Australian Capital Territory

Medical Practitioners (Decision of Board) Notice 2004 (No 1)*

Notifiable instrument NI2004-459

made under the

Medical Practitioners Act 1930, **section 43 (Publication of Notice of Decision)**

In accordance with section 43 of the Medical Practitioners Act 1930, the following is a decision of the Board brought down on 6 August, 2004 regarding MED 4635 – Dr Hanh Tran.

Dr Heather Munro AO
Chairman, Medical Board of the ACT

7 December 2004

*Name amended under Legislation Act, s 60

In reply please quote: MB/ 1000598

Decision of the Board – Dr Hanh Tran

In the matter of an Inquiry pursuant to s.42 of the *Medical Practitioners Act* 1930 (ACT) (the Act) into the practice of Dr Hanh Tran holder of certificate number 4635.

Whereas the Medical Board of the ACT ("the Board') issued a Notice of Inquiry dated 15 October 2003 to Dr Hanh Tran pursuant to s 42 of the Act for the purposes of inquiring into allegations of professional misconduct by Dr Tran.

Members of the Panel:

Dr H Munro, Chairman
Dr G Armellin
Dr P Barraclough
Ms R Chenoweth
Dr I Mitchell
Dr A Sangster

Appearances

In accordance with s 29 of the *Health Professions Board Procedures Act* (1981) Dr Tran was entitled to representation.

Counsel for Dr Tran:
Mr Michael Bozic, Barrister
Mr Nevin Agnew, Solicitor Minter Ellison

Counsel assisting the Medical Board:
Mr Phillip Walker, Barrister
Ms Mary Therese Daniel, ACT Government Solicitor

Date of Decision: 6 August 2004.

Orders of the Board

1. The Board decided that in the following charges as set out in the Notice of Inquiry dated 15 October 2003 brought against Dr H Tran it was comfortably satisfied that the complaints in these grounds were made out.

In Charge A concerning Mr AB:

(iv) you failed to inform Mr AB about the failure to remove in entirety his gall bladder and gallstones;
(v) you failed to follow up and communicate effectively the potential complications of the operation performed on 28 October 2002;
(vi) you failed to maintain a proper and safe communication with other treating personnel involved with your patient's care;
(vii) you charged the patient for an operative cholangiogram which you did not actually carry out;
(viii) you informed the patient that the patient was fit and ready for discharge when the patient was not fit and ready for discharge;
(ix) you failed to ensure adequate alternative cover during your absence;
(x) you failed to record who was covering your patient during your absence.

In Charge B concerning Mrs BC,

(ii) you failed to adequately communicate with other treating personnel involved with your patient's care;
(iii) you failed to ensure adequate alternative cover during you absence;
(v) you inappropriately objected to Mrs BC's request for a second opinion;
(viii) you did not communicate adequately or appropriately with your patient;
(ix) you conducted an inappropriate conversation with Mrs BC on 23 January 2002 using inappropriate language;
(x) you informed the patient that the patient was fit and ready for discharge when the patient was not fit and ready for discharge.

2. The Board notes that Dr Tran made admissions with respect to Charge A in particulars (iv), (v), (vi), (vii), (viii) and (x). He made further admissions with respect to Charge B in particulars (ii), (iii), (v) and (x).

3. The Board decided that on the basis of its findings in respect of the particulars (iv), (v), (vi), (viii), (ix), and (x)above under Charge A and particulars (ii), (iii), (v), (viii), (ix), and (x) under Charge B, Dr Tran was guilty of conduct that:

a. demonstrates a lack of adequate knowledge, skill, care, or judgement or care in the practise of medicine; and

b. adversely affects the practise of medicine by the practitioner or brings the medical profession into disrepute.

4. The Board decided that with respect to the particulars in these charges Dr Tran's conduct amounted to unsatisfactory professional conduct.

5. The Board decided to impose a number of conditions on Dr Tran's practice:

(1) That Dr Tran should report to two surgical mentors, appointed by the Board. Initially the meetings should be every month for a period of 3 months. If his mentors are satisfied with Dr Tran's performance, then the meetings should become 3 monthly for 12 months and then 6 monthly. The total period of mentorship is to be 5 years. The surgical mentors are to provide written reports to the Board on a 6 monthly basis for the first 2 years and thereafter annually.

(2) That Dr Tran should keep a detailed reflective diary in which he records both operative and non-operative management of his patients. He should record both positive and negative outcomes in the diary. Dr Tran should include in his diary an audit of his cholecystectomies over specified periods as determined by his surgical mentors. The diary is to be discussed in detail at every meeting with his surgical mentors. The Board will not have access to the diary.

(3) That Dr Tran has 3 monthly meetings with a communication mentor appointed by the Board for a period of 1 year and subsequently 6 monthly thereafter for a period of 12 months. The total period of the communication mentorship shall be 2 years. The mentor will report annually, in writing to the Board. If the mentor is not satisfied with Dr Tran's performance, he or she shall report this to the Board.

Recommendation

The Board recommended that the John James Memorial Hospital reviews its system of notification of Visiting Medical Officer cover for patients to ensure that staff know who is responsible for patient care at all times.

6. The Board expressed some concern about Dr Tran working at the Queanbeyan Hospital as it is relatively isolated, has limited facilities and no intensive care unit, although it is in close proximity to The Canberra Hospital. Dr Tran stated that he would only do low risk surgery at the Queanbeyan hospital and would consult with his mentors about his work there in detail.

