

**General Surgeon, Dr D**

**A Public Hospital**

**A Report by the  
Health and Disability Commissioner**

**(Case 99OP09129)**



## Parties involved

Mr A	Consumer
Mr B	Complainant, consumer's son
Ms C	Complainant, consumer's daughter
Dr D	Provider, consultant general surgeon
Dr E	Surgeon
Dr F	House Surgeon
Dr G	Anaesthetist
Dr H	Surgeon
Dr I	Urologist
Ms J	Hospital Services Manager
The public hospital	Provider, public hospital

Expert advice was obtained from Professor Iain Martin, an independent general surgeon.

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## Complaint

On 23 August 1999 the Commissioner received the following complaint from Mr B and Ms C concerning the services provided to Mr A at a public hospital. The complaint is that:

*Mr A did not receive services of an appropriate standard from a public hospital. In particular:*

- *One surgeon instead of two performed Mr A's eight-hour operation.*
- *When the operation became prolonged and difficult the surgeon did not call for assistance.*
- *During the operation a section of Mr A's ureter was removed which allowed urine to constantly flow to his abdomen resulting in:*
  - *Excessive drainage from the perineal wound.*
  - *A septic episode including severe respiratory distress on 4 April 1999.*
  - *A thrush infection.*
  - *The development of herpes.*
  - *A pulmonary embolism on 10 April 1999.*
  - *The distension of his abdomen.*
  - *The insertion of a nephrostomy tube into his kidney.*
  - *The failing of his kidneys.*
  - *A coronary.*
- *It was not detected that a section of Mr A's ureter had been removed.*
- *Mr A had continuous high temperatures, which were not investigated in order to locate the source of the infections.*

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- *On the second occasion Mr A was transferred to ICU, a chest x-ray was not undertaken, on the night he was admitted, even though he had a temperature of “over 40, ‘resps’ 46 and blood gases showing he was acidotic”.*
- *Mr A’s perineal suture was closed although it was still draining excessively.*
- *When Mr A was unable to eat due to a thrush infection, he received no additional nutrition.*
- *The physiotherapy treatment Mr A received, the use of stockings and Fragmin at 2500 units per day instead of 8000 twice daily did not prevent him having a pulmonary embolism.*
- *Mr A had a pleural effusion for three days, which was not drained.*
- *As a result of post-operative complications Mr A lost the opportunity to receive any follow-up cancer treatment and was advised a kidney may be removed when he was fit enough to undergo surgery.*

On 23 February 2000 the Commissioner extended the investigation to include an additional complaint:

*When Mr A’s family made a complaint concerning his treatment at the public hospital:*

- *The complaint was not acknowledged in writing within five working days.*
- *The family was not informed of the right to make a complaint to the Health and Disability Commissioner by the public hospital.*
- *Following numerous telephone calls and a meeting with the public hospital the family did not receive a report, regarding Mr A’s admission to the public hospital, as agreed to in the meeting.*

On 9 August 2000, the Commissioner extended the investigation to include Dr D and the complaint that:

*Mr A did not receive services of an appropriate standard from Dr D. In particular:*

- *Only Dr D, instead of two surgeons, performed Mr A’s eight-hour operation.*
- *When the operation became prolonged and difficult Dr D did not call for assistance.*
- *During the operation a section of Mr A’s ureter was removed which allowed urine to constantly flow to his abdomen resulting in:*
  - *Excessive drainage from the perineal wound.*
  - *A septic episode including severe respiratory distress on 4 April 1999.*
  - *A thrush infection.*
  - *The development of herpes.*
  - *A pulmonary embolism on 10 April 1999.*
  - *The distension of his abdomen.*
  - *The insertion of a nephrostomy tube into his kidney.*
  - *The failing of his kidneys.*

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- *A coronary.*
  - *Dr D did not detect that a section of Mr A's ureter had been removed.*
  - *Mr A had continuous high temperatures, which were not investigated in order to locate the source of the infections.*
  - *On the second occasion Mr A was transferred to ICU, a chest x-ray was not undertaken, on the night he was admitted, even though he had a temperature of "over 40, 'resps' 46 and blood gases showing he was acidotic".*
  - *Mr A's perineal suture was closed although it was still draining excessively.*
  - *When Mr A was unable to eat due to a thrush infection, he received no additional nutrition.*
  - *The treatment Mr A received of physiotherapy, the use of stockings and fragmin at 2500 units per day instead of 8000 twice daily did not prevent him having a pulmonary embolism.*
  - *Mr A had a pleural effusion for three days, which was not drained.*
  - *As a result of post-operative complications Mr A lost the opportunity to receive any follow-up cancer treatment and was advised a kidney may be removed when he was fit enough to undergo surgery.*
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## **Information gathered during investigation**

### *Care provided to Mr A*

On 23 December 1996, Mr A, a 65-year-old man with a history of rectal cancer, underwent a resection of a rectal tumour at a public hospital.

In October and November 1998, Mr A experienced rectal bleeding while he was visiting his son in Australia. Mr A believed that his bleeding was related to his travelling and did not seek medical advice until after he returned to New Zealand in January 1999. After initial treatment from his general practitioner, Mr A was referred to a public hospital in March 1999 for surgical assessment. Mr A's condition was categorised as urgent and on 3 March 1999 Mr A was seen by Dr D, consultant surgeon.

Dr D reports that at this consultation he discovered that Mr A had undergone a resection of a rectal cancer in December 1996, and that a tumour was easily palpable in the lower part of the rectum. Mr A advised that the tumour involved most of the circumference of the bowel lumen. Dr D informed Mr A of his findings, performed a rigid sigmoidoscopy and took a biopsy of the tumour. Dr D advised that he also sent Mr A for an urgent CT scan of the abdomen and pelvis to assess the local pelvic changes and to exclude the presence of metastases.

On 4 March 1999, Dr D discussed Mr A's presentation and the options for surgery with Dr E, the surgeon who performed the resection in 1996.

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On 11 March 1999, Mr A had a CT scan of his abdomen and pelvis. This showed the rectal tumour, but no evidence of metastatic disease.

Dr D saw Mr A on 18 March 1999 and discussed the findings of the scan. Dr D proposed an AP (abdominoperineal resection, removal of sections of the rectum and placement of a permanent iliac colostomy) and advised that he discussed the operation and all possible complications with Mr A.

Dr D advised Mr A that because the rectal cancer was recurrent and there had been a delay between presentation and diagnosis, the prognosis was not good. Dr D stated that he advised Mr A that there was likely to be some benefit from surgical exploration, with the aim to try to remove all of the disease.

Dr D advised that if Mr A tolerated the procedure well, and depending on the operative and final histology finding, he might be offered additional treatment. Dr D stated that this did not mean they were able to guarantee that this would prevent the growth of small undetected metastases, or the development of new recurrent disease in the pelvis or somewhere else in the body.

Dr D advised that he believed that the AP resection would take between four to five hours, although it might be longer depending on the operative findings, and whether any complications developed. Dr D stated that Mr A did not hesitate in deciding to proceed with the operation.

On 22 March 1999, Mr A attended a pre-assessment clinic prior to his admission for surgery.

On 25 March 1999, Mr A was admitted to a public hospital for surgery, which occurred on 26 March 1999.

Surgery was performed by Dr D with the assistance of Dr F, house surgeon, and an anaesthetist, Dr G. Dr D advised that the operation was extremely difficult because of scarring from previous surgery and dissection was made difficult by the presence of an abscess in the left side of the pelvis. Dr D encountered significant bleeding which resulted in a temporary drop in Mr A's blood pressure, but this was corrected with blood transfusions. Dr D was able to control the bleeding and excise the tumour and the affected bowel as planned. Dr D advised that at the end of the operation, Mr A's condition was stable and he was transferred to the HDU (High Dependency Unit).

On 27 March 1999, Mr A was reviewed by Dr D. His condition was noted to be stable and a low urine output was reported to have responded to frusemide. Dr D informed me that despite the difficult operative procedure, Mr A progressed fairly satisfactorily during his first post-operative days.

On 28 March 1999, Mr A was reviewed again by Dr D. Dr D noted that Mr A was stable but had a distended abdomen. He was noted to have a cardiac murmur and some ectopic

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heartbeats (heartbeats originating outside the sinoatrial node). Observation charts indicate that Mr A had a temperature of 38°C that night.

On 29 and 30 March 1999, Mr A's condition was noted to be stable and he started on fluids.

On 31 March 1999, Dr D noted that Mr A had been vomiting and had an oozing perineal wound and a distended abdomen.

On 1 April 1999, Mr A was noted to be improving and was commenced on a diet. Between one and two litres of fluid passed from the perineal drain. Observation charts indicate that Mr A's temperature reached 38°C.

On 2 April 1999, Mr A continued to pass large volumes of clear fluid from the perineal drain. A temperature of 37.6°C was recorded.

On 3 April 1999, Dr D's clinical notes recorded that the perineal drain continued to produce a large volume of clear fluid and that Mr A was progressing well. Dr D placed two stitches in the perineal wound.

On 4 April 1999, the notes show that Mr A's condition had worsened. He was noted to be feverish, breathing rapidly and tachycardic (having a fast heartbeat). Dr D commenced intravenous antibiotics and intravenous fluids, and the perineal drain was removed. Mr A was transferred to the intensive care unit for observation. Large volumes of clear fluid continued to drain from the perineal wound. Dr D advised that while the first post-operative days were satisfactory, Mr A's later post-operative days proved stormy. Dr D stated that every time he started to overcome one complication, another developed.

