Death caused by leaking anastomosis following bowel surgery (00HDC03311, 28 August 2002)

General surgeon ~ Private hospital ~ Public hospital ~ Bowel surgery ~ Standard of care ~ Workload ~ Co-ordination of providers ~ Private/public interface ~ Duty of candour ~ Right 4(1)

A woman complained about the services provided to her late husband, who died of septicaemia and multi-organ failure following bowel surgery. The complaint was that the surgeon:

1 did not leave the 65-year-old patient with written instructions about food intake before surgery;
2 decided to proceed with surgery even though the bowel preparation was inadequate;
3 did not carry out the operation properly;
4 failed to monitor the patient's deteriorating condition;
5 did not arrange for transfer to the Intensive Care Unit of a public hospital; and
6 did not see the patient for 24 hours after his admission to the public hospital.

The Commissioner held that the surgeon did not breach Right 4(1) with regard to some aspects of the complaint as he gave adequate instructions about food intake prior to surgery (but nurses gave conflicting information); it was reasonable to proceed with the surgery even though the bowel preparation was not ideal, especially as he had prescribed an enema; and (c) the patient was appropriately monitored at the private hospital, though concerns were expressed about the surgeon's "hands off" approach. However, the surgeon did breach Right 4(1) by failing to take adequate steps to check the integrity of the anastomosis; and in his management of the anastomotic leak. The surgeon's failure to review the patient in person was a significant failure because it underpinned the critical decision not to operate, which may well have cost the patient his life.

The private hospital did not breach Right 4(1), as it took adequate steps to ensure that the surgeon was competent to practise, and that appropriate procedures were in place. Likewise, the public hospital was not vicariously liable, as it acted responsibly and took active steps to identify and respond to concerns about the surgery.

The Commissioner commented that: (1) it was the responsibility of the surgeon to ensure that nursing staff were properly briefed about what the patient could eat after his colonoscopy; (2) continuity of care for hospital patients, with multiple staff and changing shifts, makes it imperative that there is effective communication, co-operation and co-ordination; and (3) following the death of a patient a surgeon owes a bereaved family a duty of candour.

The Commissioner referred the matter to the Director of Proceedings. The Medical Practitioners Disciplinary Tribunal upheld a charge of professional misconduct relating to the failure to adequately assess postoperatively, failure to consult with and/or transfer care to a specialist surgeon, and inadequate notes.