Surgeon, Dr D

Surgeon, Dr C

Whanganui District Health Board

A Report by the

Health and Disability Commissioner

Case 07HDC19531

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Overview

Mr B (aged 85) had a cholecystectomy[1] performed by surgeon Dr D in Wanganui Hospital in 2006. Dr D intended that a tube in the bile duct (called a T-tube[2]) be left in place for a month after surgery. However, on the evening prior to Mr B's discharge home, it was discovered that the tube had accidentally become dislodged. The nurse caring for Mr B asked surgeon Dr C for advice as he was in the ward reviewing another patient, although not on call. Dr C advised the nurse to cover the hole from which the tube had been dislodged and attempted to contact Dr D through the hospital switchboard, but did not reach him. He advised the nurse to inform the surgical team caring for Mr B. The nurse noted in the progress notes that the tube had been dislodged; however, neither Dr D nor his surgical team noticed this, and Mr B was discharged home the following day.

Over the next few days at home, Mr B's condition deteriorated. He was readmitted to Wanganui Hospital with abdominal pain. His surgical wound had also broken down and he was generally unwell. Treatment was commenced for a wound infection and possible bowel obstruction. Eventually, Mr B was taken back to theatre for a further operation. Unfortunately, his condition did not improve, and he died a few days later.

Parties involved

Mrs A	Complainant/Consumer's daughter
Mr B	Consumer
Dr C	Provider/Surgeon
Dr D	Provider/Surgeon
Dr E	Surgical registrar
Dr F	Surgical house officer
Ms G	Registered nurse
Whanganui District Health Board	Provider

Also mentioned in this report:

Dr H	Surgical registrar
Ms I	Clinical Quality and Risk Advisor

[1] Surgical removal of the gallbladder.
[2] A small tube placed in the bile duct to allow bile to drain out of the patient's body into a bag. The T-tube is attached to the skin with a stitch.

Complaint and investigation

On 8 November 2007, the Health and Disability Commissioner (HDC) received a complaint from Mrs A about the services provided to her late father, Mr B, by general surgeons Dr D and Dr C, and the Whanganui District Health Board. The following issues were investigated:

- *The appropriateness of the care and adequacy of information provided by Dr D to Mr B during his admission to Wanganui Hospital in 2006.*

- *The appropriateness of the care and adequacy of information provided by Dr C to Mr B during his admission to Wanganui Hospital in 2006.*

- *The appropriateness of the care provided by Whanganui District Health Board to Mr B during his admission to Wanganui Hospital in 2006 including:*

  — *whether there was appropriate communication between clinical staff at Wanganui Hospital to ensure the quality and continuity of services.*

An investigation was commenced on 30 November 2007. Information was obtained from Dr D, Dr C, Mrs A, and the Whanganui District Health Board. Independent advice was obtained from general surgeon Dr Ian Stewart and is attached as **Appendix A**.

Dr C provided advice from general surgeon Dr David Schroeder, which is attached as **Appendix B**. As part of its response, the DHB obtained expert advice from Dr Peter Johnston (a general, hepatobiliary and transplant surgeon), which is attached as **Appendix C**. Dr Stewart was asked to comment on the providers' responses to my provisional opinion. Dr Stewart's comments are attached as **Appendix D**.

On 29 May 2009 the HDC concluded the investigation into the care provided by general surgeons Dr D and Dr C, and the Whanganui District Health Board (WDHB). WDHB subsequently raised procedural and substantive concerns about my finding in relation to Dr C. Dr C raised similar concerns and noted that WDHB was giving careful consideration to bringing judicial review proceedings in respect of those matters.

HDC did not consider that reopening the investigation was justified, but acknowledged that a degree of misunderstanding had arisen from one sentence in the final opinion. HDC proposed to amend the final report taking into account the concerns about that sentence.

Dr C advised that the proposed amendment did not address his concerns and claimed that there had been a major injustice to him. Dr C considered that reopening the investigation was the only way the injustice could be overcome.

In considering Dr C's request to reopen the investigation in relation to his care, HDC took into account the views of the other parties to the investigation, the ambit of the proposed reopened investigation and the implications for public resources of unnecessary litigation. On 22 October 2009, HDC decided to reopen the investigation relating to Dr C's care of Mr B. The investigation in relation to Dr D and WDHB was not reopened.

Further information was obtained from Dr C, Nurse Ms G, Dr D and the WDHB. Dr C provided further submissions and advice from Professor John McCall (general, hepatobiliary and transplant surgeon), and pathologist Dr Ken Thomson, which are attached as **Appendix E** and **Appendix F.**

Dr Stewart was asked to comment on the further material. Dr Stewart's comments are attached as **Appendix G**. On 12 March 2010 Dr C provided further submissions.

Information gathered during investigation

Background

Mr B, aged 85, was an independent and active man. He had a history of rheumatoid arthritis, pulmonary embolism, and recurrent carcinoma of the bladder. He was first seen by consultant general surgeon Dr D on 12 December 2005 with obstructive jaundice. During this inpatient admission at Wanganui Hospital, Mr B was diagnosed as having gallstones with obstruction of the common bile duct.[3] He was referred to a gastroenterologist for consideration of an endoscopic retrograde cholangiopancreatography (ERCP)[4] and removal of the gallstones. The procedure was scheduled for 22 December 2005 but was not performed as there were difficulties intubating Mr B's duodenum.

Over the next few months in 2006, Mr B was followed up by both Dr D and the gastroenterologist. During an outpatient review in March 2006, Dr D noted that Mr B's jaundice had settled and his liver functions had returned to normal. Owing to Mr B's significant co-morbidities, Dr D advised Mr B and his family that surgery was very risky and recommended managing Mr B's condition without surgery.

In May 2006, Mr B required further surgery for his bladder cancer. It was noted at that stage that his liver function tests had become raised again and Mr B was referred back

[3] A duct that carries bile from the liver and gallbladder into the duodenum (first part of the small intestine).

[4] A diagnostic-therapeutic procedure that involves the X-ray of the pancreatic duct and biliary tree after the selective introduction of a contrast material into the common bile duct and pancreatic duct. The procedure involves passing a flexible endoscope through the mouth and down into the duodenum. A catheter is then passed through the endoscope and inserted into the pancreatic and bile ducts.

to Dr D. During the subsequent review on 7 June 2006, Dr D advised Mr B and his family of the need for surgery to remove his gallstones. The effect of Mr B's age and co-morbidities was discussed, and Dr D pointed out that there were significant operative and anaesthetic risks including possible death, deep vein thrombosis, myocardial infarction (heart attack), cerebral vascular accident (stroke) and pneumonia. Despite the risks, Mr B agreed to surgery. A consent form was completed, and Mr B was given written information regarding the procedure. Surgery was booked.

A fortnight before his surgery, Mr B attended an anaesthetic review and was graded ASA III.[5] The risks of surgery were reiterated and Mr B indicated that he was willing to proceed.

First admission

Dr D performed a laparotomy,[6] cholecystectomy,[7] and exploration of the common bile duct and stomach under general anaesthetic. The surgery was uneventful. The originally planned repair of a gastric volvulus[8] was not needed as the stomach appeared normal. A large stone was removed from the common bile duct and a T-tube was inserted and sutured in position. Following surgery, Mr B was admitted to the Intensive Care Unit overnight, and transferred back to the ward.

Dr D stated that Mr B received daily medical reviews while on the ward and "had a very good postoperative course".[9] Mr B also received regular reviews from physiotherapy, occupational therapy, and nursing staff.

Dr D reviewed Mr B during the ward round and explained that the T-tube had to remain in place for one month. He also told Mr B that he required a cholangiogram[10] before the T-tube could be removed. In relation to management of the T-tube, Dr D stated:

> "The dictated operation note did not mention details of the T-tube management. This is usually standard procedure and the patient was aware that the T-tube was to remain in place for at least one month. However, it was clearly documented by my registrar in the ward round notes [the following morning], in capital letters and underlined DO NOT REMOVE T-TUBE, a further note … states 'T-tube x 1/12', T-tube to remain for 1 month."

[5] American Society of Anaesthesiologists Class III. Patients under this surgical category have severe systemic disease that limits activity, but is not incapacitating.
[6] Surgical incision into the abdominal cavity to examine the abdominal organs.
[7] Surgical removal of the gallbladder.
[8] Twisting of the stomach.
[9] There are no entries by medical staff in Mr B's progress notes for the three days prior to the discovery of the dislodged tube.
[10] Radiographical procedure where contrast dye is injected into the bile ducts to visualise its course on X-ray. Used in the detection of gallstones which block the common bile duct.

Two days later, Dr D observed a small amount of upper gastro-intestinal bleeding and commenced Mr B on intravenous Losec. Staff were instructed to monitor Mr B's blood count and he was referred for a gastroscopy[11].

The next entry in Mr B's progress notes by medical staff is on the day before his discharge, when a doctor recorded the need for Mr B to "keep mobilising". That afternoon, Mr B underwent a gastroscopy, which showed a small ulcerated area at the junction of the oesophagus and the stomach, with no active bleeding.

Discovery of dislodged T-tube

Following his return to the ward that day, Mr B's nursing care was provided by duty nurse RN Ms G. While giving him a wash that night, RN Ms G noted that Mr B's wound dressing was "very oozing and smelly". After removing and inspecting the dressing, RN Ms G observed that Mr B's T-tube had been accidentally dislodged (found outside the abdominal wall). RN Ms G then left the room to page a doctor.[12] As she did, she saw consultant general surgeon Dr C, who was walking past the surgical ward after reviewing another patient in the hospital. (Dr C was not on call that evening, and Mr B was previously unknown to him.) RN Ms G asked him to review Mr B's T-tube.

Dr C noted that the T-tube was "clearly out, with no drainage from the wound site". He recalled that Mr B "was elderly, somewhat disorientated, but with normal observations". Dr C subsequently explained that he "described Mr B as being disorientated (odd) in that he was standing next to his bed, rather than lying on it as most other patients did at that time of night". Dr C considered Mr B oriented to time and place. Dr C stated:

> "At 10 o'clock that night, with a patient clinically well, and minimal drainage [from the surgical wound site] the last 48 hours, my clinical advice was to cover the wound site with an ileostomy bag and observe overnight with an ultrasound the next morning.
>
> I asked the nurse to document and inform [Dr D's] team in the morning.

[11] The visual inspection of the interior of the stomach by means of a fiberoptic instrument inserted through the oesophagus.

[12] WDHB's process for ensuring continuing medical care to patients is usually provided through the on-duty house surgeon, on-duty registrar and on-call specialist. Nurses normally observe complications with patients and report this to the junior medical staff. The junior staff hand over patients to the different specialty teams by discussing any complications that happened over night. Nurses have handover in the morning where nursing staff communicate any significant patient issues to the nurses starting the morning shift. Daily ward rounds are conducted. I have received differing views about whether nurses were always present at the ward rounds at the time.

> … It is important to stress lest there be any confusion, I did not advise the nurse to remove the T-tube. The nurse did not remove the T-tube. The T-tube was already out. …"

RN Ms G documented Dr C's instructions in the progress notes as "T-tube dislodged so removed. 20ml drainage in bag. Site covered with ostomy bag, please monitor output."

Dr C explained:

> "While I did not document this [information about the T-tube] myself, I view this advice given in the circumstances of the nature of the brief encounter, similar to a telephonic consultation, and it was not unreasonable to ask the nurse to record what had transpired."

Dr C commented:

> "While I wish now that I had documented the nurse's observations and my attendance, this is said with the benefit of hindsight given that the patient was discharged without the dislodgement of the tube being picked up.
>
> … It is my usual practice when reviewing my patients and particularly at discharge to check that all is well with the patient and the tube by examining the patient, including examining the wound and the tube to ensure that it is still fixed well, and reviewing the charts or clinical notes to find out the volume drained the previous 24 hours. If there are any concerns, I would ask for a contrast study through the tube to confirm the correct position. As this being standard postoperative care practice, I saw no need to specifically ring [Dr D] in addition to record[ing] the tube's dislodgement."

Dr C subsequently clarified:

> "… in addition to asking a nurse to document the matter in the notes, I did attempt to contact [Dr D] myself by telephone, without success. … [13]
>
> My attempt to call [Dr D] was made as a professional courtesy having seen one of his patients. …"

RN Ms G confirmed that Dr C attempted to contact Dr D:

[13] Dr C explained that he contacted the hospital telephone operator and asked to be put through to Dr D on his home phone number; however, there was no response after a number of rings so he hung up. Although Dr D was not on duty that evening, he rejects any suggestion that he was not available. He states that at the relevant time he could be contacted at home, on his hospital mobile phone, or on his hospital pager.

> "When I left the room I noticed [Dr C] sitting at the reception desk using the telephone which was a surprise as I thought he had left the ward. … I met [Dr C] as he was leaving the ward at which time he asked me to make sure it was clearly handed over to [Dr D's] team in the morning of what happened to [Mr B] as he had tried to call [Dr D] with no answer."

Dr C thought that in all likelihood the T-tube was dislodged two days earlier. He did not consider the dislodgement was a significant finding that night.

Dr C expected that in addition to the record, the wound review would easily reveal the absence of the T-tube.

RN Ms G completed her shift and handed over Mr B's care to the overnight nurse prior to 11pm. The nurse on duty overnight recorded "T-tube site [no] ooze in bag".

Discharge

The following morning Mr B was reviewed during the ward round by Dr D's team (house officer Dr F and surgical registrar Dr E).

I received conflicting accounts from Dr D about whether he attended the ward round. Dr D has subsequently confirmed that he did not see Mr B that day. He advised that he was in the endoscopy suite that morning. Dr D notes that it is not unusual for registrars to discharge patients.

Whanganui DHB submits that the weight of evidence is that Dr D was on the ward round and did see Mr B. Dr F clearly recalls that Dr D was at the ward round. Dr E cannot recall these events. WDHB advised that the clinical notes and an audit of the medical notes suggest that Dr D was present. The clinical notes indicate that Dr C was operating in the colonoscopy suite that morning.

What is clear is that Mr B was considered to be well and fit to be discharged. Furthermore, Dr D and his medical team were not aware that Mr B's T-tube had been removed the previous evening.

That afternoon, Mr B was discharged from Wanganui Hospital and referred to the community nurses for wound dressing and assessment. The referral was recorded by both medical and nursing staff in the discharge documents completed. The nursing staff noted on the referral form "T-tube site was dislodged on [day before discharge] & bag in situ draining minimal amount". An outpatient appointment with Dr D was arranged for a fortnight's time.

Community nursing

Mr B's family made an urgent call to community nurses on the morning following his discharge as they were concerned about the large amount of wound ooze. The community nurses immediately arranged to visit Mr B. During the visit, Mr B's family informed the community nurse of the "large amount of haemoserous ooze from [the]

laparotomy wound" the previous night. The wound was cleaned with saline and dressed. The community nurse documented in the care plan that there was "potential for wound to [break down]". She also documented "contacted Dr F — advised of condition, no odour, or p[urulent] discharge, no redden[ing] of wound, no temperature". It appears that Dr F advised no change in treatment. Dr F did not document or inform Dr D of the discussion with the community nurse. The community nurse arranged to review Mr B later.

Over the next four days, the community nurse continued visiting Mr B daily to assess and change his wound dressing. On the morning of Mr B's eventual re-admission, the community nurse noted that Mr B had been "vomiting ? 200mls greenish/brownish matter, ? faecal". She also recorded Mr B's lack of bowel movement "for a couple of days". Mr and Mrs B were advised to contact their general practitioner.

Shortly afterwards, Mr B was reviewed by his GP who admitted him to Wanganui Hospital. The GP recorded in his admission letter:

> "2 weeks post cholecystectomy r[ight] lower abdo pain 2/7 [2 days] constipated 3/7 vomiting 2 times today, ? faecal; vomitus passing a little wind pr [per rectum]. O/e [on examination] t[emperature] 36 p[ulse] 100 low vol abdo ooze from wound flank, tenderness no rebound ? bowel obstruction? infection, admit."

Second admission

Mr B arrived at Wanganui Hospital at 10.33am, and was admitted through the Emergency Department. An hour later, he was reviewed by Dr F, who noted that Mr B's abdomen was "slightly distended" and there was pain on palpation. Dr F recorded the possible diagnoses as "wound infection, ? bowel obstruction", and commenced Mr B on intravenous fluids and antibiotics. She advised the need for nasogastric intubation and for Mr B to remain "nil by mouth".

Dr F ordered blood tests, a wound swab, and an abdominal X-ray. The blood tests showed a raised white blood cell count (indicating infection) and the wound swab reported "heavy growth of staphylococcus aureus".[14] The abdominal X-ray showed "marked small bowel loop dilatation within the centre of the abdomen" and that the large bowel was "loaded with faecal matter, especially the rectum and lower descending colon". Based on his findings, the radiologist queried whether there was postoperative ileus[15] and advised the need for further investigation. Following his return to the ward, Mr B was monitored by nursing and medical staff.

Dr F recalls discussing Mr B with Dr E. However, there is no record of this in the clinical notes, and Dr E was unable to confirm that it had occurred. At the time, Dr D

[14] An opportunistic pathogen that is pyogenic (pus producing) and is responsible for a range of infections including severe sepsis, pneumonia and soft tissue infections.
[15] An obstruction of the intestines.

was on call and accepting acute admissions.[16] Mr B was admitted under the care of Dr D.

