# Surgeon, Dr B

# Senior House Officer, Dr C

# A Private Hospital

## A Report by the

## Health and Disability Commissioner

## (Case 06HDC13334)

Health and Disability Commissioner
*Te Toihau Hauora, Hauātanga*

## Parties involved

| | |
|---|---|
| Mrs A (dec) | Consumer |
| Mr A | Complainant/Mrs A's husband |
| Dr B | Provider/Surgeon |
| Dr C | Provider/Senior house officer |
| Ms D | Clinical Coordinator, the private hospital |
| Ms E | Director of Nursing, the private hospital |
| Dr F | Anaesthetist |
| Ms H | Registered nurse |
| Ms I | Registered nurse |
| Dr J | Duty doctor |
| Ms K | Nurse |
| Dr L | RMO |
| Ms M | Registered nurse |
| The private hospital | Provider/Private hospital |

## Complaint

On 8 September 2006, the Commissioner received a complaint from Mr A about the services provided to his late wife, Mrs A, by Dr B and a private hospital.[1] The following issues were identified for investigation:

- *The adequacy and appropriateness of care provided by Dr B to Mrs A in 2003.*
- *The adequacy and appropriateness of care provided by the private hospital to Mrs A including:*
  - *whether there was an appropriate communication system between clinical staff at the private hospital to ensure the safety of patients;*
  - *whether appropriate clinical staff were employed; and*
  - *whether the private hospital had acted appropriately to any concerns that had been raised about Dr B's practice.*

An investigation was commenced on 20 October 2006.

On 1 August 2007, the investigation was extended to include the care provided by Dr C to Mrs A. The following issue was identified for investigation:

[1] The private hospital is owned and operated by a company. References in this opinion to the private hospital include this company.

- *The appropriateness of care provided by Dr C to Mrs A.*

This investigation has taken over 19 months because of the complex issues involved in the case, and the need to extend the investigation to include the care provided by Dr C.

## Information reviewed

Information from:

- Mr A
- Dr B
- Dr C
- Ms D
- Ms E
- The private hospital
- The District Health Board (the DHB)
- Accident Compensation Corporation (ACC)
- The Coroner

Independent expert advice was obtained from surgeon Dr Ian Stewart.

## Information gathered during investigation

*Background*
In March 2002, Mrs A (aged 53) was referred by her general practitioner to surgeon Dr B (in his private practice) with a 10-day history of abdominal pain, associated with abdominal distension, nausea and diarrhoea. Dr B ordered a CT scan, which showed a hiatus hernia, and performed a colonoscopy, which showed sigmoid diverticula.[2] A small benign polyp was also removed from the transverse colon during the colonoscopy.

In April 2002, Mrs A consulted Dr B again with abdominal pain. An ultrasound scan performed on 8 April 2002 showed no biliary disease, and a gastroscopy two days later confirmed the presence of a hiatus hernia and *Helicobacter pylori*.[3] Dr B prescribed omeprazole and two antibiotics (metronidazole and clarithromycin).

[2] Diverticula are pouches formed at weak points in the walls of the gastrointestinal tract.

[3] *Helicobacter pylori*: a bacterium present in the stomach when there is also an ulcer.

*2003*
Mrs A next consulted Dr B on Day 1, when she presented at his evening clinic with abdominal pain, nausea and anorexia. Diverticulitis was suggested by Dr B as a possible diagnosis. A CT scan performed on the same day was reported as showing "several small gallstones", but "no evidence of an [abscess]".

Mrs A continued to suffer from abdominal pain, and Dr B had a "strong impression of inflammatory process in the [right iliac fossa]". However, in the absence of a definite diagnosis, Dr B discussed with Mrs A the need for a diagnostic laparoscopy. He considered caecal-diverticulitis, Meckel's diverticulitis or appendicitis as possible diagnoses. Accordingly, an exploratory laparoscopy was organised to include a probable appendicectomy and a cholecystectomy.

*Day 5*
Mrs A was admitted to the private hospital on the morning of Day 5. The nursing staff had not been provided with any information about Mrs A by Dr B. He advised that this was because Mrs A was admitted soon after the consultation on Day 1, and there had been insufficient time to deliver the information. Mrs A's operation commenced at approximately 4pm. Dr B was the surgeon and Dr F the anaesthetist.