On 5 April 1999, Mr A remained unwell. He had an irregular fast heartbeat and was feeling feverish. His venous white blood cell count increased. Large volumes of fluid were again noted to be draining from the perineal wound.

On 6 April 1999, Mr A remained unwell but was transferred back to the general surgical ward by Dr D. Mr A still had a fever and significant drainage from the perineal wound. Test results showed the presence of bacteria, and his antibiotic treatment was changed to ciprofloxacin.

On 7 April 1999, Mr A was still noted to be feverish. Dr D noted that Mr A had tachycardia with atrial fibrillation (disorganised electrical activity in the atria of the heart) and tachypnoea (rapid breathing). The perineal wound continued to drain large volumes of clear fluid and was again sutured by Dr D. Dr D advised that Mr A was suffering metabolic acidosis (excess acid in the body fluids), which was treated with intravenous sodium bicarbonate.

A chest x-ray on 8 April 1999 showed some left basal lung collapse and an effusion (escape of fluid). Dr D ordered an albumin infusion. It was noted that Mr A's high temperature

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was the result of the chest infection, and the dose of ciprofloxacin was increased. Nursing notes recorded that Mr A “looks shocking”.

On 10 April 1999, Mr A collapsed with a cardiac arrest. He was resuscitated by the medical and nursing team and intubated and ventilated in the intensive care unit. Following stabilisation, Mr A was transferred to the intensive care unit at a second public hospital. A diagnosis of septic shock was diagnosed on arrival and CT scan of the chest and the abdomen was arranged. The surgical examination indicated septic shock secondary to intra-abdominal infected collections of fluid. The chest scan showed multiple pulmonary emboli (blockages of arteries in the lung) and the abdominal scan showed multiple collections of fluid. Drainage of the fluid was performed.

On 11 April 1999, Mr A was commenced on a heparin infusion to treat his pulmonary emboli.

Mr A’s condition deteriorated further on 12 April 1999, and a further laparotomy (surgical incision into the peritoneal cavity) was performed in light of this worsening sepsis.

Mr A remained unwell on 13 April 1999 and was noted to be in renal failure with significant metabolic acidosis. During his admission to the first public hospital, Mr A had developed a rash around his mouth. The rash was reviewed by a dermatologist, who diagnosed a bacterial/fungal infection and started Mr A on topical treatment with antiseptic and antibiotic cream.

On 15 April 1999, Mr A underwent the insertion of a vena caval filter, a device inserted into the major vein of the body to prevent blood clots moving into the lungs. During this procedure, Mr A was noted to have an episode of very fast irregular heartbeat.

On 17 April 1999, Mr A was transferred to the third public hospital’s intensive care unit. Because his condition had improved, he no longer required ventilation. His condition continued to improve slowly, but a high level of clear fluid continued to drain from his perineal wound.

On 5 May 1999, an intravenous urogram (examination of the kidneys) was performed at the second public hospital, which indicated a right ureteric injury and extravasation (leakage into the tissues) from the bladder on the right-hand side.

On 10 May 1999, Mr A had a nephrostomy (incision placed into the collecting system of the kidney). Following this the drainage of urine from the perineal wound ceased.

On 13 May 1999, Mr A was discharged home.

In relation to the treatment he provided to Mr A, Dr D advised:

*“Operative Issues*

*In relation to issues additional to the general summary and specified variously in the complaint, I note as follows:*

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1. *At the time when the operation was performed, the senior surgical team in [the public hospital] consisted of [Dr E], [Dr H] and myself. As mentioned before, on the day of the operation [Dr E] was in [another city] for a meeting and [Dr H] had a commitment to attend a funeral ceremony in [a large town]. At various meetings we routinely discuss patients' matters between ourselves and help each other whenever it is needed. One surgeon routinely performs these types of operations. However, it must be remembered that these types of operations are usually long and complicated even if two surgeons were involved in the operation. Although at the time of surgery I was the only surgeon, I had good number of assistants, the anaesthetist was very supportive as well as the nurses. As I mentioned before, the difficulties that we encountered, were mainly due to the disease itself and the combination of the recurrent tumour, the previous surgery, the presence of infection and abscess, and the extension of the tumour outside the bowel. If I had needed support from one of my colleagues, I would have had no hesitation in asking for it.*

*Temperature Control and Chest X-rays, Pulmonary Embolus*

2. *[Mr A] was transferred after the operation to the HDU. He stayed two nights and then was transferred back to his bed in the ward. At that stage his highest recorded temperature was 37.5°C. In these types of operations, I usually give the patient prophylactic antibiotics only, which means one single dose of 2 types of just before the operation. However, in his case and because of the complexity of the operation, I kept the antibiotics for 5 days. [Mr A] had his operation on Friday (26<sup>th</sup> March) and continued to be afebrile until the next Saturday (3<sup>rd</sup> April) night. I saw him on the morning and afternoon of that day and he was afebrile, did not receive any intravenous fluids for the previous 3 days, was eating and drinking and passing very satisfactory amounts of urine through the urinary catheter, up to over 2 litres per day. We were planning to remove the urinary catheter on Sunday (4<sup>th</sup> April) morning, and this was done. On Saturday (3<sup>rd</sup> April) night he spiked a temperature up to 38.5°C but I was not informed. He was generally looking well and the temperature dropped back to normal. On Sunday (4<sup>th</sup> April) morning and all of a sudden he started to have shivering and his temperature climbed up to 40°C. When I assessed him, he was fully conscious, his abdomen was soft with no features of peritoneal irritation, his colostomy was working well, the perineal wound was not looking acutely inflamed, and he had no complaint relating to his legs which were normal to examination. The perineal drain was draining clear to cloudy yellowish fluid. Although he was short of breath, on listening to his lungs both were good, apart from a few scattered wheezes and some decrease in the sounds at the base of the left lung. He was given Oxygen and intravenous fluid started. Samples of blood were taken for culture and blood gases. Three types of antibiotics in its highest permissible doses were started. The drain of the perineum*

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*was removed in case it contributed to the infection as a foreign body. Swabs from the perineal wound and the tip of the drain were sent for culture, and the perineal wound was kept widely opened for free drainage. A urine catheter was reinserted for monitoring the urine output and he was transferred to the HDU. All means to drop his temperature were used and by midday it was back to 37°C and continued to be so during the following 2 nights which he spent in the HDU.*

*His respiratory rate dropped and the next day (Monday 5<sup>th</sup> April) it was in the high twenties. He had a chest x-ray on that day (Monday 5<sup>th</sup> April) that showed some density at the base of the left lung with minimal amount of pleural effusion. This was thought to be due to pneumonia or an irritation from below the diaphragm. His heart rate was still rapid even after we were successful in bringing his temperature to normal. I talked to the physician on call over the phone on the evening of that day (Monday 5<sup>th</sup> April) and he decided to give him Digoxin. As I mentioned before [Mr A] was found to have heart murmur at the time of his preoperative assessment, and at the day of the operation and according to my request he was checked by another physician who thought that the most likely cause of the heart murmur is a previous heart attack, and suggested that nothing needed to be done about it at that stage.*

*Two days later the swab from the perineal wound and the preliminary results of the blood culture revealed the presence of an Enterobacteria. We checked with the lab for the presence of other bacteria but there were none. I chose an antibiotic according to the sensitivity and discussed it with the pharmacist for the maximum dose and the availability of its stock in the ward. [Mr A's] Oxygen saturation was continuously monitored and Oxygen administered accordingly to keep the saturation within normal limits. Following his return to [the ward] he started to have spikes of temperature to a maximum of 38°C but he was gradually looking better and we thought that we needed to give a chance for the antibiotics to work. This usually needs about 3 days unless the general condition is not improving (which was not the case). On the following Saturday (10<sup>th</sup> April), and before he collapsed, he went down to the radiology department on a wheel chair for a follow up chest x-ray. This showed an improvement compared to the previous film. After he returned back to his room in [the ward], he felt well enough to go walking and have a shower. At the end of the shower he collapsed when he developed the massive pulmonary embolism.*

- 3. [Mr A] was at risk for deep venous thrombosis and pulmonary embolism. The following were the standard measures, which were undertaken to minimise the development of these complications. He was on Fragmin (a low molecular weight heparin) from the time of the operation until the*

time he developed the pulmonary embolism. The recommended dose for prophylaxis is 2500 units to 5000 units given subcutaneously daily. Because there was a significant intraoperative bleeding and the extensive raw area, which was left in the pelvis after the removal of his bowel, we decided to give him 2500 units daily. The dose of 8000 units twice daily mentioned by the family is for established deep venous thrombosis and pulmonary embolism and not for prophylaxis. During the operation, [Mr A] was wearing support stockings. He received physiotherapy after the operation, and I advised him to keep moving his feet up and down several times a day. I was regularly checking his calves for any pain or swelling (which are possible clinical features for deep venous thrombosis), but he neither had pain nor any swelling until the time he developed the pulmonary embolism. I also encouraged him to walk, and on several occasions, I took him for a walk to the lounge. Unfortunately, all these measures do not prevent thrombosis but only minimise the incidence. The thrombosis could be silent which is a known phenomenon.