On the day following readmission, Mr B was reviewed on the ward round by surgical registrar Dr H, who was covering Dr E's duties. Dr H recorded that Mr B's abdomen was mildly distended, non-tender, and bowel sounds were present.[17] Dr H instructed nursing staff to redress the wound, and to monitor Mr B's bowel movements. Further blood samples taken that day showed a reduced white blood cell count.

The next day, Dr D reviewed Mr B with Dr F during the morning ward round.[18] Mr B was observed to be passing wind, and the nasogastric tube was "not draining much". Dr D confirmed that Mr B had a wound infection. Nursing staff were instructed to keep the tube in place and to keep Mr B nil by mouth and change the wound dressing. Dr D did not notice that the T-tube was absent during this review.

Further surgery

That night, Mr B's wound became completely open. It appears that at about 10.10pm the nurse observed copious ooze through the dressing, redressed it and noted that it had "dehisced"[19] further. The nurse noted that "RMO [Dr F] stated pt [patient] could have clear fluids. Wound needs reviewing AM". It appears from the notes that a different resident medical officer was then called to assess Mr B. The resident medical officer noted (in his record of 11.30pm) that there was "intestinal fluids leaking into wound", and there was a small hole in the bowel. Dr E was contacted to assess the patient.

Shortly after midnight, Dr E attended and noted that Mr B's wound had reopened. Dr E also observed a perforation in the small bowel, and multiple adhesions. Dr E contacted Dr D.

Dr D stated:

> "When I saw [Mr B] on [the day after re-admission][20] … he told me that the tube had been taken out by a nurse on the night before discharge. This information had not been passed on to me. The site had been covered with an

[16] Whanganui DHB provided a copy of the roster for the week following readmission, which shows that Dr D was the surgeon on duty for most of that week except the day following readmission and the day two days later.

[17] It is noted that Mr B had been admitted under the care of Dr D.

[18] Dr D was first told of Mr B's readmission two days later, in the morning. Dr D stated that there had been no communication from junior staff to him about Mr B the previous two days. Dr D stated that the only patient he did not see in that time was Mr B.

[19] Premature bursting or splitting along natural or surgical suture lines. It is a complication of surgery that occurs secondary to poor wound healing.

[20] Dr D was contacted to clarify the dates, and confirmed that the correct date was two days after re-admission. In fact, it was likely early three days after re-admission when Dr D became aware the T-tube was missing.

> ileostomy bag which may be why it was not apparent to the team that the tube was not there.
>
> My initial concern was that the T-tube [had] been removed without anyone bringing this to our attention. I did not raise it as an issue as I [needed] to operate on [Mr B] immediately. …"

Dr D stated that he saw Mr B "late that night when his abdominal wound had dehisced and it was at that point that [Dr D] noted the absent T-tube".

Following discussion with Dr D, Mr B was taken to theatre for a laparotomy. The operation was performed on the fourth day of his re-admission by Dr D assisted by Dr E. The findings from the operation were biliary peritonitis[21] with pus and bile present in the abdomen, along with a necrotic-looking segment of small bowel. Dr D clarified that the small bowel "had not in fact perforated but histology reports necrotic adipose tissue on its surface". During the operation, a T-tube was reinserted. Dr E recorded in the clinical notes "DO NOT REMOVE T-TUBE" and requested that this instruction was "TO BE WRITTEN ON DISCHARGE PAPERS". Both instructions were marked with asterisks.

Following the operation, Mr B was transferred to ICU and placed on a course of antibiotics. He was also put on intravenous feeding. During the ward round the following day, Dr D noted that Mr B was "looking better" and instructed that the gentamycin (one of his antibiotics) be stopped. The next day, Mr B developed atrial fibrillation.[22] Following discussion with a physician, Mr B was started on digoxin.[23] His condition stabilised and he was transferred from ICU to the surgical ward the next day.

For eight days, Mr B was reviewed daily by Dr D's team. He was also monitored by nursing, physiotherapy, and occupational therapy staff. On the second day, Mr B's temperature increased to 38^{o}C and his white blood cell count was mildly elevated. This was investigated without any cause being found. That night, Mr B's temperature settled back to 37.2^{o}C. Over the next three days, Dr D's team reviewed Mr B and noted that he looked well on each occasion.

On the eighth day, Mr B became unwell suddenly with sinus tachycardia[24] initially thought to be atrial fibrillation. He was also noted to have a cough and was reviewed by a general surgeon and the medical team, who queried whether there was infection in Mr B's chest and abdomen. A chest X-ray and an abdominal ultrasound were ordered and carried out that afternoon. The radiologist did not detect any significant

[21] Inflammation of the peritoneum (serous membrane of the abdominal cavity).
[22] A condition where there is disorganised electrical conduction within the atrium, resulting in ineffective pumping of blood into the ventricle.
[23] Medication for treatment of various heart conditions.
[24] An increase in the heart rate above normal.

changes from the previous chest X-ray, and the abdominal ultrasound revealed "small pockets of free fluid (2–5mm diameters)" and advised a CT scan.

Following Mr B's return to the ward from the Radiology Department, he was found standing at the side of his bed and he collapsed suddenly. Full resuscitation and cardiac arrest procedures were unsuccessful, and Mr B died at 4.10pm. Dr D and Mr B's family were contacted, and his death was reported to the Coroner.[25]

A postmortem examination was carried out, which found Mr B's cause of death to be peritonitis and an abscess in the anterior abdominal wall.[26]

Subsequent events

DHB investigation
Following these events, Whanganui DHB conducted its own investigation into the care Mr B received. It reviewed Mr B's health record and conducted interviews.

The investigation report stated:

> "At the same time the General Surgeon on-call[27] walked past [Mr B's] room. The nurse sought his advice regarding the T-tube. The surgeon confirmed that the T-tube was dislodged, gave instructions to cover the tube site with a drainage bag and to observe the drainage overnight. The surgeon noted that there was minimal drainage over the last two days and felt the desired course of action would be to perform an ultrasound the next morning. The surgeon asked the nurse to document this and ensure that [Dr D's] team was informed in the morning. This consultation and the advice given is not documented in [Mr B's] health record. The Registered Nurse on night-shift has referred to the T-tube site in her documentation as does the Registered Nurse on the morning duty, however the RMO, the Registrar, nor the surgeon read the integrated progress notes during the ward round. The Registrar, when interviewed, stated that the notes do not accompany the team on the ward round. Usually a nurse is on the round to inform them how the patient has been overnight. The surgical doctors do review the notes on a daily basis. The Nurse assigned to the care for [Mr B] on the morning of [his discharge] cannot recall being present on the ward round."

[25] As at the date of this report, the Coroner has not decided whether to hold an inquest.
[26] In contrast, Dr John Simpson commented in his external review report that "peritonitis and an abscess in the anterior abdominal wall do not entirely satisfactorily explain [Mr B's] sudden deterioration and death at a time when his general condition was improving". Dr Simpson agreed with Dr D's view that "an acute cardiac event seemed more likely" and commented that "the role of the abscess in the development of the bowel perforation is unclear". According to Dr Simpson, Mr B's "bowel perforation could have contributed to the peritonitis".
[27] As noted above, Dr C was not in fact on call.

The Report's "Conclusions and Actions" notes the "communication failures and inadequacies in assessments and the documentation of ward rounds … In addition, the conflict within the Department of Surgery has the potential to increase, due to the surgeons involved in this event. For these two reasons, it is recommended that an external review be undertaken."

On 18 September 2006, Mr B's daughter, Mrs A, met with Dr D and Ms I, Clinical Quality and Risk Advisor, to discuss the findings from the DHB's investigation. Details of the discussion were also documented in a follow-up letter Ms I sent to Mrs A:

> "As discussed with you, the investigation findings to date have highlighted a number of failures in communication between members of the surgical team. It was noted that your father was actually seen by the surgical doctors on the morning of [his discharge], however, it appears he was not examined and the fact that the 'T' tube was not present was missed. Your father was discharged later that afternoon.
>
> The day following his discharge, the community nurses were concerned about the amount of oozing from your father's wound and contacted the surgical doctor on duty to express their concerns.
>
> Given the nature of these failures and the seriousness of your concerns, the Mortality and Morbidity Committee have recommended that an external review of your father's care be commissioned forthwith. This review will be conducted by a surgeon from another District Health Board to ensure independent scrutiny. …"

DHB external review

General surgeon Dr John Simpson was asked to undertake an external review of Mr B's care. Dr Simpson interviewed Mrs A and several clinical staff including Dr D, Dr C, Dr E and RN Ms G.

The report was released in February 2008. Dr Simpson concluded that Mr B's death was probably avoidable, and that "poor communication in a disunited department contributed to the outcome" (discussed below). Dr Simpson noted that the outcome "was caused by a series of events occurring together rather than a single act of incompetence by an individual staff member".

Dr Simpson concluded that the "early loss of the drainage of CBD[28] by the T-tube and hence leakage of bile into the peritoneal cavity was undoubtedly a very significant event for this patient. … [Dr D] should have been told directly about the T-tube at the earliest opportunity, at the very latest the following morning."

[28] Common bile duct.

Dr Simpson noted that the time for which the T-tube should have been managed postoperatively had been raised as an issue. His view was that "[t]he precise length of time is not important in the present context. What is important is the clarity of the directions given, and how the issue was managed at the time of, and following, its removal, which was much earlier than had been intended by [Dr D]."

Dr Simpson noted:

> "The arrangements for morning ward rounds left much to be desired. The surgical ward had become a combined orthopaedic and general surgery ward a few days before [Mr B] was a patient there. All the surgeons wanted to do rounds at approximately 8am and to be accompanied by a senior nurse. This was not possible due to the limited number of nurses and their other duties. A safe surgical environment ensures that important information is available as needed for clinical decision-making. This includes information collected by nurses being available to the medical staff and vice versa. The patients' medical records are often not available to the morning ward round."

Dr Simpson stated:

> "Communication between members of the clinical staff in general surgery was unsatisfactory at the time of [Mr B]'s death. … The word 'dysfunctional' was used to describe the department of general surgery and the poor relationship between [Dr D] and [Dr C] was referred to repeatedly. Less than satisfactory communication undoubtedly occurred. In this context, the word communication is used to describe the transfer of necessary and appropriate information. Problems of communication appeared to exist in the department at a number of levels … [I]t was quite clear that all was not well, in interpersonal terms, within the department. It was stated unequivocally that this state of affairs had some impact on patient care and must be corrected."

ACC

On 22 November 2007, Ms I completed a treatment injury claim on behalf of the family. The injury was stated as "peritonitis, abdominal abscess, wound dehiscence, bowel perforation" and under the section titled "injury(s) caused by treatment", Ms I recorded: "Tube dislodged on […]. Discharged [the next day]. Absence of T-tube not noticed prior to discharge. Re-admitted […] with numerous post-op complications." Copies of Mr B's clinical records were enclosed with the claim.

On 12 December 2007, ACC accepted the claim for treatment injury. In reaching its decision, ACC sought advice from medical advisor Dr Chris Moughan, who commented:

> "There appears clear evidence of treatment failures with removal of T tube linked to a chain of events resulting in injury — wound dehiscence and bowel perforation leading to death (confirmed at post-mortem)."

History of difficulties

Both Dr D and Dr C acknowledge that there have been difficulties between them for several years, and that this situation continued at the time of Mr B's admission. Whanganui DHB has taken steps to address these difficulties.

Dr D

Dr D stated:

> "[Dr C] and I have not got along well since 2001. I have been at pains never to allow that to affect our professional relationship and never avoided communication with him on clinical matters. I am however, concerned that he might have allowed this to occur in this case, I have been at pains to correct the relationship … with him.
>
> …
>
> … I was very fond of [Mr B] and I have been deeply affected by the outcome of this case. I am very sorry to the family for what has happened and regret any area in which my management or supervision could have been better.
>
> … I have no hesitation in making that apology known in writing to the family and I have deferred contacting them to date as I did not feel that was appropriate in the setting of an ongoing investigation. I have certainly reviewed and reflected on my practice in the light of this case and now no longer work within the public system and, as such, have no reliance on junior medical staff.
>
> … I accept that my communication could and should have been better. I am prepared to apologise for that. …"

Dr C

Dr C commented:

> "… I recognise that when an adverse outcome occurs, it is important for everybody to look at ways where, individual and collectively, we could have done better in the care of this patient. In this respect I wish I had written in the notes as well as asking the nurse to.
>
> There were acknowledged difficulties within the department that we all need to consistently address, but in this case, the focus on the department and interpersonal relationships is, I suggest, an omission in terms of looking at more significant factors that played a part in this particular case."

Dr C is adamant that he never allowed the relationship difficulties with Dr D to get in the way of patient care and rejects the suggestion that they contributed to the way he

managed the situation with Mr B. Dr C does "not believe that [he] should be in any way accountable for the negligence of others".

Whanganui DHB
Whanganui DHB also acknowledged that its clinical teams needed to communicate better:

> "Whanganui District Health Board will give immediate attention to Mr Simpson's recommendations, upon receipt of his report.[29] In the interim it was clear that communication between the healthcare team, particularly on ward rounds, needed to be improved. At the time of [Mr B's] first admission the orthopaedic and general surgical wards had recently combined. This resulted in a number of consultants arriving on the ward simultaneously in order to conduct ward rounds. This meant that a senior nurse was not always available for each consultant. In order to improve communication on ward rounds the consultants have agreed to stagger their arrival times and an additional senior nurse position has been established. Consideration has also been given to changing the timing of the morning medication round which presently clashes the consultants' ward rounds."

Whanganui DHB outlined further remedial measures that have been taken in light of this case:

> "As previously advised, the timing of the surgical and orthopaedic ward rounds has been staggered, so that a senior nurse may be present on the ward rounds. An additional position of a full clinical coordinator has been created to further support surgeons conducting their rounds. This sad case has been reviewed by the Clinical Governance Committee and the Surgical Committee and the deficits in documentation were evident to all members of these committees. The Medical Advisor has circulated the WDHB's Health Records Policy to every Head of Department. This policy mandates the standard of documentation required in patient records. The Clinical Quality and Risk Advisor has conducted two documentation audits, the second audit showing significant improvement in documenting the time that the ward round was conducted, who was present on the ward and whether the patient was seen and the surgical site examined. These audits will continue until there is full compliance with documentation standards.
>
> Looking to the future, our strategy is focusing on growing a safety culture and our priorities for action are communication including clinical documentation and handover and standardisation."

Whanganui DHB accepts that it breached the Code of Health and Disability Services Consumers' Rights:

[29] These comments were made before Whanganui DHB received Dr Simpson's report in February 2008.

> "WDHB accepts that the care provided by [Dr D's] surgical team was sub-standard; and in particular that there was poor communication. … WDHB will apologise unreservedly to [Mr B's] family for this …"

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4

Right to Services of an Appropriate Standard

(1) Every consumer has the right to have services provided with reasonable care and skill.
(2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

…

(5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

Opinion: Breach — Dr D

Mr B was an active and independent 85-year-old. In 2006, Dr D performed open surgery on Mr B and inserted a T-tube to drain bile. Dr D was responsible for his postoperative care and gave instructions for the T-tube to remain in place for a month. It was discovered accidentally dislodged after a week.

On the day before he was discharged, a nurse noted that Mr B's wound dressing was "very oozing and smelly". She inspected the wound and recorded that the T-tube had been dislodged so was removed. The wound site was covered with an ileostomy bag. Mr B was discharged the next day. The medical team did not notice that the T-tube was missing at this time. Mr B was nursed in the community then re-admitted to hospital a few days later. He was reviewed by Dr D's team.

Dr D first became aware of Mr B's readmission two days later. Dr D reviewed him that morning and confirmed that Mr B had a wound infection. Dr D did not notice that the T-tube was absent. In the early hours of the next day Dr D was contacted by Dr E.

At that point, Dr D became aware that Mr B had suffered two postoperative complications, first the dislodgement of the T-tube, and secondly the wound dehiscence. Despite further surgery, Mr B died 12 days later in hospital.

Dr D had a duty to provide an appropriate standard of postoperative care to Mr B. Dr D delegated aspects of this care to the junior doctors in his team. The fact that Dr D did not personally provide the care does not absolve him of his responsibilities to Mr B. The key question is whether Dr D appropriately delegated and supervised the care provided by his team.

Effective clinical supervision is critical for safe health care. A system based on delegation without supervision and responsibility will not work to the benefit of patients and the community.[30] A basic principle of supervision is that the supervisor may delegate care when he has good reason to believe that the supervisee is competent to carry out the delegated tasks.[31] A critical issue in cases involving supervision is whether the supervisor acted reasonably in relying on the supervisee acting in the role assigned. In deciding this, several factors are considered, including the supervisee's experience and the supervisor's knowledge of their skills and experience.

Dr Stewart, my independent advisor, was critical of the quality of supervision during the postoperative period. Dr Stewart noted that the postoperative management of the T-tube would likely have been unfamiliar to staff. He advised that Dr D should have provided more detailed instruction other than "it must not come out". Dr Stewart commented that the surgical team accepted that the T-tube was still in place and likely had "no idea what was going on because of their unfamiliarity with T-tubes". I accept his advice.

