Conduct significantly below reasonable standard

(a) Conduct that demonstrates that the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of practitioner's profession is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.

Contraventions of this Law or regulations

(b) A contravention by the practitioner (whether by act or omission) of a provision of this Law, or the regulations under this Law or under the NSW regulations, whether or not the practitioner has been prosecuted for or convicted of an offence in respect of the contravention.

82. The phrase "significantly below" is not defined in the National Law. However, in the Second Reading Speech when the National Law's predecessor, the *Medical Practice Act 1992* (which contained a similar definition of unsatisfactory professional conduct), was introduced to Parliament, it was stated that:

The first main purpose of the bill is to refocus the Health Care Complaints Commission (HCCC) on investigating serious complaints about health service providers. To achieve this, Commissioner Walker recommended that unsatisfactory professional conduct be redefined so that only significant instances involving lack of skill, judgment, or care will result in an investigation or disciplinary action. … the reference to 'significant' in that context may refer to a single act or omission that demonstrates a practitioner's lack of skill, judgment or care, or it may refer to a pattern of conduct. In any individual case, that will depend on the seriousness of the circumstances of the case.

83. The word 'significant' has been described as meaning "not trivial, of importance, or substantial": *Re A Medical Practitioner and the Medical Practice Act* [40010 of 2007].

84. The HCCC bears the onus of establishing that Dr Ramanathan is guilty of 'unsatisfactory professional conduct', the standard of proof required being the civil standard of reasonable satisfaction, subject to the requirement for the Committee to be 'comfortably satisfied' given the seriousness of the consequences for Dr Ramanathan should the Committee make findings adverse to his professional standing: *Briginshaw v Briginshaw* (1938) 60 CLR 336.

85. As stated above, the Committee is comfortably satisfied from our findings that Dr Ramanathan's conduct identified in particulars 7(c) and (d), 8 and 9(a) of Complaint 2, was significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience. Dr Ramanathan is therefore guilty of unsatisfactory professional conduct pursuant to s 139B(1)(a). The Committee is not satisfied that he is guilty of unsatisfactory conduct in respect of Complaints 1, 3 and 4.

ARE ORDERS OR DIRECTIONS WARRANTED?

86. Having found that Dr Ramanathan is guilty of unsatisfactory professional conduct, the Committee must consider whether to exercise its powers under Part 8 Division 3 Subdivision 3 of the National Law and, in particular, whether to exercise its powers under s 146B(1). This states relevantly:

146B General powers to caution, reprimand, counsel etc [NSW]

1) A Committee may do one or more of the following in relation to a relevant health practitioner the subject of a complaint referred to it-

(a) caution or reprimand the practitioner;

(b) direct that the conditions, relating to the practitioner's practising of the practitioner's profession, it considers appropriate be imposed on the practitioner's registration;

(c) order that the practitioner seek and undergo medical or psychiatric treatment or counselling (including, but not limited to, psychological counselling);

(d) order that the practitioner complete an educational course specified by the Committee;

(e) order that the practitioner report on the practitioner's practice at the times, in the way and to the persons specified by the Committee;

(f) *order that the practitioner seek and take advice, in relation to the management of the practitioner's practice, from the persons specified by the Committee.*

2) If the relevant health practitioner is not registered, a direction may still be given under this section but has effect only so as to require the conditions concerned to be imposed when the health practitioner is registered.

87. Section 3A of the National Law states the objectives of the National Law as it applies in NSW:

> *In the exercise of functions under a NSW provision, the protection of health and the safety of the public must be the paramount consideration.*

88. It is well-established that the role of the Committee in exercising its powers is protective of the public interest and not focused on punishment of the individual concerned, notwithstanding that orders made may be punitive in effect: *Lee v Health Care Complaints Commission* [2012] NSWCA 90, per Basten JA at [20].

89. As stated above, the Committee has found Dr Ramanathan guilty of unsatisfactory professional conduct in respect of particulars 7(c) and (d), 8 and 9(a) of Complaint 2. To reiterate, we are comfortably satisfied that his conduct in operating on Patient D on 4 September 2012 demonstrated poor clinical decision making in that he failed to seek additional surgical assistance (particulars 7(c) and (d)) which, in turn, contributed to the excessive operating time on that occasion (particular 8). With regard to Patient E, we are comfortably satisfied that Dr Ramanathan exercised poor surgical technique in failing to achieve percutaneous closure of the right femoral artery in his first four attempts using Proglides, and poor clinical decision-making in persisting with the use of those devices (particular 9(a)).

