Surgical error during laparoscopic cholecystectomy (08HDC03361, 27 February 2009)

General surgeon ~ Gall bladder ~ Laparoscopic cholecystectomy ~ Post-operative complications ~ Standard of care ~ Rights 4(1), 4(5)

A 52-year-old man had a laparoscopic cholecystectomy performed by a general surgeon who was employed as a short-term locum consultant by a district health board (DHB). The man was returned to theatre shortly after midnight as he had developed complications and, during surgery, it was discovered that the general surgeon had cut through the bowel wall rather than the gall bladder wall. Despite further surgery, and transfer to the intensive care unit, the man died a few days later.

It was held that the error was a serious technical error that amounted to a severe departure from the normally accepted standard of intra-operative care for a laparoscopic cholecystectomy patient. The general surgeon was found to have breached Right 4(1).

The DHB's failure was held as a severe departure from the normally accepted standard. The clinical team failed to respond appropriately to the man's worsening postoperative condition. In these circumstances, the DHB breached Rights 4(1) and 4(5).

The general surgeon was referred to the Director of Proceedings. The Director decided not to issue proceedings before the Health Practitioners Disciplinary Tribunal.