In my view, Dr D failed to provide an appropriate standard of postoperative care in the following respects: (1) the instructions regarding the management of the T-tube were inadequate. There was no specific management plan or guidance to the hospital staff or the community nurses on discharge; (2) the medical reviews were inadequate and failed to identify the emerging wound dehiscence and dislodgement of the T-tube for nine days; and (3) his documentation was deficient. My reasons for this view are set out below.

Management of T-tube

Dr Stewart advised that in contemporary practice, bile duct stones are usually removed through endoscopic retrograde cholangiopancreatography (ERCP), markedly reducing the need for open surgery. Consequently, many junior medical and nursing staff are not familiar with the use and management of T-tubes. It is an uncommon procedure. As the surgeon in charge of Mr B's care, it was vital that Dr D organised a clear and

[30] Professor John Campbell, "Supervision — why the concern?" *New Zealand Doctor*, 26 September 2007, p 14.

[31] *McKenzie v Medical Practitioners Disciplinary Tribunal* [2004] NZAR 47 (HC), Dr Roman Hasil and Whanganui DHB 2005-2006 (Opinion 07HDC03504, February 2008).

definite management plan to guide his team. There is no indication that this occurred. The only instruction given was vague. It involved Dr D telling Mr B (during the ward review on 28 June) that the T-tube had to remain in place for a month and the surgical registrar documenting this instruction in the clinical notes. Apart from that, no other written instructions were provided about the management of the T-tube. Had Dr D provided clearer and more detailed instructions about the T-tube (other than "it must not come out"), it would have assisted medical staff to recognise and respond appropriately when the T-tube became dislodged.

From reviewing the clinical records, Dr Stewart was unclear whether Dr D intended Mr B to go home with the T-tube left draining or whether the tube was to be clamped and fixed onto Mr B's abdominal wall before his discharge. Although leaving the T-tube draining is an acceptable departure from normal practice, Dr Stewart advised that the community nurses and Mr B's family needed clear instructions on how to manage an ileostomy bag that would fill with bile daily. It is unlikely that they would have been any more familiar with T-tubes than the junior medical and nursing staff in the hospital. The community nurses and Mr B's family also needed information on what volumes of bile would be considered normal and, for the family, when they should seek further medical assistance. There is no evidence in the notes that Dr D had given instructions of this nature. He appears to have assumed that the community nurses and Mr B's family would know what to do. This was unreasonable in the circumstances.

I was struck by a sense that the staff were effectively managing "in the dark" in relation to their postoperative care of Mr B. In my view, Dr D failed to provide clear and detailed instructions on the management of the T-tube to junior medical and nursing staff, the community nurses, and Mr B's family.

Adequacy of medical review

I share Dr Stewart's view that Mr B received "scant medical review", which resulted in missed opportunities along the way to pick up signs that all was not well. Mr B's T-tube had come out prematurely, and there were signs of impending wound complications. There are questions about the quality of the medical reviews as well as the level of senior medical input.

Dr D was responsible for the decision to discharge Mr B, whether he personally reviewed Mr B or not. Dr Stewart advised that Mr B was not fit for discharge.

Dr D should have been aware of the absent T-tube and discharge from the surgical wound indicating that all was not well on the day Mr B was discharged. This information was recorded clearly in the clinical notes and would have been readily observable had Mr B received an adequate wound examination.

After five days at home, Mr B was readmitted to Wanganui Hospital with a distended abdomen and wound complications. He remained in hospital for 12 days until his death. There were further gaps in the care he received during this period for which Dr D must accept responsibility.

On admission, Mr B was reviewed by Dr F, who suspected a bowel obstruction and wound infection. According to Dr F, she discussed Mr B with Dr E, although this discussion was not documented. It is unclear why Dr E did not relay this information to Dr D. It is also unclear why there was at least a two-day gap before Dr D learnt of Mr B's readmission. Dr D was on duty and accepting acute admissions to Wanganui Hospital from 8am on the day of the re-admission to 8am the following day.

As a result of suboptimal communication between junior and senior medical staff, Mr B was not reviewed by a consultant until the third day of his readmission. Dr Stewart considered this "unacceptable" and advised that "in provincial hospitals staffed at the junior level by inexperienced doctors, it is mandatory for consultant staff to closely monitor the acute [cases]". Although Dr D had apparently not been informed promptly of Mr B's readmission, there is no indication that he had attempted to see his patients on the day of Mr B's readmission, or the day after, or communicated with his junior staff about which patients had been admitted.

It was inexcusable that, because of inadequate medical review, Mr B's significant complications went unrecognised by the responsible surgical team for nine days.

Documentation

The deficiencies in Mr B's care were also reflected in the poor standard of documentation. As discussed above, there were no clinical entries by any medical staff for three of the days of his first admission. On the days Dr D's team did write notes, there was generally a paucity of information recorded.

Dr Stewart explained that in a public hospital, the consultant usually delegates the task of writing up notes to junior medical staff. Although I am not critical of Dr D not recording any notes himself, he was responsible for supervising and ensuring that his team kept good notes. There is no evidence that this occurred. The ward review notes Dr F recorded were brief and omitted important details. Apart from noting that Dr D was the consultant in charge, the notes did not list the names of all the doctors who saw Mr B during a particular ward round, and the time of the day he was reviewed. The notes also lacked information about any observations made, and the findings from any clinical examinations performed.

In my view, the record-keeping by Dr D's team did not comply with professional standards. In addition, there were several discrepancies in the accounts provided by Dr D and his team which could have easily been resolved with adequate documentation. Dr D is responsible for the deficient quality of his team's documentation.

In *J v Director of Proceedings*,[32] an appeal from a decision of the Health Practitioners Disciplinary Tribunal, Baragwanath J stated that "[f]or the reasons expressed by the

[32] High Court Auckland, CIV-2006-404-002188, 17 October 2006.

Tribunal meticulous record keeping is a fundamental obligation of the practitioner". The Tribunal stated:[33]

> "Note-keeping should not be regarded as a minor matter. … Thorough note-taking is the cornerstone of safe and effective medical practice. Poor note-taking provides poor support for clinical practice for either [the practitioner] or any other person reviewing his notes and continuing or amending the treatment plan which has been prescribed."

Conclusion

Overall, I conclude that Dr D did not manage Mr B's postoperative care appropriately and breached Rights 4(1) and 4(2) of the Code. Dr D regrets the areas where his management and supervision of Mr B's care could have been better and is "very sorry" about the outcome for Mr B and his family.

Opinion: Breach — Dr C

Dr C, another surgeon at Wanganui Hospital, saw Mr B for the first time on the night before his discharge. Dr C was not on call and had come in to hospital to see one of his patients. On his way out, duty nurse Ms G approached him for advice about the dislodged T-tube, and he came over to see Mr B. Prior to this, Mr B was unknown to Dr C.

Dr C examined the wound and confirmed the duty nurse's observations that the T-tube had been dislodged and noted there were decreasing quantities of bile draining from the T-tube over the previous days. Dr C thought it was likely the T-tube had been dislodged two days earlier. He concluded that Mr B appeared well, albeit disorientated. Dr C did not think the situation was of immediate significance.

Dr C explained that he attempted to contact Dr D at home that evening, without success. He said that he did this as a "professional courtesy". As Mr B was considered stable, Dr C instructed the duty nurse to record the findings and inform Dr D's team of the incident.

Dr C was consulted as a surgeon — even though he was not on duty — and therefore had a duty to follow up and inform the responsible surgical team about the incident. The key issue for determination is the adequacy of Dr C's follow-up and communication in these circumstances.

[33] Health Practitioners Disciplinary Tribunal decision Med05/11D.

Expert advice

A number of surgeons have provided expert advice on Dr C's role in Mr B's care (Drs Simpson, Schroeder, Johnston, Stewart and Professor McCall). It may be helpful to summarise the expert opinion.

Dr Simpson was the first expert engaged by WDHB to review the events in question as part of its own investigation. In his review report, Dr Simpson was critical of communication at WDHB at the time of these events, and specifically noted that Dr D "should have been told directly about the T-tube at the very earliest opportunity, at the very latest the following morning".

In response, Dr C asked Dr Schroeder to provide advice on "whether he agreed with Dr Simpson's views about the actions [Dr C] should have taken on the night in question to more assertively ensure [Dr D] was advised of the loss of the T tube".

Dr Schroeder advised:

> "[Dr C] was being asked to accept responsibility for something that he was not formally involved with .... He was not on call, and had no other clinical input into the patient's course, so to hold him responsible for failing to communicate formally with the other team is unreasonable."

Dr Schroeder noted that he did not have all the information and advised "if further evidence is required to clear Dr C of any allegations", he was happy to provide further advice.

My independent expert advisor, Dr Stewart, gave me initial advice, and then further advice following Dr Stewart's consideration of the responses to the provisional opinion, and again following the further material received after the investigation was reopened.

Dr Stewart advised that Dr C's communication was below an acceptable standard, given Mr B's clinical situation at the time. Dr Stewart's expectation in such circumstances is that Dr C would have acted "with a level of importance or urgency greater than just relying on a nurse to communicate the information the next morning". Dr Stewart stated:

> "… [T]he required standard … in my opinion would be at the least, for him ([Dr C]) to have verbally communicated (to the surgical team, preferably [Dr D]) that night (or if that was not possible) definitely first thing the following morning."

Dr Stewart described the clinical situation as a *significant* clinical development, since "the inadvertent loss of a T-tube could potentially be a disaster".

Following the release of HDC's provisional opinion on 10 November 2008, Dr Johnston was asked to comment on Dr C's actions. His comments were premised on the fact that Dr D could not be contacted on the night prior to Mr B's discharge by Nurse Ms G or Dr C. Dr Johnston commented:

> "It would have been typical practice for [Dr C] to speak to [Dr D] the next morning, at least as a courtesy, to make sure he knew, but it was also reasonable for [Dr C] to assume that the absence of the tube would be apparent to [Dr D's] team on their morning rounds."

He further commented:

> "I believe it would have been courteous for [Dr C] to directly inform [Dr D] in the morning, but communication via an experienced nurse who was part of the team would not generally be regarded as unsatisfactory."

Dr Johnston concluded:

> "The Commissioner's opinion follows from Mr Stewart's advice, but it may be that if this advice has suggested a rather less serious departure from ideal practice he may not have felt [Dr C's] actions amounted to a breach of the Code."

After the investigation was reopened, Professor McCall was asked by Dr C to provide fresh expert advice. Professor McCall acknowledged that miscommunication had occurred at more than one level: between Dr C and Dr D, between the nursing staff and Dr D, and between the patient notes and the medical staff. He then commented on Dr C's communication:

> "There is no doubt that a direct communication would have been the *ideal* thing to do, but the real question is whether the action he took was *acceptable* under the circumstances.
>
> [Dr C] made two separate communication attempts including asking for the event to be recorded in the notes. It would have been better for him to record in the notes himself rather than a delegate, however that is not the required standard. In my opinion his communication was not ideal but within the limits of acceptable practice. In other words a reasonable practitioner might have done the same thing under similar circumstances."

In coming to this conclusion, Professor McCall took into account that T-tube removal on day 7 is within the limits of acceptable practice. Professor McCall discussed whether there was any indication of a bile leak or an intervention at the time. He stated that his "only caveat here was that the T-tube had stopped draining 48 hours before it was found dislodged so it is possible that it became displaced from the bile

duct earlier than day 7".[34] Professor McCall advised that Mr B did not do "exceptionally well" after the first operation and he had an evident wound complication before, rather than following, Dr C's "brief encounter with [Mr B]".

Dr Stewart was invited to reconsider his advice in light of all the material, including Professor McCall's report. Dr Stewart maintains that the failure by Dr C to directly communicate his findings to either Dr D or his team was unsatisfactory.

Conclusion

Dr C was on notice of a significant finding involving Dr D's patient that needed to be communicated to the responsible surgical team. All of the experts agree that, ideally, Dr C should have communicated directly with the responsible surgical team. I have received independent expert advice that Dr C's actions were unsatisfactory; and expert advice obtained on behalf of Dr C that his actions were reasonable in the circumstances. Ultimately, the reasonableness of Dr C's actions is for me to determine, taking into account usual practice, as well as patient interests and community expectations.[35]

I note the recent comments of Ronald Young J in *Stubbs v Health and Disability Commissioner*[36] that "Parliament has entrusted the Commissioner with his particular qualifications, with expressing opinion on what will often be complex medical issues".[37] It is ultimately for the Commissioner to state his opinion whether any action was in breach of the Code.[38]

The reasonableness of Dr C's actions cannot be judged in isolation from the context of the general surgery department at Wanganui Hospital. There were acknowledged difficulties in the department. Several of the experts have criticised communication in the department at the time of these events. Dr Simpson called it "unsatisfactory" and described the department as "dysfunctional"; Dr Stewart criticised the "poor" and "unsatisfactory" communication evident at all levels in this case; and Professor McCall noted "miscommunication" at more than one level.

Against this background, I turn to consider the adequacy of Dr C's actions. The question is not whether (in Professor McCall's words) "a reasonable practitioner might have done the same thing under similar circumstances". The question is whether, in terms of Right 4 of the Code, Mr B received services of an appropriate standard from Dr C. As noted by Dr Schroeder, it was "imperative" that the surgical team knew about the dislodged T-tube prior to the planned discharge. I am not willing to endorse the actions of a surgeon, where even his own experts describe his communication as "less than ideal", in the face of clear and consistent advice from my

[34] Dr C has since stated that it was likely the T-tube had been dislodged two days before — on day 5.
[35] *B v Medical Council of New Zealand*, High Court Auckland, HC 11/96, 8 July 1996, Elias J.
[36] High Court Wellington, CIV 2009-485-2146, 8 February 2010.
[37] Para 52.
[38] Health and Disability Commissioner Act 1994, section 45.

independent expert that Dr C's communication was "unsatisfactory" and meriting "moderate disapproval".[39]

Having reviewed all the evidence and differing views of the experts, and taking account of the context in which Dr C was working, I consider that he needed to personally inform Dr D, or a member of the surgical team, of the significant finding of the dislodgement of the T-tube. Dr C failed to do so. It was not enough to tell the duty nurse to relay the information to Dr D's team.

In my view, Mr B did not receive the "co-operation among providers to ensure quality and continuity of services" to which he was entitled under Right 4(5) of the Code. The communication failures of the DHB as an organisation are noted below, and form the basis of my finding that the DHB breached Right 4(5) of the Code. But I am of the opinion Dr C's own communication failure amounted to a breach of Right 4(5). Dr C failed to adequately discharge his duty of care to Mr B.

It is hard not to feel some sympathy for Dr C, who stepped up to the plate to assist a colleague. But regrettably, he failed to see the job through. Although Dr C played a less significant role in the overall picture of Mr B's care, Dr C is responsible for his poor communication in this case.

There has been considerable comment about the cause of Mr B's death, and the contribution, if any, of the miscommunication about the dislodgement of the T-tube. I have also received submissions about the relative responsibility of Dr C, and issues of proportionality. I reject any submission that I am holding Dr C accountable for the failures of others. Dr C is responsible for his own actions, not those of others.

Dr C was also concerned that I would be setting a new standard; that medical staff would have to "go above and beyond normal standards to ensure that the failure of others does not result in inadequate care". I do not accept that I am setting a standard of communication that goes above and beyond typical practice. Dr C recognised that it was appropriate to contact Dr D, at least as a courtesy. Dr Johnston commented that it would have been typical practice for Dr C to speak with Dr D the next day. Whether such personal communication is undertaken as a "courtesy" or to fulfil a patient's right to co-operation among doctors (as is the view expressed in my report), it is clearly not a "new" practice — or contrary to the efficient and effective operating of hospitals.

[39] I note that Dr Stewart has slightly modified his initial view that the miscommunication at Wanganui Hospital, including that of Dr C, merited "moderately severe disapproval".

Opinion: Breach — Whanganui District Health Board

Poor communication at Wanganui Hospital's Department of Surgery was the key factor that compromised Mr B's care. It is clear that there were longstanding, unresolved problems in the working relationships within the department. I am left with the impression that communication difficulties impacted on Mr B's care. This should be of considerable concern to Whanganui DHB. It reflects poorly on the individuals involved, and on the DHB as an organisation.

In addition to the unsatisfactory communication between surgeons, there were also communication gaps between the medical and nursing staff. Medical and nursing staff did not communicate adequately in planning Mr B's discharge. The nurses did not notify Dr D or his team that the T-tube had become dislodged. The medical discharge papers did not mention the dislodged T-tube whereas this was noted in the nursing discharge papers. This clearly highlights the need for better communication and co-ordination of care between nursing and medical staff before discharging a patient.

On the day following discharge, Dr F was contacted by the community nurse regarding concerns about Mr B's wound. However, Dr F omitted to inform Dr D of her discussion, and to document it. After he was re-admitted, junior staff delayed informing Dr D of the readmission for at least two days.