Dr B's handwritten operation note reports that a laparoscopic cholecystectomy and appendicectomy were performed. There were normal findings within the abdominal cavity, particularly the small bowel, appendix, right colon, right ovary and gallbladder. The gallbladder was excised. The appendix was also excised and the small bowel examined. The surgery finished at approximately 6pm. Mrs A spent the next hour and a quarter in the theatre recovery room.[4]

In recovery, Mrs A was reported as awake and comfortable with no nausea. She was given 100mg of tramadol orally as pain relief. At 6.40pm, her blood pressure was noted to be low, and one unit of Haemaccel[5] was given intravenously.

Mrs A returned to the ward at 7.15pm. She was cared for by RN Ms M. Ms M recorded that Mrs A's blood pressure was 85/57mmHg, and that she was complaining of severe abdominal pain, for which 25mg of pethidine was administered at 7.15pm, and 1g of Panadol at 7.30pm. Mrs A was still experiencing pain, and 100mg of tramadol was given at 8.30pm.

*Night shift Days 5/6*
At 10pm, Dr F telephoned Ms M to advise that nursing staff should avoid the use of pethidine.[6] However, at 11.30pm, Mrs A was recorded as "distressed ++ with [left-sided] abdominal pain, restless and unable to lie still, peripherally cool and clammy

[4] PACU: Post Anaesthetic Care Unit.

[5] Haemaccel: a fluid given intravenously to increase circulatory volume.

[6] There is no recorded entry in the notes to explain why Dr F provided this advice.

[and nauseous]". RN Ms H, who was the night nurse caring for Mrs A overnight, recorded in the clinical record that she telephoned Dr C, who was the on-call doctor (RMO[7]) on duty Dr C stated:

> "On the night of [Day 5] I was on night duty … An explanation was given that [Mrs A] was an anxious patient with significant pre-operative pain and a verbal message from … [Dr F] to try and avoid pethidine, presumed by me to be on the theoretical basis of ampulla contraction and thus the possibility that this would cause more pain. My discussion with the nurse did not reveal any absolute contraindication to pethidine, and so I ordered some pethidine (100mg/IM [intramuscularly]) to be given with 500ml Haemaccel as [Mrs A] was somewhat cool peripherally. Instructions were given to recall me if this pain relief was inadequate."

Ms H recorded that 100mg pethidine, given at 11.40pm, had an "excellent effect".

At 3.20am on Day 6, Ms H administered 100mg tramadol as Mrs A was again in pain. However, at 4.45am, Ms H called Dr C again as Mrs A was "disabled by pain" on the right side of her abdomen, and "restless and clammy". Dr C ordered that Ms H give more intravenous fluids and 100mg pethidine IM. Dr C also ordered that a urinary catheter be inserted "to rule out hypovolaemia … or urinary retention". He stated that he should be contacted again if there was a low urine output. He did not attend Mrs A. He stated:[8]

> "As the telephone calls occurred over two years ago, I do not have a clear recollection of the contact. My usual practice however is to attend the patient if the observations that I am given suggest the need for assessment, if the nurses ask me to attend, or if there is any concern. It is my usual practice to advise the nurse to call back if I have given a verbal order, or attended and assessed the patient, and the proposed course is not working.
>
> …
>
> I would not have contacted [Dr B] in relation to either of [the] calls, as the first one was routine post-operative pain management, and the second call related to further pain management issues. On the second occasion I would also have anticipated that [Dr B] would have shortly been reviewing his patient, at the morning ward round."

[7] RMO: Resident Medical Officer. The private hospital employs five RMOs, who provide medical support out of hours. These doctors can be contacted by the nursing staff to provide advice. The private hospital advised that, during the day, individual consultants must make their own arrangements to provide cover in their absence. See discussion at pp 11–12, below.

[8] In his statement to the Coroner, made on 3 November 2005.

Dr C described the calls from Ms H to be "[nothing] other than routine postoperative pain management inquiries". He made no clinical record of the care he prescribed.

