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NEWS

Surgeon who operated on wrong vertebrae has no action taken against him

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A consultant neurosurgeon who operated on the wrong vertebrae in a patient's spine then kept his mistake hidden from the patient and his NHS trust has been spared any sanction by a medical practitioners tribunal, despite its finding that his practice was impaired on the grounds of dishonesty.

Nicholas Brooke's efforts to remediate his error led to the introduction of new consent and preoperative procedures that had improved patient safety where he worked, the tribunal heard.

The main charge against Brooke involved a 2012 spinal operation on an NHS patient at the private Spire Southampton Hospital. The tribunal found that he failed to adequately assess the patient's medical records or radiological imaging and carried out a repair at the L4/5 level instead of the correct L5/S1.

Brooke realised his error only three days later when he was writing a discharge letter. But he chose not to inform the patient or the trust. Instead he called the patient after three weeks to see if he was still in pain, which he was, and to offer further surgery, which he later performed.

Brooke told the tribunal that he chose not to disclose the error because the patient was already "in low spirits" and might suffer mentally. He waited three weeks, he said, to allow any placebo effect from surgery to wear off before assessing symptoms. The tribunal accepted this explanation because Brooke was able to show that in three previous cases of wrong site surgery he had always swiftly informed the patient.

Clinical misconduct was also found proved in a 2015 incident, when Brooke obtained patient consent for an L3/4 decompression instead of the correct L4/5. In that case Brooke discovered the mistake before surgery. His counsel told the hearing that this discovery was the result of changes in preoperative procedure introduced by Brooke himself after his 2012 misplaced surgery.

These changes included holding a separate "consenting clinic" two weeks before an operation, marking the patient for surgery before the event, ensuring that correct imaging was available, holding team meetings on the morning of operations, and running through two checklists in theatre.

The clinical misconduct had been remediated and did not impair Brooke's practice, the tribunal found. But his practice was found to be impaired because of the dishonesty over the misplaced surgery.

Numerous testimonials from Brooke's colleagues credited him with improving patient safety and learning from his mistakes. The chief operating officer of his employer, University Hospital Southampton NHS Foundation Trust, testified that patients would suffer if he received a suspension, the sanction sought by the GMC.

The tribunal panel's chair, Deborah Brooke, said that this consideration, and his sincere insight and successful remediation, amounted to an "exceptional circumstance such that this is one of those rare cases where it is appropriate and proportionate to take no further action."