Surgical Registrar / General Surgeon / House Surgeon

Report on Opinion - Case 97HDC9902

Complaint

The Commissioner received a complaint from the consumer and her husband about services provided to the consumer by the surgical registrar, the general surgeon, the house surgeon and the public hospital in early June 1997. The complaint is that:

- *On a date in early June 1997* [the consumer] *was admitted to* [the hospital] *suffering from vomiting and diarrhoea. A diagnosis of pelvic adhesions was made and* [the consumer and her husband] *were advised that a laparoscopy was required that evening but that a laparoscopy was minor surgery.* [The consumer's husband] *left the hospital.* [The surgical registrar] *then came and further discussed the proposed laparoscopy with* [the consumer] *and asked her to sign a consent form. She was not happy about this as she felt drowsy and did not have her glasses, so could not read the form. She asked for her husband to be called back to the hospital, to assist with the situation, but he was not called back.* [The consumer] *signed the consent form thinking she was consenting to a laparoscopy. As* [the surgical registrar] *left the room he mentioned the possibility of a laparotomy being performed but did not explain what this was.*
- [The consumer] *then underwent surgery where a laparotomy was performed by* [the surgical registrar]. [The consumer's] *healthy appendix was removed during the operation, without her consent.*
- [The consumer and her husband] *are concerned that* [the surgical registrar] *did not visit* [the consumer] *following surgery.*
- [The consumer and her husband] *are also of the view that the surgery was unnecessary as the adhesions would have been soft and not needing to be freed.*
- [The house surgeon] *prescribed Haemaccel for* [the consumer] *when her clinical records clearly showed that she was allergic to it. The Haemaccel was administered to* [the consumer] *and she had a serious reaction to it.*

Surgical Registrar / General Surgeon / House Surgeon

Report on Opinion – Case 97HDC9902, continued

Investigation Process

The Commissioner received the complaint on 13 November 1997 from Waikato Health and Disability advocate, and an investigation commenced on 13 February 1998. Information was obtained from:

The Consumer
The Consumer's Husband/Complainant
A Surgical Registrar at the Public Hospital ("the second surgical registrar")
A House Surgeon at the Public Hospital
A General Surgeon at the Crown Health Enterprise (CHE)
The Chief Executive of the CHE
The Director of General Surgery at the CHE
A Waikato Health and Disability Advocate

The Commissioner obtained the consumer's medical records from the hospital. Advice was obtained from an independent general surgeon.

Information Gathered During Investigation

The consumer underwent a hysterectomy at the public hospital in mid-May 1997. The surgery was uneventful. The consumer was discharged from hospital in late May 1997.

In early June 1997 the consumer was experiencing vomiting and diarrhoea. The consumer believed she was suffering from gastro enteritis and did not have any medication at home for these symptoms. As her general practitioner was not available on weekends her husband took her to the accident and emergency department at the hospital. The consumer was triaged in the emergency department at 9.40am. The notes recorded "*…abdo pain, diarrhoea & vomiting central abdo pain since last night-constant* [with] *colicky exacerbations*." Her temperature was recorded at 36° celsius, her blood pressure as 151/86 and her pulse rate at 136. At 2.50pm she had an abdominal x-ray which showed fluid levels and she was referred for a surgical consultation.

Continued on next page

Surgical Registrar / General Surgeon / House Surgeon

Report on Opinion – Case 97HDC9902, continued

Information Gathered During Investigation, *continued*

The consumer was subsequently assessed by a surgical registrar who recorded, "*…sudden onset last night of central abdominal pain…several hours after onset began to vomit – dark material…diarrhoea smelly dark….".* The first surgical registrar discussed the results of his findings with the general surgeon, who suggested that the consumer should have a CT scan. A naso-gastric tube was inserted but was uncomfortable for the consumer and was removed following the scan. The CT scan, taken at 5.30pm, showed that there were multiple dilated loops of small bowel and decompressed small bowel loops in the pelvis. The radiologist concluded that the appearances were consistent with a small bowel obstruction.

The consumer was admitted to ward 12 by the house surgeon soon after at 5.30pm. The naso-gastric tube was reinserted in the ward. The house surgeon recorded that the consumer would possibly require surgery. The house surgeon explained the surgery to the consumer and her husband and obtained the consumer's consent. The form recorded that the consumer's surgery would be a laparotomy (open exploratory surgery), with or without division of adhesions, with or without resection, with or without *"open"* procedure. The house surgeon advised the Commissioner (through the director of surgery at the hospital) that she spent a significant amount of time with the consumer explaining the procedure. The consent form for a laparotomy was signed by the consumer and witnessed by the house surgeon.

The consumer advised the Commissioner that when she went to the hospital she was hoping that she would be given some medication for nausea and diarrhoea and would then be discharged. She advised that:

> *"…they wanted to perform more tests. They did an x-ray and said that it seems that there is some adhesion in some bowel due to my previous surgery (I had hysterectomy* [in early] *May 1997 at* [the hospital]*) 3 weeks ago. At this stage I strongly felt that they should contact the surgeon,* […]*, regarding the previous surgery. They did not consult her and were planning for a small surgical process known as laparoscopy, to see inside my stomach with a tiny telescope and remove the adhesions. That is what they explained to my husband and to me, and convinced us that it was a very minor surgical procedure.*