Ms H contacted Dr B at 5.40am because she was still very concerned about Mrs A's condition. Ms H told Dr B about "[Mrs A's] pain, low [blood pressure] and feelings of impending doom". Dr B recommended that a different analgesia be given (Buscopan), and that the catheter was to be left in place. He also stated that he would review Mrs A later, and he "did not feel it was necessary for [Mrs A] to be seen by RMO". Dr B stated:

> "I was rung by the night nurse … the morning after [Mrs A's] surgery. [The nurse] explained to me that [Mrs A] was in pain and her blood pressure had been a little low but this had responded to intravenous infusion of Haemaccel on the prescription of the resident medical officer employed for overnight duty. My understanding was that this doctor had visited [Mrs A] and examined her.
>
> The nurse and I discussed the case including whether I wanted the Doctor to examine [Mrs A]. By this, I interpreted the question as did I want him to examine her again. I only found out later that he had not in fact examined [Mrs A].
>
> I explained to the night nurse that I would be in to see [Mrs A] within two or three hours anyway and it seemed that as the hypotension, which was not at all uncommon after laparoscopic cholecystectomy, had resolved, there seemed to be no urgency. Given the extensive pain [Mrs A] had suffered prior to surgery I was not surprised that she was experiencing pain post-operatively, but was concerned that I should visit to see her if there were any major problems."

Dr F called the ward at 6.20am; Ms H described Mrs A's condition and related her concerns to him. Dr F prescribed 5mg of frusemide, which was given at 6.30am. Ms H also administered 20mg Tilcotil and 1g Panadol as Mrs A was still in pain.

Ms H decided to complete an incident form at the end of her shift as she was "unhappy about the way [Mrs A] had been". The form was completed by the after-hours manager; there is no record on the form of any later actions taken by the management of the private hospital. The form records the care provided to [Mrs A] during the night, and that [Dr C] was called twice and [Dr B] once.

*Morning shift Day 6*
Ms M took over from Ms H for the morning shift.

Dr B visited Mrs A "sometime before" 8am. He stated that she was complaining of "diffuse abdominal pain". He noted that she had a raised temperature (37.8°C). He concluded that the pain "was the same as her preoperative pain":

> "I decided that what she was experiencing was a problem of pain management, so care for her should involve pain relief along with watchful observance for any deterioration."

Dr B decided that the raised temperature was caused by a chest infection or "? atelectasis".[9] Dr B recorded that Mrs A was to stay in hospital and, if her temperature "spiked" again, she should have a chest X-ray.

Clinical coordinator Ms D accompanied Dr B on the ward round. She stated that she and the other nurses were not satisfied with Mrs A's progress, and she discussed with Dr B whether further investigations should be done to try to diagnose the cause of Mrs A's pain. Ms D said that Dr B did not believe further investigation was necessary, and to "just get [Mrs A] up and going". Ms D stated:

> "[W]hen [Dr B] came around that morning to do the ward round I told him about the night that [Mrs A had] had. I told him how [Ms H] had been in touch because we'd had problems with pain, the blood pressure management … So [Dr B], before he went into the room to see the patient was aware of the patient's condition. And when we went into the room he then saw how she was and decided that she wouldn't go home that day."

Ms M stated that Mrs A had some pain and nausea, which was "somewhat relieved with analgesia and anti-emetics". Ms M described Mrs A's progress, in the context of being the first day after surgery, as "somewhat slow". Ms M added that she had been able to gain "some control over [Mrs A's] pain". However, Ms M's clinical note recorded that, because of the pain, Mrs A could be moved to the edge of her bed only with the assistance of two nurses, and she was unable to walk. Because Mrs A was still in pain, 20mg Buscopan was given at 11am, and 50mg tramadol at midday.

At 12.27pm, a facsimile was sent to the private hospital from the medical laboratory that had analysed Mrs A's blood test, which had been received by the laboratory at 11.34am. The C-reactive protein was 97mg/L (normal: 0–7mg/L), and the serum albumin 28g/L (normal: 34–50g/L).

*Afternoon and evening shift Day 6*
RN Ms I was on duty in the afternoon and evening, caring for Mrs A. Ms I gave 1g Panadol to Mrs A at 1pm.

Dr B returned later that day, at 6pm. He stated that Mrs A was still experiencing abdominal pain, but was sitting out of bed, "eating her dinner". Dr B stated that her clinical observations and urine output were all "normal".[10]

In contrast, Ms I stated that Mrs A's "level of pain had increased throughout the afternoon", and recorded that Mrs A was tolerating only fluids, and needed

[9] Atelectasis: incomplete expansion of a lung.

[10] In his statement to the Coroner dated 20 June 2005, Dr B stated that "[Mrs A] seemed able to mobilise and eat satisfactorily postoperatively" until late on Day 7, and that "[t]he pain was not requiring a lot of narcotic analgesia (pethidine was given only twice on the first postoperative day, at [4.30am and 8pm] after I had visited)."

encouragement to drink. The fluid chart indicated that, by the evening, Mrs A was taking only sips of water; in the morning, she had taken only 150ml in total.