4. There are two types of acidosis, respiratory and metabolic. [Mr A] had metabolic acidosis due to the sepsis. This condition usually disappears once the sepsis is controlled. That is why his respiration returned back to the twenties and his needs [for] the Oxygen inhalation started to get less and less (monitored by regular Oxygen saturation). For 2 days before his collapse his need for the Oxygen was intermittent not continuous. In addition, I was checking his blood results daily and treated him accordingly. Every morning I was careful to calculate the input and output fluid balance. This includes the urine output, fluid coming through the colostomy, any fluid coming through the perineum, and the insensible loss from the skin and breathing. Then I put on the instruction of how much intravenous fluid needed to be given besides the oral intake. In the afternoon I would check the fluid balance again and made modifications as necessary. The function of the kidneys and the level of the electrolytes were checked routinely every day by blood tests. When [Mr A] started to mobilize the body fluids and when the faeces started to be more formed the loss through the colostomy became less, and he was producing good amounts of urine, sometimes up to 180 ml per hour.
5. The chest x-ray on Monday 5<sup>th</sup> April showed the presence of some reaction at the base of the left lung with minimal fluid collection (Pleural effusion). The angle between the diaphragm and the ribs that we call the costo-phrenic angle was still seen. At that stage the pleural effusion was considered to be either reactionary to an infection in the lung or due to irritation from below the diaphragm. Unless the effusion is of a significant amount that affects the expansion of the lung the recommended treatment is to treat the underlying cause and not to aspirate. The follow up chest x-ray on Saturday 10<sup>th</sup> April that was taken on the day [Mr A]

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*collapsed from the massive pulmonary embolism showed that the reaction is improving and the pleural effusion did not increase. No aspiration of pleural fluid was carried out while [Mr A] was in the intensive care unit of [either public] hospitals. After his transfer to the general surgical ward in [the second public hospital], he apparently accumulated more fluid and an aspiration of approximately 600 ml was performed. The treating doctors wanted to know whether the effusion was malignant in nature or due to heart failure.*

*Nutritional status*

6. *[Mr A's] nutritional status was addressed. Initially (during the first week) there were no problems because from the second day after operation he was allowed to drink and both the quantity and variety of the fluids were steadily increased. He was eating a high-protein diet and his nutritional status gradually improved until he developed the fever. Even after the fever he was encouraged to eat and his appetite was good. I discussed his condition with the dietician aiming to give him between 1500 to 2000 calories per day through special diet rich in calories, high in protein, and supportive elements. We also discussed the availability of intravenous vitamins and essential elements with the pharmacy and daily doses were started. In addition he was given 100 ml of Albumin every 8 hours daily. However, he started to have problems swallowing when he developed the mouth lesions. These lesions came suddenly and progressed very rapidly. They were due to fungal infection and some nutritional disturbances. Treatment in the form of mouth cleaning antifungal medication and other medicine to ease the pain during swallowing was instructed. Had his nutritional status not improved, it was my intention to feed him through a fine nasogastric tube. Unfortunately he collapsed from the massive pulmonary embolism. For the Total Parenteral Nutrition (TPN) to be given it should be infused through a central venous line which means inserting a line with its tip in a large vein in the chest. TPN and the required intravenous line are not without potential problems. Infection and septicaemia are causes of concern. When the intestine can be used it is the preferred route of nutrition. Drinking and eating will also prevent atrophy of the inner lining of the alimentary tract. Prior to his collapse, [Mr A's] intestine could be used. Unfortunately, as mentioned before, there was not enough time to watch for the progress, because he collapsed.*

*Post-operative drainage*

7. *The operative procedure was conducted through an abdominal and perineal wounds. At the end of the procedure both wounds were closed and a drain was left in the pelvis, which was brought through the lower abdomen. That drain, ceased to bring anything after 3 days and was therefore removed. [Mr A] started to trap fluids in his body including his*

*abdomen (ascites). This was attributed to many factors but mainly the drop in his serum protein and more important the albumin fraction (which is mainly produced by the liver), and the fluid which he received during his support during and after the operation. Although his kidneys and liver function tests were normal before the operation, the lab results [do] not reflect the absolute function of these vital organs almost always, and they may be affected temporarily under severe stress, resulting in the drop of the level of the serum protein and albumin, which is very common in these cases. The above factors may lead to changes in the fluid shift within the body. The perineal wound was the weakest point in the domain of the abdomen and [Mr A] began to lose fluid through it. This was managed initially by changing the perineal wound pads and bed covers. I felt uncomfortable seeing him wet from the perineal wound, which would lead to skin damage. The next day I passed a drain through the perineal wound and kept it inside. It was draining well, he was dry, and there was no need for changing the pads frequently. When he developed the fever, I removed the drain to prevent contamination. I didn't suture the wound but kept it draining for 2 days. Later on when I found the temperature was under control, I decided to suture it to reduce the loss of fluid. I was carefully watching for adverse effects. These measures seemed to be working until he collapsed. At that time the sutures were removed, a minimal amount of fluid drained and the wound was kept open.*

*On many occasions I wondered whether the fluid that was draining from the perineum was all of it due to the ascites or some urine or other fluid with it. At one occasion [it was] a nurse who was taking care of [Mr A] who raised this. On several occasions I smelled it but it didn't smell as urine. Sending a sample to be tested in the lab was not applicable because the presence of urine can't be confirmed when the fluid is mixed with significant amount of blood and serum. The fluid started to reduce in amount and the urinary catheter was bringing satisfactory amount of urine and on many days more than the acceptable total daily urine output. In addition to that the urine from the urinary bladder was clear. All these observations assured me to wait and see. However, I was planning to investigate the matter further if it remained unchanged. When [Mr A] collapsed and transferred to the ICU in [the second public hospital] this matter was not taken further. It was only investigated when [Mr A] was transferred from the ICU of [the third public hospital] to the general surgical ward in that hospital and after his condition was more stable. He had a cystogram and a urethrogram that showed an intact urinary bladder and urethra. They suspected a ureteric injury and therefore consulted a Urologist from [the second public hospital]. [Dr I] called me before assessing the condition of [Mr A] and we discussed the matter over the telephone. We had another discussion later on and we also discussed the various options if ureteric injury was unfortunately confirmed. Because*

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*[the third hospital's] Radiology refused to perform Intravenous Urography (IVU) to study the urinary tract, [Mr A] was transferred to [another public hospital] and had cystoscopy with catheterisation of the right ureter. The catheter only passed for 3 cms. Later on Mr A had an IVU at [the second public hospital] Radiology that confirmed the injury to the right ureter. This was later on treated by one of the Radiologists at [the second public hospital] Radiology by inserting a catheter through the skin to drain the right kidney (nephrostomy).*

*Explanation – Right Ureteric Injury*

*The most likely explanation for the right ureteric injury is that it was involved with the recurrent disease and the previous dense scarring. Apparently it was cut at the same area where there was severe bleeding on the right side of the pelvis. When the bleeding points were controlled the area was observed for a while until it was dry. Certainly, at that time there was no evidence of urine leakage. Also, the drain that was left in the pelvis ceased bringing any fluid after 3 days, and during the 3 days' observation period, it was draining diminishing amounts of fluid until it stopped, that is why I removed the drain. After removal of the drain, I didn't suture the wound but kept it draining for 2 days. Later on when the temperature was under control I decided to close the drain area to reduce the loss of fluid. I was watching carefully for adverse effects. These measures seemed to be working until [Mr A] collapsed with a pulmonary embolism. At that time the sutures were removed, a minimal amount of fluid drained and the wound was kept open. Unfortunately [Mr A] developed several other complications, which didn't allow time to further investigate the persistent fluid drainage through the perineum.*

*Post-operative Adjuvant Therapy*

- 8. In regard to the possible post-operative therapy for his cancer, this matter was fully discussed with [Mr A] before the operation and with his family after the operation. He had a recurrent cancer of the rectum, which carries poor prognosis. After surgical resection, the median survival is estimated to be around 16 months. Because of the significant delay in his presentation, and the inability of the preoperative investigations to pick up small metastases, recurrent disease might develop any time later on. Even if there was a chance for him to receive any adjuvant therapy, there is no guarantee of controlling his disease permanently.*

*I have previously expressed my regrets to [Mr A] and his family for the difficult course that he has had. I would be happy to provide any further information requested."*

*Complaint made to the public hospital*

On 20 April 1999 Ms C, Mr A's daughter, and several other members of his family wrote a letter of complaint to the public hospital about the care provided at the hospital. Ms C advised me that shortly after this letter was posted, they received a phone call acknowledging their complaint, but no written acknowledgement was ever received. Upon ringing the hospital Ms C was informed that a report had been written, but that Mr A's consent was needed before this would be released. Shortly thereafter Ms C called the hospital again and was informed that staff would prefer to have a meeting to discuss the complaint.

On 11 May 1999 several members of Mr A's family met with Dr E, surgeon, and Ms J, Hospital Services Manager, to discuss the complaint. At this meeting a copy of a report completed by Dr D was discussed and the family asked that amendments be made. Ms C stated that she was informed that a copy of the report would be forwarded as soon as the amendments had been made.

On 21 May 1999 Ms C was forwarded a copy of the minutes from her meeting with Ms J and Dr E and answers to questions she and her family had posed to the hospital. On receipt of the minutes, Ms C rang the hospital and asked why Dr D's report had not been attached. Ms C said that she was told that it had been decided not to forward a copy to her. Ms C contacted a solicitor who advised her of her rights under the Official Information Act and the Privacy Act, and also suggested that she contact an advocate. Ms C stated that her lawyer was the first person to tell her of her rights and that the advocate was the first person to tell her that her father had rights as a patient.