The following comment from Dr Stewart is telling:

> "This whole case is characterised by poor communication. A complex clinical case (such as [Mr B]) exposes this. At all levels ([Dr C–Dr D], nursing staff–[Dr D], junior staff—[Dr D] and [Dr D]–junior staff) communication was unsatisfactory. Erroneous assumptions were made. Had exemplary clinical practice and communication occurred it is still possible that [Mr B's] outcome may have been the same, but with his complications and the associated unsatisfactory communication a poor outcome was inevitable."

The care of patients should never be jeopardised because of dysfunctional working relationships and communication difficulties. In my view, the unsatisfactory care and communication at Wanganui Hospital supports a finding that Whanganui DHB breached Rights 4(1) and 4(5) of the Code. The DHB accepts that the care provided by Dr D's surgical team was substandard and that its communication was poor.

Actions taken

Dr D

Dr D has provided a written apology to Mr B's family for his breaches of the Code and reviewed his practice in light of this report.

Dr C
Dr C has provided a written apology to Mr B's family and reviewed his practice.

Whanganui DHB
Whanganui DHB has provided a written apology to Mr B's family for its breaches of the Code. WDHB has provided HDC with the results of a further surgical ward round audit of documentation and evidence of improvement in documenting the time of the round and listing who was present. The surgical committee has met to discuss this case, as has the medical advisor and the heads of each specialty. WDHB will arrange a meeting of key surgical, medical and nursing staff to review this report and the lessons from Mr B's case, and update HDC on the steps being taken to improve the quality and co-ordination of care for patients at Wanganui Hospital.

Recommendation

I recommend that Whanganui DHB update HDC by **30 April 2010** on the outcome of the review meeting to discuss this report, and on the steps being taken to improve the quality and co-ordination of care for patients at Wanganui Hospital.

Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand, ACC, and the Wanganui Coroner.

- A copy of this report with details identifying the parties removed, except the name of the experts who advised on this case, Whanganui District Health Board, and Wanganui Hospital, will be sent to the Director-General of Health and the Royal Australasian College of Surgeons and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Names have been removed (except Whanganui DHB/Wanganui Hospital and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix A

Independent advice to Commissioner

Initial advice
The following expert advice was obtained from Dr Ian David Stewart:

"My name is Ian David Stewart. I am a general surgeon at North Shore Hospital in Auckland. My scope of surgery involves both acute and elective surgery for biliary tract disease. I was asked to review the notes and documentation for Mr B who was treated surgically for common bile duct stones in Wanganui Hospital [in 2006].

Expert advice required

To advise the Commissioner whether, in my professional opinion the care provided by general surgeons, [Dr D] and [Dr C], and Whanganui District Health Board were of an appropriate standard.

1. Care provided by [Dr D]

a) Please comment generally on the standard of care that [Dr D] provided to [Mr B] [during his first admission]; and [second admission]. Please give reasons for your opinion, with reference to other health providers involved.

[Day of operation until discharge]. [Mr B] had gallstones with the added complication of stones in the common bile duct. He had continuing abnormal LFTs including jaundice. Removing the CBD stones by ERCP was the appropriate initial management but unfortunately, ERCP ([the gastroenterologist]) was not possible for technical reasons (a presumed gastric volvulus preventing access to the duodenum). [Dr D] therefore recommended open surgery, cholecystectomy with exploration of the CBD. The surgery and possible complications were apparently discussed appropriately with [Mr B] and his family and this included a pre-op anaesthetic assessment. [The surgery] involved cholecystectomy (removal of the gallbladder), exploration of the common bile duct with removal of a large stone and insertion of a T-tube. At operation the anatomy of the stomach was observed to be normal (he did not have a gastric volvulus). According to the typed operative note (page 00018 in the documents) all aspects of the surgery I find satisfactory including the size and placement of the T-tube and the technique (using 4/0 Vicryl) of securing it. [Dr D's] use of a completion cholangiogram likewise is entirely appropriate.

There were 3 significant issues during the post-operative period:

i. vomiting (?haematemesis) — managed satisfactorily with blood count monitored, gastroscopy performed and Losec prescribed.

ii. the dislodgement of the T-tube

iii. the development of wound complications.

An added issue documented several times in the nursing and physiotherapy notes is a reluctance by [Mr B] to mobilize which for someone of 85 years who has had major surgery is understandable and 'within normal'.

Neither of the developments (ii and iii) were either picked up or acknowledged before [Mr B's discharge]. However both of these complications (the T-tube dislodgment and the wound dehiscence), were highly likely initiating events/or indicators beginning a deterioration that firstly led to the second operation and secondly to his death. There were opportunities for both these complications to have been recognised. [Dr D] in his statement claims he saw [Mr B] in the ward 'each day of his admission including the day prior to [his discharge]'. According to the submitted hospital notes there is documentation supporting [Dr D] visiting [Mr B] on the [day following the operation, and two days later] and again on [the day prior to his discharge]. I found nothing in the notes to support a visit to [Mr B] by [Dr D] for the [three days prior to the discovery of the dislodged tube], in fact no convincing evidence that [Mr B] was seen by **any** medical staff on these days.

The T-tube 'fell out' on the night [prior to discharge] so possibly even if [Mr B] had been medically reviewed on the preceding 3 days it is unlikely any untoward developments with the T-tube would have been evident. However, any developing wound complications (particularly a discharge) should have been noted. A note from the nurse on the night of [prior to discharge] (the same night the T-tube fell out) reports the wound to be 'very oozing and smelly'. There was no mention in the medical discharge summary (page 00225) of either the wound discharge or any instruction on the T-tube. However in the nurses discharge referral note to the community wound nurse, the fact the T-tube is out is acknowledged.

These 2 significant complications (wound and T-tube) following the first operation are both technical problems and directly relate to the surgery. They are unfortunate but are well recognised potential complications that can occur even with exemplary surgical management. [Mr B] with his multiple co-morbidities particularly interstitial lung disease was at significant risk of postoperative wound problems including wound dehiscence. He spent a lot of time in the immediate postoperative period being moved around by others (nurses, physiotherapists etc) including being sedated for a gastroscopy. At any time during this period the T-tube is at risk of inadvertent removal (catching on something, getting pulled out). There's nothing I've read in the documents to suggest the dislodgment of the T-tube was anything other than unfortunate.

I am however **moderately critical** of the medical supervision during the postoperative period following the first operation.

a. There is no comment throughout this period on the state of [Mr B's] wound despite a nursing reference late on the [day prior to discharge] saying the wound/dressing was oozing and offensive. Clearly the wound had begun to cause problems before [Mr B] left hospital. Was the wound ever looked at by the medical staff?

b. No-one from the medical staff reacted to the importance of the dislodged T-tube. Clearly the communication between [Dr C] (who was aware the tube had come out) and [Dr D] was non-existent; it wasn't sufficient for [Dr C] to rely on a nursing note to convey the message. I agree with [Dr D's] statement that to expect a nursing note as satisfactory communication is inadequate. I will elaborate more on the role of [Dr C] later, but [at discharge] there should have been specific instructions given by [Dr D] regarding the management of the T-tube. The responsibility for this is with [Dr D]. With the widespread use of therapeutic ERCP, open exploration of the common bile duct has become an uncommon procedure and the use of T-tubes relatively unusual. The postoperative management of the T-tube would likely have been unfamiliar both to the junior medical and nursing staff. Had [Dr D] given instructions (including the relevance of bile output volumes, when should the tube be clamped), he would have probably quickly learnt (even if he hadn't examined the patient) that the tube was no longer there. The only instruction [Dr D] gave was that he wanted the T-tube left in place for one month, (documented in the notes on the [day following the operation]). Routine management of T-tubes would have patients going home with the T-tube clamped, that is, bile would no longer be draining and the T-tube clamped off (usually with a spiggot in the end of it) and 'strapped' to the abdominal wall with a dressing. In his submission [Dr D] says it is '… not unusual to allow the tube to drain into an ileostomy bag' … I challenge that statement. T-tubes drain bile through a sealed connection into a bag. An ileostomy bag placed over the exit of the tube from the abdominal wall is only ever used if the tube has come out and bile continues to drain through the abdominal wall exit site, or perhaps remotely if a seal can't be established between the tube and the draining bag. I suspect rather than the 'team' accepting the T-tube was still in place when they saw the ileostomy bag, they probably had no idea what was going on because of their unfamiliarity with T-tubes. My interpretation of what [Dr D] wanted for [Mr B] was for him to go home with the T-tube draining. Whilst this would not be regarded as routine, there are situations, (particularly with retained common bile duct stones) where the T-tube continuing to drain on discharge would be appropriate. Either way (T-tube left draining, or T-tube clamped), more detailed instruction other than 'it must not come out', should have been given. Had that instruction occurred it seems highly likely his ([Dr D's]) attention would have been alerted to the fact that the T-tube was no longer there.

I am critical that [Mr B] appeared to receive scant medical review (particularly clinical examination) in the 3 days prior to his discharge. Had this review been satisfactory then it is possible there would have been recognition of a developing wound complication (the dehiscence) and, on the day of discharge, the absent T-tube would have been noted. There is no evidence (no documentation) that [Mr B] was seen by medical staff on [the three days prior to the discovery of the dislodged tube]. This is unsatisfactory which I view with **mild disapproval**.

[Readmission]
At his readmission he was unwell with abdominal pain, bloating and vomiting. His abdominal wound was leaking fluid ('dressings soaked'). His blood tests reflected probable severe infection with a high white blood cell count (20, normal 4–11), a neutrophilia with toxic changes. I could not find a formal report of his plain abdominal X-ray[40] in the documents but the house surgeon interpreted the films as showing 'dilated bowel loops', with [Dr D] stating 'faecal loading'. [Dr D] first saw [Mr B] [the following day] and despite examining him, did not comment that the T-tube was missing. There are conflicting statements from [Dr D] in his submission. On page 00011 he says that he first became aware of the absent T-tube on [two days after readmission]; on page 00012 he states that when he saw [Mr B] on the [day after readmission], he was 'told (by [Mr B]) that the tube had been taken out by a nurse the night before discharge'.

[Dr D] in his evidence is correctly critical of [Dr C] for not immediately informing him that the T-tube had dislodged. He argues correctly that had he known earlier he would have operated immediately. Yet when he did ([Dr D]) become aware of the absent T-tube he did not consider immediate surgery.[41] Surgery only occurred on the early hours of [day] when [Mr B] deteriorated. Presumably [Dr D] only became aware of both the dehiscence and the absent T-tube [two days after readmission] despite the conflicting evidence in the documents. It would be unfair in hindsight to be critical of [Dr D] for not operating earlier if he was not aware of the complications, but clearly if [Mr B] had had earlier surgery, the outcome may have been better.

b) Please advise whether [Dr D] performed the two surgeries on [… and …] to appropriate standard.

[40] The abdominal X-ray report states: "There is marked small bowel loop dilatation seen within the centre of the abdomen. The large bowel is loaded with faecal matter, especially the rectum and the lower descending colon. Multiple surgical clips are seen in the right hypochondrium since the previous cholecystectomy. This appearance could be due to the post-operative ileus, but a further study is suggested."
[41] In his response to the provisional opinion, Dr D clarified that he first became aware of the absent T-tube when he was called to see Mr B on the night [two days after readmission]. Dr D was told that Mr B's wound had dehisced. Following Dr D's review, Mr B was taken to theatre for a laparotomy, and Dr D considers that he "*did* operate as soon as [he] was aware that the T-tube was displaced".

Both these operations were performed satisfactorily. In view of the failed ERCP in dealing with [Mr B's] stones there was no option other than surgery and in most general surgeons' hands this would require an open procedure with exploration of the common bile duct. [The first] surgery performed followed accepted operative surgical technique. He explored the duct and removed the stone and followed this with an on table cholangiogram to confirm no further stones. He then placed a T-tube in the common bile duct. The size of tube used and the technique used to secure it and close the common bile duct was appropriate. Likewise the [second] surgery with [Mr B] clearly demonstrating signs of generalised peritonitis was also appropriate. The operative indication on that occasion was two-fold, evidence of a biliary peritonitis and a full thickness wound dehiscence. There was no perforation of the small bowel (which was suspected preoperatively) but the small bowel involved in the dehiscence was such that it would not have been safe to leave that segment of bowel and appropriately [Dr D] excised it. At that stage he was also aware that the original T-tube had fallen out and he replaced it.

c) *Please comment on the appropriateness of [Dr D's] clinical decision to leave the T-tube in place following [Mr B's first surgery]*.

The decision to leave the T-tube for one month was appropriate. [Dr D] wanted the T-tube left draining bile for this one month period.[42] The usual management of a T-tube within the common bile duct is to have it left open and draining bile whilst the patient is in hospital but clamp it prior to discharge. Unless there have been complications, the tube is usually clamped or spiggoted and bile then drains internally the normal way through the bile duct rather than externally down the tube. There are rare situations where leaving bile draining through the T-tube for an extended period would be appropriate the most common probably being if there are known retained stones within the common bile duct. Having examined the notes and all submitted documents I cannot find any evidence to suggest [Dr D] wanted the tube clamped prior to [Mr B's] discharge. I assume therefore that he anticipated [Mr B] going home with the tube draining bile. Whilst this is probably acceptable it would require a lot more close attention by the district nursing service and in general be a lot more difficult to manage. Leaving the T-tube in the bile duct (whether draining bile or not) for a month is routine. Some people would possibly leave the tube for more than a month (perhaps 6 weeks) although after a month there is almost certainly an established tract to the outside and at that stage provid[ed] the duct has been shown to be clear of gall stones then it would be reasonable to remove it. This is usually done at an outpatient visit.

[42] Dr D clarified that Mr B had been scheduled to attend an outpatient review a fortnight following his discharge "at which point the T-tube would have been clamped and a cholangiogram arranged".

d) Please advise the adequacy of [Dr D's] management in relation to [Mr B's] T-tube.

I have already (in question e) discussed the unusual feature that [Dr D] seems to have wanted [Mr B] to go home with the T-tube **draining**. This would be an acceptable departure from normal practice. My criticism regarding [Dr D's] management of the T-tube was that he did not organise a definite management plan. Neither the junior medical staff, the nursing staff in the hospital, nor the community nurses were given any detailed instruction in management of T-tubes. On the assumption that [Dr D] expected the T-tube to still be draining bile then instruction should have been given particularly to the district nursing service and his family about how to manage a bag that would fill with bile every day and what volumes of bile they should expect to see. One of the obvious potential difficulties of sending a patient home with a T-tube draining bile is that the bag will fill with bile, become heavy and awkward to manage. A full bag of bile will place traction on the tube itself and increase the risk of it falling out. For that reason, if indeed he planned on bile still draining through the tube at discharge there needed to be strict instructions about the care of the tube. On the other hand if [Dr D] always anticipated [Mr B] going home with the tube clamped then there had to be instruction about clamping (spiggoting) the tube and then fixing the clamped tube onto his abdominal wall. I can find no evidence in the notes that any of these instructions were given. In 2006 and indeed over the past decade open exploration of the common bile duct and insertion of a T-tube is a relatively uncommon operation. Most common bile duct stones are now removed through ERCP and the need for open exploration has reduced markedly. Many junior medical staff and most nursing staff would therefore be unfamiliar with T-tubes and their management. It was important that [Dr D] laid out very clear instructions how the tube should be managed. My examination of the notes showed only that [Dr D] on more than one occasion made it clear that the T-tube was not to be removed but he should have given much more detailed instructions than that. He may have verbally given more instruction but there is nothing in the notes to support that. I view his failure to do so with **mild disapproval.**

e) In [Dr D's] response to the HDC he stated:

'*I do not feel that a small note in the nursing notes was an adequate enough way of alerting my team to a sentinel event in our patient. It is usual for us to receive verbal handovers of significant events at the time or at least the following day. We do not rely on reading every aspect of the notes on our rounds of our patients. While those notes are paramount in record keeping, they do not constitute our usual method of communication and passing information to each other.'*

I agree with [Dr D's] statement. Relying on the nurse to convey (either verbally or by written note) the fact the T-tube had become dislodged is not satisfactory. This is not a criticism of the nurse (RN [Ms G]) who appropriately recorded the event (page 00155) in her report on the night [prior to discharge].

The dislodgement of the T-tube within 7 days of the surgery is potentially a serious complication requiring immediate action. [Dr C] had an obligation to inform [Dr D] immediately (ie, on the night [prior to discharge]) or at the latest early the next day ([of discharge]).

f) Please comment on the appropriateness of the decision to discharge [Mr B] on the afternoon of [discharge]

In the submitted documents there are conflicting reports about whether or not [Dr D] saw [Mr B] on the day of discharge. The hospital clinical notes state (on page 00156) that [Dr D] did a ward round on the [day of discharge] and it is written that [Mr B] can be discharged with follow-up in surgical outpatient department in 2 weeks. [Dr D's] name is written above that note with the words 'ward round' written alongside. Whilst it doesn't appear to be [Dr D's] handwriting on the page, it does seem as though [Dr D] did do a ward round and presumably saw [Mr B] that day. However in [Dr D's] own submission he states: 'I did not personally see him on the day of discharge. I had discussed him with my junior staff who raised no issues and were happy for him to be discharged.'