Ms I also recorded that it had taken the assistance of two nurses, the physiotherapist, and the use of a walking frame to assist Mrs A to get out of bed.

On Dr B's instructions, and on account of Mrs A's persistent pain, Ms I administered 20mg Buscopan at 6.35pm. However, Ms I was still concerned that Mrs A's pain was not controlled, and she spoke to Dr F. On his instructions, she administered 100mg pethidine at 8pm.

Although she thought there was "some improvement" in Mrs A's condition, Ms I was still concerned. Accordingly, she contacted the duty doctor, Dr J, to review Mrs A.

*Night shift Days 6/7*
Ms H was on duty overnight, looking after Mrs A for a second night.

Dr J assessed Mrs A at 10.15pm. Dr J recorded that Mrs A said that the pain she was experiencing was similar to what she had experienced preoperatively. Following a clinical examination (which included a temperature of 37.4°C) Dr J's plan was to send a specimen of urine, give pain relief, keep "nil by mouth" and on intravenous fluids, and for the nurses to call him again if Mrs A's pulse rose or blood pressure fell. Dr J also indicated that Mrs A was to be reviewed the following morning by the surgeon. Ms H gave Mrs A 1g Panadol at 11.45pm.

Ms H recorded that Mrs A had been "unsettled at times", and was "mobilising very slowly". Although Ms H recorded that Mrs A's clinical observations had been stable, she noted that her abdomen was distended. During the night, Ms H administered 20mg Tilcotil at 12.20am, 50mg pethidine at 2.30am and 1g Panadol at 5.15am.

*Morning shift Day 7*
Ms K was the nurse caring for Mrs A on the morning of Day 7.

Dr B assessed Mrs A at 7.30am (there is no record of this assessment and no description of Mrs A's abdomen). Ms D was present. She stated that she and the other nurses were not satisfied with Mrs A's progress, and she discussed with Dr B whether further investigations should be done to try to diagnose the cause of Mrs A's pain. Ms D said that Dr B did not believe further investigation was necessary, and to "just get [Mrs A] up and going".

Dr B said that Mrs A described "persisting but intermittent pain". He stated that he examined her, but found no signs of peritonitis. He said that the nursing staff commented that there had been difficulty "mobilising Mrs A". He added:

> "That turn of phrase was consistent with them expressing that they also thought there was no serious illness present. Normally they would use other phrases if they had concerns about a patient's condition."

Ms D advised that Dr B "considered it was the same as [Mrs A's] preoperative pain".

Ms D stated:

> "When [Dr B] said we were going to get [Mrs A] up and going, I said to him: 'This lady needs two nurses and a physio to help get her out of bed, she's got unrelenting pain.' And I took from saying those things and things similar to that that he got the idea that we were not going to get this lady home. And also by asking him about more tests, I said something's not right … we need more tests and I took from that he understood that I was trying to explain to him the severity of the situation [because] I also went through [Mrs A's] observations, all the other things, it wasn't just the unrelenting pain, there are a few factors that would say this lady is not going home today and we wanted more tests done and he knew that. I feel very confident he knew I was not happy with this patient."

Ms K stated that, at the stage Dr B assessed Mrs A, "[she] had not had her breakfast and had not been mobilised". At 8.05am, Mrs A was given 50mg tramadol.

Ms K assisted Mrs A to have a shower, but the abdominal pain worsened, and Ms K administered 1g Panadol at 9.30am and 50mg pethidine at 9.40am. Ms K spoke to Ms D as she felt that "something was not quite right with [Mrs A]".

Although surgical registrar and on-call RMO Dr L was not employed to provide care for Dr B's patients (he was responsible for the care of another surgeon's patients), Ms K was instructed by Ms D to ask Dr L to assess Mrs A while he re-sited her venous cannula.

In a retrospective note, written on Day 8, Dr L stated that he "briefly assessed" Mrs A. He found her "comfortable after the pethidine injection"; her abdomen was soft, with no distension, and she had "mild tenderness" in her right iliac fossa. He recommended that the nursing staff continue with the observations and contact Dr B if there were any concerns. He added: "I was not [on] his team and I was going to theatre for a whole day shortly."