Ms J advised me that the public hospital took the complaint from Mr A's family very seriously and that, although no written acknowledgement was sent, the fact that several phone calls were made and a meeting was held on 11 May 1999 reflects the seriousness with which the complaint was treated. Ms J stated that Mr A would have received information about the role of the Commissioner in his information pack when he was admitted to the hospital. This information is supplied on admission as a matter of course. Ms J further stated that contact details for the Commissioner are included on the standard complaint acknowledgement letter, and that it was an unfortunate consequence of holding a meeting instead of supplying a written response that this information was not posted.

Ms J stated that at no time was the family informed that a report had been completed on Dr D's care. Ms J advised that the family was told that a timeline of Mr A's care was being prepared but that when the family obtained a full copy of Mr A's notes on 11 June 1999, they were informed that, as the timeline was no longer necessary, it would not be provided. A letter to Mr A from Ms J on 11 June 1999 stated:

“As we are sending you the notes, I have not forwarded the timeline – which was in effect a copy of the notes integrated in sequence.”

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## Independent advice to Commissioner

The following expert advice was obtained from Professor Iain Martin, an independent general surgeon:

*“I, Iain Gregory Martin, have prepared this report at the request of the Health and Disability Commissioner. It details the care received by Mr A during the course of treatment for a recurrent rectal carcinoma between the dates of 9<sup>th</sup> March 1999 and 13<sup>th</sup> May 1999. I have prepared this report using hospital notes from [three public hospitals]. The report will comprise four parts:*

- 1. a chronological summary of the relevant events*
- 2. my interpretation of these events*
- 3. answers to specific questions raised by the Commissioner’s office*
- 4. my opinion as to the standard of care in this case.*

### **Part 1: Chronological Summary**

- 9<sup>th</sup> March 1999. [Mr A] was seen in the surgical out-patient clinic of [the first public hospital] by [Dr D], locum consultant general surgeon. He had been referred by his general practitioner ... with a complaint of rectal bleeding. It was noted by [his GP] that [Mr A] had undergone an anterior resection for a rectal carcinoma in December 1996. The relevant finding on clinical examination was that of a recurrent rectal cancer lying some 7-8cm from the anal verge. This was biopsied and a CT scan arranged.*
- 11<sup>th</sup> March 1999. [Mr A] had a CT scan of abdomen and pelvis. This demonstrated the rectal tumour but showed no evidence of metastatic disease.*
- 18<sup>th</sup> March 1999. [Mr A] was again seen by [Dr D] in surgical outpatients. The diagnosis and implications of the diagnosis were explained. It was arranged to admit [Mr A] for further surgery; the plan being, if possible to carry out an abdomino-perineal excision of the rectum.*
- 22<sup>nd</sup> March 1999. [Mr A] attended the pre-assessment clinic prior to admission for surgery.*
- 25<sup>th</sup> March 1999. [Mr A] was admitted to [a ward] of [a public hospital] for his planned surgery.*
- 26<sup>th</sup> March 1999. [Mr A] underwent surgery for recurrent rectal carcinoma. The operation was performed by [Dr D], assisted by [Dr F]. Anaesthesia was started at 09:15 and the operation finished at 16:00. This was clearly a difficult operation with adhesions from the previous surgery. Significant bleeding was encountered with 7325ml of measured blood loss. The bleeding was associated with significant hypotension (systolic BP 60mmHg). An*

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*iatrogenic injury [an injury caused by treatment or diagnostic procedures] to the posterior wall of the bladder was noted which was repaired intra-operatively. [Mr A's] surgery was then completed as planned as an abdomino-perineal excision of the remaining rectum. A colostomy was fashioned at the end of the operation. Following the operation [Mr A] was transferred to the intensive care unit for stabilisation and electric overnight ventilation.*

- *27<sup>th</sup> March 1999. [Mr A] was reviewed on the intensive care unit by [Dr D]. He was noted to be stable. A low urine output was reported to have responded to frusemide. Nursing notes document stable condition.*
- *28<sup>th</sup> March 1999. [Mr A] was reviewed by [Dr D]. He was noted to be stable but to have a distended abdomen. He was also noted to have a new cardiac murmur and to be having some ectopic heartbeats. In addition to a number of routine post-operative instructions, Fragmin was restarted at a dose of 2500IU day. On reviewing the observation charts, it is clear that [Mr A] was pyrexial with a temperature of 38°C on the night of the 28<sup>th</sup> March.*
- *29<sup>th</sup> March 1999. [Mr A] was still on the intensive care unit. He was stable and breathing well. No specific changes were made to his management.*
- *30<sup>th</sup> March 1999. [Mr A] was noted to be somewhat improved. He had passed some flatus via his colostomy and hence was started on some oral fluids. No other specific changes in management made.*
- *31<sup>st</sup> March 1999. [Mr A] was reviewed by [Dr D]. He was noted to have been vomiting, to have an oozing perineal wound and a distended abdomen. He was also noted to have the clinical sign of shifting dullness, an indication of fluid accumulation within the abdominal cavity. It is noted that the serum albumin [a major protein in blood plasma] had fallen to 19g/l.*
- *1<sup>st</sup> April 1999. [Mr A] was reviewed by [Dr D]. Noted to be improving and commenced on diet. Between one and two litres of fluid were passed from the perineal drain. [Mr A] was again pyrexial [feverish] with a temperature of 38°C.*
- *2<sup>nd</sup> April 1999. [Mr A] was again reviewed by [Dr D]. He continued to pass large volumes of clear fluid from the perineal drain. Again he had a spike of temperature up to 37.6°C.*
- *3<sup>rd</sup> April 1999. [Mr A] was reviewed by [Dr D]. The perineal drain continued to produce large volume of clear fluid. [Mr A] had a spike of fever up to 38.5°C. 2 stitches were placed by [Dr D] in the perineal wound.*

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- *4<sup>th</sup> April 1999. [Mr A] was far less well. Noted to be pyrexial, breathing rapidly and tachycardic. He was commenced on intravenous antibiotics and intravenous fluids and the perineal drain removed. He was reviewed by [Dr D]. [Mr A] was transferred to the intensive care unit for observation. Large volumes of clear fluid continued to drain from the perineal wound.*
- *5<sup>th</sup> April 1999. [Mr A] remained unwell. He had an irregular fast heart beat (atrial fibrillation). He was again pyrexial. The antibiotics were continued. Large volumes of fluid were again noted to be draining from the perineum. His venous white blood cell count increased to  $38.5 \times 10^9/l$  (upper limit of normal 10.5).*
- *6<sup>th</sup> April 1999. [Mr A] remained unwell but perhaps slightly improved and was transferred back to the general surgical ward. He continued to have a swinging pyrexia and the profuse drainage of perineal fluid. Cultures from blood taken on 4<sup>th</sup> April showed *Enterobacter cloacae* [a common bacteria]. His antibiotic treatment was changed to ciprofloxacin on the basis of this culture. He was reviewed by [Dr D].*
- *7<sup>th</sup> April 1999. [Mr A] continued to be unwell. The swinging pyrexia was again seen. He was again noted by [Dr D] to have a tachycardia consequent upon atrial fibrillation and tachypnoea. The perineal wound was again noted to be draining large volumes of clear fluid. It was sutured again by [Dr D]. He was noted by [Dr D] to be acidotic and treated with intravenous sodium bicarbonate. I was not able to find laboratory evidence of the acidosis in the results.*
- *8<sup>th</sup> April 1999. [Mr A] remained unwell. He continued with the swinging pyrexia. He was reviewed by [Dr D] who ordered an albumin infusion. A chest x-ray was noted to show some left basal collapse and an effusion. It was though[t] that his temperature originated from the chest and the dose of ciprofloxacin was increased.*
- *9<sup>th</sup> April 1999. [Mr A's] condition remained much the same. The pyrexia continued.*
- *10<sup>th</sup> April 1999. At 11:40am [Mr A] collapsed with a cardiac arrest. He was resuscitated by the medical and nursing team and transferred intubated and ventilated to the intensive care unit. Following initial stabilisation, [Mr A] was transferred to [the second public hospital] intensive care unit. On arrival in [the hospital] he was felt to be in septic shock. CT scans of chest and abdomen were arranged along with a surgical review. The surgical review conducted by [a] surgical registrar supported a diagnosis of septic shock secondary upon intra-abdominal infected collections of fluid. The CT scan of the chest showed evidence of multiple pulmonary emboli and that of the*

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*abdomen of multiple collections. Radiological drainage of the abdominal collections was performed.*