Preliminary Issues

7. Counsel for Dr Tran submitted to the Board that there were issues concerning apparent bias which should be considered prior to the commencement of the hearing. There were two matters to be considered.

8. Firstly he submitted that Dr I. Mitchell should be disqualified on the grounds of actual or apprehended bias. Secondly, he submitted that four members of the Board,

Dr H. Munro, Dr G. Armellin, Ms R. Chenoweth and Dr A. Sangster should be disqualified on the grounds of apprehended bias from hearing particulars (iv), (vi) and (vii) of Amended Charge B of the complaint.

9. In relation to the first matter, Mr Bozic submitted a statement from Dr Tran providing details of one instance in early 1998 and one in late 2000 at the Royal Prince Alfred Hospital and two instances in late 2000 at The Canberra Hospital when Dr Mitchell and Dr Tran had had a difference of opinion concerning the clinical care of patients. It was submitted that these incidents showed that Dr Mitchell had, in the past, not only differed from Dr Tran on questions of patient care but had called into question his clinical judgement, and that it was therefore not appropriate for Dr Mitchell to sit on the Medical Board at this Inquiry.

10. In relation to the second matter, it was submitted that the four members of the Board objected to had sat on a previous Inquiry into Dr DE, and had made a finding in that decision that Mrs BC, one of the complainants at the Inquiry, had expressed an opinion to Dr Hahn Tran that she did not wish to be referred to a psychiatrist. Thus the Board had made a finding in an issue which would again arise in the present proceedings namely, whether Mrs BC had told Dr Tran that she did not wish to be referred to a psychiatrist.

11. Mr Bozic submitted that the test of apprehended bias as set out in *Livesy v New South Wales Bar Association* (1983) 151 CLR 288 at 293-294 is whether in the circumstances a fair minded and informed member of the public might entertain a reasonable apprehension that the decision maker might not bring an impartial and unprejudiced mind to the resolution of the issues before him or her. He further submitted that the *Livesy* case was followed in *Bainton v Rajski* (1992) 29 NSWLR 539 at 540F where it was held that "*The High Court adopted…standards based upon the possibility rather than the likelihood of the apprehension that, if the judge sits, justice may not be done…"* Further in C*arruthers v Connolly* (1998) 1 Qd R 339 at 371 it was held that these principles applied to disciplinary tribunals and the test was stated as *"…whether the circumstances are such as would give rise, in the mind of a party, or in the mind of a fair minded and informed member of the public of a reasonable apprehension of a prejudiced mind or a lack of impartiality on the part of the decision maker."*

The Board adjourned to consider these issues.

12. In relation to Dr Mitchell it decided that she should not be disqualified from sitting on this Inquiry as the test for apprehended bias as set out above was not satisfied for the following reasons:

a. Dr Mitchell had no recollection of any of the incidents referred to by Dr Tran.

b. The incidents referred to occurred between 3.5 and 6 years previously and therefore did not have the required recency to give rise to a reasonable apprehension of bias.

c. None of the cases referred to by Dr Tran had any bearing on the current cases.

d. Dr Mitchell was not employed at Royal Prince Alfred Hospital in 2000 as she was at that time employed at The Canberra Hospital.

e. Dr Mitchell was not at Royal Prince Alfred Hospital until mid 1998 so that she could not have been there in early 1998.

f. Dr Mitchell's role as an intensive care specialist requires her to question medical practitioners about patient care in an intensive care unit. Her role is to meet and discuss with many specialists to decide on a plan of action. As the specialist in charge of the unit she seeks the advice of outside colleagues but may agree or disagree with their ideas on the clinical management of the patient. Disagreement with other practitioners is a common occurrence in her area of specialisation.

g. Dr Mitchell considered that in the present circumstances she would bring an impartial and unprejudiced mind to the matters before the Board.

13. The Board decided that it was not necessary for the other four members nominated members to stand aside. The Board noted that in the previous Inquiry concerning Dr DE, there had been no cross examination of Mrs BC and therefore there was no cause to dispute the evidence. The members concerned considered that they were able to bring an impartial and unprejudiced mind to the matters under consideration. It also took into consideration that the Board would not be able to convene an inquiry if four of its members were not able to sit and this would frustrate the purposes of the legislation. Therefore under the doctrine of necessity it was necessary that the four members sit on this inquiry.

Legal Principles

14. The Board, in considering the charges as set out in the Notice of Inquiry, must decide whether, if sustained, the behaviour complained of would constitute either unsatisfactory professional conduct or professional misconduct.

Unsatisfactory Professional Conduct. This includes a number of matters which are set out at s 35 of the Act. In the present case, the Board is concerned with subsection (1), which provides:

(1) *Any conduct that demonstrates a lack of adequate knowledge, skill, judgement or care by the practitioner in the practise of medicine;*

Professional misconduct is defined at subsection (3) of section 35. It provides:

(2) *In this part, a reference to* ***professional misconduct*** *in relation to a medical practitioner is a reference to unsatisfactory professional conduct of a sufficiently*

serious nature to justify suspension of the practitioner from practising medicine or for the removal of the practitioner's name from the register.