At 10.25am, Mrs A was given 20mg Tilcotil. Ms K also recorded Mrs A's clinical observations, which included a respiratory rate of 30 breaths per minute (bpm).[11] Ten minutes later the respiratory rate had fallen to 26bpm.

At 11am, Mrs A was still experiencing pain, and Ms K discussed pain relief with Dr F, who happened to be in the ward. Following the discussion, Ms K administered 100mg tramadol at midday. At that time, Mrs A's respiratory rate had risen to 36bpm, and Ms K noted that Mrs A "had only a few nibbles" of food.

[11] Normal respiratory rate is between 12–20 breaths per minute.

Ms K took Mrs A's observations again at 1.15pm. Her pulse had risen to 129 (normal: 60–100), her respiratory rate was 36bpm, and her temperature 37.1°C. Ms K assisted Mrs A to the toilet, where she passed 15ml of urine. This was the first time she had passed urine since 4am. Mrs A was given 1g Panadol at 1.45pm.

Ms K was concerned about Mrs A's condition, based on her "unrelenting pain", deteriorating clinical observations, and low urine output. Ms K discussed her concerns with Ms D, and they decided to call Dr B together. At this time, Dr B was at a clinic approximately 65km from the private hospital.

Ms K stated:

> "I spoke with [Ms D] and she was with me when I telephoned [Dr B] at [2pm]. I strongly verbalised the need for him to come and review [Mrs A], due to her increased pulse which was 129, and decreased oxygen saturations[12] … and her decreased [urine] output … I told him [Mrs A] had unrelenting right flank and abdomen pain despite the analgesia given. I told him we had taken a blood [test] and were awaiting results from the lab … [Dr B] said he would come and review her [after his clinic]."

Ms D stated:

> "[Ms K] rang and I was there encouraging her with the conversation and prompting her [because] [Dr B] was not getting the message that this patient was not progressing and the same message that we had given him [that] morning that we wanted more done. He said he was going to come in at the end of his clinic. We took that to mean that his clinic was soon finishing and he would be coming in soon from [the clinic].
>
> …
>
> I think [Ms K] made it very clear … Our understanding was that he was finishing clinic soon, not several hours later."

Ms K's clinical record states:

> "Called [Dr B] [at 2pm]. Verbalise need for him to review [Mrs A] due to [increasing pulse] and [decreasing oxygen saturations and decreasing urine output]. Told of unrelenting pain … despite analgesia … [Dr B] said he would come and review [Mrs A after] [clinic]."

[12] 92% at 9.30am, 95% at 10.35am, 93% at 12pm, 96% at 1.15pm.

Dr B stated:

> "I was rung by the nursing staff at 2pm that afternoon. The nurse suggested that I might like to review [Mrs A] again as there had been a deterioration. She had not passed any urine that morning and she had become tachycardic. I asked the nurse to arrange an abdominal ultrasound … At that stage I was at [a clinic] and I explained to the nurse that I would be returning within two to three hours and would see [Mrs A] then."

*Afternoon shift Day 7*
Ms K handed over to RN Ms M.

At 3.33pm, the ultrasound report was sent to the ward by fax. The conclusion stated:

> "Marked limited visualisation due to extensive bowel gas. It is not certain whether the gallbladder has been removed, and if so there is fluid in the gallbladder fossa, as well as free fluid in the pelvis."

Ms M discussed the report with both the morning shift of nurses (who were still present) and the afternoon shift nurses. She advised Dr B of the ultrasound report and blood results during a telephone conversation with him. According to Ms M, "[h]e said he would be in to see [Mrs A] soon". Ms K gave Mrs A 25mg Buscopan, and commenced an IV infusion at 4pm.

In contrast, Dr B stated that the next time he was called after the 2pm call from Ms K and Ms D was "by one of the resident medical staff to say that [Mrs A] had deteriorated".

Ms M stated that the Buscopan had no effect. At 4.30pm, Ms M was unable to obtain an oxygen saturation recording, and Mrs A's pulse and blood pressure were heard "only faintly". The nursing staff contacted Dr L, who immediately came to the ward to assess Mrs A, bringing with him a consultant surgeon who happened to be present at the time in the private hospital.

Dr L stated that, when they arrived, Mrs A was in shock, with no radial pulse, and no urine output since the catheter had been removed. Resuscitation was commenced, and Dr L telephoned Dr B, who arrived "shortly" after the call.