- *11<sup>th</sup> April 1999. [Mr A] remained very unwell with evidence of ongoing sepsis and poor renal function. He was stabilised somewhat and commenced on a heparin infusion to treat his pulmonary emboli.*
- *12<sup>th</sup> April 1999. [Mr A's] condition deteriorated. He was more septic and his renal function had deteriorated. In view of the worsening sepsis he was taken back to the operating theatre by [a] consultant surgeon. A further laparotomy was performed. Several collections of purulent fluid were found in the abdominal cavity, together with some old blood clot around the spleen. The collections were drained and the peritoneal cavity lavaged with warm saline. Post operatively he returned to the intensive care unit.*
- *13<sup>th</sup> April 1999. [Mr A] remained profoundly unwell. He was in renal failure with a significant metabolic acidosis. He had clear evidence of ongoing sepsis. He was requiring inotropic support [support for the heart muscles] to maintain an adequate blood pressure and a frusemide infusion to try to increase his urine output. The peri-oral ulceration that had started in [the first public hospital] was reviewed by a dermatologist (the name and signature is cut off the photocopy I received). They believed this was due to bacterial / fungal infection and he was started on some topical treatment with antiseptics and antibiotic cream.*
- *14<sup>th</sup> April 1999. [Mr A] remained critical but stable. He continued to be managed on the intensive care unit.*
- *15<sup>th</sup> April 1999. [Mr A] underwent the insertion of a vena caval filter, a device inserted into the major vein of the body to prevent further blood clots moving to his lungs. During this procedure he had an episode of very fast irregular heart beat requiring treatment. He continued to require intensive care support.*
- *16<sup>th</sup> April 1999. [Mr A] remained on intensive care in a critical but stable condition.*
- *17<sup>th</sup> April 1999. Because of pressure on the [the second public hospital] intensive care unit, [Mr A] was transferred to [the third public hospital] intensive care unit. His condition had improved somewhat and he no longer required ventilation.*
- *18<sup>th</sup> April 1999 – 30<sup>th</sup> April 1999. [Mr A] remained in [the third public hospital]. His condition, with some fluctuations, slowly improved, but he continued to drain 1-2000mls of clear fluid from the perineum each day. It*

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*was recognised that the fluid draining from the perineum was urine. He was referred to [the second public hospital] for a Urology opinion.*

- *5<sup>th</sup> May 1999. An intravenous urogram was performed which indicated a right ureteric injury and extravasation of contrast from the bladder on the right hand side.*
- *10<sup>th</sup> May 1999. [Mr A] had a tube placed (nephrostomy) under x-ray control into the collecting system of the right kidney. Following this the drainage of urine from the perineum ceased.*
- *13<sup>th</sup> May 1999. [Mr A] was discharged from hospital.*

### **Part 2 – My interpretation / summary of events**

*[Mr A] had a cancer of the rectum treated surgically in 1996. Histological examination showed that the tumour had been excised completely and that none of the removed lymph nodes were involved. Unfortunately as is the case in between 5 and 20% of such patients, [Mr A] suffered a local recurrence of this tumour in 1999. Following surgical investigations and staging with CT scan, [Mr A] underwent further surgery to remove the recurrent tumour. At operation, the tumour was found to be more advanced than anticipated and extensive bleeding occurred during the operation. Also during this surgery the bladder was damaged and repaired. It is my belief from the description of the location of the injury that the ureter entering the right side of the bladder was injured at the same time. Pathological examination of the resected recurrent tumour showed that the tumour had been incompletely excised with tumour found at the radial resection margin.*

*Post operatively, [Mr A] had evidence of ongoing infection which for 10 days from 31<sup>st</sup> March to the 10<sup>th</sup> April showed the swinging pyrexia consistent with an infected collection. At the same time, [Mr A] was noted to have extensive fluid drainage from the perineum and ascites; my interpretation is that urine was leaking from the damaged ureter into the abdominal cavity and from there out through the perineal wound. Some of this urine remained in the abdomen as infected collections of fluid, eventually precipitating [Mr A's] collapse with overwhelming sepsis. The events that followed document the slow recovery of a patient with an episode of severe sepsis and the treatment of the urinary tract injury. During this illness [Mr A] developed a deep vein thrombosis which led to several pulmonary emboli. He also suffered from significant cardiac problems, all of which I believe are secondary to the sepsis and pulmonary emboli.*

### **Part 3 – Answers to specific questions**

- 1) *Was one surgeon appropriate for an eight hour operation? I do not feel that it is inappropriate for one surgeon to perform an eight hour operation.*

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*Many modern complex procedures last for 6-8 hours and are often carried out by one consultant. I do not believe that this represents a breach in the standard of care.*

- 2) *Should the surgeon have called for assistance? This is very difficult to answer objectively. Although this was a difficult operation with considerable bleeding, the surgeon may have felt in control throughout the operation. Whilst with the benefit of hind sight it may have seemed desirable to have sought assistance, I do not believe that failure to seek assistance represents a breach in the standard of care.*
- 3) *Was the ureteric injury in itself a breach in duty? There is no doubt that the right ureter was injured during the operation but this in itself is not a breach of standards. This was a technically very difficult operation and even at far more straight forward pelvic surgery, the ureters can be injured.*
- 4) *Were the listed complications a result of the operation? All of the listed complications were a direct or indirect results of the operation and the subsequent severe sepsis. Essentially they all resulted from the damaged ureter or the ensuing sepsis. I do not believe that I can give meaningful figures as to risks of these complications in such circumstances; however with such major surgery there is a real and appreciable risk of major complications and death even when performed meticulously.*
- 5) *Should the ureteric injury have been detected earlier? The answer to this question is yes. Whilst the injury was not recognised at operation, the persistent drainage of large volumes of clear fluid from the perineum should have alerted the surgeon to the possibility of a urinary fistula, particularly given the intra-operative bladder injury. A test of urea content of the fluid would have indicated that this was urine and this probably could have occurred within the first 4-5 days of surgery.*
- 6) *Should action have been taken regarding the continuous high temperatures? From the 4<sup>th</sup> post operative day [Mr A] had a swinging pyrexia. In a patient who has recently undergone major pelvic surgery, this should have alerted the surgeon to the possibility of an abscess or infected collection. This should have been investigated and in 1999, a CT scan was the investigation of choice for such collections.*
- 7) *Should a chest x-ray have been performed on [Mr A's] readmission to [the first public hospital] ICU? At that stage [Mr A] was profoundly unwell and hypoxic and I believe that a chest x-ray should have been part of the routine work up at that stage. That having been said I do not believe that failure to perform the x-ray had a material impact upon the outcome of the patient.*

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- 8) *Should the perineum have been sutured? I do not think this point is that relevant when discussing the standard of care. The major issue was failure to recognise the possibility of a urinary tract injury and suturing the perineum had no impact upon [Mr A's] clinical course.*
- 9) *Should additional nutrition have been provided? I believe that either naso-jejunal or intravenous nutrition should have been started at or around day 8-10 when it was clear that [Mr A's] recovery was not straightforward. I do not believe that this would have prevented any of the subsequent complications but it may have reduced their severity or shortened the recovery period.*
- 10) *Should other measures have been taken to prevent a pulmonary embolism. It is important to recognise that all treatments designed to prevent post-operative venous thrombosis offer risk reduction not risk removal. Pelvic surgery for cancer places the patient at high risk of such an event but almost all surgeons would not use any other treatment other than low dose heparin or low molecular weight heparin such as Fragmin. This drug was administered at a dose of 2500IU / day which is recommended for lower risk patients (see enclosed data sheet information). It was elected not to give [Mr A] a higher dose because of the severe bleeding he had suffered; a reasonable clinical decision.*
- 11) *Should the pleural effusion have been drained? The effusion was a reaction to [Mr A's] severe illness and almost all patients with such severe sepsis will have some evidence of pleural effusion. Not all patients have a drainage of these effusions and it is a matter of judgement at the time as to whether drainage is required. I do not believe that not draining this effusion was a breach in the standard of care.*

#### **Part 4 – Opinion as to the standard of care**

*The management of recurrent rectal cancer is a difficult and complex task. I have enclosed a review article published in 1998 (contemporaneous with the case) [Miller AR, Multidisciplinary management of recurrent colorectal cancer. Surgical Oncology 7 (1998) 209-221] which highlights many of the management issues. It is my belief that such cases are best managed within the context of a multidisciplinary specialist cancer team because of the issues involved, a view supported by the literature. I do not feel that I can fairly comment on whether this would have been standard practice in New Zealand in 1999 as at that stage I was working in the UK. Both in the UK and the USA the involvement of a multidisciplinary team would have been the standard approach.*

*[Mr A] was assessed appropriately using CT scanning. Although now we would always add in a magnetic resonance scan, I do not believe that this was the case*

*in 1998-99. There appears to have been a full and frank discussion of the magnitude of further surgery with [Mr A] by [Dr D].*

*The operation was clearly technically difficult and the ureter and bladder were damaged intraoperatively. As I have indicated above, I do not believe that the occurrence of such an injury in itself represents a breach in the standard of care.*

*Post-operatively [Mr A's] course was complex and stormy. There is no doubt that [Dr D] kept a very close watch on [Mr A's] progress and was meticulous in his notes. There are two areas in which I believe that the care received by [Mr A] was compromised. Firstly the failure to recognise the persistent urinary leak and secondly the failure to act on a persistent swinging pyrexia. As a consequence of these two events, [Mr A] suffered a severe septic insult significantly delaying his recovery.*

*The pulmonary embolism was an additional complication. I do not believe that the occurrence of this complication represents any breach in the standard of care. [Mr A] received low molecular weight heparin prophylaxis, albeit at the lower recommended dose (a decision made on reasonable clinical grounds). Such treatments reduce risk but do not remove risk of venous thrombo-embolism.*

*I feel that nutritional needs should have been assessed earlier in the post operative period and either naso-gastric, naso-jejunal or intravenous nutrition instituted. Whilst this would not have stopped the post operative complications it may well have attenuated their course.*

*In summary I believe that [Dr D] is a caring and dedicated surgeon who failed to recognise a significant complication of a major pelvic operation which resulted in a prolonged hospital stay and recovery for the patient.”*

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## **Response to Provisional Opinion**

In response to my provisional opinion Dr D stated:

“There are a number of matters that I wish to address, and these are as follows, using your headings:

### **1. Diagnosis of Ureter Injury**

[Mr A] was producing good amount of urine that was draining through the catheter, which was placed in the urinary bladder. As I said in my response to you, the fluid contained blood and serum. I discussed this specifically with our laboratory, in terms of whether or not it was possible to analyse

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urine in such a composite of fluid. They advised me that it was difficult to analyse, and would be impossible to say with 100% certainty whether or not the fluid was urine.