15. The principal considerations of the Board in exercising its power for the protection of the community are the maintenance of the standards of the medical profession and the maintenance of the public's confidence in the profession.

16. Onus and Standard of Proof. The standard of proof is that referred to in *Rejfec v McElroy* (1965) 112 CLR 517 at 521 as applied in *Bannister v Walton* (1993) 30 NSWLR 699. In that latter case it was held that the requirement is that the Board be "Comfortably satisfied on the balance of probabilities".

17. In applying such a standard of reasonable satisfaction on the balance of probabilities the Board has regard to the gravity and importance of the matters to be determined by it in accordance with the principles set out in *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 360-363 per Sir Owen Dixon:

"Except upon criminal issues to be proved by the Prosecution it is enough that the affirmative of an allegation is made out to the reasonable satisfaction of the Tribunal. But reasonable satisfaction is not a state of mind that is obtained or established independently of the nature or consequences of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must effect the answer to the question, whether the issue has been proved to the reasonable satisfaction of the Tribunal. In such matters "reasonable satisfaction" should not be proved by inexact proofs, indefinite testimony, or indirect inferences."

18. The Board further had regard to the decision in *Yelds v Nurses Tribunal and Others* [2000] NSWSC 755 in which it was held that it was not sufficient to find that certain behaviour was inappropriate in order to find that there is unsatisfactory professional conduct. While this decision is not strictly binding in the ACT, the Board noted that it is persuasive authority which dealt with legislation in which the definition of unsatisfactory professional conduct was very similar to that contained in s35 of the *Medical Practitioners Act 1930* (ACT).

Reasons for Decision.

19. The charges before the Board in this matter were as follows:

Charge A.

That on or about 28 October 2002 to 3 November 2002 you acted in a manner amounting to professional misconduct in relation to your patient Mr AB in that:

i you failed to confirm that you had controlled the presenting problem by performing a partial cholecystectomy and leaving gallstones in situ;

ii you failed to convert the first laparoscopy to an open procedure when the laparoscopic approach was no longer adequate;

iii you failed to convert the second laparoscopy to an open procedure when the laparoscopic approach was no longer adequate;

iv you failed to inform Mr AB about the failure to remove in entirety his gall bladder and gallstones;

v you failed to follow up and communicate effectively the potential complications of the operation performed on 28 October 2002;

vi you failed to maintain proper and safe communication with other treating personnel involved with your patient's care;

vii you charged the patient for an operative cholangiogram which you did not actually carry out;

viii you informed the patient that the patient was fit and ready for discharge when the patient was not fit and ready for discharge;

ix you failed to ensure adequate alternative cover during your absence;

x you failed to record who was covering your patient during your absence;

xi in the foregoing you have been guilty of conduct that demonstrates a lack of adequate knowledge, skill, judgement or care in the practise of medicine, and

xii in the foregoing you have been guilty of conduct that adversely affects the practise of medicine by the practitioner or brings the medical profession into disrepute."

Charge B

You are charged that on or about 7 January 2002, to 23 January 2002 you acted in a manner amounting to professional misconduct in relation to your patient Mrs BC in that:

i you failed to recognise and control the complications of surgery;

ii you failed to adequately communicate with other treating personnel involved with your patient's care;

iii you failed to ensure adequate alternative cover during your absence;

iv you failed to provide Mrs BC her right of choice of care by referral to Dr DE against her express instructions;

v you inappropriately objected to Mrs BC's request for a second opinion;

vi you inappropriately referred your patient to a psychiatrist;

vii you inappropriately referred your patient to your partner;

viii you did not communicate adequately or appropriately with your patient;

ix you conducted an inappropriate conversation with Mrs BC on 23 January 2002 using inappropriate language;

x you informed the patient that the patient was fit and ready for discharge when the patient was not fit and ready for discharge;

xi in the foregoing you have been guilty of conduct that demonstrated a lack of adequate knowledge, skill, judgement or care in the practise of medicine; and

xii in the foregoing you have been guilty of conduct that adversely affects the practise of medicine by the practitioner or brings the medical profession into disrepute."

Charge A concerns the complaint made against Dr Tran by Mr AB.

20. Reasons for decision for each of the items in the charges are as follows:

Charge A

(i) you failed to confirm that you had controlled the presenting problem by performing a partial cholecystectomy and leaving gallstones in situ;

21. The Board was not comfortably satisfied that the complaint in this ground was made out.

22. The Board heard evidence from Mr AB, the complainant, that he had believed that all of the gall bladder and gallstones had been removed at the first operation on 28 October 2002. He stated that he had been given the gallstones in a jar.

23. Dr FG, General Surgeon, provided oral evidence that in his opinion, the operation performed by Dr Tran did not actually resolve Mr AB's presenting problem and in fact made it worse. Dr FG considered that the only way to deal with the presenting problem of severe inflammation of the gall bladder was by removal of the stones which have precipitated the inflammation of the gall bladder and the removal of the gall bladder, neither of which occurred.

24. The Board took in to consideration the evidence presented by Professor Ham, Emeritus Professor of Surgery University of New South Wales. Professor Ham was asked by counsel for Dr Tran to comment on the written submission by Dr Tran where at paragraph 8(d) Dr Tran states "*At the operation I was able to deal with the problem which was severe inflammation of the gall bladder"*. Professor Ham agreed that the operation as performed by Dr Tran on 28 October 2002 dealt with the presenting problem.