90. The Committee informed the parties of its tentative findings on the evidence and heard submissions from the parties about the exercise its powers under s 146B(1) of the National Law. Mr Barnes, for Dr Ramanathan, submitted that his client had made appropriate concessions in the course of what have been very lengthy proceedings. Dr Ramanathan has learned from the complaints and has undertaken further training to address the shortcomings identified. Ms Petrie, for the HCCC, pointed to the protective nature of the proceedings and provided the Committee with proposed orders and conditions providing for supervision of Dr Ramanathan should he obtain re-registration to enable him to practise in Australia.

91. The Committee notes that for the purposes of subdivision 3 of the National Law, which sets out the powers of Professional Standards Committees, 'relevant health practitioner' is defined as meaning "a health practitioner registered under this Law". Dr Ramanathan is currently working as a vascular surgeon at Nassau University Medical Center in New York and is not registered as a health practitioner in Australia. This was an issue considered in the Professional Standards Committee decision in *Khamis* (15 September 2017). In that case, like this one, the practitioner was no longer registered under the National Law. The Committee found, in our view correctly, that by virtue of this fact, the Committee's powers were limited under s 146B(1) and, in particular, that it was not open to the Committee to caution or reprimand

the practitioner under s 146B(1) subparagraph (a) nor to make an order under s 146B(1) subparagraphs (c) to (f). However, s 146B(2) empowers the Committee, where a health practitioner is not registered, to give a direction imposing conditions on the health practitioner should he or she be registered in the future.

92. In Dr Ramanathan's case, had he have been currently registered, we would have issued him with a caution in respect of the unsatisfactory conduct detailed above. However, since he is not currently registered we are not empowered to do so. As explained above, we may, nevertheless, pursuant to s 146B(2), direct that conditions be imposed on his registration should he at some future time apply to be re-registered under the National Law.

93. In our view, the evidence indicates that Dr Ramanathan would benefit from some further training in clinical decision making and we consider it appropriate that should he re-register to practise in Australia, he should undertake the RACS's Clinical Decision Making course. We consider that the (Level B) supervision proposed by Ms Petrie was not required in this case for the protection of the health and safety of the public but, with this in mind, should Dr Ramanathan return to practise in Australia, we consider that his practice should be subject to an audit of his peers. In our view, the most appropriate way of achieving this is to impose a condition that he participate in the Australian Vascular Audit of his full medical practice according to the criteria identified by the Australian and New Zealand Society for Vascular Surgery. When required he should then submit this data to the NSW Medical Council.

DETERMINATION

94. We therefore direct that for the protection of health and the safety of the public the following conditions be imposed on Dr Ramanathan's registration should be apply to be re-registered under the National Law:

1. (a) To submit to an Australian Vascular Audit (AVA) of his full medical practice annually according to the criteria identified by the Australian and New Zealand Society for Vascular Surgery for a period of five years from the date of his re-registration.
   (b) To submit the data produced by this audit to the Medical Council of NSW within 14 days of the issue of the annual Australian Vascular Audit report.
   (c) To meet all costs associated with the audit and in providing audit data to the Medical Council.

2. To complete within 6 months of his re-registration the 'Clinical Decision Making Course' organized by the Royal Australasian College of Surgeons, and:
   (a) within 3 months of his re-registration, he must provide evidence to the Medical Council of his enrolment in this course;
   (b) within 7 days of his completing the course, he is to provide documentary evidence to the Medical Council that he has satisfactorily completed it; and
   (c) to bear responsibility for any costs in meeting this condition.

In the event that the RACS Clinical Decision Making course is unavailable, he must propose to the Medical Council for approval a similar course to be satisfactorily completed in accordance with the requirements of this condition no later than 6 months from the date of his re-registration.

3. To advise the Medical Council in writing at least seven days prior to changing the nature or place of his practice.

APPEAL AND REVIEW RIGHTS

95. Dr Ramanathan has the right to appeal this decision to the NSW Civil and Administrative Tribunal.

96. An appeal must be lodged with the Tribunal within 28 days of the date of these written reasons.

97. Dr Ramanathan also has the right to seek a review by the Medical Council of NSW of the Committee's order to impose conditions. Should Dr Ramanathan's principal place of practice be anywhere other than NSW at the time of seeking a review of conditions, Dr Ramanathan may make an application for review to the National Board.

NON-PUBLICATION ORDER

98. A non-publication order was made on 11 September 2017 in respect of Patient A, B, C, D, E, F so that the names, addresses and any information identifying these people is not to be published.

