Obstetric Registrar / Crown Health Enterprise

Report on Opinion - Case 98HDC11995

Complaint

The Commissioner received a complaint from a consumer and her husband about the services provided by an Obstetric Registrar in a Hospital. The complaint is that:

- *At the Hospital in early January 1998 the consumer had a STOP (suction termination of pregnancy). During the procedure the consumer's uterus was perforated by the rods used and the suction device attached to her bowel.*

Investigation

The Commissioner received the complaint on 5 February 1998 and an investigation was undertaken. Information was received from:

The Consumer
The Consumer's Husband
The Provider/Obstetric Registrar
An Obstetric Consultant

The consumer's medical records were obtained from the Hospital and the Commissioner sought independent advice from a gynaecologist.

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Report on Opinion - Case 98HDC11995, continued

Outcome of Investigation

In early January 1998 the consumer was referred to the Hospital where she saw the Consultant Obstetrician/Gynaecologist ("the Obstetric Consultant"). The consumer was 7-8 weeks pregnant and had been suffering from severe vomiting which had persisted for two weeks. Following discussions with the Obstetric Consultant, the consumer was admitted to the Hospital for suction termination of pregnancy (STOP) to be performed two days later. The Consultant prescribed intravenous fluids to treat the consumer's dehydration and medication to control her vomiting and completed the necessary consultant certification for the operation.

The consumer does not recall the Obstetric Consultant's pre-operative explanation. The consumer assumed that he thought she knew all about it because of her background. The consumer is a midwife and has worked in obstetric wards. As a midwife she knew of the risks but did not associate them with herself. The consumer received nothing in writing, and she did not have any support person with her because her husband was living in a different city.

During the afternoon, the medication the consumer received controlled the nausea to a limited extent. The day before the termination, the consumer's nausea continued and she remained unwell. She was not tolerating oral fluids or foods and the decision was made to proceed with the proposed termination the following day. The Obstetric Consultant's Registrar performed the task of asking the consumer to sign a theatre consent form. The consumer remembers signing the consent form but is unable to recall a female doctor or anything that was said about the surgery or the risks involved. The consumer thought that the Obstetric Consultant would perform the operation.

That morning, the Obstetric Registrar was asked to perform the consumer's operation. He advised the Commissioner *"For clinical reasons [the Obstetric Consultant] decided the operation should occur earlier than he had originally planned and therefore put [the consumer] on my list [that] morning….*

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Outcome of Investigation, *continued*

I was the gynaecology registrar in theatre that day. It is the usually [sic] *practice at [the Hospital] that one registrar is assigned to theatre for the day and, in addition to their arranged operations, that registrar performs urgent operative procedures at the request of consultant staff.*

Therefore the first time I had any knowledge of [the consumer] was that morning. As she was placed on my list by [the Obstetric Consultant], all her preparatory work prior to theatre was completed by someone else.

This system, where urgent cases are referred for operation to the registrar in theatre was introduced to improve efficiency. If the surgeon in charge of the patient's care had to stop their current duties (eg. clinics, other theatre sessions, assessments of acutely ill patients or those in labour) to attend theatre, significant delays would arise for the other patients." The consumer does not remember the Obstetric Registrar seeing her prior to her surgery on that morning.

The Obstetric Registrar advised the Commissioner that:

"I first met [the consumer] prior to the surgery where I introduced myself, reviewed her notes and checked her consent".

The consumer was prepared for theatre but there was no pre-medication ordered or given. The consumer proceeded to theatre for the operation. The operation report, signed by the Obstetric Registrar, states:

- *Procedure – 7/40 VSTOP, repair of perforated uterus*
- *GA*
- *prepared in usual manner.*
- *difficult catheterisation - unable to enter urethal orifice.*
- *VE-full bladder, retroverted 7/40 uterus-vulva & vagina N* [normal].
- *50 mmol 8 mm – dilated 10 hagar.*
- *sponge forceps inserted into uterus. Tissue pulled from cervix with ease. Tissue recognised as bowel.*
- *[The Senior Registrar…] present contacted [a Consultant].*
- *[Consultant] commenced laparatomy-abdomen entered through routine Pfannensteil incision.*
- *Perforation through uterine fundis noted-bowel removed from enlarged perforation and mesentary torn from small bowel. General Surgeon contacted.*

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Outcome of Investigation, *continued*

- *Bladder emptied & TOP completed by [Senior Registrar].*
- *Uterine perforation closed with two layers of vicyl.*