Charge A

(ii) you failed to convert the first laparoscopy to an open procedure when the laparoscopic approach was no longer adequate;

25. The Board was not comfortably satisfied that the complaint in this ground was made out.

26. The Board noted that there was a degree of conflict in the evidence provided by witnesses on this issue.

27. Dr FG, in his evidence to the Board stated that he considered it would clearly have been preferable to convert the first laparoscopic procedure to an open procedure. He considered that the possible dangers to the patient in converting to an open procedure were far outweighed by the benefits in terms of the efficacy of the surgical intervention.

28. Dr Michael Stephen, Vascular-upper G.I.T.-General Surgeon, in his written submission to the inquiry stated that he did not think that Dr Tran should have converted the operation to an open procedure. He noted that after 2 ¼ hours of laparoscopic surgery a degree of control had been obtained of the acute problem. He noted that the patient was obese, suffered from sleep apnoea, and that open surgery would have been dangerous. He noted that the operation was conducted in a private hospital, rather than a large teaching hospital and there may have been little back up for a surgeon. He also noted that the operation continued into late in the day and that the surgical team could have been becoming tired.

29. Professor Ham, in his oral evidence to the Board, stated that about an hour into the operation it would have been apparent that there were problems with this procedure and at that point, in his opinion, conversion to an open procedure would have been appropriate and preferable. He also noted in his written statement that conversion to an open procedure was a common practice, being indicated in about 5% of patients. However, Professor Ham also agreed that although he would have done things differently, and other surgeons may have done things differently, nevertheless within the parameters of reasonable surgical management, the decision made to do a partial cholecystectomy rather than convert to an open procedure was one that was open to Dr Tran. He further noted that there was support for this in the literature. He stated that the question was how much better that decision was in the context of this particular patient, and that this was a question that he could not answer. He considered that the

time of day should not have been a problem as surgeons are frequently called on to operate late into the night.

Charge A

(iii) you failed to convert the second laparoscopy to an open procedure when the laparoscopic approach was no longer adequate;

30. The Board was not comfortably satisfied that the complaint in this ground was made out.

31. Dr FG, in his oral evidence to the inquiry stated that definitive control of the bleeding was not achieved at that operation.

32. Dr Michael Stephen, in his written submission stated that the operation should not have been converted to an open procedure.

33. Professor Ham, in his written submission noted that the records in relation to the second operation are unclear. He noted that Dr Tran's written operation report stated *"Small amount of blood from the left abdo stab wound became obvious at closure oversewn in layers."* Although there is no specific mention of a laparotomy he notes that Dr TU, the anaesthetist at the operation referred to a laparotomy in his anaesthetic notes. Professor Ham concluded:

> "*In my opinion, Dr Tran's initial choice of laparoscopy was correct. He identified a bleeding point, and controlled this by opening up the left abdominal stab wound externally. He then checked that the bleeding was controlled by internal inspection through the laparoscope."*

Charge A

(iv) you failed to inform Mr AB about the failure to remove in entirety his gall bladder and gallstones;

34. The Board was comfortably satisfied that the complaint in this ground was made out.

35. The Board noted that Mr AB stated that he was under the impression, on being given the gallstones after the operation, that his gall bladder had been totally removed. It noted that Dr Tran saw Mr AB the day after the surgery but at that time Mr AB was receiving morphine for pain relief and there was evidence of postoperative bleeding. In addition, Mr AB was not wearing his hearing aids at that time and although he lip-reads to some extent, he has difficulty even in normal circumstances in understanding Dr Tran's speech. These factors contributed to his lack of understanding of the operation performed and its potential ramifications. The Board concluded that even if Dr Tran had

communicated the details of the operation to him at that stage, it would have been difficult for him to understand.

36. The Board noted that Mr AB's care was transferred to Dr HI, an endocrinologist, on 3 November. No evidence was presented that there was adequate transfer of care. Dr Tran should have told Dr HI that there were complications from the surgery and that he needed to review Mr AB to explain the implications of this, including that the gallbladder had not been entirely removed, that there may have been remaining gallstones and that he would need further surgery to complete the cholecystectomy.

Charge A

(v) you failed to follow up and communicate effectively the potential complications of the operation performed on 28 October 2002.

37. The Board was comfortably satisfied that the complaint in this ground was made out.

38. The Board considered that when Dr Tran handed over to Dr HI he still had an obligation to follow up the potential complications and make arrangements for appropriate investigations.

39. The Board noted that in a post operative letter to Dr RS, Mr AB's General Practitioner, dated 30 October 2002 Dr Tran failed to make explicitly clear that a partial cholecystectomy had been performed and the implications of this procedure. This was apparent when Dr RS gave evidence to the Board by phone and stated that he was not clear what the header note (partial cholecystectomy) in the letter meant and that he relied on the later descriptive procedure note that "*the gall bladder was removed*". It was Dr RS' understanding that this meant the gall bladder had been removed in its entirety.

40. Professor Ham, in his evidence stated that it was unreasonable to expect any medical practitioner other than a general surgeon to understand the implications of a partial cholecystectomy.

Charge A

(vi) you failed to maintain proper and safe communication with other treating personnel involved with your patient's care;

41. The Board was comfortably satisfied that the complaint in this ground was made out.

42. The points made above in Charge A (iv) and (v) are relevant to this finding.

43. In addition, the Board noted that Dr Tran had failed to put anything in the hospital notes to the effect that he would be away and was handing over to Dr JK to cover for him during his absence.