If I had seen persistent drainage of large volumes of clear fluid with low urine output, then this would have alerted me more to the possibility of a urinary fistula, however that was not the presentation that [Mr A] had.

I would also like to point out that the discharge from the perineum was not readily diagnosable. This was also borne out by [Mr A's] transfer to [a second public hospital]. While there was some discharge from the perineum at the time that [Mr A] was managed in [the second public hospital], [Mr A's] ureteric injury was only discovered when he was transferred to [the third public hospital].

## **2. Temperature Fluctuations**

[Mr A] was treated with prophylactic antibiotics, and tested continuously for infection and managed with any necessary available investigations and modifying the usage of antibiotics when necessary. After a complicated surgical procedure similar to the one [Mr A] had, the patient usually has several connections, which include a central venous line, a peripheral venous line, a urinary catheter, and drain. In addition to that there is the inevitable serosanguinous/lymphatic fluid collection in the dead space in the pelvis as a result of the removal of the rectum. All of these factors will contribute to some degree of a rise in the temperature.

Your opinion says that I should have arranged a CT Scan to investigate the possibility of ongoing intra-abdominal infection. No doubt, your adviser is not aware that at the time that [Mr A] was at [the first public hospital] it had no CT Scanner. Therefore we would have had to consider whether or not the limited information that could have been obtained from a scan would have been worth transferring [Mr A] to [the second public hospital] or [a private radiology centre] for that scan.

Because, at that time, [Mr A's] condition was relatively stable, he would have had to be travelled by road as opposed to helicopter, to [the second public hospital] over [a mountain range]. One has to balance the need for such a scan against the possibility of a diagnosis being provided, and against any deterioration in the patient's condition caused by travelling what is a reasonably arduous journey.

It has been assumed by your adviser that at the time of [Mr A's] collapse, he was suffering from septic shock. In my view, technically and clinically, this was not the case. I believe that [Mr A] collapsed from a pulmonary



embolism. This is because I spoke to the nurse who was on over the weekend of [Mr A's] collapse. She said that [Mr A] went down to the x-ray department to have a follow-up chest x-ray according to my request, and on returning back to the ward using a wheelchair he wanted to have a shower. Because he was feeling well, he wished to do that by himself, and walked through the corridor to the shower and then collapsed while he was taking his shower. In my view, that is not consistent with a deteriorating state prior to septic shock, but is more consistent with a sudden event consistent with the development of a pulmonary embolus. I understand that pulmonary embolus was the diagnosis made by the doctors who were in charge of resuscitating [Mr A] in [the second public hospital], and that the CT scan subsequently taken at [the second public hospital] showed pulmonary emboli. When the diagnosis of the ureteric injury was diagnosed at [the third public hospital] the general condition of [Mr A] was stable in spite of the fact that there was a discharge from the perineum.

### 3. Nutrition

The day after surgery, [Mr A] was allowed to have something to drink, as he was suffering neither from nausea nor vomiting. My practice in this situation is to allow fluids in small quantities and monitor that intake carefully. If I found the patient is tolerating the oral intake well, then I increase the quantity and change it to a soft then a full diet. If this was well tolerated then usually it takes around five days after the operation. At no stage during the 8 days post-surgery was [Mr A] nil by mouth. [Mr A] was, very shortly after the surgery allowed to eat normally, and I understood was doing that. He was moving around and his colostomy was working well. Two days before he collapsed, he had a skin reaction around his mouth which gave him some difficulty in swallowing, however his food and fluid intake, to my understanding, was not limited and he was allowed to eat and drink as he required. If there had been a delay in feeding, i.e. [Mr A] had been completely nil by mouth, then of course he would have received additional nutrition. That, however, was not the case by [Mr A], and my understanding was that although there was difficulty in eating, [Mr A] was still able to eat and drink, supplemented by intravenous fluids and the administration of intravenous vitamins and essential elements.

I would also like to address a comment that your adviser has made regarding falls in protein levels. All patients undergoing major surgery have their serum protein and albumin checked pre-operatively. In my experience and the experience of others these levels almost exclusively fall after surgery in all cancer patients. The liver produces the albumin part of the protein, and apparently it needs some time to recover following surgery. Even if patients were able to eat full meals very satisfactorily, the rise to normal levels will take some time depending on several factors. As a result of the lowered

level of the protein and albumin, and the intravenous fluids administered during the surgical procedure and during the post-operative period, several patients have some trapping of fluid in their body which will be mobilised in due time. Intravenous albumin is not recommended because the benefit only lasts for a few hours and is then excreted with the urine.

I would note, that when [Mr A] went from [the first public hospital] to [the second public hospital], he did not have any significant fluid collection in his lungs, and the changes shown in the x-ray were a reaction in the base of the left lung, which did not need any treatment other than chest physiotherapy besides antibiotics. During [Mr A's] presence in [the second public hospital's] ICU no drainage of fluid from the chest was carried out.

I went from [the first public hospital] to the ICU in [the second public hospital] and visited [Mr A] and spoke to his wife at length. I also reviewed the CT scan, which showed the pulmonary emboli. I continued to contact the Hospital and my colleagues the anaesthetists who were in charge about [Mr A's] progress, until he was transferred to [the third public hospital]. My contacts about his progress continued until I was advised that he did not wish to have me further associated with his care. I respected that request.

You have made remarks that show that your provisional opinion is that I showed a serious lack of clinical competence. As you might imagine, I do not accept that, particularly when it is apparently judged on the basis of one case, without knowing my background in detail. I would like to be co-operative in assisting in supporting the rights of [Mr A] and his family and all other patients, but I would like to do so without jeopardising my rights as a human being and as a caring and dedicated surgeon. We shouldn't forget that [Mr A] had a delayed, recurrent rectal cancer. There were several people and factors, which contributed to the recurrent disease and the delay until the diagnosis was reached. To assist you with an assessment of my standard and practice, I would like to mention that in spite of my vast experience in my field before coming to New Zealand, I was very pleased to work over a one year period under the supervision of ... at [a private hospital] and ... at [a public hospital]. It was only after their (and other colleagues) high recommendations that the New Zealand Medical Council allowed me to practise general surgery in this country. I also enclose my current curriculum vitae, and many other relevant documents, which clearly show my serious intention to advance and progress and my dedication to the continuous medical education. Since I started working in [the public hospital], I picked up the management and performing most of the major cases and my colleagues and my patients will testify the quality of care and results that I achieved. I enclosed a sample of that workload which is relevant to the diagnosis of [Mr A].

Please take my comments into account. I would be grateful if you could show your adviser my comments, as they may have some bearing on the advice that he has given.”

Dr D’s legal advisor made the following submission on his behalf in response to my provisional opinion:

“It is my submission that the breaches that you have found in your provisional opinion cannot be supported in light of the factual situation as explained by [Dr D]. In particular, the final paragraph of your opinion is not justified in my submission, as there is no evidence from your advisor that [Dr D’s] treatment of [Mr A] demonstrated as you have said ‘a serious lack of clinical competence’. The material provided by [Dr D] shows to the contrary, a dedicated and caring general surgeon.

It is necessary for you, in my submission, to take into account the practising situation of any doctor about whom a complaint is made, and in particular the resources, or lack thereof, available to that practitioner. This is particularly significant in [Dr D’s] case, as you will see that [the public hospital] did not have a CT scanner at the time of [Mr A’s] admission, and the time relevant to the complaint.”

[The public health service] responded to my provisional opinion as follows:

“Thank you for giving us the opportunity to respond to your findings in the investigation of [Mr A’s] treatment by [Dr D] and [the public hospital].

We should like to comment on:

- A. Three aspects of the clinical care provided by [Dr D]:
  - 1. The issue of whether or not a chest x-ray should have been requested.
  - 2. The issue of the role of a CT scan.
  - 3. The issue of nutrition.
- B. The interpretation that your findings call into question [Dr D’s] clinical competence.
- C. [Dr D’s] and [the public hospital’s] activities to ensure [Dr D’s] clinical competence.
- D. Your recommendations.
- A. Three aspects of the clinical care provided by [Dr D].**

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1. [Dr D] undertook a very careful and comprehensive examination of [Mr A's] respiratory system and determined that a chest x-ray could be obtained the following morning. This may be considered to be a brave decision but when obtained on 05-04-99 the x-ray did not alter clinical management in any way.

Professor Martin did not believe 'that failure to perform the chest x-ray had a material impact upon the outcome of the patient'.

The chest x-ray findings did not instigate any change in decision making.

2. In March 1999 [the public hospital] did not have a CT scanner. The investigation however is always available to clinicians at [the public hospital] but did at that time involve the patient travelling to [another city]. The clinical inconvenience to the patient of having an ambulance journey compared to 'a trip down a hospital corridor' inevitably influences the clinician's decision. We have found that since having a CT scanner at [the public hospital] the practice of requesting scans has changed. Criticism of the investigation of [Mr A's] postoperative illness should be made in the light of the resources available and their location at the time.