General Surgery

Findings - small bowel mesenteric tear
Involving terminal ileum, devascularised
Over 60cm (not measured unstretched)
With multiple perforations of ileum
Affected small bowel mesentery and bowel
Excised – 3.0 Vicryl ties to mesentery
3.0 Vicryl interrupted all costs single layer
end – end anastamosis
Mesenteric defect closed interrupted 3.0 Vicryl

The Obstetric Registrar advised the Commissioner that:

"[The Senior Registrar] was present at theatre to supervise the procedure. Following the induction of the general anaesthetic by [the] Anaesthetist, [the consumer] was cleaned and draped and the termination was commenced. The cervix was dilated routinely and an instrument was introduced into the uterus to remove tissue. This proceeded normally until it was recognised by myself that bowel tissue was coming from the uterus. The operation was stopped. [The Senior Registrar] immediately informed [the Obstetric Consultant] [and] *as he was unable to attend, […] a Consultant at the Hospital attended immediately.*

The patient's abdomen was opened by [the Senior Registrar] who recognised the bowel as being damaged and we required a General Surgeon's input. […] a General Surgeon attended immediately from [another] Hospital and performed a bowel resection on the damaged bowel tissue. The termination was completed by [the Senior Registrar]."

The Obstetric Registrar further advised the Commissioner that:

"The procedure was supervised by [the Senior Registrar], … who was present in the theatre during surgery. She was not scrubbed which is normally the case when supervising operative procedures of this nature."

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Outcome of Investigation, *continued*

When the Obstetric Consultant was questioned by the Commissioner about the adequacy of the Obstetric Registrar's supervision he advised that:

"*I understand that [the Obstetric Registrar] has indicated that he was under the supervision of [the Senior Registrar]. This is not correct. [The Senior Registrar] is one of our more experienced Registrars, having recently gained her FRACOG. I discussed the situation regarding the current events with [her] and she indicates that she was not present in the theatre suite at the time [the Obstetric Registrar] was performing surgery. She was in fact in the opposite theatre. Having heard that there had been an injury occur in [the Obstetric Registrar's] theatre she offered her opinion and advice*."

The Commissioner confirmed with the Senior Registrar that she was present in theatre with the Obstetric Registrar and that the opposite theatre was not working at that time.

The Commissioner asked the Obstetric Registrar for his qualifications to perform this type of surgery. The Obstetric Registrar advised that:

"I commenced work at [the Hospital] as an Obstetric and Gynaecology Registrar [in] December 1997. This was my first position as a Registrar. I previously worked as an SHO in Obstetrics and Gynaecology [elsewhere] for one year.

This was the second STOP procedure I had performed at [the Hospital] having previously performed approximately fifteen at [the other hospital]."

The Commissioner asked the Obstetric Consultant if he was satisfied that the Obstetric Registrar had the necessary qualifications to perform the surgery. In reply the Obstetric Consultant said that:

"The operation of suction termination of pregnancy is a minor surgical procedure, performed either under a local anaesthetic or a light day patient general anaesthetic. The surgical procedure was initially scheduled to be undertaken by myself later in the week. However, in view of her hyperemesis, (vomiting), and failure to improve clinically, a decision was made that the acute team of the day would undertake Suction Termination Of Pregnancy, in order to facilitate the recovery of this young lady…

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Outcome of Investigation, *continued*

[The Obstetric Registrar] is the Registrar of the consulting team, […]. He was experienced in this type of surgical procedure (including D&C and Evacuation of Uterus) and capable of performing the operation unsupervised.

Inexperienced staff will perform surgical procedures in the operating theatre during their training under the direct supervision of the Registrar or the Specialist. [The Obstetric Registrar] …would supervise junior staff in performing minor surgical procedures. All Specialists, including myself, undertake formal training programmes in surgery for both under-graduate and post-graduate Doctors on a regular weekly basis."

The consumer cannot recall the Obstetric Registrar's visit or explanation during the immediate post-operative period. She recalls that the Consultant spoke to her in the recovery ward but cannot remember the explanation. The next time she saw the Consultant was when he came to see her in the ward later that same day. He again gave her an explanation of what had happened. By that time the consumer understood that something had happened during the operation but cannot remember the details. She was in more pain that she had anticipated and she was on a patient controlled analgesic pump. When the consumer's condition was satisfactory she was returned to the ward at 3.30pm.

The medical records indicate that the Obstetric Registrar also visited the consumer that day at 4.40pm. He discussed the procedure with the consumer and indicated that he would review her the next day with the Obstetric Consultant.