44. The Board noted the comment made in a written statement by a member of the nursing staff, LM, the Clinical Nurse Consultant, at paragraph 18. She states:

"Dr PQ then had a telephone conversation with Dr Tran who advised that Dr JK was covering for him while he (Tran) was away on the weekend. This was the first time I had been made aware of this arrangement.

45. The Board noted that there is a provision at John James Memorial Hospital for the use of yellow stickers which alert staff to the fact that another doctor is caring for a patient during the absence of the doctor responsible. It noted that there was neither the use of a yellow sticker nor a hand written note put in the patient notes to alert staff to this.

The Board notes that the John James Memorial Hospital By-laws for visiting practitioners provides:

E. Clinical Responsibilities

7. Visiting Medical Officers in the hospital shall be contactable at all times and available to attend the hospital within one hour, either in person or by a deputy who shall have clinical privileges in the same specialty. When appointing a deputy, the Visiting Medical Officer shall notify to the hospital in writing the name of his/her deputy.

46. The Board also noted that Dr PQ, gave evidence concerning a telephone conversation with Dr Tran on 2 November 2002. It considers that it was unprofessional of Dr Tran to criticize Dr PQ for seeing his patient in hospital as it is part of her role to do so when nursing staff have raised issues regarding a patient. It was also unprofessional for Dr Tran to criticize the nursing staff in that conversation. His language in this conversation was both rude and abusive.

47. The Board considered that Dr Tran did not liaise adequately with nursing staff and that he failed to acknowledge the repeated professional concerns of the nursing staff about the patient's condition and the implications for planned discharge.

48. The Board further noted that there was inadequate communication with Dr HI, Dr FG and Dr RS, all of whom were involved in Mr AB's ongoing and subsequent care.

<u>Charge A</u>

(vii) you charged the patient for an operative cholangiogram which you did not actually carry out;

49. The Board was comfortably satisfied that the complaint in this ground was made out.

50. The Board noted evidence before it of an account sent to Mr AB dated 21 May 2003 from Dr Tran. The account is for Medicare Schedule Item number 30439 which is the appropriate number for a cholangiogram. The date of the procedure as stated on the account is 28 October 2002. Mr AB paid this account. Although Dr Tran stated that this was sent in error by his secretary, as the treating doctor he must be held responsible for the account.

Charge A

(viii) you informed the patient that the patient was fit and ready for discharge when the patient was not fit and ready for discharge;

51. The Board was comfortably satisfied that the complaint in this ground was made out.

52. The Board noted that the clinical notes for Mr AB dated 29 October have an entry by Dr Tran stating "*aim for home tomorrow (30th)".* The Board notes that there is evidence that when Mr AB was seen at 8.00 am by Dr Tran he was still bleeding. The clinical notes for 30th October note that Mr AB was seen at 9.30 am by Dr Tran and told that he could go home the next day and could be seen in Dr Tran's rooms the following week.

53. The witness statement by Mr AB also states at paragraph 4 "*The day after the operation Tuesday 29 October 2002. When he saw me at about 8 am Dr Tran told me I could go home the next day and see him in his rooms the next Tuesday".*

54. There is evidence in the clinical notes that at this time Mr AB was still bleeding. A further operation was performed later that evening to control the bleeding. On 30 October when Dr Tran again noted that he wanted to discharge Mr AB, the clinical notes indicate that Mr AB had low blood sugar levels and that he had had surgery the previous night. At this time he was still receiving intravenous morphine for pain relief. The notes indicate that on the 31st Mr AB continued to have low blood sugar levels and that he was oozing blood from the drain site. He was significantly hypoxic on room air (SaO2, 78%) at 11.30 am. On 1st November the patient was still hypoglycaemic and hypoxic (SaO2, 81%) Dr Tran records in the notes that the pressure dressing should be removed. On removal of the dressing a large constant ooze followed from the right laparoscopic site. Dr Tran suggested repeated pressure dressings.

55. The clinical notes reported that Mr AB had persistent hiccups which Professor Ham suggested was a sign of diaphragmatic irritation.

56. The evidence presented indicates that whilst Dr Tran was repeatedly recommending that Mr AB be discharged from the hospital, the patient had significant medical and surgical problems and was not fit and ready for discharge.

Charge A

(ix) you failed to ensure adequate alternative cover during your absence.

57. The Board was not comfortably satisfied that the complaint in this ground was made out.

58. The Board noted that the patient progress notes contain a nursing staff entry to the effect that Dr JK was covering for Dr Tran. The Board noted that in oral evidence, and at paragraph 18 of her statement, Ms LM, Clinical Nurse Consultant, referred to a telephone conversation between Dr PQ and Dr Tran. As a result of this phone call Dr PQ communicated to Ms LM that she had been told by Dr Tran that Dr JK was covering for him. Ms LM stated that this was the first time that she had been told that Dr JK was covering for Dr Tran.

59. The Board considered that although it appears that Dr Tran had arranged surgical cover for his patient, this was inadequately communicated to the nursing staff. It notes that Dr Tran at no stage personally told that nursing staff of his arrangements for surgical cover for Mr AB. He neither utilised the system of yellow stickers in the clinical notes as recommended by the hospital, nor wrote in the clinical notes himself to ensure that other staff were aware of this arrangement. It considers that proper and adequate communication of cover arrangements is essential to safe and effective patient care.

