Issues arising in surgical training

Brus v Australian Capital Territory [2007] ACTSC 83

By Bill Madden

The recent decision of *Brus v Australian Capital Territory* [2007] ACTSC 83 raises a number of interesting issues in the context of surgery where a medical practitioner is in training.

The plaintiff was admitted to Canberra Hospital as a public patient for a vaginal hysterectomy. She had been scheduled for elective surgery by her treating specialist, Dr Heaton, whom she had previously retained on a private basis. However, on this occasion, she was admitted as a public patient. After the surgery, it became apparent that the plaintiff's right fallopian tube had prolapsed into her vagina, causing various problems and ultimately giving rise to a medical negligence claim.

The plaintiff alleged that the prolapse occurred when part of the fallopian tube was caught in the suturing to close the vaginal vault at the end of the operation. While the experts agreed that it was possible for a fallopian tube to work its way through a partially healed wound, the plaintiff's experts said that this was most unlikely,[1] and that poor surgical technique was the more likely explanation.[2]

It transpired that the surgery had been performed not by Dr Heaton, but by a surgical registrar, Dr Cree, with Dr Heaton assisting. A registrar is a trainee surgeon; in this case, a qualified medical practitioner, who had undergone basic medical training and performed some hospital work before being accepted by the Royal Australasian College of Obstetricians and Gynaecologists (the College) for its training program. A registrar, by definition, is less experienced than a qualified surgeon, who is a fellow of the College.

When it became apparent that the defendants would concede that the procedure had been performed by Dr Cree, the plaintiff amended her pleadings. She alleged negligence in permitting Dr Cree to perform the procedure, failing to inform her that the operation was to be performed by Dr Cree, and failing to inform her of Dr Cree's qualifications and experience.

Dr Heaton gave evidence (which the court accepted over the plaintiff's evidence[3]) that he always told his public patients that the surgery would be performed under his name, but that he may be assisted by, or he would assist, a registrar. The public patient admission form signed by the plaintiff acknowledged that the hospital would make the decision as to which doctor would perform the procedure.

The plaintiff conceded that there was no authority supporting the proposition that a public hospital owed a duty of care to a public patient to allow them to choose between a consultant surgeon and a registrar. The trial judge commented, at [15]:

> 'Such a duty, it seems to me, would be inimical to the broader public interest, in that it would undermine the future provision of health care. Most people would say, as the plaintiff has said in this case that, given the choice between an experienced consultant surgeon and a registrar, who is a qualified medical practitioner undertaking a training program to qualify as a specialist, they would choose the experienced consultant. This would have two effects if such a duty existed. The waiting list for procedures would clearly expand significantly, but more seriously, registrars would not be able to perform the procedures, under close supervision, that they need to qualify as specialists, resulting eventually in a dearth of suitably trained specialists.'

The plaintiff also called evidence of adverse reports about Dr Cree's surgical skills, generated during her placement at another hospital some three months prior to this procedure. More significantly, closer examination of the records provided by the College suggested that Dr Cree was regarded by Canberra Hospital, and held out to Dr Heaton, as a level three registrar, when in fact her classification and skills were commensurate only with that of a level two registrar. The significance of this came from Dr Heaton's unchallenged evidence, supported by the other experts. While it was appropriate to permit a level three registrar to undertake a vaginal hysterectomy under close supervision, it would never be appropriate to permit a level two registrar, such as Dr Cree, to do so.[4]

The court ultimately held[5] that the defendant hospital was negligent in permitting Dr Cree to perform a procedure that was beyond the capacity of a second-year trainee with adverse training assessments for surgical skills; and that, on the balance of probabilities, Dr Cree inadvertently caught the plaintiff's fallopian tube in the suture line while performing the suturing of the vaginal wound. Relevantly[6] the court said:

> 'I do not accept that there is a general duty of care on a public hospital to in effect provide public patients with a choice of doctor, or to appraise a patient as to the academic standing of a registrar. However, there is a duty on a hospital to ensure that it provides patients with suitably qualified staff.'

Given that the case was not pleaded as a failure to warn of a foreseeable complication, and that all the experts agreed that this was not a complication about which a patient should be warned, the issue of whether the risk of the complication occurring was greater – given the surgeon's qualifications and experience – did not arise.[7] ■

Notes: **1** At [10]. This case was not pleaded as a *Rosenberg v Percival* [2001] HCA 18; (2001) 205 CLR 434 action of failure to warn a patient of a foreseeable complication. All the experts agreed that this was *not* a complication about which a patient should be warned. **2** At [7]. **3** At [14]. **4** At [19]. **5** At [59] – [60]. **6** At [62]. **7** Cf *Chappel v Hart* [1998] HCA 55; 1998 195 CLR 232.

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