In hindsight it was not appropriate for [Mr B] to be discharged on [that day]. He had a discharging abdominal wound and his T-tube had come out prematurely the night before (or possibly earlier than that). According to the note [Mr B] apparently appeared well but at no stage in his last few days in hospital during that admission is there any indication (from the notes) that any of the medical staff examined his abdomen. The developing dehiscence may not have been obvious although it seems likely there would be signs from the wound (particularly discharge) indicating all was not well. Also, at discharge very clear instructions for the management of the T-tube should have been given both verbally and written.

I view the lack of satisfactory instructions for the T-tube management with **mild disapproval**.

g) Please advise the adequacy of [Dr D's] standard of documentation

The standard of documentation by the medical staff (including [Dr D]) during the first admission is poor. I do not criticise him ([Dr D]) not personally writing in the notes; usually in the public hospital setting the medical junior staff write up the notes and even in a complicated prolonged admission it is not unusual for the consultant him/herself to never make any notes. However there are [3 days during the first admission] where there is no record of **any** of the medical staff having seen [Mr B] let alone any medical documentation. Either no-one from the medical staff saw him (unlikely) or if they did, they made no notes. Either situation is unsatisfactory and would be viewed with **mild disapproval**.

2. Care provided by [Dr C]

a) Please comment on the appropriateness of [Dr C's] advice to RN [Ms G] regarding [Mr B's] T-tube.

[Dr C] was in the hospital on the night [prior to discharge] attending to other matters when he called by the attending nurse to see [Mr B]. The nurse had noted that the T-tube was lying free on the abdominal wall and had obviously been dislodged. [Dr C] commented that [Mr B] seemed well although he was disoriented. He confirmed that the T-tube had been dislodged. He also noted that there had been decreasing quantities of bile draining from the tube over the previous days and in the 24 hours prior to his visit only 20mls had drained. He gave advice to RN [Ms G] to place an ileostomy bag over the exit site on the abdominal wall and apparently suggested an ultrasound should be done the following morning. He asked the nurse to document that recommendation. According to the hospital notes, the entry by RN [Ms G] on [the night prior to discharge] at 2215 hours confirmed the T-tube had dislodged. The note went on to report 'the site was covered with an ostomy bag please monitor output'. There was no mention made in this documentation of seeking an ultrasound in the morning.

The dislodgement of the T-tube was first noted on the night [prior to discharge] but as [Dr C] correctly says in his statement the decreasing bile output over the previous couple of days possibly indicated that the T-tube may have dislodged itself from the bile duct a day or two earlier. Obviously it was only on the night [prior to discharge] that the tube was found outside the abdominal wall. In other words, it is reasonable to suspect that the dislodgement of the tube noted on the night [prior to discharge] was not a sudden event and possibly occurred a couple of days earlier. If that was the case ([Dr C] considered it a possibility), then it places even more emphasis on the fact that [Mr B] at that time (on the night [prior to discharge]) may have had an established biliary peritonitis. Consideration of the development of biliary peritonitis should always be made if a T-tube comes out prematurely. Certainly a T-tube becoming dislodged within a week of its placement should raise considerable concern about the possibility of biliary peritonitis. I believe most general surgeons would regard the dislodgement of the T-tube within one week of surgery as a surgical emergency and strong consideration given for ERCP (plus stent) or perhaps laparotomy. At the very least I believe [Dr C] had an obligation to ring or contact [Dr D] on the night [prior to discharge] and discuss this situation. [Dr C] gave evidence that [Mr B] was disoriented at the time he saw him. This is possibly an indication of the patient being septic and in this particular situation biliary peritonitis was a likely cause. I will concede there may be situations whereby a period of observation and perhaps radiological imaging would be justified but in [Mr B's] case with [Dr C] having not previously been involved, he should have made immediate contact with [Dr D]. In [Dr C's] evidence he emphasises that he only had momentary

contact with [Mr B] ('brief view of the patient', 'literally in passing') implying that this brief contact is a mitigating circumstance for not becoming further involved. Once he was called to the patient he had an obligation to make a full diagnosis and appropriate management plan. [Dr C] also in his evidence talks of the decreasing volumes of T-tube bile output implying that the T-tube had already dried up and the subsequent dislodgement was of no consequence. The counterview should have also been considered namely that the reducing volumes may have indicated that the T-tube had fallen out a couple of days earlier in which case there was a possibility of an established biliary peritonitis.

I am not convinced by [Dr C's] argument that there are studies supporting early T-tube removal. Whilst I have not read the articles he quotes I am confident in asserting that most general surgeons would be very loathe to remove a T-tube at least within a couple of weeks, more likely one month. In any event the question in this situation is not about the length of time a T-tube should be left. The debate centres on satisfactory communication to [Dr D] that the tube had dislodged. It was written in the notes that [Dr D] wished the tube to stay in place for one month. That fact along with the awareness of a potential for biliary peritonitis should have led [Dr C] to make immediate contact with [Dr D] to discuss the possibility of immediate intervention be it ERCP (and stent) or surgery.

Junior staff would be expected to notify his/her consultant if a T-tube dislodged. That same communication should occur from one surgeon to another. I would regard failure to immediately notify the consultant in charge of the patient of this position with **moderate disapproval**.

a. In [Dr C's] response to the HDC, he stated:
   'The second T-tube stopped draining [four days following the second operation]. The post-mortem did not confirm the T-tube in the CBD, its expected place. It is possible that a second dislodgement took place [following the second operation].'

This paragraph refers to the postoperative period following the second operation. [Dr C] was not involved at all during this period of [Mr B's] admission. In his evidence [Dr C] states he had no involvement in the second admission. That comment is therefore conjecture and just his views on possible reasons for [Mr B's] death. I doubt this is relevant to this inquiry.

b. In the same response, [Dr C] also stated:
   'While I did not document (the advice) myself, I view my advice given in the circumstances of the brief encounter, similar than a telephonic consultation, and it was not unreasonable to ask the nurse to record what transpired.'

I have covered my reply to that in section 2a.

3. Care provided by Whanganui DHB

Overall I do not have any criticisms of Whanganui DHB. There is no clear evidence to suggest any communication difficulties between the nursing and surgical staff. RN [Ms G] who was on duty the night [Mr B's] tube dislodgement became evident correctly called [Dr C] for assistance. She followed his instruction and documented the dislodgement in the notes. It perhaps could be argued that the nursing staff on the morning of [discharge] could have emphasised to the medical staff that the tube had come out overnight but I believe this was something for the medical staff to have been aware of without any prompting from the nurses. As I have stated earlier that information should have come from [Dr C] in a direct communication with [Dr D] or at the very least, members of his surgical team. It is not appropriate that the nursing staff or indeed Whanganui DHB should take responsibility for that communication indiscretion. Likewise, I consider the discharge planning for [Mr B] was satisfactory. As far as the nursing staff were concerned there was no clinical concern with the T-tube having become dislodged. They were aware of [Mr B's] wound infection for which they appropriately arranged for district nurse follow-up. Again it perhaps could be argued that a senior experienced nurse would have noted the severity of the wound complications and possibly requested further in-hospital treatment but the full responsibility for this type of decision was with the medical staff. The nurse on duty on the night [prior to discharge] documented the dislodgement of the T-tube in the notes and although she perhaps could have emphasised this in some way, I presume it was not impressed upon her the possible severe complication that dislodgement of T-tube could mean and for that reason she did not make more of it other than a single line in the notes. Again, the responsibility for communicating the T-tube dislodgement was a medical not a nursing responsibility.

Summary

[Mr B] sustained two severe complications following his first surgery. The T-tube dislodgement and dehiscence both would have contributed to the peritonitis. Neither of these complications was recognised[43] and they both had clearly occurred during the first admission. Whilst at home following that admission he gradually deteriorated and required further admission and a subsequent second operation. At this second operation everything was done to try and reverse the situation namely the small bowel resection, the dehiscence was repaired and the T-tube replaced. However, it seems likely that irreversible septic events had already begun and despite the fact that the notes attest to him making reasonable

[43] Dr D stated that the complications were recognised "by [Dr C] and nursing staff but [were] not passed on to [him] and [his] team". Dr D also stated that Mr B's wound complications were "recognised by community nurses while [Mr B was] at home [but it was] not communicated to [him]".

progress during the second postoperative period he was still troubled with significant intra abdominal sepsis which eventually led to his collapse and sudden demise. The post mortem indicated peritonitis and an abdominal wall abscess. He died of sepsis.

I wish to reiterate that this situation could occur even with the most exemplary surgery and postoperative care. The two severe complications [Mr B] had, whilst uncommon, are well recognised and not a reason for harsh criticism. My criticism of [Dr D] and his team is the lack of close postoperative monitoring particularly after the first operation. Had [Mr B] been reviewed closely particularly on days [prior to the discovery of the dislodged tube] it is possible the emerging wound dehiscence would have become evident and had he been examined on the [day of discharge] there would have been another opportunity to see a deteriorating wound and the absent T-tube. Had these problems been recognised, [Mr B] would have undergone earlier surgery with possibly a better outcome. I view the lack of strict postoperative supervision and particularly the inadequate instruction for the T-tube after the first surgery with **mild disapproval**. With respect to [Dr C] and the lack of communication regarding the T-tube dislodgement, I view with **moderate disapproval**.

The only further aspect I wish to comment on is if there are known established communication difficulties between the two surgeons ([Drs C and D]) then this is a significant problem for them and Whanganui DHB. This case clearly demonstrates where this communication breakdown can have serious negative repercussions on satisfactory clinical performance. If that is the case and it is influencing their clinical behaviour then that should be of considerable concern to Whanganui DHB."

Additional advice

Following receipt of additional information, Dr Ian Stewart was contacted for further expert advice. On 11 August 2008, Dr Ian Stewart advised:

"My numbered response to your request for further review follows.

1. *Should [Mr B] have been reviewed by a consultant within 24 hours following his readmission to Wanganui Hospital?*

   Yes. It is standard practice in NZ (and in most other countries for that matter) for patients admitted acutely to be reviewed on the first post-acute day by the consultant under whose care they are admitted. In many situations these patients are seen by the consultant on the day of admission and perhaps therefore don't need to be seen again on the first post-acute day. But, one way or another, acutely admitted patients need a review by the consultant either on the day of their admission or the following day. There can be variations to that policy. For example, the admitting consultant may not be immediately

available on the first post-acute day, but in that situation he/she needs to make arrangements with another consultant to have those patients reviewed. In some cases where the acute admitting doctor is senior (perhaps a senior registrar) and the case is of a minor nature and has been discussed with the consultant, then the consultant may not personally see the patient. This later example is unusual but does occur occasionally in the larger hospitals that are staffed by senior surgical trainees.

In provincial hospitals staffed at the junior level by inexperienced doctors, it is mandatory for consultant staff to closely monitor the acute take. In [Mr B's] case it was unacceptable for him to be admitted on [the day of readmission] and then wait 2 nights before he was reviewed by a consultant ([Dr D]). [Dr D] states it was on the ward round [two days after readmission] that 'was the first time that I had been made aware of his re-admission'. The fact he was not made aware of [Mr B's] re-admission is perhaps a mitigating factor if he ([Dr D]) had made genuine attempts on [two days following readmission] to either see his patients or at the least communicate with his junior staff over what patients had been admitted and they had overlooked to inform him about [Mr B].[44]

It seems from [Ms I's] e-mail (page 00375) that there were assumptions (erroneous as it turned out) made amongst the junior staff in handing on the acute care of the patients. [Dr F], who admitted [Mr B], claims she discussed the case with the registrar [Dr E] (? did he review [Mr B]). Did [Dr E] discuss the acute take with [Dr D] either on the night of [or readmission or the following day]? [Dr E] was apparently absent on the [day following readmission] and the covering registrar was [Dr H]… did [Dr E] and [Dr H] discuss the patients?

There was clearly poor communication between the junior staff and I suspect no communication either on the night of [readmission] or on the [following day] between the junior staff and [Dr D].

In summary, if there was communication between [Dr D] and members of the junior staff on [the two days following readmission] and they (the junior doctors) neglected to inform him of [Mr B's] re-admission then this possibly mitigates criticism of [Dr D] in not seeing [Mr B] earlier than [two days later]. However evidence in the submitted documents would suggest there was no communication between [Dr D] and the junior staff on [the two days following readmission] and importantly neither party made an attempt at communication. In other words, following his acute call on the [day of readmission] (**it needs to be confirmed that [Dr D] was definitely on call on the day of**

[44] Dr D advised HDC that communication did in fact occur and that many mitigating factors have been ignored.

[readmission]), [Dr D] had no contact with his patients (including [Mr B]) until 2 days later. If that was the case this is unsatisfactory which I would regard with **moderate disapproval.**

2. *Please comment on the adequacy of [Mr B's] review on:*
   (a) [the day of readmission] by the house officer
   (b) [the day following readmission] by the surgical registrar.

   Clearly neither [Dr F] (house surgeon) nor [Dr H] (registrar) who saw [Mr B] on the [two days following readmission] respectively recognised a significant problem (absent T-tube, wound dehiscence) having occurred. In their defence [Dr D] also didn't recognise the absent T-tube [a day later]. [Drs F and H] are inexperienced and I firstly would not expect them to have much (or any) understanding of the management of a T-tube let alone a complication such as inadvertent dislodgement of the T-tube. The fact an ileostomy bag covered the T-tube site almost certainly was a mystery to them and probably something they assumed was 'normal'. I doubt whether they would recognise signs of impending full wound dehiscence … this apparently wasn't obvious to [Dr D] on [that morning]. My only criticism of these doctors ([Drs F and H]) therefore is that following their assessments they didn't call [Dr D] to discuss the acutely admitted patients.

3. *Please comment on the adequacy of [Dr D's] review of [Mr B] [two days following readmission].*

   I am surprised after his assessment on [this day] that [Dr D] did not notice that the T-tube was missing. Whilst [Dr D] states (page 00013) that 'It is not unusual to allow the tube to drain into an ileostomy bag …' I would argue that it is unusual for that to happen and the only reason to use an ileostomy bag is if there has been some complication with the T-tube. I am not critical that on his morning round [this day] [Dr D] did not recognise the developing wound dehiscence. Usually a developing dehiscence will display some early signs (excessive serous wound discharge, wound infection etc), but also it may be a sudden event with little warning signs.

   [Dr D's] failure to recognise either the absent T-tube or the wound dehiscence whilst perhaps surprising, should not be regarded with disapproval.

4. *Should Whanganui DHB have an organisation policy requiring a consultant to review a patient within 24 hours of (re) admission?*

   Patients admitted acutely whether new patients or re-admissions should all be reviewed by a consultant within 24hrs of admission. There can be variations around that as I have documented in (1). I doubt however if any DHB has this written as an organisational policy largely because it is such an accepted practice by surgeons the world over. In a situation where consultant staff are

not adhering to that practice then there may be a case to have it written in the organisation's policy.

5. *Based on your review of the further information from [Dr D] and Whanganui DHB, please state whether you wish to amend any aspect of your previous advice, giving reasons for your view.*

6. *Please outline any recommendations you may have for this case.*

7. *Are there any other aspects of [Dr D], [Dr C] and Whanganui DHB's care that you consider warrant additional comment?*

   This whole case is characterised by poor communication. A complex clinical case (such as [Mr B]) exposes this. At all levels ([Dr C]–[Dr D], nursing staff–[Dr D], junior staff–[Dr D] and [Dr D]–junior staff) communication was unsatisfactory. Erroneous assumptions were made. Had exemplary clinical practice and communication occurred it is still possible that [Mr B's] outcome may have been the same, but with his complications and the associated unsatisfactory communication a poor outcome was inevitable.

   In summary I regard the absence of satisfactory communication between individuals with **moderately severe disapproval** and this problem is not only for the individuals but also reflects badly on the Whanganui DHB organisation."

Appendix B

Expert advice provided by Dr David Schroeder to Dr C

The following expert advice was provided by Dr David Schroeder, general surgeon.

"Thank you for asking me to further review this case. I have available for analysis:

1. A copy of the patient notes.
2. A copy of the reports provided by [Dr C].
3. A copy of the final report by Mr Simpson.

I have reviewed the notes in total, and will address the questions posed in response.

1. Considering both the first and the second hospital admissions, is it your view that the failure of [Dr D] to be aware of the loss of the T-tube was causative of the patient's death?

Response
The report by Mr Simpson makes a fundamental assumption that the cause of the peritonitis that necessitated the second operation was biliary (ie, due to bile leakage from the T-tube site), and all the other arguments relating to the T-tube and its removal follow on from this assumption. Certainly [Dr D's] operation note dated [the day of readmission] (but apparently actually from [three days later] would suggest this was the case. However, there are several features that suggest otherwise, and without further evidence and testimony, it makes it hard to be entirely sure what the sequence of events was.

Over my 12 years as a hepatobiliary surgeon at Waikato Hospital, I saw many patients with bile leaks and biliary peritonitis, referred to us as a tertiary centre, for ERCP (endoscopic) or operative treatment. There were two persistent features about these patients:

1. The LFT (liver function tests) pattern – they all have a pattern of normal or slightly raised hepatocellular enzymes (AST, GGTP), surprisingly normal ALP and raised billrubin.
2. If they have an external leak, the fluid that they leak out of their drains, port sites, or wounds is almost pure bile.