Charge A

(x) you failed to record who was covering your patient during your absence;

60. The Board was comfortably satisfied that the complaint, in this ground, was made out.

61. As discussed above, under Charge A (ix), the Board considers that although it appears that Dr Tran had made arrangements for surgical cover for Mr AB during his absence he had not himself recorded this in the clinical notes nor told the nursing staff about these arrangements.

Charge B concerns the complaint made against Dr Tran by Mrs BC.

Charge B

(i) you failed to recognise and control the complications of surgery;

62. The Board was not comfortably satisfied that the complaint in this ground was made out.

63. In this matter that Board considered the evidence presented by Professor Ham in his written submission.

64. Professor Ham noted that on 7 January 2002 Dr Tran was initially consulted by Dr WX, Obstetrician and Gynaecologist, in the course of surgery on Mrs BC, to check an area of damage to the small bowel which had been perforated during the surgery. Dr WX asked Dr Tran to check the adequacy of the repair to the small bowel. Dr WX again consulted Dr Tran on 9 January 2002 and Dr Tran recorded "*possible small bowel leak".* Dr Tran also recorded abdominal findings compatible with peritonitis. Professor Ham considered that it would have been appropriate to consider a laparotomy at that time and noted that Dr Tran chose to use conservative non- operative treatment. The patient was reviewed by Dr WX on 10 January and an improvement in her condition was noted. Dr Tran saw her again on 10 January and ordered an urgent small bowel series using Gastrografin which Professor Ham considered was not appropriate in the circumstances. The test did not reveal a leak but could not exclude it. On 11 January Dr Tran again reviewed her and noted improvement. Dr Tran also stated in the clinical notes that he would be absent until Sunday 13 January and that Dr WX would continue with her care.

65. On 13 January following further referral from Dr WX Dr Tran reviewed her and later that day performed a laparotomy. His operative findings were: "*Small bowel contents++. Hole in small bowel 30 cm from terminal ileum with 15 cm segments on either side oedematous and with serosal tears."*

66. Professor Ham concluded that Dr Tran's operative treatment – bowel resection and ileostomy- was appropriate.

Charge B

(ii) you failed to adequately communicate with other treating personnel involved with your patient's care;

67. The Board was comfortably satisfied that the complaint, in this ground, was made out.

68. The Board noted evidence from Professor Ham that, in view of the possibility of bowel leakage, Dr Tran should have arranged cover with another experienced general surgeon rather than leaving her care to a Gynaecologist for the period that Dr Tran was out of town. In the clinical notes Dr Tran had written that Dr WX would continue with Mrs BC's care during this period. Professor Ham considered that this was not appropriate.

69. Professor Ham noted that Dr JK, who had a loose arrangement with Dr Tran to provide cover had stated in his written submission at paragraph 6. *"However, my care of*

Dr Tran's patient's is restricted to a monitoring or observation role only and any serious matters would be referred back to Dr Tran for his attention." This level of cover was not appropriate in circumstances where postoperative surgical complications may require urgent re-operation. Dr Tran could not provide this care if he was away from Canberra, and Dr JK's treatment options were limited by the arrangements.

70. The Board considered that it was not sufficient for Dr Tran to assume that Dr WX would be responsible for the care of Mrs BC even though he was the admitting medical officer who was responsible for the surgery in which the general surgical complications arose. It considered that Dr WX, in consulting with Dr Tran during the process of the surgery, must have had a good reason to request specialist general surgical opinion. Having agreed to the consultation there was accordingly an obligation on Dr Tran to understand his role, and the importance of his involvement. In these circumstances Dr Tran had a professional obligation with respect to Mrs BC in the event of general surgical complications.

71. The Board considered that it was incumbent on Dr Tran to take responsibility for the general surgical supervision of Mrs BC from the time of the initial consultation. An integral part of this is would have been the comprehensive communication with Dr WX in the days immediately following the surgery. This responsibility extended to ensuring that there was adequate communication with other staff involved in her treatment. It appears that Dr Tran acknowledged some responsibility in that he ordered the Gastrografin swallow. He should have taken this further and arranged formal general surgical cover during his absence in Sydney.

Charge B

(iii) you failed to ensure adequate alternative cover during your absence.

72. The Board was comfortably satisfied that the complaint, in this ground, was made out.

73. The reasons for this decision are closely related to those in Charge B, particular (ii) above. As noted there, the Board considered that Dr Tran should have handed over surgical care of Mrs BC to a specialist general surgeon in his absence and have ensured that there was adequate communication with that surgeon. It was incumbent on Dr Tran not to leave town until he had arranged specialist general surgical cover. It was unsatisfactory to expect Dr WX to find another surgeon in the event of an emergency.

Charge B

(iv) you failed to provide Mrs BC her right of choice of care by referral to Dr DE against her express instructions.