The Obstetric Registrar advised the Commissioner that:

"Immediately following [the consumer's] recovery, I went with [the Consultant] to see [the consumer]. I introduced [the Consultant] and we explained the procedure and that the above complications had occurred. We further explained to [the consumer] that she would require an elective caesarean section for any further births due to the repaired hole in the uterus and discussed with her that the perforation of the uterus and bowel damage, whilst regrettable, was a recognised complication of Suction Termination Of Pregnancy.

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Outcome of Investigation, *continued*

Over the recovery period, [the Obstetric Consultant, the General Surgeon] and myself saw [the consumer] daily and made ourselves available to her to answer any questions or discuss any concerns she had.

The consumer recovered well from her surgery and was discharged home [five days later].

…It is unfortunate that [she] suffered this complication of termination of pregnancy, and I took all available steps to ensure she was given the best care under the circumstances."

The consumer said that the Obstetric Registrar visited her either the second or third post-operative day. She did not understand that the Obstetric Registrar had actually performed the procedure until the after surgery. The consumer said that the Obstetric Registrar told her that he knew how she felt because he had had a similar experience when he had had surgery. The consumer does not remember an apology from the Obstetric Registrar and when she asked to see him prior to her discharge from Hospital she was told that she was under the care of another surgical team.

The consumer remembers seeing the Obstetric Registrar only twice during her admission. The records indicate that the Registrar and the Obstetric Consultant visited the consumer the day after surgery and she was seen by both of them the next day, and two days after that. On the day of the consumer's discharge, the dietitian visited the consumer and advised her on her diet when she returned home. The consumer was further advised that she may require a caesarean section for any future pregnancies. The consumer was then discharged.

The Commissioner questioned the Obstetric Registrar on the steps he took to minimise the risk of perforation. The Registrar advised the Commissioner that:

"Precautions used to minimise the risk of perforation were standard for the procedure of suction termination at [the Hospital]. They were as follows:

- *The size of the pregnancy was estimated with ultrasound prior to the procedure commencing.*
- *The cervix was softened one hour prior to surgery with 400 mcgs of mesoprostil.*

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Outcome of Investigation, *continued*

- *We would normally drain the bladder but I was unable to introduce a catheter into the uretheral orifice. We proceeded without doing this, which is equally acceptable practice.*
- *A vaginal examination was performed to estimate the size of the uterus and confirm that estimated by ultrasound.*
- *A sound was introduced into the cervix to again confirm the estimated size of the uterus.*
- *Cervical dilators were introduced into the cervix with gentle force to open the cervix. The size 8 Hagar used was appropriate given the size of the uterus as estimated by ultrasound, and confirmed by direct examination and sound.*
- *Sponge forceps were then introduced with gentle force into the uterine cavity to remove pregnancy tissue. At that point we were surprised to find bowel tissue on removal of the forceps."*

There is no record of the consumer receiving mesoprostil 400mgs as indicated by the Obstetric Registrar in his response to the Commissioner's questions. All other steps the Obstetric Registrar identified to lessen the risk of perforation have been identified in the medical records.

The Obstetric Registrar responded *"I had understood that mesoprostil had been given to [her]. This preparation is given one hour preoperatively and requires specific consent for this use. Therefore medical staff on the ward completing the consent procedures are responsible for consenting and charting this medication. Had [the consumer] not been put on my list but been my patient, I would have performed these duties… Because [she] was placed on my list in the manner she was, and mesoprostil is required to be given prior to theatre, in fact I could not have prescribed the drug. At the time of [her] operation, the administration of mesoprostil was not standard for all patients. Had we been aware that it had not been given, the operation would have proceeded none the less."* In mid-August 1999 the Crown Health Enterprise advised the Commissioner that *"Mesoprostil is given to make cervical dilation easier and to reduce the risk of cervical trauma and its consequences and is prescribed pre theatre. Mesoprostil if indicated would have been prescribed by the doctor arranging the case in the ward. This would not be [the Obstetric Registrar].*

It is also important to realise that Mesoprostil was not given at the time to reduce the risk of perforation at [the Hospital], it is related to reduce the risk of cervical trauma."

Obstetric Registrar / Crown Health Enterprise

Report on Opinion - Case 98HDC11995, continued

Independent Advice to Commissioner

The Commissioner sought the advice of a gynaecologist. In particular the Commissioner asked for advice on the performance of the operation itself, whether the Obstetric Registrar had the pre-requisite experience to perform the surgery and whether the consumer would likely suffer any long-term effects. Furthermore, the Commissioner required advice on the appropriate course of action needed to reduce the risk of such an event occurring in the future.