Continued on next page

Surgical Registrar / General Surgeon / House Surgeon

Report on Opinion - Case 97HDC9902, continued

Information Gathered During Investigation, *continued*

They admitted me in ward 12. We were not prepared for this, we were expecting some medication and discharge. Then they wanted to do a CAT scan also to further confirm their doubts, for which they put a nasal tube to put liquid dye in my stomach, which I vomited out before I reached the CAT scan lab. ***(So far I had not been given any medication for nausea*** *and diarrhoea* ***– only the saline drip****). So they injected some medication into me, before taking CAT scan.*

I very clearly explained to them that I am not ready for any surgery because I am still recovering from my previous surgery – Hysterectomy – three weeks before. They explained to me in detail about Laparoscopy [closed exploratory technique for investigation or surgery] *and said it is a very minor surgical procedure and that I need not worry."*

The consumer was prepared for theatre at 8.00pm. Her preoperative check list recorded, "*Allergies Flagyl – nausea Haemaccel – rash*." The name of the nurse completing the checklist is not recorded. These allergies were also noted on her anaesthetic record. The house surgeon advised the Commissioner that *"…when* [the consumer] *was admitted* [in early] *June 1997 she was asked by myself as well as two other members of the nursing staff if she was allergic to anything. She replied to all enquiries that she was not. My admission note confirms her account to me, that she was taking no medication ("med-nil") and that she had no known allergies (NKA)."* The Emergency Assessment also noted *"allergies nil".*

The consumer advised that following the initial explanation of the procedure by the house surgeon, a doctor (whom she assumed from the medical records was the surgical registrar) came in at about 10.00pm and gave her some papers to read and sign.

Continued on next page

Surgical Registrar / General Surgeon / House Surgeon

Report on Opinion - Case 97HDC9902, continued

Information Gathered During Investigation, *continued*

The consumer advised the Commissioner that she told the surgical registrar she could not read the papers as she did not have her glasses but that the surgical registrar:

> *"…read out some thing to me which I cannot recall, because of my drowsy state. Then he explained to me the procedure of Laparoscopy once again, which was explained to me in the presence of my husband earlier, and asked me to sign at some place. I can sign with my eyes closed also, so I signed at the indicated place.*
>
> *All this time, I am quite sure the Doctor was aware of my drowsy and tired state. He very specifically asked me if he should inform my husband. I, very positively said YES that they must inform him. They never informed him. Before leaving he mentioned that there is a remote chance that they may have to do the laparotomy if they find something wrong in laparoscopy. I did not know what is Laparotomy."*

The consent form signed by the consumer shows that she signed her name next to an amendment made by the surgical registrar which provided for a laparoscopy as well as a laparotomy.

Continued on next page

Surgical Registrar / General Surgeon / House Surgeon

Report on Opinion – Case 97HDC9902, continued

Information Gathered During Investigation, *continued*

The consumer further advised that:

> *"I went to* [the hospital] *with a small complaint of nausea and diarrhoea. There was no danger to my life, and all I expected was some simple medication, as in the past in India. But they performed a major surgery on me, probably to teach a student how to do "Laparotomy." I am an Indian. Is that the reason why I was treated like a guinea pig? … I now know from the medical records that my perfectly healthy appendix was also removed. The medical staff has limited rights only, so long as the life is not threatened. Was a condition created during the surgery by the incompetence of the surgeon, which threatened my life? I have a right to be informed, and I demand this right. (Do I still have two kidneys please?)…. I was informed in some detail about the procedure called laparoscopy before the uncalled for surgery. I understand and speak English perfectly well, as does my husband. I was also told laparoscopy is a very minor surgical procedure. As the person who explained laparoscopy to me was leaving, he mentioned something about laparotomy, which I could not comprehend. No details were given, only something about this procedure not being necessary. In my exhausted and miserable condition, and in confidence that my husband must have been contacted, I kept quiet and did not ask any further questions."*

The consumer advised the Commissioner that she wished her appendix, which was removed without her consent, to be returned back to her. The hospital advised the Commissioner that it was unable to return the consumer's appendix, because at that time specimens were disposed of once the necessary investigations were completed. The policy has since changed and if the events occurred today the consumer would be consulted before disposal of her appendix.

The surgical registrar advised the Commissioner he was the surgical registrar on call that night and commenced duty at 10.00pm. In his opinion the consumer had a small bowel obstruction and required urgent surgery. The clinical notes made at 10.45pm in early June 1997 recorded a discussion between the surgical registrar and the general surgeon, who suggested that the surgical registrar perform a diagnostic laparoscopy prior to laparotomy. The general surgeon advised the Commissioner that he suggested the lesser procedure first because it is sometimes possible to free adhesions using a laparoscopic technique.

Continued on next page

Surgical Registrar / General Surgeon / House Surgeon

Report on Opinion – Case 97HDC9902, continued

Information Gathered During Investigation, *continued*

The surgical registrar further advised that*:*

> *"The operation she was booked for was an operation called laparotomy. This was to be an open procedure and included division of adhesions of small bowel with the possibility of bowel resection. She was, as I stated, booked for a laparotomy and not a laparoscopy as she seems to imply in her letter of complaint. After discussion with* [the general surgeon] *at 10.45pm that evening, he thought a diagnostic laparoscopy should also be undertaken. I went back to* [the consumer] *and explained to her what laparoscopy was. She countersigned the additional consent for laparoscopy. I was convinced that she understood if the laparoscopy was not possible then we were going ahead to do the open procedure which was laparotomy. As stated before, this was the initial operation she had consented to and was waiting for surgery."*

The surgical registrar further advised that he did an initial laparoscopy but, as he noted extensive adhesion of the small bowel, he proceeded to do a laparotomy.