DISTRIBUTION OF DECISION

We will provide a copy of this written statement of our decision to Dr Ramanathan, the Commission, the National Board, General Medical Council (UK).

Mr Robin Handley
Chairperson

_____
20 December 2017

Attachment 1

Relevant Provisions of the *Health Practitioner Regulation National Law (NSW)*

139B Meaning of "unsatisfactory professional conduct" of registered health practitioner generally [NSW]

(1) **"Unsatisfactory professional conduct"** of a registered health practitioner includes each of the following-

(a) Conduct that demonstrates the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of the practitioner's profession is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.

(b) A contravention by the practitioner (whether by act or omission) of a provision of this Law, or the regulations under this Law or under the NSW regulations, whether or not the practitioner has been prosecuted for or convicted of an offence in respect of the contravention.

…

146B General powers to caution, reprimand, counsel etc [NSW]

(1) A Committee may do one or more of the following in relation to a relevant health practitioner the subject of a complaint referred to it-

(a) caution or reprimand the practitioner;

(b) direct that the conditions, relating to the practitioner's practising of the practitioner's profession, it considers appropriate be imposed on the practitioner's registration;

(c) order that the practitioner seek and undergo medical or psychiatric treatment or counselling (including, but not limited to, psychological counselling);

(d) order that the practitioner complete an educational course specified by the Committee;

(e) order that the practitioner report on the practitioner's practice at the times, in the way and to the persons specified by the Committee;

(f) order that the practitioner seek and take advice, in relation to the management of the practitioner's practice, from the persons specified by the Committee.

(2) If the relevant health practitioner is not registered, a direction may still be given under this section but has effect only so as to require the conditions concerned to be imposed when the health practitioner is registered.

(3) If a Committee acting under this section makes an order or directs that any condition be imposed on a health practitioner's registration, the Committee may order that a contravention of the order or condition will result in the health practitioner's registration in the health profession being cancelled.

(4) The order or condition concerned is then a **"critical compliance order or condition"** .

Attachment 2

AMENDED COMPLAINT
HEALTH PRACTIIONER REGULATION NATIONAL LAW (NSW)

Executive Officer
Medical Council of NSW
Punt Road
GLADESVILLE NSW 2111

The **Health Care Complaints Commission** of Level 13, 323 Castlereagh Street, Sydney, NSW, having consulted with the **Medical Council of New South Wales** in accordance with sections 39(2) and 90B(3) of the *Health Care Complaints Act 1993* and section 145A of the *Health Practitioner Regulation National Law* (NSW) *('the National Law')*;

HEREBY COMPLAINS THAT

Dr Anantha Kumarasamy Ramanathan of **Suite C28, 654 Pacific Highway 2259 Kanwal NSW**, being a medical practitioner formerly registered under the *National Law* ("the practitioner"),

COMPLAINT ONE

Is guilty of unsatisfactory professional conduct under section 139B(1)(a) of the *National Law* in that the practitioner has:

(i) engaged in conduct that demonstrates the judgment possessed or care exercised, by the practitioner in the practice of medicine is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.

The particulars in Complaint One relating to the practitioner's surgical planning and decision making for Patients A, E and F justify separate findings of unsatisfactory professional conduct for each patient or in the alternative, a

cumulative finding of unsatisfactory professional conduct for two or more of the patients.

Background to Complaint One

The practitioner obtained his medical degree from Sri Lanka in 1990. In May 2010 he became a Fellow of the Royal Australasian College of Surgeons (vascular). On 23 September 2010, the practitioner was first registered as a medical practitioner in Australia and then commenced working with the Central Coast Local Health District as a vascular surgeon. At all relevant times the practitioner was a specialist vascular surgeon.

PARTICULARS OF COMPLAINT ONE

Patient A

1. On 3 April 2013, Patient A consulted the practitioner in his rooms for his infective aneurysm. On 3 April 2013, the practitioner inappropriately planned to operate on Patient A's aneurysm at Wyong Hospital on 5 April 2013 in circumstances where:

    a. the practitioner had limited time for a perioperative workup of Patient A's medical and surgical history.

    b. the practitioner was uncertain of the exact location of the presumed infective aneurysm and he considered it may have involved paraduedenal arteries.

    c. an operation on the vessels in the region of Patient A's infected aneurysm was likely to be very challenging;

    d. Patient A underwent surgery at Royal North Shore Hospital on 4 March 2013. Post-operatively, Patient A's cardiothoracic surgeons made arrangements for Royal North Shore Hospital vascular surgeons to further manage Patient A's infective aneurysm involving the superior mesenteric artery;

e. the practitioner should have referred Patient A back to Royal North Shore Hospital.

