Damage to major blood vessels during laparoscopic appendicectomy; failure to inform patient of nature and severity of complications (03HDC05563, 6 April 2004)

Public hospital ~ Laparoscopic appendicectomy ~ Standard of care ~ Disclosure of complications ~ Duty of candour ~ Competence concerns ~ Ethical responsibility ~ Credentialling ~ Vicarious liability ~ Rights 4(1), 4(2), 6(1)(a), 6(1)(e)

The parents of a 17-year-old woman complained about the standard of care their daughter received from a surgeon at a public hospital. The woman was admitted to hospital acutely with abdominal pain and vomiting, and diagnosed with a mild attack of acute appendicitis. The attending surgeon discussed treatment options with the patient and informed her that, although the appendicitis might resolve without treatment, she would almost certainly experience further attacks. The woman agreed to undergo a laparoscopic appendicectomy.

The operation involved the placement of three ports through the abdominal wall. The first port was inserted into a sub-umbilical incision and the camera introduced. A problem with insufflation occured, but this was resolved, and the second port was introduced. However, during insertion of the third port, significant bleeding occurred, and the surgeon commenced an urgent laparotomy and requested the assistance of another surgeon. The bleeding was controlled satisfactorily and the operation completed. It was found that the surgeon had inadvertently lacerated the inferior vena cava and a lumbar artery, and the surrounding psoas muscle. It appears from the evidence of the assisting house surgeon and theatre nurses that the second port was not put in under direct vision, and was inserted prior to the abdomen being fully inflated with gas and therefore able to be visualised. The evidence strongly suggests that the ports were put in blindly and that no insufflation occurred.

The Commissioner's advisor noted that the complication experienced by the patient is extremely rare during any laparoscopic procedure. Although complications may arise during any surgery, the severity of the complication during a procedure that should have been routine and uncomplicated led him to conclude that the surgeon had exhibited "an inferior and inappropriate standard of care [that] was a severe departure from a normal standard of care". The surgeon was held to have breached Right 4(1) of the Code.

Once the patient was in the recovery room, the surgeon told her that there had been a complication, a "slight nick in a minor vessel during surgery", but nothing serious. The surgeon continued with his operating list, and it was several hours before he spoke to the patient's parents about the complications encountered. The Commissioner's advisor commented that once the patient arrived in the recovery room, the surgeon was obliged to leave theatre and talk to her parents, rather than wait until he finished another operation. He had an obligation to fully explain which vessels had been damaged, particularly the significance of a tear in the inferior vena cava, which is a major vessel, that there was significant bleeding from within the psoas muscle, and that it was potentially a life-threatening situation. The patient's parents found out about the severity of the injury only after looking up information at home.

Physicians have a duty of candour and patients have a right to full disclosure when something goes wrong. Open and honest disclosure of surgical complications is consistent with ethical values of honesty and respect for autonomy. Candour promotes

trust in the medical profession. Disclosure of adverse events also serves to minimise the potential harm of unknown conditions going untreated. Omission of information or false information about the outcome of an operation calls the doctor's professional conduct into question. In this case, the surgeon did not inform the patient or her parents about the result of the appendicectomy, or give an adequate explanation of the patient's condition. This is information that the patient would want to know and would expect to receive — and was entitled to under Right 6(1)(a). The surgeon misled the patient and her parents about the nature and extent of the complications of the operation. He sought to minimise the seriousness of the injury to the inferior vena cava and omitted to disclose the damage to the lumbar artery and the psoas muscle. This omission was a serious infringement of the surgeon's professional and ethical duty, and he was held to have breached Rights 6(1)(a) and (e) of the Code.

The DHB was found to be vicariously liable for the surgeon's breaches of the Code. This case raises important issues about the obligations of employing DHBs when faced with escalating concerns about an employee's competence and fitness to practise, in particular in relation to the threshold for initiating conditions on practice (restrictions, supervision, or suspension). Hospitals owe a duty to patients to select, review and monitor staff carefully. A hospital's failure to ensure the competence of its medical and nursing staff through careful credentialling processes creates an unreasonable risk of harm to its patients.

The Commissioner commented that while a number of the surgeon's colleagues had concerns about the surgeon's competence, only the operating theatre nurses and the Clinical Director of Anaesthesia and Critical Care were prepared to document their concerns. Health professionals have a responsibility to respond to concerns about the competence of a colleague. A fundamental ethical principle of health care — "first, do no harm" — implies that if one is aware that patients may be at risk of harm from the practice of a colleague, one has a duty to act. Right 4(2) of the Code requires providers to comply with "ethical and other relevant standards". Thus the ethical responsibility is also a legal obligation.

This case was referred to the Director of Proceedings and, at a hearing before the Health Practitioners Disciplinary Tribunal, the surgeon admitted a charge of professional misconduct, which was upheld by the Tribunal. The surgeon was censured and ordered to practise under supervision for a period of two years, and to contribute towards the costs of the hearing.