Ms M recorded that Dr B arrived at approximately 5.15pm, and Mrs A was taken to theatre at 5.30pm. The anaesthetic record indicates that the operation commenced at 6.15pm. However, Dr B's operation note states that the operation started at 3.58pm ("1558"), and the "knife to skin" time was 4.25pm (1625").

Mrs A was taken to theatre, where Dr B performed a laparotomy. He found "extensive blood-stained fluid in the abdomen", and repaired three perforations and two "incipient" perforations of the small bowel. Mrs A was transferred from theatre to the intensive care unit at the private hospital.

*Days 8-10*
Because Mrs A's condition remained critical, she was transferred to a public hospital's intensive care unit at 1am on Day 8. Unfortunately, Mrs A's condition deteriorated further, and she died on Day 10.

## Coroner's findings

An inquest into Mrs A's death was carried out. The Coroner released his findings on 11 July 2006. He stated that Mrs A died of "multi-organ failure consequent upon intra-abdominal sepsis due to perforation of the jejunum (small bowel) which occurred at [the private hospital] … and the circumstances of her death being delayed diagnosis and treatment of that perforation at [the private hospital]".

The Coroner stated:

> "They are matters of great regret, and also circumstances of [Mrs A's] death that
>
> - [Dr B's] failure to address the possible causes of the high pulse rate [Mrs A] had at [5.30am] on [Day 7] and to make explicit orders to take hourly observations led to delay in recognition of how ill she was;
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> - [Dr L] did not recognise how ill [Mrs A] was when he saw her at about [10am] … and did not report to [Dr B]; and
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> - [Dr B], when informed of [Mrs A's] condition at [2pm], did not immediately return to [the private hospital] and in the meantime arrange for the attendance of a senior doctor to organise her resuscitation and further treatment on his behalf."

The Coroner made the following recommendations:

> "[The private hospital] undertakes a complete review of its working relationships with visiting specialists, paying particular attention to compliance with hospital policy in respect of the provision of information, the format and completion of clinical records, and RMO employment policy; and
>
> [The private hospital] obtains and implements such advice as will obviate, as far as is possible, the many failures of communication at multiple levels demonstrated in this inquest. It may well be appropriate that this advice be obtained from external sources with expertise in these matters."

## Employment of RMOs at the private hospital

*Medical cover at the private hospital*
The private hospital employs five RMOs to provide after-hours cover. During the day, individual consultants must make their own arrangements to provide cover in their absence.

On 3 October 2002, Ms E, Director of Nursing, wrote to Dr B. She suggested that Dr B employ an RMO. Dr B chose not to employ an RMO to cover in his absence. He said that he expected to be called by the nursing staff "for every problem".

The private hospital submitted:

> "The suggestion that [Dr B] share the employment of an RMO was also because of a sense that [Dr B] was isolated from his surgical peers in [the area]. This meant he was less likely to involve them in the more difficult judgement decisions in relation to particular patients.
>
> However, at this stage the Hospital did not consider it was appropriate to require [Dr B] to employ such a person."

The private hospital advised that the policy has been altered since this incident, to state that if an RMO is consulted twice by telephone, the RMO "must physically assess the patient and make a clinical record entry". In addition, the RMO must inform the consultant of the care delivered.

*RMO job description*
The private hospital's RMO job description stated the main purpose of the role:

> "To assist with the care and treatment of patients at [the private hospital] as directed by the medical consultants and provide immediate patient care in the event of emergencies."

The key tasks included:

> "…
>
> - Ward work, including checking of selected patients, IV lines, etc.
> - Assistance with care of inpatients.
>
> …
>
> - Initial call to urgent medical problems."

[The private hospital] standard *Junior Medical Staff, Assessment of Patients after Hours* (12 April 2001) states:

> "**Standard: To appropriately respond to patient's medical care requirements**
>
> …
>
> - When called to assess a patient after hours, attend to the request as soon as possible.

- Find out from the attending nurse relevant information.
- Introduce yourself to the patient.
- Gather necessary information.
- If the situation is not immediately life threatening, inform the attending consultant and follow his advice.
- Document the history and findings and the action taken in the progress notes."

*Employment of Dr C as RMO*
Dr C was employed as an RMO at the private hospital in 2003. In his statement to the Coroner dated 3 November 2005, Dr C stated:

> "In 2003 I embarked on the general practice training course. I was also, in 2003, employed at [the private hospital] to provide after hours care, one day a week, in the capacity of a Registered Medical Officer. I continue to be employed in that capacity. …
>
> I was the Registered Medical Officer rostered on duty on the night of [Day 5]."