Whilst I only have access to one set of laboratory results in the entire notes of [Mr B], it was on the day of readmission, where it is noted that the bilirubin was only 28. Without the local laboratory range of normal I can't comment further, but this would be very low for a patient representing with biliary peritonitis.

The drainage of the fluid from the wound is an important issue and one that seems to have been overlooked in the other report.

A large amount of haemoserous drainage resulted in a worried call by the 'grandson' to the district nurse the day after discharge. This was attributed to a wound infection, yet the fluid had 'no odour or plurerent (sic) discharge'. The wound ooze continued to be haemoserous and intermittently would 'saturate' the clothes. After readmission, the wound continued to have 'ooze++' on [the day following readmission] and it was always reported as serous. On the early hours [of the third day of readmission] [Mr B] complained of a new pain in the lower abdomen, and for the first time a note is made that the leakage is 'greenish-yellow'. At 2330 hrs […] the wound finally opened up completely and small bowel content was seen leaking […] wound. The patient then returned to theatre where the findings of peritonitis were […].

In my experience, persistent high volume haemoserous discharge has always indicated underlying deep wound dehiscence. This means that the wound was probably dehisced leaking and open from [the day following discharge], and at no stage in the notes prior to [two days following readmission] is any mention made of anything other than haemoserous colouration of the discharge. If the patient had a billiary peritonitis at this stage, it would have been very obvious as the fluid would have been greenish-yellow. A dehiscence would also explain the bowel obstruction, and the eventually damaged small bowel, as the exposed suture incarcerated and caused the perforation, or 'cheesewired' the bowel.

I suspect that the most likely sequence of events, as evidenced by the information I have available, was that there was a dehiscence initially on [the day after discharge] with associated obstruction, the bowel perforated when the patient developed pain on [the third day of readmission], and the small bowel content leaked into the abdominal cavity, producing the findings [Dr D] found at operation.

The cause of death then, if this was the case, is most likely sepsis secondary to bowel perforation, secondary to wound dehiscence.

In the absence of any further information, it is my view that the failure of [Dr D] to be aware of the loss of the T-tube was <u>not</u> causative of the patient's death.

2. Do you share Mr Simpson's views about the actions [Dr C] should have taken on the night in question to more assertively ensure [Dr D] was advised of the loss of the T-tube?

Response
I agree that inadvertent removal of a T-tube is a cause for further observation in hospital for at least 24 hours to ensure that bile peritonitis does not develop. At one week, if the patient was asymptomatic, I would simply observe. I feel that [Dr C] has summarised the literature very well regarding the timing of T-tube removal. Going back to theatre at one week is not easy and can increase the complication rate.

However, it was imperative that the team was aware the next day that the T-tube had come out so that they could alter their discharge planning. It appears that the information was known to the nurses, and I would have assumed, like [Dr C], that the information would be given or be obvious to the primary medical team the next day. T-tube fixation is essential, as we have all agreed, and prior to discharge a doctor would normally check that the stitch was safe and not cutting out. I am therefore surprised that the primary medical team failed to notice anything missing prior to discharging the patient, and think that they must accept the responsibility for doing so.

I also feel that [Dr C] has been asked to accept responsibility for something that he was not formally involved with. He was simply asked whether the tube self-removal should be completed, and ascertained that this was indeed the case. He was not on call, and had no other clinical input into the patient's course, so to hold him responsible for failing to communicate formally with the other team is quite unreasonable.

3. Any other comments you have to make on this matter.

[Mr B] was an old man with a number of co-morbidities. Return to theatre in this group for any reason raises the mortality rate considerably. I am sure his death was as a direct result of the dehiscence, but this in turn was a reflection of his generally poor condition. Rather than look for blame, it would be more useful to see what lessons could be learnt from his story, and Mr Simpson has addressed the issues of ward rounds […] communication. There are two other learning points here.

1. Should T-tubes be used at all? This has been the subject of some debate, and the evidence now would suggest that primary closure with or without a transampuilary stent is actually safer. It would have been interesting trying to retrieve the stent in this case with the endoscopist's inability to get to the duodenum, but in general this is straightforward and safe.
2. The degree of wound discharge absolutely signalled a wound dehiscence. However, these are so rare nowadays that I can understand the district nurse and house-staff failing to recognise the fact. It would be useful for them to be made aware of this phenomenon.

I realise there are a number of assumptions in my opinion, but no more than in the opinion offered by Mr Simpson. If further evidence is required to clear [Dr C] of any allegations, I am happy to review the original records, lab test results and post-mortem results, and try and interview the relevant staff, although after this length of time, the latter would probably prove unhelpful.

Yours sincerely

David Schroeder
MBChB (Dist) FRACS"

Appendix C

Expert advice provided by Dr Peter Johnston to Whanganui District Health Board

The following expert advice was provided by Dr Peter Johnston, General, Hepatobiliary and Transplant Surgeon:

"This report is given by Peter Stuart Johnston MBChB, FRACS. I have practiced as a General, Hepatobiliary and Transplant Surgeon since 1986.

I am asked to review and provide comment on this case by [the lawyer] who acts for the Whanganui DHB.

[The lawyer's] instructions to me are given as follows, copied from his email to me 11.12.2008.

> 'The issues raised in the case are multi-faceted. However, this instruction to you relates simply to the role played by [Dr C], a WDHB general surgeon late [in the evening]. In particular, your instructions are to review the documentation that will be provided to you (and is referred to below), and to provide a written report on the following questions:
>
> *'Whether [Dr C's] actions on [the day before discharge] were reasonable. Without limiting the generality of this assessment, please comment on the following provisional findings in the HDC report:*
>
> *(a) That [Dr C's] observation that the T-tube was dislodged was a significant development that ought to have resulted in [Dr C] immediately consulting the surgeon responsible for the patient;*
>
> *(b) That it was unsatisfactory for [Dr C] to rely on the nursing staff to communicate this development to the surgical team; and*
>
> (c) *That [Dr C] should personally have documented his attendance, as opposed to relying on the nurse to document the attendance.*'

Documentation provided to me includes, in no particular order:

1. The HDC's provisional opinion on this case (10.11.2008), which contains as appendix expert advice provided to the Commissioner by Mr Ian Stewart.
2. Confidential external review of these same events by Mr John Simpson 17.12.2007, commissioned by Whanganui DHB.

3. Report by Mr David Schroeder, Hepatobiliary and General Surgeon, evidently commissioned by [a lawyer] acting for the Medical Protection Society on behalf of [Dr C], in response to Mr Simpson's report.
4. Statement by [an] RN, RN [G] and [another] RN, in response to Mr Simpson's report.
5. Document by [Dr C] in response to Mr Simpson's report.
6. Document by [Dr C] in response to the HDC's provisional opinion.
7. Copy of Whanganui DHB case records of the late [Mr B].

I will address the above questions in turn. I will not repeat the history of the events, as the documents cited above are mutually consistent as to the facts, except for one point which will be commented upon.

(a)That [Dr C's] observation that the T-tube was dislodged was a significant development that ought to have resulted in [Dr C] immediately consulting the surgeon responsible for the patient;

The unplanned loss or removal of a T-tube would always be a significant event. Whether immediate action is called for depends very much on the circumstances. I will preface my remarks by stating my own opinion on what the optimal management would have been at the time at which [Dr C] was asked to look at the almost-removed tube: this was about 10pm at night, [Mr B] had normal observations on his chart, appeared to [Dr C] to be perhaps disorientated but otherwise not unwell. [Mr B] was evidently judged well enough to be allowed home the next day, which is not consistent with his having bile peritonitis the night before. Also, his blood tests did not show a septic picture or raised bilirubin (the significance of which is pointed out by Mr Schroeder in his document).

If I was managing this case I would have asked for an ultrasound or CT scan first thing in the following morning, with a view to percutaneous (ie, through a needle guided by a radiologist) positioning of a drainage tube into any collection of fluid in the region of the bile duct. ERCP could have followed subsequently if bile drainage had been persistent (for example, longer than a week). There appears to me to have been no indication to take [Mr B] back to theatre that night to reposition the tube; the only indication to do this as an emergency would be evidence of a bile peritonitis, and no evidence of that is found in the information provided. [Dr C] is to my knowledge an experienced surgeon, and his quick global assessment of [Mr B] is a relevant and acceptable clinical account. An ERCP as initial management is suggested by Mr Stewart in his advice to HDC; in most hospitals (and I would take this to have been the case in Wanganui at this time) ERCP is only available on certain days of the week, and at night generally not at all. I accept that ERCP may have helped to address the potential issue of bile leakage into the peritoneal cavity, but would still probably have needed to be accompanied by percutaneous drainage if any bile collection had been present.

The timing of removal of the tube receives much comment in the documentation. [Dr C] writes at length and produces a review of the literature on the timing of T-tube removal; the context of this discussion is whether removal of the tube at day 7 is to be seen as a potentially hazardous or unusual event or not. [Dr C] cites many papers which support early (about day 7) removal, and it may be that this was also his practice, such that he did not see that this was an unusual or threatening event. Mr Stewart states:

> 'I am not convinced by [Dr C's] argument that there are studies supporting early T-tube removal. Whilst I have not read the articles he quotes I am confident in asserting that most general surgeons would be very loathe to remove a T-tube at least within a couple of weeks, more likely one month.'

I have read a number of these papers in the past, and can recommend the study by Jorgensen (ANZ J Surg 2002 72: 177–180) as sensible comment by a highly regarded Sydney hepatobiliary surgeon. Mr Jorgensen's conclusion was that prolonged presence of the tube is not associated with a lower rate of bile leakage than early (7–8 days). In the 1980s, when open common bile duct and T-tube placement was a frequent general surgical operation, it was my own practice to have the T-tube removed at day 7, after a cholangiogram X-ray to confirm no stones remained in the duct. I may, at times, have left the tube in for longer on an individual basis if there had been some concern about the patient's healing ability. Today, open common bile duct exploration is a very uncommon operation; I do not use T-tubes any longer, but would not be critical of [Dr D] for using this technique. The experience acquired from the time when these tubes were commonly used is still valid.

Mr Stewart states that 'the question in this situation is not about the length of time a T-tube should be left', but I would suggest, with respect, that it is, at least in part, as this question informs [Dr C's] views and actions when confronted unexpectedly with a patient whose tube has been lost at this time. It appears that [Dr C], when he saw the patient, did not have concerns about an urgent or unusual situation existing. [Dr C] was not aware of a plan to leave the tube for one month; all I can find in the case notes is a note from [Dr D's] ward round on the first postoperative day stating (underlined) 'do not remove T-tube'. No time frame is stated; certainly nobody would want the tube removed on the first postoperative day.

The fact that the tube could have been dislodged from its original position in the bile duct a couple of days before its emergence through the skin (as evidenced by cessation of drainage) does not alter my view that from the time [Dr C] saw [Mr B], optimal management would have been radiologic imaging with or without tube placement the next day.

That being the case, the issue of whether [Dr C] should have immediately contacted [Dr D] can be commented upon. [Dr C] asked the nurse ([Nurse G]) to document this in the case notes. He states that she had worked on the surgical service for about five years, he knew her well, and trusted her to do this, which she did (although, as Mr Simpson points out, not in a particularly emphatic way). [Dr C] clearly states in his original comment on the case that [Nurse G] had not been able to contact [Dr D] on the night in question, and implies that this is why she approached him. This is not, however, commented on by the three nurses in their statement. (It appears that in his interview in the course of Mr Simpson's review, [Dr C] states that he had attempted to contact [Dr D], but this is not repeated elsewhere in this documentation.)

I can accept that it was reasonable for [Dr C] not to attempt to make contact at 10pm at night, given that he did not feel there was a significant clinical problem to be addressed immediately at that time, and that [Nurse G] had not been able to contact [Dr D]. It would have been typical practice for [Dr C] to speak to [Dr D] next morning, at least as a courtesy, to make sure he knew, but it was also entirely reasonable for [Dr C] to assume that the absence of the tube would be apparent to [Dr D's] team on their morning rounds. That the team overlooked the absence of the tube and discharged [Mr B] home without knowing this was an oversight, and I do not suppose it entered [Dr C's] mind that this would go unnoticed. I found it difficult to follow the various iterations of the question of whether [Dr D] saw [Mr B] on the day of his discharge from hospital.

(b)That it was unsatisfactory for [Dr C] to rely on the nursing staff to communicate this development to the surgical team;

I have touched on this question in my answer above. Communication about hospital inpatients is often passed through nursing members of the team, at least in part because the nursing service is on the ward at all times. Individual surgeons and their junior staffs have various commitments off the ward or in the private sector, and may or may not see each other on a particular day. I believe it would have been courteous for [Dr C] to directly inform [Dr D] in the morning, but communication via an experienced nurse who was part of the team would not generally be regarded as unsatisfactory.

(c) 'That [Dr C] should personally have documented his attendance, as opposed to relying on the nurse to document the attendance.'

Ideally, [Dr C] would have written in the notes himself. This would not in practice have made a difference to the outcome, as it is clear the notes relevant to this event were not in fact read by [Dr D's] team. Nurses' entries in the case notes are often used in medico-legal context to confirm consultant's presence and instructions.

The HDC provisional opinion states:

> 'It is often stated by medical defence lawyers that "If it isn't documented, it didn't happen."'

In a broadly philosophical sense one could question the logic of this, as it is not difficult to see that many more events must in fact happen, at least in relation to health care interventions. In this case, the loss of the tube was documented: [Dr C] asked a nurse whom he knew to be reliable to do this. The facts of [Dr C's] presence and actions on this evening are not in contention here.

Summary
I believe [Dr C] was quite within acceptable practice in not attempting to contact [Dr D] on the night in question. I would submit that Mr Stewart, in his report, has come down rather heavily on [Dr C], based at least in part on his own understanding of various possibilities in managing T-tubes. As I have attempted to explain above, other views are possible and are well substantiated in the surgical literature. I note from the Commissioner's provisional finding that he does not regard the fact that [Dr C] was not on duty at the hospital, and was answering a request for advice in lieu of [Dr D] who could not be contacted, as a mitigating factor, in his opinion. The Commissioner's opinion follows from Mr Stewart's advice, but it may be that if this advice had suggested a rather less serious departure from ideal practice, he may not have felt [Dr C's] actions amounted to a breach of the Code.

Peter Johnston
19 December 2008"

Appendix D

Further independent advice to Commissioner

The following further expert advice was obtained from Dr Ian Stewart:

"**Further review**

Complaint: [Mr B] (dec)
Your ref: 07/19531

The 'new' information given for me to comment on is

1. report from Dr Schroeder
2. report from Dr Johnston
3. additional information from Whanganui DHB including the fact that [Dr C] attempted to contact [Dr D] on [the day before discharge].

I have never read or had access to Mr Simpson's report but from what is written in other reports it seems he (Simpson) and I share a similar view that [Dr C's] subsequent communication attempts on finding the dislodged T-tube was not satisfactory. The emphasis or importance placed on the dislodged T-tube is the fundamental difference between my report and that of Drs Johnston and Schroeder. In effect they are saying the loss of the T-tube may well have been clinically insignificant (Johnston quotes a paper from the literature suggesting T-tubes can be removed in 7 days and Schroeder argues that there was no evidence of biliary peritonitis presumably suggesting there had not been any negative sequelae from the T-tube falling out). Johnston's argument that the literature supports the early (7 days) removal of T-tubes implies he considers the T-tube coming out at that stage is unlikely to have negative consequences. He then goes on to say 'the unplanned loss or removal of a T-tube would always be a **significant** event'. If it is permissible **in all cases** to remove the T-tube at day 7 why is the loss of the T-tube on day 7 (everyone acknowledges it may have been earlier than that) a '**significant** event'? This illustrates the problems of quoting the literature; the circumstances of what was occurring with [Mr B] (an elderly man with multiple co-morbidities, arguably septic, had not had a T-tube cholangiogram, the surgeon had stipulated he did not want the T-tube removed) and that occurring with the types of patients described in the paper (quoted by Dr Johnston) is highly likely very different. I will concede there might be situations where surgeons with significant experience in this area may remove the T-tubes at 7 days. I would venture to say however (irrespective of the literature) that most surgeons would be considerably more conservative and leave the T-tube in place for at least 2–3 weeks, probably longer. My experience in discussing the timing of T-tube removal with other surgeons (over many years) would support

that view. It was clearly the intention of [Dr D] to leave the T-tube longer than 7 days.