The records indicated that the operation commenced at 1.25am on the following day. The surgical registrar performed the operation. An operation note made at 3.00am recorded:

> "*1. Laparoscopy*
> *2. Laparotomy*
> *3. Adhesolysis*
> *4. Appendicectomy*
>
> *Finding: Soft adhesion between small bowel loop. Two loops of small bowel stuck in pelvis (extensive). A band adhesion producing proximal dilation of small bowel from mid ileum. Appendix stuck in pelvis. No pelvic collection pus.*
>
> *Procedure: Laparoscopy to laparotomy via lower midline incision. Bowel freed with sharp dissection. Appendisectomy done. Terminal ileum had adhesion – granulation tissue on multiple sites."*

Continued on next page

Surgical Registrar / General Surgeon / House Surgeon

Report on Opinion – Case 97HDC9902, continued

Information Gathered During Investigation, *continued*

The surgical registrar advised that:

> *"*[The consumer] *had a band adhesion producing an obstruction, however she also had extensive other adhesions of small bowel and when such a situation arises, instead of proceeding with laparoscopy, it is safer to do an open laparotomy. If we proceeded with laparoscopy there was always a danger that the bowel could have been perforated and she would have ended up with a fistula. If we had not gone ahead and carried out the operation I feel she may have had resection of the bowel. She would have required a more complicated procedure if we had allowed the bowel to become ischaemic and gangrenous."*

In answer to the consumer's complaint that the surgical registrar did not visit her following the operation, the surgical registrar advised the Commissioner that he did see the consumer following the operation prior to his going home at 8.00am. However, he advised that the consumer was still recovering at this time and that she was under the care of the general surgeon and his team who continued to look after her during the post-operative period. The surgical registrar advised that when he came on duty the following day at 10.00pm he saw the consumer again but did not examine her as she continued to be under the care of the general surgeon and his team.

The surgical registrar advised the Commissioner that the normal practice at the hospital after carrying out surgical operations is that where a patient is under the care of a particular team, post-operative care is usually left with that particular team so as to provide the best care to the patient. He further advised that if the adhesions had not been removed there was the possibility that the consumer would have lost part of her bowel and, accordingly, an urgent operation in this situation was the correct decision. He advised the Commissioner that there are some adhesions that can be removed with laparoscopy, however such adhesions are usually "*band adhesions*".

Continued on next page

Surgical Registrar / General Surgeon / House Surgeon

Report on Opinion – Case 97HDC9902, continued

Information Gathered During Investigation, *continued*

The consumer and her husband returned to India for several months following the consumer's operation and, while there, consulted a doctor in Madras. As a result of this consultation, the consumer and her husband made a further complaint. This complaint is more detailed than the initial complaint, but is not fundamentally different from the original complaint. The consumer and her husband asked the following questions:

> *"1. Why a proper conservative regimen was not followed for the suggested simple diagnosis of Gastroenteritis with dehydration?*
>
> *2. Who authorised Laparotomy and Appendisectomy under the setting, where finally soft adhesions were found and a band was also found needing re-section? Is it not a fact that the appendix was perfectly normal and any extension of surgery and additional manipulations for adhesions at that stage is inviting more adhesions in future?*
>
> *Do the soft adhesions of immediate post operative period (17th day – ie from the operation day of* [mid-]*May to* [early] *June) require surgery, or do they dissolve on their own with conservative therapy? Is it common to find soft adhesions between two loops of small bowel and simultaneously a band adhesion (or could it also be a part of the same soft adhesions?). At no time doctors have recorded rigidity and muscle guard and constipation, but for tenderness and mild rebound, which was not an unusual and unexpected feature for a patient of acute gastro-enteritis and recovering from major lower abdominal surgery...*
>
> *...It is not clear whether the band adhesion producing proximal dilation of small bowel from mid ileum was the sole causative factor responsible for the patient's condition. Condition of small bowel at this point and distal to the band has not been mentioned. Can it be inferred that this band adhesion was a part of generalised soft adhesions he found in the pelvis? He has also mentioned under the heading "procedure" at the bottom, that the "terminal ileum had adhesion and bowel freed with sharp dissection".*

Continued on next page

Surgical Registrar / General Surgeon / House Surgeon

Report on Opinion – Case 97HDC9902, continued

Information Gathered During Investigation, *continued*

3. *How was it conceived by the H/S at 17.30 hrs on* [early] *June itself; that the patient shall need LAPAROTOMY, DICISION OF ADHESIONS, AND APPENDECTOMY?? – at a stage where the operating doctor had not even seen the patient? At the same time, OT I/C was informed and subsequently the patient given bath, (?) before even obtaining the consent!*

4. *Why was the advice of the consultant (*[the general surgeon]*) totally ignored?*

5. *Whether or not the laparoscopy was done at all as per the directions of* [the general surgeon]*? The anaesthetist* […] *has recorded the operative procedure as <u>Laparotomy</u> only. The operative notes do not mention about the insertion of laparoscope, laparoscopic findings and the reasons thereafter to convert/extend the procedure to laparotomy. It is also not clear from the notes that if laparoscopy was not performed and laparotomy had to be undertaken directly, what were the compelling reasons to do so?*

6. *Was the "consent" a manipulation or afterthought?*

7. *Why was the patient put to serious and life threatening reaction, when the records clearly stated her sensitivity to Haemaccel, and was not attended by any doctor during the entire critical period of this reaction?*