74. The Board was not comfortably satisfied that the complaint in this ground was made out.

75. The Board considered that there was conflicting evidence in this matter.

76. The Board noted the evidence of YA, registered nurse, who was working on Mrs BC's ward. Ms YA stated in her evidence to the Board that she considered that Mrs BC had agreed to see a psychiatrist. Ms YA recalled that there were a number of nursing staff who had encouraged Mrs BC to see a psychiatrist for treatment of her anxiety. She had taken Dr DE down the ward to see Mrs BC and had introduced her, by name, to Mrs BC. Ms YA could not recall Mrs BC having any visitors in her room at that time. She stated that at the time, Mrs BC had raised no objection to seeing Dr DE.

77. The Board heard evidence from Mrs BC who stated that she had not wanted to see a psychiatrist. She stated she had only ever wanted to see the hospital counsellor. She said that at the time that Ms YA had brought Dr DE to her room she had not realised that Dr DE was a psychiatrist. Had she realised this she would have refused to see her both because she did not want to see any psychiatrist and because, in particular, she did not want to see the psychiatrist whom she knew to be Dr Tran's personal partner. She considered that this entailed a conflict of interest.

78. The Board heard evidence from Pastor EF. Pastor EF stated that he and Pastor GH were visiting Mrs BC at the time that Ms YA brought Dr DE to see Mrs BC. He stated that there had been no introduction of Dr DE by Ms YA. The two pastors had left the room while the consultation was in progress.

79. The Board considered evidence from a letter written by Dr DE to Mr Phil Lowen, Chief Executive Officer John James Memorial Hospital dated 4 July 2002. This document was obtained under summons from the Board. In this letter Dr DE states that before she proceeded to do a psychiatric assessment, she ensured Mrs BC had a clear understanding of who she was, and that she was the partner of Dr Tran. She stated that Mrs BC was agreeable to having the psychiatric assessment done.

80. It is difficult for the Board to reconcile these different accounts. It notes that Mrs BC stated that she talked to Dr DE for 45 minutes to one hour. Taking all the evidence into account however, the Board is unable to be comfortably satisfied that there is sufficient evidence for the compliant in this ground to be made out.

Charge B

(v) you inappropriately objected to Ms BC's request for a second opinion.

81. The Board was comfortably satisfied that the complaint, in this ground, was made out.

82. The Board noted evidence from Mrs BC. In her written submission Mrs BC stated that she had asked the nursing staff and Dr IJ, who was acting as locum tenens for Dr WX, to arrange a second opinion. Dr Tran had telephoned her on Wednesday 23

January at about 7.30 pm and had been rude and disparaging about her request for a second opinion. She stated that he had said words to the effect *"BC, you are putting shit on me by asking for a second opinion. How dare you put shit on me like that when I operated on you until 1.30 in the morning…"* He insisted on coming in to see her that evening even though she had told him on the phone that she did not want to see him. When he came in she told him again that she wanted to have a second opinion. He had said he was happy for her to have a second opinion. He had also said "*but be very careful what you decide to do*." She had taken that as a threat. She stated that Dr DE had also telephoned her to discourage her from seeking a second opinion.

83. In his written statement, at paragraph 49, Dr Tran noted that in the telephone conversation with Mrs BC he had used inappropriate language and said "*It is a shitty thing to do asking for a second opinion but that is up to your admitting doctor to decide not me."* Dr Tran also notes that he did not refer Mrs BC for a second opinion but left that up to Dr IJ on the grounds that he considered her to have the primary care of Mrs BC.

84. The Board noted that Dr IJ, in her written submission, at paragraph 16 stated that when she spoke to Dr Tran by phone on 23 January she said to him that Mrs BC wanted a second opinion. She noted that she did not say that Mrs BC did not want him to look after her anymore, just that Mrs BC wanted a second opinion. She recalled Dr Tran saying the following:" *I hate Dr FG. I hate Dr KL, I saved this lady's life. She's not very grateful, if you want to get a second opinion, then get it."* She was definite in her recall of the conversation and Dr Tran's comments about Dr FG and Dr KL.

85. The Board considered that patients have a right to a second opinion if they so wish. As the second opinion related to a surgical issue it would have been appropriate for Dr Tran to have referred Mrs BC for a second opinion himself. It was not appropriate for him to discourage her in any way from seeking this second opinion.

Charge B

(vi) you inappropriately referred your patient to a psychiatrist.

86. The Board was not comfortably satisfied that the complaint in this ground was made out.

87. The Board considered that there was conflicting evidence in this area. It considered evidence presented by Mrs BC that she had not wanted to see a psychiatrist but instead wanted to see the hospital counsellor. Mrs BC is certain that she told Dr Tran that she did not want to see a psychiatrist and in particular that she did not want to see Dr DE.

88. The Board also considered the written submission from Ms YA. At paragraph 4 of the submission she states:

"*I remember that BC was speaking to MN, the counsellor that works at JJMH. BC was very anxious and some nurses including myself discussed with her that she may benefit from talking to a psychiatrist and that she may consider that she needed medication for her continuing anxiety."*

89. In oral evidence, Ms YA stated that on one occasion, in a conversation with Ms YA before Mrs BC saw Dr DE, Mrs BC actually did agree to see a psychiatrist.

90. Professor Ham in his submission notes that Mrs BC was understandably (and justifiably) anxious about developing peritonitis as her father had suffered the same complication. He also stated that the patient's wishes in respect of referral to a psychiatrist must always be respected unless they are at risk to themselves or others.