The real issue however concerns [Dr C's] assessment at the time he was called and secondly did he communicate his findings adequately. At the time [Dr C] 'examined' [Mr B], the T-tube was noted to have become dislodged and he noted [Mr B] was disorientated. The nurses documented that [Mr B's] wound was 'very oozing and smelly'. These are important observations yet neither Drs Schroeder nor Johnston made reference to them in their reports. Their reports solely emphasize the issue of the dislodged T-tube whereas there were these other developments; developments of such importance that it was not sufficient to rely on nurses or junior medical staff to sort it out in the morning. I suggest these observations could suggest more serious developments and more definite communication plans should have occurred. Subsequent events with [Mr B] have supported my view. Dr Schroeder gives us his experience of biliary peritonitis. I agree it seems very unlikely [Mr B] had **generalized** biliary peritonitis but I think it highly probable the loss of the T-tube led to a bile collection localized in the right side of his abdomen which possibly was only mildly symptomatic. Particularly in elderly people the development of a localized collection (be it bile or pus) can be quite subtle. The disorientation manifested by [Mr B] coupled with the finding of the dislodged T-tube (perhaps also with the infected wound) should raise the question of possible sepsis and a potential cause in this case would have been a bile collection. Having made those observations if he ([Mr B]) was stable then it might be permissible to wait until morning before investigating but the potential negative sequelae (of losing the T-tube) heightens the importance of the dislodged T-tube and mandates a conversation at the least between [Dr C] and the junior medical staff or better still between [Dr C] and [Dr D]. That conversation never took place and neither [Dr D] nor his team was aware of these developments at his discharge. It is reasonable to think that had these developments been relayed then [Dr D's] team would have acted to investigate the potential of a bile leak and hopefully would have also acted on what was an emerging wound dehiscence.

Even Drs Schroeder and Johnston agree that [Dr D] should have been made aware the T-tube had dislodged. What was not known to me in writing my original report was that [Dr C] made an attempt to contact [Dr D] by phone on the night of the 4th (after he was told of the dislodged T-tube). It was entirely appropriate he made that attempt and I also accept that if he considered [Mr B] clinically stable then communication of the problem (and subsequent investigations) could occur the next day. I disagree however with the notion (promoted by Drs Schroeder and Johnston) that it was sufficient for [Dr C] to rely on the nursing staff (and or junior staff) to realize the potential importance of the absent T-tube. Drs Schroeder and Johnston state it would have been ideal (a 'courtesy') if [Dr C] had spoken to [Dr D] but both assumed the nursing staff would relay the information (of the dislodgment of the T-tube) or it would be picked up by the medical team

the next day, and yet Dr Schroeder says it was 'imperative the team was aware the next day…'. Surely if it was imperative to be known (by [Dr D]), then the onus was on [Dr C] to ensure that communication took place. Dr Johnston states that it was an 'extraordinary oversight' that no one the next day picked up on the missing tube. If it was such an oversight and therefore of such importance (and I believe it was) then that gives further weight to my opinion that the onus was on [Dr C] to communicate this, at the least, to [Dr D's] junior staff or better still [Dr D] himself.

I strongly disagree with Dr Schroeder's contention that [Dr C] should not have to accept responsibility for 'something he was not formally involved with'. [Dr C] is a surgeon who was asked advice on a dislodged T-tube. He ([Dr C] was in the ward (or near vicinity) at the time and upon the request (from the nurse) had an obligation to check the situation out further. Whatever previous arguments Drs Schroeder/Johnston have promoted I am sure we all agree the inadvertent loss of a T-tube could potentially be a disaster. Whether [Dr C] was formally involved is not relevant. I strongly disagree with Dr Schroeder who claims because [Dr C] was not formally involved (whatever that means!) with the patient he cannot be held responsible for failing to adequately communicate.

In continuing to be critical of [Dr C] in not communicating satisfactorily, I do not wish to imply this failure mitigates the responsibility [Dr D's] team (or [Dr D]) had in ensuring [Mr B] was fit for discharge [that day]. If they had examined him properly at that discharge they hopefully would have seen both the missing T-tube and secondly the complicated discharging wound. The point I make is that had [Dr C] informed them of the developments that occurred on the night [prior to discharge] then these problems would not have been overlooked; the shortcomings of [Dr D's] team just compounded the problem.

…

In summary, having read the reports of Dr's Schroeder and Johnston, I am not convinced by their arguments that [Dr C's] lack of communication to [Dr D's] surgical team deserves lesser emphasis. They regard it as a less serious departure from ideal practice. His failure to communicate with [Dr D] or his team I regard with moderate disapproval."

Appendix E

Expert advice provided by Professor John McCall to Dr C

The following expert advice was provided by Professor John McCall, General, Hepatobiliary and Transplant Surgeon:

> "This report is provided by Professor John McCall MBChB, MD, FRACS, General, Hepatobiliary and Transplant Surgeon.
>
> I have been asked to review the Report by the Health and Disability Commissioner (Case 07HDC19531) with respect to the role of [Dr C] in the care of [Mr B], who died [in 2006] from complications after elective surgery performed at Wanganui Hospital.
>
> I have been provided with the following documents:
>
> - A copy of the inpatient notes for the two hospital admissions
> - Initial Statement of [Dr C]
> - Provisional Report by the Health and Disability Commissioner
> - Response to the Health and Disability Commissioner from [Dr C]
> - Final Report by the Health and Disability Commissioner (contains Reports by Drs Schroeder and Johnston and further advice to the Commissioner from Dr Stewart in the appendices)
> - Letters to the Health and Disability Commissioner from [Dr C's lawyer] (dated 23 December 2008 and 5 June 2009)
> - Copy of second operation note dated (erroneously) [day of readmission]
> - Copy of the Coroner's postmortem dated [day following death].
>
> [Dr C] has been found to be in breach of the Code for failing to adequately communicate the dislodgement of a T-tube to [Dr D]. The implications of the alleged communication failure were that, 1) [Dr D] unknowingly discharged a patient at risk of developing biliary peritonitis and, 2) [Mr B] suffered severe consequences that might have been averted had [Dr D] been aware of the dislodged T-tube.
>
> I have approached this from the position of what a reasonable practitioner might have done under similar circumstances. I have also considered whether the alleged communication failure was a factor in the subsequent course of events.
>
> The report addresses four key questions.
>
> I. Did [Dr C's] communication about the T-tube fall short of an acceptable standard?
>
> II. Why was the absence of a T-tube not recognised before the patient was discharged?

III. Was dislodgement of the T-tube at day 7 a 'sentinel' event?

IV. Did [Dr C's] alleged miscommunication contribute to the adverse outcome that occurred?

I. Did [Dr C's] communication about the T-tube fall short of an acceptable standard?

[Dr C] was asked by a nurse to see [Mr B] at 10.00pm on the evening [prior to discharge] as [Dr C] was passing through the ward to see one of his own patients. [Dr C] was not on call and [Mr B] was not his patient, nevertheless he acceded to the request. [Mr B] had had open cholecystectomy, bile duct exploration and T-tube insertion performed by [Dr D] [seven days earlier]. A completion cholangiogram was performed at the operation and showed free passage of contrast into the duodenum. When [Dr C] saw [Mr B] there had been minimal drainage of bile from the T-tube for two days. The tube was already dislodged and the patient's condition was apparently stable and unchanged. [Dr C] advised placement of a stoma bag over the exit site so that any discharge could be observed. He attempted to telephone [Dr D] but was not able to get through to him. He asked the nurse to record the event in the notes and ensure the team was notified the next morning. [Dr C] had no other involvement with the case.

[Dr D] was apparently not aware of the absence of a T-tube when he discharged [Mr B] the next morning (discussed in more detail under II), even though the notes indicated that the nursing staff were certainly aware of it (nursing entries in the notes plus request to district nurse to continue monitoring the exit site).

Miscommunication therefore had to occur at more than one level; between [Dr C] and [Dr D], between the nursing staff and [Dr D], and between the patient notes and the medical staff. [Dr C] has been held responsible for these failures because, in agreeing to see [Mr B], he accepted a duty of care that includes the duty to communicate.

In retrospect [Dr C] wishes that he had called [Dr D] himself the next morning. Had he done so, he would have been absolved of any further responsibility. There is no doubt that a direct communication would have been the *ideal* thing to do, but the real question is whether the action he took was *acceptable* under the circumstances.

[Dr C] made two separate communication attempts including asking for the event to be recorded in the notes. It would have been better for him to record in the notes himself rather than delegate, however that is not the required standard. In my opinion his communication was not ideal but was within the limits of acceptable practice. In other words a reasonable practitioner might have done the same thing under similar circumstances.

In coming to this conclusion I have tried to avoid making a judgment based on hindsight and have taken into account the assumptions that a reasonable practitioner would be entitled to make under similar circumstances. 1) It was reasonable to assume that [Dr D] would have a management plan for the T-tube. If such a plan had existed it would have been impossible for the absence of the T-tube to go unnoticed (see more detail under II). 2) The notes indicated that a completion cholangiogram had been performed and was satisfactory, thus the major pre-requisite for safe T-tube removal had already been fulfilled. 3) T-tube removal on day 7 is known to be within the limits of acceptable practice (see under III). Taken together these considerations would lead a reasonable practitioner to conclude that [Dr D] would become aware of the absence of the T-tube, whether this was directly communicated by him or not, and that accidental dislodgment and removal of the T-tube at day 7, after a satisfactory T-tube cholangiogram, in a clinically stable patient, was not a reason for immediate concern. Under these circumstances his communication is deemed to be adequate.

I disagree with Dr Stewart's suggestion that dislodgement of the T-tube was an event of such import that '[Dr C] should have made immediate contact with [Dr D] to discuss the possibility of immediate intervention be it ERCP (and stent) or surgery'. On the contrary, there was no indication for either intervention at that time. Both interventions are themselves potentially harmful and would only be indicated to treat an actual bile leak. At the time there was no indication to suggest a bile leak had occurred or was even likely to occur (see III below). I do agree that ultrasound or CT would have been a reasonable precaution although these investigations would not be considered routine had a decision been made, in identical clinical circumstances, to electively remove the T-tube at day 7.

The only caveat here was that the T-tube had stopped draining 48 hours before it was found dislodged so it is possible that it became displaced from the bile duct earlier than day 7. …

[Dr C's] communication was less than ideal but I regard it as acceptable in light of the circumstances he found at the time and the assumptions he was fully entitled to make regarding the appropriate management of a T-tube.

II. Why was the absence of a T-tube not recognised before the patient was discharged?

There were multiple opportunities for the absence of the T-tube to come to [Dr D's] attention.

…

In his report Dr Stewart regarded [Dr D] and his team's lack of postoperative monitoring with mild disapproval whereas he regarded [Dr C's] 'lack of communication' with moderate disapproval. In my opinion this judgment is markedly disproportionate. [Dr C] did communicate, albeit imperfectly. There

were numerous other lapses that led to failure to recognise that the T-tube was not present at the time of discharge.

III. Was dislodgement and removal of the T-tube at day 7 a 'sentinel' event?

In the report [Dr D] was quoted as referring to the removal of the T-tube as a 'sentinel event'. Dr Stewart also regarded the loss of the T-tube as a critical event and rebutted the contrary views provided by Drs Johnston and Schroeder. He also dismissed the surgical literature as a useful source of information or guidance regarding the timing of T-tube removal.

The published literature does indicate that T-tube removal at day 7 is within the limits of safe and acceptable practice. Dr Stewart admits that he has not read this literature. Nevertheless he argues that it is at odds with his own experience and he believes that 'most surgeons would be considerably more conservative'. He claims there are problems with 'quoting the literature' and applying that to individual cases where circumstances might be different. [Mr B] was elderly with co-morbidities. However, choledocholithiasis is most prevalent in the elderly and the literature does include such patients.

Dr Stewart has presented a view that is based on tradition and personal experience but not evidence. That view should not override the published evidence that represents the collective experience of a large number of surgeons and hundreds of patients, including experimental studies that provide the highest level of evidence available. On this matter I concur with Dr Johnston; T-tube removal at day 7 is an acceptable practice.

In my opinion the most important pre-requisite for safe T-tube removal is not the timing of removal but the prior demonstration of free and unobstructed passage of contrast into the duodenum on a T-tube cholangiogram. In [Mr B's] case that pre-requisite had been met.

IV. Did [Dr C's] alleged miscommunication contribute to the adverse events that occurred?

[Dr D's] operation note of [three days after readmission] (erroneously dated [day of readmission]) states the following.

'Indication: This 85 yr old man had a laparotomy and removal of a common bile duct stone with T-tube placement [sic] did exceptionally well postoperatively. However, unbeknown to me someone pulled out his T-tube. His abdomen collected bile, he got a wound infection and full wound dehiscence with a fistular [sic] of the small bowel. He came forward for laparotomy.'

…

The question of what really happened to [Mr B] after [the day prior to discharge] is highly relevant because it appears to me that [Dr C] has been judged to a large extent because of the severe adverse outcome that unfolded. [Dr D] inferred a clear link between T-tube removal and these subsequent events. Dr Chris Moughan from ACC appears to have accepted [Dr D's] assertion ('There appears clear evidence of treatment failures with removal of T tube linked to a chain of events resulting in injury – wound dehiscence and bowel perforation leading to death [confirmed at post-mortem]'). Dr Stewart has also accepted this explanation.

… [Mr B] did not do 'exceptionally well' postoperatively, [Dr C] did not 'pull out' the T-tube, and the wound infection preceded rather than followed [Dr C's] brief encounter with [Mr B]. Furthermore, there is no convincing evidence that a bile leak was the initiating event in [Mr B's] decline.

The facts are as follows:

1. [Mr B] did not do 'exceptionally well' after the first operation. He had a wound complication that was evident to nursing staff [the day prior to discharge], *before* [Dr C] saw him. The wound at this time was described by the nurse as 'very oozing and smelly'. … [I]t was impossible for [Dr C] to have been in any way responsible for a wound complication that was documented prior to [Dr C] seeing [Mr B].
2. [Dr D] and his team failed to identify or act upon the wound complication prior to discharging [Mr B] on [the day of discharge].
3. [Just one day after ward discharge], the district nurse contacted [Dr F] about the large amount of ooze from the wound. [Dr F] advised no change in treatment and did not discuss it with anyone else. At that time the wound ooze was described as 'haemoserous'.
4. This situation continued at home for three more days until [Mr B] began vomiting and was re-admitted at the request of his General Practitioner.
5. [Mr B] was assessed by [Dr F] on [the day of readmission]. An abdominal X-ray showed a dilated loop of small bowel in the mid-abdomen. According to nursing notes the abdomen continued to 'ooze ++' over the next two days.
6. [Over the next three days] there were multiple references to wound ooze in the notes. On no occasion was it described as other than 'serous'.
7. [Dr D] saw [Mr B] on [the third day of readmission]. The notes written by [Dr F] include a request to, 'change dressing on wound'.
8. Later that day (no time recorded) a house officer describes the wound discharge, for the first time, as 'greenish yellow'.
9. At 11.30pm on [the third day of readmission] an RMO noted that the wound was 'completely open' and that there 'Appears to be a hole in small bowel'.

10. These findings were confirmed at emergency laparotomy carried out by [Dr D] in the early hours of [the following day].

The verifiable evidence thus indicates that [Mr B] suffered a deep wound dehiscence ('burst abdomen'). It is likely to have developed from a wound infection that was documented on [the day before discharge] ('very oozing and smelly') and therefore present when [Mr B] was [discharged]. Deep wound dehiscence is characterised by copious serous discharge from the wound and that was certainly occurring from [the following day] onwards. The ongoing discharge was recorded in the nursing notes repeatedly [after re-admission] but the junior medical staff did not realise its significance. [Dr D] did not see [Mr B] until [the third day of readmission] for unspecified reasons. … At an unspecified time on [the third day of readmission] the description of the wound discharge changed from serous to 'greenish yellow' and the dehiscence was finally recognised at 11.30pm when the wound became 'completely open' with a visible 'hole in the small bowel'.

Unless recognised and treated, deep wound dehiscence is a mortal condition. In this case it was likely to have been present for seven days before being recognised. The vomiting and abdominal X-ray findings on [readmission] indicate that small bowel was incarcerated in the wound defect at that time. [Mr B] was not seen by a consultant for two days after readmission …. The dehiscence was not recognised until herniated small bowel fistulated through the open wound.

[Dr D] implied in his operation note that a bile leak initiated this process. This assertion appears to have been accepted by Dr Moughan and Dr Stewart. I regard that explanation as improbable. I have treated many patients with bile leaks from iatrogenic injury (including leakage after T-tube removal) and trauma. I have not encountered or heard of a bile leak causing deep wound dehiscence or small bowel fistula. The usual pre-condition for deep wound dehiscence is wound infection, which was present on day 6 postoperatively, in combination with other co-morbidities that [Mr B] had. I have never encountered a patient with serous or haemoserous wound discharge due to an underlying biliary peritonitis or bile leak. The wound discharge in these patients is bile stained. The discharge from [Mr B's] wound was repeatedly described by numerous observers as 'haemoserous' or 'serous' up until the latter part of [the third day of readmission].

In my opinion the most likely course of events was an unrecognised and therefore untreated deep wound dehiscence with small bowel incarceration, partial obstruction and eventual perforation. In his operation note [Dr D] stated, 'there was a copious amount of bile in the abdominal cavity and extensive fibrinous adhesions'. This is the only evidence that a bile leak may have occurred. Small bowel obstruction with perforation also produces bile stained fluid and peritonitis. [Dr D] was operating on an end-stage process. I could find no corroborative evidence to suggest that a bile leak was the initiating event.