After reading all available information, the gynaecologist advised the Commissioner that the operation met professional standards subject to the following comments:

(a) Perforation is much more likely under general anaesthesia because of the loss of the patient's response to pain, but it was appropriate, given the patient's necessary prior rehydration within [the Hospital] that the procedure occur under [general anaesthetic].

(b) The administration of the uterine tonic mesoprostil 400mcg is usual practice in multiparous patients undergoing a termination at 8 weeks and should have reduced the risk of perforation… If it had not been given or charted, then this could be a breach of practice standards when current, although it was only about then that mesoprostil was being introduced in practice.

(c) Although the bladder was described as full, the failure to be able to undertake the planned preoperative catheterisation is probably not an issue, as so often the procedure is undertaken without even attempting catheterisation and knowing there is a full bladder. Recognising which way the uterus is tilted, retroverted or anteverted is probably more important, and catheterisation would only be important if the surgeon was unable to recognise which way the uterus was tilted.

(d) Dilatation to an 8 Hagar [the operation notes show a size 10 was used] would probably be appropriate, especially if the patient had been conscious, but this small variance on usual practice would probably would not have contributed to the perforation.

(e) The comment the uterus was retroverted, and the perforation was through the anterior uterine wall confirms the retroverted tilting of the uterus, the uterus may also have been additionally retroflexed (tilted further) as the pregnancy gestation was less than 8 weeks, and this could have contributed to the increased risk of perforation.

(f) Immediate recognition of the problem, as occurred, is important.

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Independent Advice to Commissioner, *continued*

With reference to whether the Obstetric Registrar had enough experience to perform the operation without supervision, the gynaecologist stated that:

"Although [the Obstetric Registrar] responds to a direct question that he would have then undertaken only 15 terminations, this would understate his experience in sounding the uterus and removing products of conception which would be much greater even just because of his previous role as a House Surgeon in [another location] undertaking evacuations of incomplete miscarriage, and missed miscarriage without supervision in theatre. Thus I believe that [the Obstetric Registrar] had the appropriate experience to perform this operation without supervision in the theatre."

The gynaecologist further commented:

"Preoperative comments by his associates and supervisors [the Senior Registrar and the Obstetric Consultant] might have not endorsed the possible increased risk of perforation given that [the consumer's] nutritional status which would have been compromised because of the hyperemesis that required hospitalisation in [two Hospitals], and this would have contributed to the increased risk of perforation."

The advising gynaecologist did not feel competent to comment on the possible long-term effects of the surgery or the appropriate course of action needed to reduce risks of similar events occurring in the future. However he did advise that:

"Apart from the individual supervisory preoperative comments and mesoprostil (above), I cannot recognise any actions that should be taken to reduce the risk of similar events occurring in the future.

In making this comment I note that there were difficulties with the patient being admitted to [a Hospital in another city], and then choosing, (presumably because she was intending, in part, to subsequently practice [in that city]) to have the termination in [a different city], flying [there], and then requiring hospitalisation ...where she had worked. Regretfully, it is just such patients that seem to have more complications, and although this is recognised within the health profession, it should continue to be stated and restated."

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Report on Opinion - Case 98HDC11995, continued

Independent Advice to Commissioner, *continued*

The gynaecologist concluded:

"It is clear to me that the sponge forceps damaged the bowel, and the drawing of the bowel through the uterus when grasped by the forceps damaged the vascular integrity of the bowel, and hence the need for partial resection. The bowel was not damaged by the suction."

The gynaecologist further stated:

"...I have no personal or professional conduct to disclose, but have particular empathy for the situation, as a perforation with bowel damage has occurred with me in patients requiring a termination or uterine evacuation a few times in the 20+ years I have been in specialist practice. Regretfully, when it does occur, it is devastating for the mother, especially if bowel surgery is required or when the family is dislocated, and, aside from the pain etc at the time, it does involve the possibility of gut absorption problems and caesarean section in the future."

Code of Health and Disability Services Consumers' Rights

RIGHT 4
Right to Services of an Appropriate Standard

2) Every consumer has the right to have services provided with reasonable care and skill.

RIGHT 6
Right to be Fully Informed

1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –...

g) The results of procedures.

RIGHT 7
Right to Make an Informed Choice and Give Informed Consent

1) Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.