8. *Why repeat radiological investigations (including sonography) not done as advised in the first place and patient treated conservatively under the watchful eyes of a team of various consultants?*

9. *Why the gynaecologist who operated upon the patient just 18 days ago was not involved?*

10. *How and why the ASAP call from the duty nurse ignored by the doctor* [in mid] *June 1997 for more than 4 to 5 hours?*

Continued on next page

Surgical Registrar / General Surgeon / House Surgeon

Report on Opinion – Case 97HDC9902, continued

Information Gathered During Investigation, *continued*

11. Patient is an Indian. Whether the diagnosis of tuberculosis of intestine, …regional ileitis, worm infestations ever considered? Her stools were examined once only and did not indicate the presence/absence of ova/cysts. Her eosinophil count were found to be ↑ … Whether or not Idiopathic intestinal pseudo obstruction was one of the diseases for differential diagnosis? It is a known fact that appendisectomy could have become a source of fistula if the diagnosis would have been regional enteritis.

12. Profuse diarrhoea, vomiting, previous surgery and restricted and modified diet of the patient led to electolytic and protein imbalance (low calcium, low magnesium, hypoprotenemia ↓ total protein, ↓ albumin, ↑ globulin). This definitely contributed to the bizarre clinical picture of the patient. The patient at no time ever had constipation, let alone obstipation. It is only once on record that bowel sounds - "difficult to hear, sparse". Otherwise they remained active and mention of their presence probably saved the patient from subsequent surgery…"

The General Surgeon's Response to the Further Complaints

The general surgeon responded to the consumer and her husband's questions as follows (the paragraph numbers correspond to the paragraph numbers of the complaint listed above):

"1. [The consumer] *did not have gastroenteritis with dehydration. She had a small bowel obstruction secondary to adhesions. This diagnosis was confirmed by both plain abdominal films and a CT scan.*

Continued on next page

Surgical Registrar / General Surgeon / House Surgeon

Report on Opinion – Case 97HDC9902, continued

Information Gathered During Investigation, *continued*

The appropriate treatment for a small bowel obstruction is insertion of a naso-gastric tube, administration of intravenous fluids to rehydrate the patient, and, if the symptoms are bad enough, surgery. If surgery is not performed in a timely fashion there is a risk of the small bowel losing its blood supply and becoming gangrenous. This is not only a life threatening condition for the patient in the long term but even if the patient recovers, it may result in serious long term problems."

The general surgeon advised that an example of this is:

"If a sufficient quantity of small bowel becomes infarcted and has to be removed, the patient may not be left with adequate small bowel to maintain their nutritional state. ["Infarction" means the death of part or the whole of an organ that occurs when the artery carrying its blood supply is obstructed.] *In the extreme some patients require permanent home feeding via an intravenous catheter."*

2. The general surgeon advised the Commissioner that the physical findings and results of the investigations were discussed with him in early June 1997 and he recommended going ahead with a laparotomy and division of adhesions if necessary. He advised that:

"…it is true that some bowel obstructions due to adhesions will resolve in time. Others will not. Once a patient develops rebound tenderness (as she did), this is suggestive that the bowel may be in serious jeopardy. With the CT scan in addition suggesting a complete obstruction with "decompressed small bowel loops seen in the pelvis" distal to the obstruction in my judgement surgery was the safest course of action to undertake.

The operation was authorised by myself. The patient had originally been consented by my house surgeon [the house surgeon] *for a "laparotomy plus or minus division of adhesions, plus or minus resection…."*

Continued on next page

Surgical Registrar / General Surgeon / House Surgeon

Report on Opinion – Case 97HDC9902, continued

Information Gathered During Investigation *continued*

The general surgeon advised the Commissioner that he discussed the consumer's case with the surgical registrar who was at the time the hospital's most experienced surgical registrar.

> *"…We decided that it would be appropriate to do a laparoscopy as the initial procedure in case there was a relatively easy to free up band adhesion…*
>
> *…At the time of operation the lesion found to be causing the obstruction was the band adhesion. A band adhesion is not a soft adhesion. There were in addition soft adhesions and the appendix appeared sufficiently abnormal that its removal was justified. This judgement was made by* [the surgical registrar] *and has proved the correct decision as supported by pathology of the appendix."*

3. The general surgeon noted that the house surgeon's note regarding the need for surgery was based on discussion with the admitting registrar and the findings from the CT scan.

4. The general surgeon advised that his advice was followed.

5. The general surgeon noted that in the detailed typed operation note recorded under "*Procedure*", the placement of the laparoscope using a "*Hasson technique*" is documented and the decision to proceed to laparotomy because of the "extent of the adhesions seen".

6. With respect to consent, the general surgeon noted that the consumer consented on two occasions, the first occasion being several hours before her operation.

7. The general surgeon referred to the house surgeon's letter and noted that if the consumer had an allergy to anything in particular, it was necessary for her to inform the staff for them to be aware of this. Three documents in her notes recorded that the consumer has no allergies. He noted that she had Haemaccel during her admission without complication and therefore could be assured that she does not have an allergy to Haemaccel.

Continued on next page

Surgical Registrar / General Surgeon / House Surgeon

Report on Opinion – Case 97HDC9902, continued

Information Gathered During Investigation, *continued*

8. The general surgeon advised that:

"An ultrasound was not the investigation of choice (it is a very poor method of visualising the bowel). As a small bowel obstruction was clearly demonstrated on the CT scan, conservative management was not the safest cause of action here."