[Mr A's] progress, including his temperature, was closely monitored by [Dr D]. When a CT scan was performed in [the second public hospital] it showed 'multiple collections' which were drained radiologically and found to be collections of 'serosanguinous fluid'. No mention of pus or the degree of infection is made. The CT findings themselves did not initiate a laparotomy and did not lead to the diagnosis of the urinary leak.

3. [Dr D's] notes make it clear that the patient's nutrition was regularly reviewed. The role of oral, nasogastric and intravenous nutrition were all considered. [Mr A] did have an oral intake and it was anticipated that this would increase. [Mr A's] pyrexia caused [Dr D] to be sensibly cautious in the commencement of intravenous feeding via a central venous catheter. It is always hoped that oral intake will improve and obviate the need for supplementary feeding. Only in retrospect can a clinician wish that supplementary feeding had been commenced earlier. This also assumed that supplementary feeding will be uncomplicated. The complications of inserting a central venous line and of feeding regimens can, sometimes, outweigh any benefit.

**B. The interpretations that your findings call into question [Dr D's] clinical competence.**

[Dr D] and the [public hospital] acknowledge that the management of [Mr A's] condition was complex, that different decisions could have been made and that the ureteric injury was not recognised. We would suggest,

however, that the scenario is not adequate evidence to call into question a surgeon's competence and that your determinations are somewhat harsh.

Professor Martin suggests that the evidence shows [Dr D] to be 'a caring and dedicated surgeon' who failed to recognise a significant postoperative complication. Indeed [Dr D's] documented progress notes, his documented decision making and his personal involvement in all aspects of [Mr A's] care would not support the questioning of his competence.

The enclosed audit of [Dr D's] colorectal work is evidence that [Mr A's] complicated course was the exception in the otherwise very satisfactory record of a dedicated surgeon.

**C. [Dr D's] and [the public hospital's] activities to ensure [Dr D's] clinical competence.**

Prior to his appointment by the [public hospital] [Dr D] had gained excellent surgical reputation at [a public] and [a private] hospital as evidenced by the opinions of his New Zealand colleagues in those hospitals.

Recently the medical council requested reports regarding [Dr D's] suitability for vocational registration. *Attachment 1* is a copy of the recommendations of his surgical colleagues in [his district].

[Dr D] conscientiously maintains his continuing professional development activities. Evidence of this is attached [*attachment 2*].

The above activities are both facilitated and supported by the [public hospital].

[Dr D] was granted the following leave by the [District Health Board] for continuing education and quality assurance:

1999	80 hours
2000	120 hours
2001	88 hours

We have extracted from the surgical audit system [Dr D's] activity in colorectal surgery. This documentation is attached [*attachment 4*].

We propose to have this documentation reviewed by a New Zealand surgeon who is at present in a locum position at [the public] hospital.

The [public hospital], having received your draft report, having had some independent external advice and having had internal discussions with surgical and anaesthetic staff will clarify its role in the management of recurrent rectal cancer.

#### **D. Your recommendations**

In the light of the above comments and evidence we would respectively request that you reconsider both your recommendations and your intentions for further actions.”

The responses of [Dr D] and [the public hospital] were forwarded to my independent advisor, Professor Martin, for review. Professor Martin provided the following additional expert advice:

“At the request of the Health and Disability Commissioner, I Iain Gregory Martin MMd, MD, FRCS, FRACS, Professor of Surgery and consultant general surgeon have provided this supplementary report in case 99/09129/AM. This report has been prepared using written materials provided by the Commissioner’s office together with responses from the surgeon concerned [Dr D] and [the public hospital].

This report deals only with the issues raised following the production of the report by the Commissioner. Four areas have been raised for my comments:-

- 1) The lack of a CT scanner in [the public hospital]. Having seen the response of both [Dr D] and [the public hospital], I do not wish to alter my opinion that the patient [Mr A] should have been investigated for the cause of this sepsis earlier and that CT scanning would have been the investigation of choice. As this investigation modality was not available, [Mr A] should have been transferred to a larger hospital for radiological assessment.
- 2) Nutrition. I believe as I indicated in my report that nutritional supplementation should have been instituted sooner. Clearly, and I do not think this is in dispute, [Mr A’s] nutritional intake was inadequate. Whilst I recognise that total parenteral nutrition is associated with significant risks, in this case enteral supplementation would have been entirely feasible. A fine bore naso-jejunal tube can easily be passed on the ward and feeding commenced. This approach is not associated with the risks of an intravenous cannula. As I indicated in my report the issues of nutritional supplementation should have been considered after 8-10 days at most and [Mr A] was transferred on day 16 post-operatively. The general suggestion by [the public hospital] that it ‘only in retrospect can a clinician wish that supplementary feeding had been commenced earlier’ indicates a level of organisational complacency regarding nutritional issues. In addition I did not indicate that [Mr A] should have intravenous nutrition; in such a case naso-jejunal supplementation would have been cheaper, safer and the preferred option.

[Dr D] raises the issue of serum albumin. I noted in my initial report that the serum albumin had fallen to 19g/l. At no stage did I link this with comments about nutrition. Acute falls in serum albumin after surgery are most usually caused by either the stress response of surgery or sepsis. A serum albumin

as low as 19g/l is unusual as just a consequence of surgery and in my experience is often associated with on going sepsis. I would agree with the comments of [Dr D] in his response letter that it [is] not often of benefit to give albumin intravenously in such patients although I do note that in this case albumin was given by [Dr D]. I fully stand by my comment in the initial report regarding nutrition.

- 3) Difficulty in diagnosing the ureteric injury. Whilst I fully recognise that such an injury can be difficult to diagnose I believe that in this case the diagnosis of ureter injury should have been considered earlier and investigated. Firstly the bladder was injured at the time of surgery which should have kept the urinary tract in the mind of the surgical team. Secondly the volumes of drainage coming from the perineum were far greater than would be usually encountered after such an operation. Finally it is very easy to test the fluid for urea which would usually be considerably higher in the fluid than the blood if this is urine. I recognise that no individual test is 100% accurate in this situation (indeed there is probably no test for any condition which is) but I believe that the possibility of ureteric injury should have been entertained much earlier.
- 4) Other issues. I dispute [Dr D's] interpretation that the swinging pyrexia could have been caused by normal post-operative events. The temperature chart in my mind clearly indicated an ongoing septic process, which with this pattern of temperature most usually indicates an abscess or infected collection. [Dr D] also disputes the fact that [Mr A] was septic when transferred to [the second public hospital]. I would agree that the cardiac arrest itself was finally precipitated by a pulmonary embolism, there is I believe enough evidence to clearly implicate a septic process in this illness. Indeed, both the intensive care team and the surgical team at [the second public hospital] placed sepsis at the top of their list of clinical problems.

In addition I was forwarded copies of [Dr D's] CV showing his clinical achievement and contributions. I was also forwarded audit figures for [Dr D's] colorectal work in [his district]. The CV indicated that [Dr D] is participating in a satisfactory and appropriate programme of continuing medical education. The audit figures seem satisfactory in all but one area with which I have some concern. When the rectal cancers are considered, 26 cases were performed of which 11 (42%) involved excision of both the rectum and the anal canal (abdomino-perineal excision). Whilst the numbers are relatively small most specialist colorectal surgeons would expect between 10 and 20% of their cases to use this approach as opposed to anterior resection where the anal canal is preserved. Whilst this is only one of many markers of 'surgical cancer resection quality control' I was surprised to see quite so many abdomino-perineal resections in the figures; clearly however this could easily be a statistical aberration as a consequence of the low numbers of patients treated. This is an area that should be explored in a competence review if this takes place.

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I would however make one comment and that is that it is very difficult to judge a surgeon's performance on the basis of one case. There is much in the clinical notes to indicate that [Dr D] was deeply involved with the day to day care of this patient and indeed his notes and record keeping were detailed and complete. I would suggest that until a full review of [Dr D's] practice takes place then his overall competence should not be judged deficient on the basis of this one case."

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## **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(1)*

#### *Right to Services of an Appropriate Standard*

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

### *RIGHT 10*

#### *Right to Complain*

...

- 3) *Every provider must facilitate the fair, simple, speedy, and efficient resolution of complaints.*
- 4) *Every provider must inform a consumer about progress on the consumer's complaint at intervals of not more than 1 month.*
- 5) *Every provider must comply with all the other relevant rights in this Code when dealing with complaints.*
- 6) *Every provider, unless an employee of a provider, must have a complaints procedure that ensures that -*
  - a) *The complaint is acknowledged in writing within 5 working days of receipt, unless it has been resolved to the satisfaction of the consumer within that period; and*
  - b) *The consumer is informed of any relevant internal and external complaints procedures, including the availability of -*
    - i. *Independent advocates provided under the Health and Disability Commissioner Act 1994; and*
    - ii. *The Health and Disability Commissioner; and*
  - c) *The consumer's complaint and the actions of the provider regarding that complaint are documented; and*
  - d) *The consumer receives all information held by the provider that is or may be relevant to the complaint.*

...

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## **Opinion: No Breach – Dr D**

### **Right 4(1)**

#### *The operation*

Mr A's family complained that Dr D should not have performed the AP resection by himself and should have asked for assistance when he realised that the operation was going to be prolonged and difficult. Dr D advised that he had a good number of assistants and a very supportive anaesthetist, as well as nursing staff. Dr D also stated that he would have had no hesitation in asking for assistance if he had felt this was needed. My advisor informs me that it is not inappropriate for a consultant to perform an operation of this length and complexity by himself.