91. The Board considers that the treating doctor must make the professional opinion concerning whether to refer to a psychiatrist. If, in Dr Tran's opinion, the need for this referral was indicated, then it was appropriate for him to do so. However this is only so if Mrs BC had not in fact told him she did not want a referral to a psychiatrist. There was no evidence that at the time she was a danger either to herself or others. The Board notes that there may have been some confusion in Mrs BC's mind between the counsellor and the psychiatrist.

92. Taking all the evidence into account, the Board cannot be comfortably satisfied that Mrs BC explicitly refused to be seen by a psychiatrist prior to the referral.

Charge B

(vii) you inappropriately referred your patient to your partner.

93. The Board was not comfortably satisfied that the complaint in this ground was made out.

94. The Board noted the comments made in Charge B, particular (vi) above. The Board considered that in general, it is not appropriate for a doctor to refer a patient to his or her personal partner unless there are exceptional circumstances. It noted that there may be a perceived or actual conflict of interest in so doing. This was particularly so in this matter where Mrs BC had expressed a desire for a second surgical opinion and it was apparent that there was some degree of conflict between her and Dr Tran. It would have been far more appropriate for Dr Tran to refer to another independent psychiatrist.

Charge B

(viii) you did not communicate adequately or appropriately with your patient.

95. The Board was comfortably satisfied that the complaint, in this ground, was made out.

96. The Board considered that the inappropriate language used by Dr Tran referred to in Charge B (v) above is relevant to this finding. It notes that the language used by Dr Tran to Mrs BC during the telephone call was offensive and did nothing to allay her understandable anxiety.

97. There is no evidence from the clinical notes that the complications of the surgery were ever discussed with Mrs BC apart from Dr WX's comments on the day following the surgery. Dr Tran's insistence on her discharge as soon as possible from the hospital increased Mrs BC's anxiety in circumstances where this was clearly inappropriate. His further resistance to her requests for a second surgical opinion only exacerbated her anxiety.

Charge B

(ix) you conducted an inappropriate conversation with Mrs BC on 23 January 2002 using inappropriate language.

98. The Board was comfortably satisfied that the complaint, in this ground, was made out.

99. The reasons for the Board's decision are set out above under Charge B, particulars (vi) and (viii). It notes Dr Tran's comments in paragraph 49 of his statements. In particular, the language used as set out *"BC, you are putting shit on me by asking for a second opinion. How dare you put shit on me like that when I operated on you until 1.30 in the morning"* were clearly inappropriate. It also notes Mrs BC's account of this conversation.

100. The Board considered that medical practitioners should always seek to communicate courteously with their patients.

Charge B

(x) you informed the patient that the patient was fit and ready for discharge when the patient was not fit and ready for discharge.

101. The Board was comfortably satisfied that the complaint, in this ground, was made out.

102. Professor Ham in his written submission noted that Dr Tran had indicated on a number of occasions that he planned an early discharge Mrs BC. This was apparent from the notes for 21, 22 and 23 January. Dr Tran also wrote in the notes on 23 January:" *I will NOT see her again until Dr IJ personally requests a consultation as an in-patient."* Professor Ham stated that while it was unclear what the state of the wound and the ileostomy were at that time, on 24 January, the following day there were problems with wound breakdown and discharge, and with maintaining adherence of the ileostomy bag. This is referred to in the hospital notes and also in the written submission from Dr FG.

After noting this documented evidence, Professor Ham considered that it was unlikely that Mrs BC was medically fit for discharge on 23 January 2002, and she clearly did not wish to be discharged either to her home or to Respite Care.

103. The Board noted the comments by Dr Tran in his submission at paragraph 56 where he recommends Mrs BC goes for convalescence for 1-2 weeks and that he would see her in his rooms on the following Wednesday.

104. The Board noted that considering her medical circumstances it is unlikely that Mrs BC would have been able to cope in respite care. The Board heard that there is no respite care facility available in Canberra which could offer the level of expert stoma nursing care that was required. At the time that discharge was being contemplated by Dr Tran, Mrs BC was having frequent dressing to the wound, she was not able to see the ileostomy bag and there was considerable excoriation of the skin at the site of the stoma. In addition, she had a high fluid output from the ileostomy leading to electrolyte imbalance. In addition Mrs BC was having difficulty coping emotionally with her ileostomy as this reminded her of her father's previous similar difficulties in 1992.

105. Mrs BC gave oral evidence to the Board that she was not feeling well enough to be discharged from hospital and had said so on several occasions both to Dr Tran and to the nursing staff. In her written submission Mrs BC stated at paragraph 33 that on Monday 21 January 2003 Dr Tran told her that: " *Hospitals are for sick people and you aren't sick, you have to be out by Wednesday"* In the same paragraph she stated: *"He dismissed everything we said. He repeated several times 'you have to be out'"*.

106. The Board considered that it is fundamental to the process of good communication with a patient that the treating doctor is able to hear and understand the realistic concerns of the patient with regard to ongoing treatment and eventual discharge. In this case, it considers that Dr Tran failed to communicate effectively with his patient. He sought to discharge Mrs BC at a time when she still required considerable nursing assistance and was not fit and ready for discharge.

Dated:

……..	……..
Heather Munro AO	Gloria Armellin
Chairman	Member
……..	…….
Phillip Barraclough	Rieteke Chenoweth
Member	Member
……..	……..
Imogen Mitchell	Anthony Sangster
Member	Member