9. The general surgeon noted that:

"…gynaecologists are not experts in the treatment of small bowel obstructions. In fact if a bowel obstruction develops in one of their patients post operatively the patient is routinely handed over to a general surgeon for further care."

10. The general surgeon noted that the clinical records for early June 1997 recorded that it was not the duty nurse but the consumer and her husband who asked to see the on-call registrar. The notes recorded that the registrar was unable to see the consumer until 10.00pm as it was extremely busy in the accident and emergency department and this was explained by the nurse involved as well as the unit co-ordinator to the consumer and her husband. In the meantime the notes recorded that the on call house surgeon saw the consumer and was satisfied with her condition.

11. The general surgeon noted that:

"There are many potential differential diagnoses when a patient presents with abdominal pain…. The history, physical findings, abdominal x-ray and CT scan were all consistent with and demonstrated a small bowel obstruction. This was confirmed at operation. The patient did not have any of the other suggested diagnoses."

12. The general surgeon commented that he was not clear as to the substance of the twelfth complaint.

Continued on next page

Surgical Registrar / General Surgeon / House Surgeon

Report on Opinion – Case 97HDC9902, continued

Information Gathered During Investigation, *continued*

The general surgeon noted that the staff involved had already apologised to the consumer and her husband for the failure to inform the consumer's husband of the planned surgery for the consumer. The general surgeon reiterated this apology in his letter dated early August 1998. He noted that Saturday nights are often extremely busy and while the staff do their best to keep all relevant people informed as events occur, they have to deal with a number of other emergency admissions and occasionally communication with a patient's relatives can be overlooked.

The consumer returned to ward 12 from post-operative recovery ward at about 4.15am the day after she was admitted and was seen by the general surgeon at about 9.00am. Her urine output had been low for the previous three hours and the general surgeon prescribed Haemaccel in an effort to prevent acute renal failure. Haemaccel was administered and duly improved the consumer's urine output. There is no record of any adverse reaction to the Haemaccel.

The house surgeon informed the Commissioner that:

> "*At no time during her stay in hospital did she report any adverse reaction to the Haemaccel, signs or symptoms consistent with a reaction, nor were any signs or symptoms consistent with a reaction or any description noted by nursing or medical staff.*"

The clinical notes did not record any reaction.

A histopathology report, dated early June 1997, on the consumer's appendix notes that, "*...the appendix was seen with some acute inflammation within the lumen"* and concluded that the consumer was suffering from low grade appendicitis with a low grade peritoneal reaction.

The remainder of the consumer's recovery was routine and she was discharged home from hospital in mid-June 1997. The consumer failed to attend an outpatient follow-up appointment in early August 1997.

In July 1997 the consumer and her husband returned to India. It was during this visit that they sought the advice of doctors in Madras and subsequently lodged a complaint with the Commissioner.

Surgical Registrar / General Surgeon / House Surgeon

Report on Opinion – Case 97HDC9902, continued

Independent Advice to Commissioner

The Commissioner obtained advice from an independent general surgeon who advised the following:

> ***"1. Whether more conservative treatment, for example intravenous fluids and nasogastric drainage should have been attempted before surgical procedures were undertaken. Whether the laparotomy was necessary.***
>
> [The consumer] *was admitted to* [the hospital] *at 9:40am* [in early June 1997], *complaining of peri-umbilical pain, diarrhoea and vomiting, that came on during the night. There was a constant element to the pain, with exacerbations of a colicky nature. I think it is important to pick up on three aspects to her pain:*
>
> *i) It was central – in other words peri-umbilical – and pain experienced in this area belongs to the embryonic mid-gut, of which the small bowel is part. Up to this point she had been well but was still recovering from an abdominal hysterectomy.*
>
> *ii) There was a constant element to her pain, consistent with embarrassment of small bowel (see later).*
>
> *iii) There were 'exacerbations of a colicky nature' suggestions that the non-embarrassed bowel was working against resistance. What is not clear from the notes is whether or not she vomited at the peak of these exacerbations. If that is so, this is pathonomonic of a relatively high small bowel obstruction.*
>
> *The medical staff then had done:*
>
> *a) An erect and supine x-ray of the abdomen. This showed dilated loops of small bowel proximally and collapsed loops of small bowel distally and there was NO GAS TO BE SEEN IN THE LARGE BOWEL.*

Continued on next page

Surgical Registrar / General Surgeon / House Surgeon

Report on Opinion – Case 97HDC9902, continued

Independent Advice to Commissioner, *continued*

Out of thoroughness, they proceeded to carry out:

b) A C.T. of the abdomen…

[The consumer] *was then given the appropriate conservative treatment of nasogastric drainage and intravenous fluids, which were carried on from the time of admission until she eventually came to operation at 1:25am on* [the day after her admission].

On perusing [the hospital] *notes, I find the prescribed intravenous fluids appropriate. Nasogastric suction at times like this is a must.*

You ask whether 'more conservative treatment… should have been attempted before surgical procedures were undertaken'…. Three weeks before this episode, [the consumer] *had undergone an abdominal hysterectomy, via a Pfannenstiel incision (supra-umbilical transverse), which was commented on by* [the gynaecologist] *as being 'quite difficult'. On the (L) side there was dense adhesions to a TUBO-OVARIAN ABSCESS, CONTAINING PUS… The significance of this was perhaps not given quite enough emphasis in the letters of* [the surgical registrar] *and* [the general surgeon] *to you. Although these findings were very competently dealt with by* [the gynaecologist] *at the time of the hysterectomy, it is impossible to operate on a tubo-ovarian abscess without leaving raw areas that predispose towards adhesions….*

With this in mind, and with dilated proximal loops of bowel, and rebound tenderness, the diarrhoea that she was experiencing could rightly be regarded as a sign that the proximal or mid-small bowel was embarrassed to the point of possibly showing signs of early ischaemia…. The syndrome that [the consumer] *was demonstrating was therefore highly significant and it must have been weighing heavily on* [the surgical registrar's] *mind in that, because of the pressure of the day, he could not get her to theatre before midnight.*

My very definite answer to your query as to whether conservative treatment should have been extended is 'no'….