I note that Dr Schroeder came to a similar conclusion regarding the sequence of events leading up to the second operation. In response to this Dr Stewart revised his opinion stating, 'I agree it seems very unlikely that [Mr B] had generalized biliary peritonitis but I think it highly probable the loss of the T-tube led to a bile collection localized in the right side of his abdomen which possibly was only mildly symptomatic' (Appendix D, Final Report from the HDC). However there was no evidence indicating the presence of a localised bile collection in the right side of the abdomen. If there had been a localised bile collection it would have been obvious at the time of reoperation. There was no such finding. The conjecture about a localized collection appears to be based on Dr Stewart's belief that a bile leak was likely to occur after early T-tube removal (see III above). The surgical literature does not support that view and there was no clinical or radiological evidence to suggest that [Mr B] had either a localized or generalized bile collection.

In summary:

[Dr C];

- saw [Dr D's] patient when asked, even though he was not on call.
- made a reasonable assessment based on the circumstances he found.
- attempted to telephone [Dr D].
- asked the nurse to document the event in the notes and notify [Dr D's] team the next morning.

…

I regard the criticism of [Dr C] to be disproportionate and based on an interpretation of events that is not verified by documented evidence. [Dr C's] communication was less than ideal but adequate under the circumstances whereas major failings occurred elsewhere in [Mr B's] care. In my opinion [Dr C] has been unjustly held to account for occurrences that were not of his making."

Appendix F

Expert advice provided by Dr Kenneth Thomson to Dr C

The following expert advice was provided by Dr Kenneth Thomson, pathologist:

> "I have spoken with [MPS] and received copies of the operation notes from [readmission] (laparotomy with replacement of T-tube), the pathology report on the specimen of resected small bowel from that operation, and the subsequent post-mortem report, as well as a report on the microbiology swab which was believed to be from the abdominal wall. I have also more recently received a copy of Professor McCall's report.
>
> I note that the operation notes describe a fistula in the small bowel, which was resected, but the subsequent pathological examination did not identify a perforation in the operation specimen. There was evidence of significant inflammation in the specimen, with adherent omentum, and inflammatory exudate on the outer bowel surface. These changes would certainly be what one might expect had there been a perforation, and it would appear that the inflammation is basically on the outer surface of the bowel, with no obvious abnormality of the bowel lining or the muscular wall.
>
> The post-mortem report describes an area of necrosis in the abdominal wall associated with the surgical wound, with pus formation, and the underlying peritoneal cavity contains cloudy fluid. The intestinal serosa is described as 'dull', and these changes would support the pathologist's view that there was some peritonitis in association with the infected abdominal wound.
>
> I find it hard to disagree with the conclusion of the pathologist that death was due to the infected abdominal wound. The age of the patient would obviously have been a contributing factor, as would the fact that he was recovering from previous surgery. There were no other obvious causes of death noted, although I note that the post-mortem was not a complete examination as there is no record of the brain being looked at — a significant omission in an elderly patient in these circumstances.
>
> I note that there are suggestions that the peritonitis was a biliary peritonitis, secondary to the withdrawal of the T-tube. I am certainly not qualified to comment on the clinical issues relating to the timing of T-tube withdrawal.
>
> I would have to say however that in over 7000 coronial autopsies I have often encountered peritonitis, but I do not recall any cases which could be called biliary peritonitis. On the other hand, peritonitis associated with wound infection and sometimes wound dehiscence was not infrequent in post surgical deaths."

Appendix G

Further independent advice to Commissioner

The following further expert advice was obtained from Dr Ian Stewart:

> "It is difficult to respond fully to Professor McCall's submission without making some reference to [Mr B's] clinical course, particularly as Professor McCall himself spends a lot of the time discussing issues other than strictly those surrounding the communication (or lack of it) by [Dr C].
>
> Whilst it has been amply documented before, I will briefly summarise [Mr B's] clinical course. He had an open cholecystectomy with exploration of the common bile duct. A T-tube was left draining the bile duct (which was shown to be free of stones). On the night of either the 6th or 7th postoperative day, [Dr C], who happened to be in the ward at the time, was asked by the attending nurse to review [Mr B], particularly because she had noticed the T-tube had become dislodged and was lying on his anterior abdominal wall. The nurse also documented in the notes that his ([Mr B's]) wound was 'oozy and smelly' and there was also a note (I am not sure whether the nurse or [Dr C] made this observation) that [Mr B] was disoriented. Allegedly [Dr C] said that as he ([Mr B]) was stable nothing needed to happen until the next morning. In the information first submitted, my interpretation was that [Dr C] had directed his instructions through the attending registered nurse. Subsequent information has been issued to state that [Dr C] did try to call [Dr D] on the evening in question (on his cell phone) but there was no reply. Allegedly [Dr C] told the nurse to record the event in the notes (the T-tube dislodgment) and ensure the medical team was notified the next day.
>
> Professor McCall refers to 'the facts'. My list of 'facts' (and it is on these I have based my opinions) are:
>
> 1. The T-tube was found to be inadvertently dislodged (not electively removed) at about day 7 postoperatively.
> 2. At the time the dislodged tube was noted, [Mr B] had a smelly, oozy wound (written in the notes).
> 3. At the time the dislodged tube was noted, [Mr B] was said to be disoriented (written in the notes).
> 4. [Mr B] was 85 years of age.
> 5. Subsequently (approximately 10–12 days after the dislodged tube was noted) [Mr B] died from a combination of factors including wound dehiscence, small bowel perforation and abdominal sepsis.

Specifically referring to Professor McCall's submission

1. *He states that a 'direct communication would have been the ideal thing to do but the real question is whether the action he took was acceptable …' He goes on to say that, 'it would have been better for him to record in the notes himself rather than delegate, however that is not the required standard. In my opinion his communication was not ideal but was within the limits of acceptable practice.' (All on page 2 of Professor McCall's submission.)*

These terms, **ideal, acceptable practice** and particularly the **required standard** are subjective and, in the context of this inquiry, allow these reviewers (McCall, Johnston and Schroeder) seemingly to have options either way. At what point does Professor McCall's **acceptable practice** become unacceptable or put another way, when does his **less than ideal**, not meet the required standard? (What is the required standard?) These statements by Professor McCall are reminiscent of those made by Dr Johnston and Dr Schroeder who said '*extraordinary oversight*' (in reference to the failed communication) and '*imperative the team was aware the next day*'. I agree with both of those statements and also agree with Professor McCall's '**less than ideal**'. They, having made those statements, then went on to be critical of me for placing such importance on the need for him ([Dr C]) to have better communicated. Based on these statements, it seems all three reviewers (McCall, Johnston and Schroeder) **are** critical of the lack of (or poor) communication but they stop short of applying some grade of disapproval, which is inconsistent, particularly taking into account their forceful descriptions. Looked at another way, if they truly believe the lack of communication (concerning the dislodged tube) was such a non-event then why come out with such statements ('less than ideal', 'extraordinary oversight', 'imperative the team was aware the next day')?

Further, [Dr C] says in his submission of 20 December 2009, '*I do not believe that I should be in any way accountable for the negligence of others. Nor do I think that a new standard should be set where competent medical staff must try to anticipate incompetence by others and go above and beyond normal standards …*'

My instruction was to give an opinion on the communication by [Dr C] subsequent to his attendance at [Mr B]. The role of other doctors in treating [Mr B] either before the night of the 6th or afterwards is irrelevant and has not influenced my opinion. There is no 'new' or higher standard expected (because of the incompetence of others). My expectation is that with the clinical situation as he ([Dr C]) found it, I would expect the **normal standard** to mean acting with a level of importance or urgency greater than just relying on a nurse to communicate the information the next morning. To use the McCall terminology, the **required standard** (or **normal**) in my opinion would be at the least, for him

([Dr C]) to have verbally communicated (to the surgical team, preferably [Dr D]) that night (or if that was not possible) definitely first thing the following morning.

2. He is critical on page 3 of his submission that I have said discussions should have taken place about the possibility of immediate interventions (ERCP, surgery).

He (Professor McCall) is conveniently leaving out parts of my total submission; the parts which puts the possibility of ERCP and surgery in perspective. In my initial report I raised ERCP/surgery as possible interventions should a bile leak have been demonstrated. In making that recommendation there is an assumption (which I am sure an experienced clinician like Professor McCall would understand!) that prior to ERCP/surgery some sort of imaging (scan) would be done. Furthermore, in the initial submissions, I did not see any reference to the patient 'being stable', or anything to confirm [Dr C] had tried to ring [Dr D]. It was only in follow-up reports that this latter information became available.

Having found that out I modified my recommendations (in the second report) to accept that an ultrasound scan, the next morning, might be reasonable if the patient was stable. (I said, '*provided [Mr B] was stable it might be permissible to wait until morning before investigating*.') Professor McCall did not acknowledge this and by emphasising the ERCP/surgery recommendation was clearly trying to portray my stance as overly aggressive. What I perhaps could have said or emphasised is that some sort of scan (ultrasound or preferably CT) was mandatory in the morning but probably should have occurred on the night in question. There is a certain irony in what he (Professor McCall) says with respect to ERCP/surgery ... '*both interventions are themselves potentially harmful …*' (Professor McCall's statement page 3.) Ironically had these 'harmful' interventions occurred then it is reasonable to suspect the complications suffered by [Mr B] would have been recognised earlier, with a subsequent better outcome.

3. He (Professor McCall) states (page 3), 'There was no indication to suggest a bile leak had occurred.'

Among the differing opinions I have with Professor McCall, my opposition to this statement is probably the greatest. It is difficult to understand how, when taking all the known facts into account (elderly disoriented man, not progressing day 7 post-op which Professor McCall acknowledges. '*[Mr B] did not do exceptionally well postoperatively*', an oozy, smelly wound, T-tube **accidentally** has fallen out), that any clinician would not at least have a slight suspicion that a bile leak might have occurred or at least raise it as a possibility. To use Professor McCall's **acceptable standard** notion, I would expect a surgical trainee if given such a scenario (in the fellowship exam) to emphasise the need for immediate appropriate investigations (scans at the least) and if he could not/would not facilitate those investigations then make sure appropriate communication

occurred to ensure it did happen. Anything less than that would be a failed answer.

The T-tube had apparently stopped draining bile 2–3 days after the initial operation. The benign interpretation of this is that the bile was now **all** flowing down the bile duct and the T-tube was still lying within the bile duct. It is very uncommon for a functioning T-tube to stop draining (at least some bile), so short a time (2–3 days) after the surgery. Hence the most plausible explanation for the lack of any bile drainage in the days leading up to the dislodgement, is that the tube had become dislodged from the bile duct earlier (probably at the time the nil drainage was first noted). This highly likely would have resulted in a bile leak and although not proven, might explain [Mr B's] poor progress and subsequent complications. Whilst a bile leak may not have occurred, certainly in the context of how he ([Mr B]) was, it had to be thought of and ruled out. And if it is going to be investigated (and I strongly believe it should have been), then sooner rather than later, which brings us back to the communication issue.

Both Dr Johnston and now Professor McCall make much of the literature evidence supporting removal of the T-tube at 7 days and seemingly use this to override the stark reality of how [Mr B] was, on the night in question. This is not a case of 'elective removal of a T-tube', so surely any remarks about timing of elective removal of T-tubes is irrelevant. This is an accidental dislodgement of such a tube in an elderly sick man.

Given the ultimate fate of this patient, it is highly likely, or at least a realistic possibility, that the primary aetiology of the subsequent events was accidental partial dislodgment of the T-tube allowing accumulation of bile at the operative site, which possibly would set the scene of the ensuing sepsis dehiscence and peritonitis.

I have been careful to use words such as 'possible' or 'highly likely'. No scans were ever done, so absolute proof cannot be established but I emphasise the known facts (as outlined above) concerning [Mr B] on that night. He was unwell and several factors mandated the need for further investigations and appropriate communication, neither of which were done.

I believe Professor McCall has erred in applying a **general rule** described in the academic literature to the **specific** matters of this acute case. He has compounded his error in concentrating on the elective (not accidental) removal of T-tubes about which we concede there is a wealth of (often conflicting) literature. So whilst he has concentrated on the virtues of safe early T-tube removal, he then says that … '*he would agree that ultrasound or CT would have been a reasonable precaution*'. Furthermore, Professor McCall says '*[Mr B] did not do particularly well after the first operation*' but then goes on to promote the safety of early removal, based on a normal cholangiogram done seven days earlier. This man

was not well (we all agree on that) so surely any notion of comparing him to what the literature may say about elective removal of T-tubes in presumably healthy patients is nonsense! If it is so safe to remove T-tubes early (and therefore my concern about the dislodgment of this tube is unfounded) then why is Professor McCall promoting a 'precautionary' ultrasound or CT? Despite what the literature says Professor McCall probably does recognise that comparing [Mr B's] situation to the literature is not a valid comparison and he (Professor McCall) likely does accept that this premature accidental dislodgment of the T-tube could have led to a complication, otherwise why do the scan?

Finally, Professor McCall himself says on page 3 of his submission, '*The only caveat here was that the T-tube had stopped draining 48 hours before it was found dislodged so it is possible that it became displaced from the bile duct earlier than day 7*.' And then in [Dr C's] last submission (20 December 2009), he states … '*in all likelihood, the T-tube was lost 2 days earlier*'.

They have argued strongly that the literature supports elective day **7** removal of T-tubes (and therefore the loss of [Mr B's] T-tube at day 7 is not a problem) but both (Professor McCall and [Dr C]) then concede the T-tube probably was out of the bile duct two days earlier (which I agree with), that is, day **5**. Which raises the question … is there any literature support for removing the tube on day **5**?

4. *Professor McCall states … 'Dr Stewart has presented a view that is based on tradition and personal experience but not evidence.'*

Professor McCall, whilst critical of me using my 'personal experience', then gives his own anecdotal experience of treating patients with bile leaks (page 6) and uses this to support his assertion that because [Mr B] had both a wound infection and wound dehiscence, he could not have had a bile leak.[45] Do we have to accept because Professor McCall has never seen such a combination, that it cannot occur?

Professor McCall casts doubts on the validity of my 'personal experience' but is not afraid to proffer his own, as worthwhile evidence! His 'other evidence' I presume is based on the literature supporting the T-tube coming out at 7 days. As noted above, he then admits this tube likely came out earlier than 7 days!

[45] Professor McCall considered Dr Stewart's reponse and did not wish to alter his original report. He commented "Dr Stewart accuses me of using a double standard with respect to citing evidence from the literature on t-tube removal on the one hand and citing my own personal experience with respect to the manifestations of biliary peritonitis on the other. There is an obvious reason for this; there is an extensive literature including randomised trials dealing with the former issue but no such literature dealing with the latter matter. If there had been I would have referred to it. When there is no literature to provide guidance on a matter such as this one has to depend on the next best thing, which is expert opinion. There was no double standard."

5. *On page 4 of his report Professor McCall states ... 'In his report Dr Stewart regarded [Dr D] and his team's lack of postoperative monitoring with mild disapproval whereas he regarded [Dr C's] "lack of communication" with moderate disapproval. In my opinion this judgement is markedly disproportionate.'*

On page 3 of my report (14 April 2008) in response to the question, **Care provided by [Dr D]**, I stated ..., 'I am **moderately critical** of the medical supervision during the postoperative period following the first operation.' Professor McCall's accusation [of] me being disproportionate in my criticism, in favour of [Dr D], is therefore not justified. In that report I have been critical of [Dr D] several times, including the above. With respect to the lack of postoperative care issue, I have stated, with [Dr D] and [Dr C], I am equally critical (moderate **disapproval**).

I accept that [Dr C's] involvement with [Mr B] was only over a short period of time and it does seem unfortunate he has to share some of the culpability, but the fact remains that had he communicated satisfactorily, likely [Mr B] may have survived.

Summary

Professor McCall's report does not add further evidence or fact with respect to the issue of [Dr C's] lack of communication. Professor McCall agrees this communication was less than ideal. In the same way that Dr Johnston resorted to literature references on T-tube removal to support his stance, so did Professor McCall. For cogent clinical reasons, (we all agree that on the night in question, this man was not progressing ... there does not seem to be any dispute on that), there is no justification to compare literature evidence demonstrating the safe early removal of T-tubes in the **elective** situation, with the acute situation of [Mr B] whose tube had **accidentally** fallen out.

It is difficult to divorce issues around [Dr C's] lack of satisfactory communication with the clinical situation. Clearly, had [Mr B] survived and suffered no ongoing complications then any criticism of [Dr C's] communication would likely never have arisen. But that is not the case, [Mr B] sustained a number of serious complications (leading to his death) some of which were not recognised, but one complication was seen, namely the inadvertent dislodgement of the T-tube. Whilst I cannot prove this was pivotal, there was certainly enough clinical evidence on the night in question to raise concern the loss of the T-tube may have been highly significant. The responsibility for responding to the loss of the T-tube was with [Dr C] either by himself organising appropriate investigations or at the very least, communicating satisfactorily with [Mr B's] medical attendants.

I still maintain that the failure by [Dr C] to satisfactorily communicate his findings to either [Dr D] or his team is unsatisfactory and view it with moderate disapproval. Subsequent evidence from [Dr C] to suggest he did try to make contact with [Dr D], confirms that [Dr C] himself did regard it important to make that contact and therefore he needed to ensure that if he could not contact him that night it had to happen the next day. The repercussions of that contact not being made (and no appropriate investigations being done) I would argue were severe and whilst possibly not the sole cause of his problems, I am sure had that contact occurred [Mr B] may well have survived."