Patient E

2. On 3 December 2013 at the angiography room at Gosford Hospital, the practitioner inappropriately planned to perform surgery on Patient E in circumstances where:

    a. the practitioner performed Patient E's surgery with the assistance of a junior nurse who had not assisted with this type of procedure before.

    b. the practitioner performed Patient E's surgery in a poorly lit radiology facility which required him to wear a head lamp.

Patient F

3. In January 2016, the practitioner inappropriately planned to perform arterial revascularisation surgery on Patient F on 25 February 2016 in circumstances where:

    a. Patient F's peripheral arterial disease was asymptomatic;

    b. Patient F was experiencing no symptoms suggestive of intermittent claudication;

    c. Patient F had no evidence of critical limb ischemia;

    d. the practitioner's surgical plan was to attempt to revascularise Patient E's right superficial femoral artery using a contralateral approach passing an access sheaf from the left common femoral artery over the aortic bifurcation to the right common femoral artery. The practitioner's contralateral approach carried an increased risk of procedural complications;

    e. the practitioner had not arranged scans pre-operatively to assess Patient F's abdominal aortic aneurysm;

    f. the practitioner failed to first trial compression stockings for management of the venous insufficiency.

COMPLAINT TWO

Is guilty of unsatisfactory professional conduct under section 139B(1)(a) of the *National Law* in that the practitioner has:

(ii) engaged in conduct that demonstrates the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of medicine is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.

The particulars in Complaint Two relating to the practitioner's clinical decision making and surgical technique during vascular surgery for Patients B, C, D and F justify separate findings of unsatisfactory professional conduct for each patient or in the alternative, a cumulative finding of unsatisfactory professional conduct for two or more of the patients.

Background to Complaint Two

As for Complaint One.

PARTICULARS OF COMPLAINT TWO

Patient B

1. The practitioner exercised poor clinical decision making and surgical technique during Patient B's surgery on 24 February 2013 in circumstances where:

    a. the practitioner did not adequately suture the infra-renal aortic anastomosis on his first two attempts.

    b. the practitioner did not achieve aortic cross clamping in a timely manner, ideally within minutes, during Patient B's surgery on 24 February 2013.

c. the practitioner failed to advocate for the performance of the embolectomy after Patient B's aneurysm repair in a timely manner.

2. The practitioner's operating time for Patient B's surgery on 24 February 2013 was approximately seven hours which was excessive and not in Patient B's best interests.

Patient C

3. The practitioner inappropriately used a transverse infra umbilical abdominal incision to commence Patient C's surgery on 14 August 2012 in circumstances where:

    a. the incision is more challenging than an incision superior to the umbilicus, risks transection of multiple collateral vessels in the abdominal wall and increases the risk of lower extremity ischaemia;

    b. the transverse infra umbilical abdominal incision used by the practitioner was not justified as Patient C was not morbidly obese and did not appear to have significant obstructive airway disease.

4. The practitioner exercised poor clinical decision making and surgical technique during Patient C's surgery on 14 August 2012 in circumstances where:

    a. the practitioner inappropriately performed the aortobifemoral bypass graft and right femoro popliteal bypass graft together;

    b. the left sided component of the aortofemoral bypass graft presented greater risk to the patency of the previous left femoropopliteal bypass graft which added to the complexity of the operation;

    c. the dissection of the left groin during Patient C's surgery was more technically demanding given the left sided component of the aortofemoral bypass graft;

    d. the practitioner inappropriately harvested the great saphenous vein over its thigh length and undertook a valvulotome instead of using a

reversed long saphenous vein, despite the distal anastomosis being performed to the below knee popliteal artery.

5. Anaesthetic in theatre commenced at about 1000 hours and continued until about 2130 hours. The practitioner's operating time for Patient C surgery was approximately eight to nine hours in length which was excessive and not in Patient C's best interests.

6. The practitioner exercised poor clinical decision making and surgical technique during Patient C's surgery on 5 February 2013 in circumstances where:

    a. the practitioner delayed in obtaining suitable stenting for interventional treatment of the ruptured limb of the aortobifemoral graft;

    b. the practitioner failed to seek surgical assistance from a more senior colleague or colleagues to assist with the bleeding complication, to achieve vascular control of the aortobifemoral graft or to assist generally at surgery.