Continued on next page

Surgical Registrar / General Surgeon / House Surgeon

Report on Opinion – Case 97HDC9902, continued

Independent Advice to Commissioner, *continued*

All the signs from the syndrome, the clinical findings, the radiological findings, as well as the CT which was super-added, no doubt to look for evidence of collections, such as pus within the pelvis, added up to one thing and that is that conservative treatment should not be carried on. Operation was indicated….

No doubt what has gone through the minds of [the consumer and her husband] *and the Medical Adviser from Madras, is the difficulty in accepting that her bowel was not showing* <u>*obstipation*</u>*, but rather* <u>*diarrhoea*</u>*. In the early stages of ischaemic bowel, diarrhoea is frequent. Had she simply had gastro-enteritis, the gaseous pattern within the abdomen would have been entirely different from that which is shown from the investigations that were done when* [the consumer] *was admitted to* [the hospital].

2. Whether the appropriate investigations were carried out before surgery and if not, what further investigations should have been done.

The answer to this question is simply 'Yes'. In some respects the CT scan was an almost unnecessarily additional procedure to the plain films of the abdomen. However, from the point of view of looking for any other pathology, such as a collection within the pelvis, the CT was certainly necessary. There was nothing else that could be done, or needed to be done.

3. Did [the consumer] ***have a laparoscopy, followed by laparotomy?***

It is clearly stated in [the surgical registrar's] *letter that a Hassan canula was inserted just below the umbilicus. The significance of this is that it provides a port for a look with a laparoscope and one glimpse with the laparoscope in a situation like this would be enough to tell a Surgeon of any experience that he or she must desist from attempted laparoscopy and proceed to laparotomy….*

Continued on next page

Surgical Registrar / General Surgeon / House Surgeon

Report on Opinion – Case 97HDC9902, continued

Independent Advice to Commissioner, *continued*

Small bowel obstructions have to be handled with the skill that [the surgical registrar] *has obviously exhibited in his handling of* [the consumer].

4. Was the extension of this procedure necessary?

…I have emphasised that the hysterectomy was done via a transverse supra-pubic incision. While this was an incision that gave good exposure with respect to the hysterectomy, it is an incision that simply does not give adequate exposure in small bowel obstruction. There is no alternative to a mid-line incision in a situation such as this.

5. Why was Haemaccel administered and was this necessary, and did it cause an adverse reaction for [the consumer]***?***

In the post-operative period such as this, Haemaccel is a volume expander. Immediately after surgery [the consumer] *was showing signs of needing extra volume in the vascular bed, and as she had not been losing blood, Haemaccel is usually an excellent agent to be given. Unfortunately it was not noted by the Anaesthetist that it was thought to have caused a rash after* [the consumer's] *hysterectomy. The cause of an allergic reaction immediately after an operation is extremely difficult to pin-point. Her rash was much more likely to be from an allergy to the antibiotics. There are many anaesthetic agents that people can react to, but in* [the consumer's] *case it must have been thought that it was the Haemaccel that gave her the rash.*

On this particular occasion, however, i.e. immediately after her laparotomy, there was no rash, so in retrospect we can say the Haemaccel was safe to administer….

Continued on next page

Surgical Registrar / General Surgeon / House Surgeon

Report on Opinion – Case 97HDC9902, continued

Independent Advice to Commissioner, *continued*

In [the consumer's] *case, this was not the same as administering a wrong drug. The agent of choice would have been Haemaccel for the very reasons for which it was given. It did what it was meant to do and it was fortuitously fortunate that her previous rash had been caused from something other than Haemaccel. Nevertheless it was obvious that the warning was not seen. Had it been seen, Haemaccel would not have been given.*

6. Why was the Gynaecologist not included in her care?

The only indication to include the Gynaecologist in [the consumer's] *case was simply a professional courtesy one. Gynaecologists and Surgeons share the same abdominal cavity, each approaching it with incisions and by methods best suited to their speciality. Small bowel obstruction is quite outside the domain of a Gynaecologist in an acute situation such as this, and apart from the above mentioned professional courtesy, which is likely to have come later on when meeting up with the Gynaecologist, no purpose would have been served by including the Gynaecologist in what was clearly a surgical problem.*

7. Should other causes of gasto-enteritis have been considered, for example tuberculosis, worm infestation and ileitis?

I am afraid this is a situation where 'perception' has been confused with 'reality', where 'possibility' has been confused with 'probability', and where the 'wood has been lost for the trees'. Had this been gasto-enteritis there would have been a uniform distribution of gas through both small bowel and large bowel, as observed in the plain radiology of the abdomen, and the subsequent CT. Of course it is possible to mistake gastro-enteritis, which can masquerade as a small bowel obstruction, but it would not have given the x-ray findings, such as [the consumer] *was demonstrating, even though it is possible for gastro-enteritis to show some fluid levels scattered throughout the bowel….*

