Consent for surgery with increased risk not known to patient (07HDC11318, 17 October 2008)

General surgeon ~ Obesity ~ Liver biopsy ~ Liver function tests ~ Increased risk of complications ~ Informed consent ~ Communication ~ Documentation ~ Preoperative assessment ~ Discharge summary ~ Rights 4(1), 4(2), 4(5), 6(1)(b), 7(1)

A man was admitted to a private hospital for surgery. However, abnormal liver function blood tests (increasing the risks of surgery) were not noticed until immediately prior to surgery, by which time the man had been anaesthetised. The general surgeon decided to operate without advising the man of the increased risks, which the general surgeon subsequently estimated increased the risk of death fivefold.

The man was discharged six days after surgery, during which time his liver function tests deteriorated. However, this deterioration was not noticed by the clinical team, and no plans were made for investigating the cause of the abnormal results.

He was admitted a week later to a public hospital for an emergency operation for a perforated bowel. He developed complications following the operation, including liver failure, and died a few days later in hospital.

It was held that the surgeon breached Right 6(1)(b) by failing to give the man an updated assessment of the increased risk of complications from the operation. It follows that the man did not give informed consent to the surgery, and the surgeon also breached Right 7(1). The fact that the increased risk of complications was disclosed after the operation was not legally relevant — inadequate preoperative consent cannot be cured retrospectively.

By failing to review the man's liver function tests prior to anaesthesia, and by failing to respond to the clues pointing towards deteriorating liver function, and in particular to order further investigations after discharge, the surgeon did not provide services with reasonable care and skill, and therefore breached Right 4(1).

The surgeon's documentation of the man's care fell short of the expected standard, breaching Right 4(2). By failing to adequately advise the man's GP of the problems encountered during his admission, the surgeon failed to co-operate with a fellow health care professional to ensure quality and continuity of care, breaching Right 4(5).

The surgeon was referred to the Director of Proceedings, who commenced proceedings in the Health Practitioners Disciplinary Tribunal. The Tribunal upheld a charge of professional misconduct, noting that the surgeon's actions were a serious departure from accepted standards and fell seriously below the standards considered acceptable and appropriate by competent, ethical and responsible medical practitioners.

Link to Health Practitioners Disciplinary Tribunal decision:
http://www.hpdt.org.nz/Default.aspx?tabid=230