#### *The ureteric injury*

During the AP resection surgery Mr A suffered an injury to his ureter which resulted in a number of serious complications. My advisor informed me that an AP resection is a technically difficult operation in which such an injury can occur even when the surgery is performed meticulously. I also accept that the risk of injury was made greater by the recurrent nature of Mr A's cancer.

#### *Suturing the perineum*

Mr A's family complained that his perineum should not have been sutured given that it was still draining excessively. My advisor informed me that suturing the perineum had no impact on Mr A's clinical course and that it is not a relevant consideration when looking at the standard of care in this case.

#### *Preventative measures*

As measures to prevent venous thrombosis, Mr A received physiotherapy, stockings and Fragmin at 2500 units per day. Mr A's family were concerned that these steps were inadequate and failed to prevent Mr A suffering a pulmonary embolism on 10 April 1999. My advisor stated that the type of surgery Mr A underwent placed the patient at high risk of deep vein thrombosis. Steps can be taken to reduce the risk of post-operative venous thrombosis, but these do not remove the risk entirely. My advisor informed me that almost all surgeons in Dr D's place would not have taken the additional steps he took, but would simply have prescribed low dose heparin or a low molecular weight heparin such as Fragmin.

In addition, my advisor stated that the decision to place Mr A on a 2500 unit per day dose of Fragmin was made because of the severe bleeding he had suffered and that this was a reasonable clinical decision.

#### *Draining the pleural effusion*

Mr A's family stated that his pleural effusion, which lasted for three days, should have been drained. My advisor stated that the majority of patients experiencing severe sepsis will have some evidence of pleural effusion and not all will require drainage. My advisor stated that it

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is a matter of clinical judgement whether drainage of a pleural effusion is required. In this instance, the decision not to drain Mr A's effusion was not a breach in the standard of care.

My advisor concluded that Dr D's management of Mr A's surgery, his suturing of the perineum, the steps he took to prevent venous thrombosis and the decision not to drain the pleural effusion were all appropriate. I am guided by my expert advisor. In my opinion, in respect to the matters discussed above Dr D did not breach Right 4(1) of the Code.

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## **Opinion: Breach – Dr D**

### **Right 4(1)**

#### *Diagnosis of ureter injury*

Mr A's family complained that the injury to Mr A's ureter was not detected quickly enough and that it should have been detected once urine began to appear from the wound. Dr D advised that the fluid flowing from Mr A's wound in the days after surgery could have been attributed to a number of causes. Although he considered the possibility that it was urine, Dr D considered that it did not smell like urine. Dr D further stated that it would have been impossible to test the composition of the fluid given that it was mixed with blood and serum.

My advisor informed me that the persistent drainage of large volumes of clear fluid should have alerted Dr D to the possibility of a urinary fistula, particularly given the intra-operative bladder injury. My advisor further stated that a test of the fluid for urea content would have indicated that this was urine and that this could probably have occurred within the first four or five days of surgery.

Mr A's family complained that no action was taken in response to Mr A's continuous high temperature in the days after his surgery. From the fourth day after his surgery Mr A developed a swinging fever. Dr D stated that he provided Mr A with prophylactic antibiotics, tested continuously for infection, and treated the infection with further antibiotics when it was detected. My advisor stated that Mr A's swinging pyrexia should have alerted Dr D to the possibility of an abscess or an infected collection and that Dr D should have arranged Mr A's transport to a centre that offered a CT scanning facility.

#### *Chest x-ray*

Mr A's family stated that a chest x-ray should have been taken on Mr A's readmission to ICU. At this admission Mr A had a high temperature and rapid breathing, and was suffering acidosis. My advisor informed me that a chest x-ray should have been a routine part of Mr A's assessment, but that the failure to perform an x-ray did not have a material impact upon the outcome.

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*Nutrition*

Mr A's family advised that when Mr A was unable to eat because of a thrush infection, he received no additional nutrition. Dr D reported that he did address Mr A's nutritional status in the early stages of his recovery, but that the sudden development of mouth lesions restricted the patient's ability to swallow. Dr D advised that he provided treatment for the mouth lesions and, had Mr A's nutritional status not improved, he would have fed Mr A through a naso-gastric tube. Dr D was cautious about using a naso-gastric tube as this can result in infection and septicaemia; Mr A's collapse occurred before he was able to assess whether it was necessary.

My advisor informed me that Mr A's nutritional needs should have been assessed earlier and that naso-gastric, naso-jejunal or intravenous nutrition should have been commenced at some time between the eighth and tenth post-operative day, when it became obvious that his recovery was not straightforward.

My advisor also stated that although the failure to provide naso-jejunal, naso-gastric or intravenous nutrition from around the eighth to tenth day after surgery would not have prevented the complications, it may have reduced their severity or shortened the recovery period.

My advisor informed me that the failure to act on Mr A's persistent urinary leak, coupled with the failure to act on his fever, resulted in severe sepsis, which significantly delayed recovery. In turn, the development of sepsis directly or indirectly led to complications including:

- excessive drainage from the perineal wound
- severe respiratory distress on 4 April 1999
- a thrush infection
- the development of herpes
- a pulmonary embolism on 10 April 1999
- the distension of his abdomen
- the insertion of a nephrostomy tube into his kidney
- the failure of his kidneys
- cardiac arrest.

I accept the advice of my advisor. In my opinion, Dr D's failure to respond appropriately to Mr A's persistent urinary leak, his fever, and his nutritional needs amounted to a failure to provide services with reasonable care and skill and is a breach of Right 4(1) of the Code.

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## **Opinion: No Breach – the public hospital**

### *Response to complaint*

Mr A's family stated that after complaining to the public hospital, the complaint was not acknowledged in writing within five working days, the family was not informed of the right to make a complaint to the Commissioner, and did not receive a report regarding Mr A's admission to the public hospital, as agreed in a meeting on 11 May 1999.

Ms L, Hospital Services Manager at the public hospital, advised me that the reason for not providing a written response to the complaint made by Mr A's family was that a meeting was arranged instead. Ms L further stated that an unfortunate consequence was that the information about the role of the Commissioner usually supplied with written responses to complaints was not supplied. However, Ms L stated that information about the role of the Commissioner and the rights of patients had been supplied to Mr A on his admission to the public hospital. No report was completed on Mr A's care in response to the initial complaint, but the family was offered a timeline of the care. Ms L stated that when the family was supplied with a full copy of Mr A's notes it was decided that the timeline was no longer needed and the family was informed of this in the letter of 11 June 1999.

Right 10 of the Code outlines a provider's duties in handling complaints. The provider must acknowledge the complaint in writing within five working days, advise the complainant of external complaints procedures including the Health and Disability Commissioner, and provide the consumer with all information held by the provider that is relevant to the complaint (Right 10(6)). I accept that technically, the public hospital did not meet the first of these obligations. However, clause 3 of the Code states that a provider is not in breach if it has taken reasonable actions in the circumstances to give effect to the rights and comply with the duties in the Code. The decision to meet with Mr A's family rather than supply a written response was reasonable. Accordingly, in my opinion, the public hospital's failure to acknowledge in writing the complaint made by Mr A's family is excused.

In respect of the other complaints concerning the manner in which their complaint was dealt with, I am satisfied that the public hospital took appropriate steps to meet with the requirements of the Code. Mr A was supplied with information about his rights and the role of the Commissioner on admission to the public hospital. In addition, the public hospital supplied Mr A and his family with all relevant information relating to the complaint when it sent minutes from the meeting and answers to the family's questions on 21 May 1999, and medical records on 11 June 1999. Accordingly, in my opinion, the public hospital did not breach Right 10 of the Code.

### *Standard of care*

In addition to any direct liability for a breach of the Code, employers are vicariously liable under section 72(2) of the Health and Disability Commissioner Act 1994 for ensuring that employees comply with the Code of Health and Disability Services Consumers' Rights. Under section 72(5) it is a defence for an employing authority to prove that it took such

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steps as were reasonably practicable to prevent the employee from doing or omitting to do the thing that breached the Code.

Dr D was an employee of the public hospital. However, in the circumstances I am satisfied that by implementing a training and continuing education programme, the public hospital took reasonable steps to ensure Dr D remained competent to practise as a consultant general surgeon. Accordingly the public hospital is excused from vicarious liability for Dr D's breach of Right 4(1) of the Code.

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## **Actions**

I recommend that:

- Dr D apologise in writing to Mr A for breaching the Code. This apology is to be sent to the Commissioner and will be forwarded to Mr A.
  - Dr D review his practice in light of this report, in particular his treatment of rectal cancer and his use of abdomino-perineal excision.
  - The Medical Council of New Zealand undertake a review of Dr D's competence to practise medicine.
- 

## **Further Actions**

- A copy of this opinion will be sent to the Medical Council of New Zealand.
- A copy of this opinion with all personal identifying details removed will be sent to the Royal Australasian College of Surgeons for educational purposes.
- I have decided to refer this matter to the Director of Proceedings in accordance with section 45(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any further action should be taken in relation to Dr D.

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## **Addendum**

The Director of Proceedings laid before the Medical Practitioners Disciplinary Tribunal a charge alleging professional misconduct. On 29 August 2003 the charge was upheld by the Tribunal and it ordered payment of \$26,992.69 towards the costs and expenses of and incidental to the investigation, prosecution and hearing. Following an appeal to the District Court on 8 December 2004, a finding of conduct unbecoming a medical practitioner was substituted for the finding of professional misconduct, and Dr D was granted permanent name suppression.

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