Continued on next page

Surgical Registrar / General Surgeon / House Surgeon

Report on Opinion – Case 97HDC9902, continued

Independent Advice to Commissioner, *continued*

Tuberculosis of the bowel is a condition not uncommonly seen in Asiatic immigrants into the UK and even NZ. It has a much more insidious course and in an abdomen that has recently been opened by a Pfannenstiel incision, inadequate though it was for access to the bowel, there would have been signs of a tuberculosis peritonitis noted during hysterectomy. The same can be said of regional ileitis (Crohn's disease). The history of Crohn's disease is something quite unlike that which [the consumer] *presented with. Criticism was made from the Madras Doctor that the appendix should not have been removed, if it had been ileitis, as it could be the cause of a fistula. Yes, that is how things were in the 14th edition of Bailey and Love, which is now in its 20th edition. Besides, sometimes an appendicectomy is indicated in order to gain histology on an inflammatory bowel condition. This is something that a Registrar of the seniority of* [the surgical registrar] *would be quite familiar with. Of more significance, however, is the fact that had* [the consumer] *been suffering from regional ileitis, it would have been glaringly obvious at laparotomy. The fact was, that she wasn't.*

The right thing to do at times like this is to remove an appendix which can be showing signs of only mild serosal reaction in a bowel obstruction. In this particular case the appendix was showing signs of early acute inflammation. Had it developed into an acute phlegmanous appendicitis during the recovery phase of a laparotomy for small bowel obstruction, it would have added insult to insult, stress to stress, and it is simply regarded as good practice at times like this to remove the appendix. The histology on the appendix shows signs of early acute appendicitis….

Continued on next page

Surgical Registrar / General Surgeon / House Surgeon

Report on Opinion – Case 97HDC9902, continued

Independent Advice to Commissioner, *continued*

8. Is it necessary that [the consumer] ***should have a history of constipation as an indication of bowel obstruction?***

No it is not necessary, for reasons outlined above. It is usual that there is a history of constipation or shall we say OBSTIPATION with a bowel obstruction, and the way that we know that the obstruction is relieving itself with intravenous fluids and nasogastric suctioning, is that the patient, who has a non-tender abdomen, starts breaking wind. This is a good scientific sign that progress is occurring. In a situation like this, however, the diarrhoea, the opposite of constipation, could be rightly regarded as a sign of an ischaemic embarrassment of the small bowel, as a result of it being kinked around a band adhesion or obstructed by dense adhesions.

It was quite apparent that [the consumer's] *adhesions included some soft adhesions, some dense adhesions, as we would expect with pelvic inflammatory disease, and that there was also a band adhesion as well. That 'band' is most likely to have been as the direct result of the pelvic inflammatory disease and subsequent hysterectomy, but it is possible for us to have 'congenital' band adhesions, which are in themselves dangerous, should a loop of bowel become wedged under, or looped around, such an adhesion. In such a case, before the bowel goes on to infarction and then profound constipation with toxic shock, there can be a period of frank diarrhoea….*

No Surgeon ever wants to be taking on a bowel obstruction in the small hours, but in [the consumer's] *case the outcome could have been so different had proper surgical management not been undertaken…."*

Surgical Registrar / General Surgeon / House Surgeon

Report on Opinion – Case 97HDC9902, continued

Code of Health and Disability Services Consumers' Rights

The following Rights are applicable in this case:

RIGHT 2
Right to Freedom from Discrimination, Coercion, Harassment, and Exploitation

Every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial or other exploitation.

RIGHT 4
Right to Services of an Appropriate Standard

…
2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.
…

RIGHT 6
Right to be Fully Informed

1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –
- *a) An explanation of his or her condition; and*
- *b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; and*
- *…*
- *e) Any other information required by legal, professional, ethical, and other relevant standards; and*
- *f) The results of tests; and*
- *g) The results of procedures.*

…

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

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

…

Surgical Registrar / General Surgeon / House Surgeon

Report on Opinion - Case 97HDC9902, continued

Opinion: No Breach - The Surgical Registrar

In my opinion the surgical registrar did not breach Right 2, Right 4(2) or Right 7(1) of the Code of Health and Disability Services Consumers' Rights.

Right 2

There is no evidence that the surgical registrar discriminated against the consumer on the basis of her race or any other factor.

The consumer was triaged on admission to the emergency department of the hospital and subsequently assessed and referred for tests to ascertain the cause of her symptoms. The test results were reviewed by the surgical registrar and the general surgeon and the decision was made to operate based on those results. There is no evidence to support the consumer and her husband's claim that the consumer was used as a "guinea pig".

Right 4(2)

The surgical registrar performed surgery on the consumer only after he assessed her condition, consulted the results of her abdominal x-ray and CT scan and following discussion with the general surgeon. These investigations suggested that she had a small bowel obstruction. The general surgeon agreed with this diagnosis and suggested that the surgical registrar perform a laparoscopy to confirm the findings and free the adhesions laparoscopically if possible. In my opinion the surgical registrar's actions met professional standards and he did not breach the Code.

In the surgical registrar's opinion the consumer's appendix was inflamed and he removed it. The histopathology report confirms this. The independent general surgeon advised me that it was appropriate that it be removed because of the early inflammation and also to find the cause of the infection. It was good practice to remove it and in my opinion the surgical registrar did not breach Right 4(2) of the Code by doing this.

The surgical registrar did not remove the consumer's kidneys.