Patient D

7. The practitioner exercised poor clinical decision making and surgical technique during Patient D's surgery on 4 September 2012 in circumstances where:

    a. [deleted]

    b. the practitioner only recognised the accumulation of blood from an injury to a venous structure after approximately four hours of Patient D bleeding;

    c. the practitioner failed to seek additional surgical assistance to discern the site of bleeding and to determine the best method of definitive haemorrhage control after re-opening the abdomen;

d. following achievement of immediate haemorrhage control, the practitioner failed to seek additional surgical assistance to reassess for a method of definitive haemorrhage control;

e. the practitioner did not initiate expedient haemorrhage control including by evacuating the abdominal cavity of blood and clots, and by using directed and immediate pressure to the point of presumed bleeding.

8. The practitioner's operating time for Patient D's surgery was approximately 12 hours which was excessive and not in Patient D's best interests.

Patient E

9. The practitioner exercised poor clinical decision making and surgical technique during Patient E's surgery on 3 December 2013 in circumstances where:

a. the practitioner failed to achieve percutaneous closure of the right common femoral artery puncture in his first four attempts;

a2. the practitioner failed to achieve rapid haemorrhage control during Patient E's surgery;

b. the practitioner inappropriately used a Coda balloon in the aortic graft with 20 minutes of inflation which risked thrombosis within the body of the graft and would not prevent retrograde bleeding from the more distal common vessels;
c. the practitioner inappropriately inserted a dilator over a soft (Glide) wire which is of an inferior standard to a stiff (Lunderquist) wire;
d. the practitioner failed to call for senior surgical assistance despite his multiple attempts at using the percutaneous closure device and technical device failures.

Patient F

10. The practitioner exercised poor clinical decision making and surgical technique during Patient F's surgery on 25 February 2016 in circumstances where:

    a. the practitioner inappropriately persisted with multiple attempts to enter the right superficial formal artery occlusion for between 60 minutes and two hours;

    b. the practitioner ought to have been aware that Patient F did not have critical limb ischemia and would not require amputation if the revascularisation surgery was unsuccessful.

COMPLAINT THREE

Is guilty of unsatisfactory professional conduct under section 139B(1)(a) of the *National Law* in that the practitioner has:

(iii) engaged in conduct that demonstrates the judgment possessed, or care exercised, by the practitioner in the practice of medicine is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.

The particulars in Complaint Three relating to the practitioner's post-operative care and management for Patients A, C and F justify separate findings of unsatisfactory professional conduct for each patient or in the alternative, a cumulative finding of unsatisfactory professional conduct for two or more of the patients.

Background to Complaint Three

As for Complaint One.

PARTICULARS OF COMPLAINT THREE

Patient A

1. [deleted]

Patient C

2. The practitioner failed prior 6 February 2013 to prepare a formal and documented transfer of care to a vascular surgical colleague in circumstances where:

a. following Patient C's surgery on 5 February 2013, the practitioner left to go overseas on 6 February 2013;

b. the practitioner was aware prior to leaving that Patient C's left foot was not well perfused.

Patient F

3. After Patient F's operation on 25 February 2016, the practitioner failed to make arrangements with a vascular surgeon with appropriate admitting rights to be able to take over the management of Patient A (at any time) if urgent admission to a public hospital facility was required.

4. After Patient F's operation on 25 February 2016, Patient F consulted with the practitioner on 2 March 2016. The practitioner inappropriately advised Patient F on 2 March 2016 to return to see him in 3 months or earlier if his leg pain did not improve in circumstances where at the consultation on 2 March 2016, Patient F presented to the practitioner complaining of severe pain in the right groin and profuse sweating.

COMPLAINT FOUR

Is guilty of unsatisfactory professional conduct under section 139B(1)(b) of the *National Law* in that the practitioner has:

(i) contravened the *Health Practitioner Regulation (New South Wales) Regulation 2010* (**the Regulation**).

Background to Complaint Four

As for Complaint One.

PARTICULARS OF COMPLAINT FOUR

1. The practitioner failed to ensure that the operation report for Patient B's surgery on 24 February 2013 contained sufficient detail regarding the quality of the vessels in the region of the aortic bifurcation.

2. By reason of Particular 1, the practitioner acted contrary to:
   a clause 7 of the Regulation;
   b. Schedule 2, clauses 2(1) and/or 2(2) of the Regulation.

3. On 5 April 2013, the practitioner failed to document adequate directions for hospital staff to follow for Patient A's post-operative care and management.

4. By reason of Particular 3, the practitioner acted contrary to:
   a clause 7 of the Regulation;
   b. Schedule 2, clauses 2(1) and/or 2(2) of the Regulation.