Obstetric Registrar / Crown Health Enterprise

Report on Opinion - Case 98HDC11995, continued

Opinion: No Breach, Obstetric Registrar

In my opinion the Obstetric Registrar did not breach Right 4(2), Right 6(1), and Right 7(1) of the Code of Health and Disability Services Consumers' Rights as follows:

Right 4(2)

Perforation of the uterus is a recognised complication of STOP. In the consumer's case this was further complicated by the need for a general anaesthetic and her compromised nutritional state, a consequence of continued vomiting and inability to eat over several weeks. Although steps were taken to rehydrate the consumer and control her vomiting these were only partly successful and a decision was made to bring her surgery forward. The Obstetric Registrar could have prescribed Mesoprostil which acts as a uterine tonic and further reduces risk of uterine rupture. However withholding this medication would have delayed the surgery. I accept the advice that although routine administration of Mesoprostil was the Hospital's policy, at that time it was prescribed for women who had not previously had a baby. However I am concerned that given the systems operating at that time, the Obstetric Registrar, being the gynaecology registrar in theatre, was not responsible for checking pre-operative medication and preparation. In my opinion this would contribute to fragmentation of care and the increased risk of mistakes.

There is nothing to support the view that the Obstetric Registrar failed to meet professional standards. He had performed the procedure before, correctly recognised bowel tissue and immediately sought assistance. In my opinion his actions were reasonable in the circumstances.

Right 6(1)(g)

I accept that the Obstetric Registrar offered the consumer an adequate explanation of what happened. He visited the consumer about six hours after surgery and she was able to talk with him coherently. The consumer does not remember this visit but she was recovering from the anaesthetic, experiencing post-operative pain and on a morphine pump and may not have understood the explanation given at that time. The Obstetric Registrar visited her on the following two days. When the consumer asked to see him, he was not available because he was on leave for family reasons, but the consumer was visited daily by senior staff. The Obstetric Registrar resumed her care the following week.

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Obstetric Registrar / Crown Health Enterprise

Report on Opinion - Case 98HDC11995, continued

Opinion: No Breach, Obstetric Registrar, *continued*

Right 7(1)

Although the consumer was seen by two doctors before the Obstetric Registrar, as the operating surgeon he had an obligation to ensure that the consumer was fully informed about the procedure including the likely risks, and had given consent to the procedure. While delegation of the process can occur the operating surgeon has the ultimate responsibility to ensure this has occurred. While the consumer does not remember any pre-operative explanation, there is therefore no evidence that the Obstetric Registrar did not offer the consumer an adequate explanation and check consent had been obtained.

Obstetric Registrar / Crown Health Enterprise

Report on Opinion - Case 98HDC11995, continued

Opinion: No Breach, Crown Health Enterprise

In my opinion the Crown Health Enterprise did not breach Right 4(2) of the Code.

The Obstetric Consultant and my advising gynaecologist advised that the Obstetric Registrar did not require supervision because they had no doubt about the Obstetric Registrar's ability. Both based their opinion on his training which occurred while he was a house surgeon. The consumer's surgery was the second such operation he had performed at this Hospital.

I accept that the Obstetric Registrar did not require supervision. However the consumer's operation had an increased risk because of her prolonged vomiting and poor nutritional state. In these circumstances the Obstetric Registrar was supervised by the Senior Registrar and the Crown Health Enterprise therefore did not breach the Code. It was reasonable in these circumstances that the Obstetric Registrar was supervised.

Obstetric Registrar / Crown Health Enterprise

Report on Opinion - Case 98HDC11995, continued

Other Comments

Supervision

While I have formed the opinion that the Crown Health Enterprise did not breach the Code, I am concerned that it did not have a policy about the standards required or the means of assessing the competence of a newly appointed registrar to perform surgery. The Obstetric Registrar advised me that the Senior Registrar was supervising him and he re-affirmed this in his letter of 4 August 1999. The Obstetric Consultant advised that the Registrar would be supervising junior doctors in minor procedures. The Crown Health Enterprise has advised me that they will take steps to ensure their registrars are competent before allowing them to practice unsupervised, to remove any uncertainty.

Co-ordination

I am concerned that the Crown Health Enterprise's system may result in a fragmented approach to patient care and acceptance of responsibility. During the course of this investigation I was advised by the parties that several doctors had seen the consumer from her admission until she went to theatre and therefore the Obstetric Registrar could not be responsible for what had been omitted before he performed the surgery. In my opinion professional standards cannot improve where there is such clear demarcation in responsibility. Where so many individuals are responsible for "their part" there must be one professional who has overall responsibility.

Actions: Crown Health Enterprise

The Crown Health Enterprise is establishing written standards for ensuring that newly appointed registrars are competent to practice unsupervised and have undertaken to ensure these standards are a part of each registrar's orientation to the Hospital. I would be pleased to receive a copy of these standards when available.

The Crown Health Enterprise should also review its procedures to ensure consumers receive co-ordinated care. The Crown Health Enterprise has advised that they will provide a written apology to the consumer for the mishap she endured.