Continued on next page

Surgical Registrar / General Surgeon / House Surgeon

Report on Opinion – Case 97HDC9902, continued

Opinion: No Breach - The Surgical Registrar, ***continued***

Right 7(1)

The consumer presented in the accident and emergency department of the hospital on a Saturday morning at 9.40am. Following an abdominal x-ray she was referred for a surgical consultation with the admitting registrar who indicated that she may require surgery. The admitting registrar discussed her case with the general surgeon who ordered a CT scan. The results of the CT scan were not available until late afternoon and it was not possible to fully inform the consumer of the results of the scan and the options available to her until late afternoon.

The consumer was seen by the house surgeon at approximately 5.30pm when she obtained the consumer's consent for a laparotomy and not a laparoscopy. The consumer's husband was with his wife at that time. The consumer informed me that she knew about the laparoscopy because she was told it was a simple procedure which was explained by the house surgeon. The surgical registrar saw the consumer following his discussion with the general surgeon at about 10.45pm. The surgical registrar noted that she had consented to the laparotomy but the form did not specifically state laparoscopy. The surgical registrar then gained written consent for the laparoscopy.

The surgical registrar apologised for not talking to the consumer's husband about his wife's surgery. Although the surgical registrar did not talk with the consumer's husband, in my opinion the consumer was alert enough to understand the various explanations she received through the course of the day. The surgical registrar confirmed what had been previously explained and, in addition, ensured that the consumer understood what was involved with a laparoscopy and a laparotomy and, therefore, the surgical registrar did not breach Right 7(1) of the Code.

While the consumer did not specifically consent to the removal of her appendix, the purpose of her surgery was to identify the cause of her abdominal pain. Appendicitis is a common cause of abdominal pain. In my opinion the surgical registrar had obtained consent to operate to investigate and, if appropriate, surgically remove tissue which may be causing the consumer's abdominal pain. This included the appendix.

Surgical Registrar / General Surgeon / House Surgeon

Report on Opinion – Case 97HDC9902, continued

Opinion: No Breach - The General Surgeon

In my opinion the general surgeon did not breach Right 2 or Right 4(2) of the Code of Health and Disability Services Consumers' Rights.

Right 2

I have seen no evidence to suggest that the general surgeon discriminated against the consumer on the basis of her race or any other factor. The consumer's test results indicated that she had a small bowel obstruction and this was confirmed at surgery. There is no evidence to support the consumer and her husband's claim that the consumer was used as a "*guinea pig*".

Right 4(2)

The general surgeon ordered Haemaccel when the consumer's urine output was low. I am advised that Haemaccel is the replacement of choice in such situations. The consumer indicated on admission both in the emergency ward and ward 12 that she did not know of any allergies. There is no record of any adverse reactions following the administration of Haemaccel. In my opinion the general surgeon's action were reasonable in the circumstances and he did not breach the Code.

The consumer's signs and symptoms and the preoperative investigations suggested an obstruction of the small bowel possibly due to an adhesion following her previous surgery. The general surgeon recommended that the surgical registrar perform a diagnostic laparoscopy before proceeding to the more complex laparotomy because in some instances the adhesion can be freed laparoscopically and would be a less invasive solution. My independent general surgeon advised me that the consumer's condition could have been life threatening if it had been allowed to progress further. In my opinion the general surgeon's actions met professional standards.

Surgical Registrar / General Surgeon / House Surgeon

Report on Opinion – Case 97HDC9902, continued

Opinion: No Breach - The House Surgeon

In my opinion the house surgeon did not breach Right 4(2) or Right 6(1) of the Code of Health and Disability Services Consumers' Rights.

Right 4(2)

I note that the Pre-operative Assessment Sheet and Anaesthetic Record dated the day of the operation recorded that the consumer was allergic to Haemaccel. However when the consumer was admitted by the house surgeon on the day prior to the operation, the consumer said she did not have any allergies that she knew about. This is documented on her admission form and in her clinical record. If at a later time the consumer remembered that she did in fact have an allergy to Haemaccel, it would have been reasonable that she inform the nursing staff of this so that her clinical records could be corrected. In my opinion the house surgeon correctly recorded no allergies during her examination of the consumer when the consumer was first admitted.

Right 6(1)

In my opinion the house surgeon did not breach Right 6(1) of the Code. The house surgeon spent a considerable amount of time with the consumer and her husband. The form signed by the consumer recorded that she would have a laparotomy with or without removal of adhesions and resection of the bowel. It is also documented that it may require open surgery. The consumer understood that she was to have a simple operation. The house surgeon saw her at about 5.30pm and the full extent of the surgery was not known until the surgical registrar discussed the results of the investigation fully with the general surgeon. The house surgeon did not see the consumer after she gained the written consent at 5.30pm. In my opinion the house surgeon told the consumer as much as she was able to tell her at that time and did not breach the Code.

The consumer and her husband thought that the consumer had gastro-enteritis, would be given medication and sent home. They did not expect that the consumer would require admission to hospital or that she was faced with a potentially life threatening obstruction of the small bowel. In my opinion the house surgeon tried to explain the results of the investigations and the possible surgical requirements. This was done while the consumer's husband was in attendance. In my opinion the house surgeon did not breach Right 6(1) of the Code.

Surgical Registrar / General Surgeon / House Surgeon

Report on Opinion – Case 97HDC9902, continued

Other Comments

In all the circumstances surrounding this complaint, in my view no further action is required. The report will be copied to New Zealand Medical Council, Health Funding Authority and Crown Company Monitoring Advisory Unit for education purposes. In particular it should be compared with case 97HDC8854 where in a similar surgical situation, the outcome was extremely different.