Management of gynaecological patient
(14HDC00991, 28 November 2016)

Obstetrician/Gynaecologist ~ Laparoscopic surgery ~ Injury ~ Deterioration ~ Information ~ Documentation ~ Rights 4(1), 4(2)

A woman in her early fifties, who had a left ovarian cyst, was booked to have a laparoscopy performed by an obstetrician and gynaecologist at a public hospital.

The woman saw the obstetrician/gynaecologist preoperatively, and consented to surgery. There is no documentation on file outlining that operative risks specific to the woman were discussed with her. The obstetrician/gynaecologist said that he discussed specific risks of surgery with the woman and provided her with a leaflet. The woman said that the obstetrician/gynaecologist broadly discussed risk and that she could not recall whether any leaflet was provided to her.

Tumour marker blood test (CA125) results were ordered by the obstetrician/gynaecologist and a risk of malignancy index (RMI) calculated in the afternoon following his consultation with the woman. The obstetrician/gynaecologist telephoned the woman about the tumour marker result (which was negative) he had received. The obstetrician/gynaecologist could not recall whether he discussed the RMI score (99). The woman told HDC that he did not discuss it. The telephone call and RMI calculation were not documented.

The surgical procedure was complicated owing to adhesions. An operative injury to the bladder occurred, which was repaired by a urologist called to assist in theatre. The obstetrician/gynaecologist handed over to a second obstetrician and gynaecologist. The woman had a difficult postoperative course. A senior house officer reviewed the woman over the weekend. The senior house officer communicated the possibility of a ureter or bowel injury, instigated a number of investigations, and brought her concerns to the attention of the second obstetrician/gynaecologist, on three occasions, the first by telephone.

The following morning, the second obstetrician/gynaecologist reviewed the woman. His impression was that, potentially, medication side effects explained her nausea. A differential diagnosis of bowel injury was made. The second obstetrician/gynaecologist did not order investigations.

By 12.15am two days later, the woman's urine output had decreased. It had been "minimal to none" over the previous four hours. The laboratory informed the senior house officer that the blood cultures had grown a gram negative bacillus. The senior house officer telephoned the second obstetrician/gynaecologist. He did not review the woman or arrange a surgical review.

It was considered at an early morning team meeting handover that the woman must have a bowel perforation. She was referred to the surgical team. She had a laparotomy that day, and faecal peritonitis from two holes in the sigmoid colon was discovered. The woman had further surgery including a colostomy, and then

additional surgery 48 hours later. She was cared for in ICU and then transferred to the ward. She later developed a fistula from her bladder to the rectal stump. The woman was later discharged to the care of surgeons in another region.

While it was accepted that the first obstetrician/gynaecologist telephoned the woman about the tumour marker result, criticism was made that he discussed the proposed surgery with the woman that morning without the knowledge of important clinical factors (the tumour marker result and a quantified risk of malignancy) — factors that were relevant to a preoperative discussion and her consideration of whether or not to proceed with surgery.

Although it was accepted that some of the first obstetrician/gynaecologist's peers would consider it appropriate for him to have commenced the procedure given his level of skill, adverse comment was made that he did not appreciate, or think critically about, the potential surgical difficulties he might face given the woman's history of extensive adhesive disease.

The first obstetrician/gynaecologist did not meet his obligations to keep clear and accurate clinical and surgical records. Accordingly, he failed to comply with professional standards, and breached Right 4(2).

Postoperatively, there was a delay in the second obstetrician/gynaecologist recognising that the woman might have a bowel injury, given that the possibility had been brought to his attention on more than one occasion, particularly once the blood culture results were available, and he made a decision not to review her or refer her for surgical review. Accordingly, the second obstetrician/gynaecologist failed to provide services to the woman with reasonable care and skill and, therefore, breached Right 4(1).

It was found that the DHB had overall responsibility for the series of deficiencies in care experienced by the woman. In addition, at the commencement of the first obstetrician/gynaecologist's employment, and at the time of the woman's surgery, the first obstetrician/gynaecologist was not made aware of RANZCOG guidelines pertaining to performing advanced operative laparoscopy. The DHB's surgical consent form in use at the time had no space for the purpose of recording risks specific to the patient. There were several administrative shortcomings identified in this case. The DHB therefore failed to ensure that the woman was provided with services with reasonable care and skill, and breached Right 4(1).

It was recommended that the first obstetrician/gynaecologist:

a) Have an independent colleague review a random selection of his surgical consent forms from the last 12 months to report on whether specific surgical risks/concerns for each patient are written on the consent form, and report the results to HDC.
b) Provide HDC with a copy of the template (as recommended by his supervisor) used in his dictation in relation to information discussed in the consent process, to be dictated at the beginning of the operation note and also handwritten on the operation note.

c) Provide a formal written apology to the woman.

It was recommended that in the event that the second obstetrician/gynaecologist returned to New Zealand to practise, the Medical Council of New Zealand consider whether a review of his competence is warranted.

The Commissioner made a series of detailed recommendations to the DHB including requesting an update report on the progress and effectiveness of all steps taken to improve services as a result of this case, including its changes to practise, changes to policy, and the results of surveys and audits of staff compliance with those changes.

The Commissioner also recommended that RANZCOG consider whether the wording of a relevant consensus statement concerning advanced operative laparoscopy requires revision.