**Prior concerns about Dr B's practice**

The private hospital stated that the concerns expressed about Dr B's practice prior to Mrs A's operation had not reached a level where it was appropriate to take action to restrict his practice. In response to the provisional opinion, the private hospital stated:

> "In early 2002 there had been difficulties with one of [Dr B's] operations at [another] Hospital and this had been reported to [the DHB]. [The private hospital] became aware of the issue. (It should be noted that at that time [the other] Hospital was not part of the [private hospital] group and operated independently.)
>
> The General Manager of [the private hospital] spoke to [Dr B] after becoming aware of this matter. The content of the discussion is recorded in letters to [Dr B] dated 22 February and 11 April 2002. Further information about the incident was requested. [Dr B] did communicate with the senior management and the other hospitals involved did not take further action. The Medical Council was involved to review [Dr B's] practice.

> In August 2002 a letter was written to [Dr B] asking about the Medical Council review. The letter records [Dr B's] reluctance to discuss the matter with [the private hospital]. A specific request was made requiring a response with the indication that the issue was to be referred to [the private hospital's] Credentials Committee.[13]
>
> This exchange of correspondence led to a meeting with [Dr B] on 17 September 2002. The content of the discussion was outlined in a letter to [Dr B] dated 3 October 2002. This letter records the discussion about missing pre-admission patient information and other issues which included the rumours which were circulating. Further information was sought.
>
> All this information was considered by the hospital's Credentials Committee at its meeting on 10 October 2002. It was considered that clearer practice guidelines had been established and agreed with Dr B. It was expected that the relationship (including communication) would improve as a result.
>
> In addition to these efforts, on 29 May 2003 [the private hospital] wrote to the Medical Council to ask about the review of [Dr B's] practice. This followed advice from the Medical Council to [Dr B] dated 15 May 2003 confirming he had satisfactorily completed a competency review. [The private hospital] received a reply dated 12 June 2003. The Council had decided [Dr B's] practice was not deficient. It was only after receipt of this advice that the Credentials Committee recommended the renewal of [Dr B's] annual operating privileges."

The Medical Council advised that Dr B underwent a competence review in late 2002 to early 2003. The Council advised that no recommendations were made as a result of the review.

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[13] The private hospital had a well established credentialling/privileges process in place in 2003, and is moving towards defining specific clinical responsibilities (scopes of practice). Any clinician seeking operating privileges at [the private hospital] must be credentialled, on appointment and then annually. The clinician submits an application which is considered by the Credentials Committee. The Committee makes a recommendation to the Chief Executive, which is then considered by the Board.

## Independent advice to Commissioner

The following expert advice was obtained from surgeon Dr Ian Stewart:

> **"Purpose**
> To provide independent advice about whether [Dr B], general surgeon, and [the private hospital] provided an appropriate standard of care to [Mrs A] (dec).

[At this point, Dr Stewart provides: a background to the case; a list of the information provided to him; and the questions asked of him, which he repeats in his report. This section of Dr Stewart's report has been omitted for brevity.]

> **Background**
> [Mrs A] was referred by [her doctor] to [Dr B] in March 2002 with a 10 day history of right iliac fossa pain associated with abdominal distension, nausea and diarrhoea. She admitted to some mild weight loss. In 1995 a gastroenterologist, had diagnosed [Mrs A] with irritable bowel disease. At this March consultation she was mildly tender in the RIF; this was the only significant physical finding. All blood tests were normal. A CT scan was organised which showed a hiatus hernia and commented on faecal loading of the colon. [Dr B] organised a colonoscopy and this demonstrated sigmoid diverticula and a small benign polyp was removed from the transverse colon. Apart from the diverticula there was no particular diagnosis reached from this consultation or the subsequent investigations. A month later in April of 2002 she consulted [Dr B] again, this time with the pain more localised in the right upper quadrant and radiating through to her back. On a couple of occasions she was woken with the pain. [Dr B] queried biliary pain although again investigations were non contributory. The blood tests done including liver function tests, amylase and C-reactive protein were normal. An ultrasound of her abdomen done on 8th April showed no evidence of biliary disease. On 10th April 2002 a gastroscopy confirmed a hiatus hernia and gastric biopsies were positive for helicobacter pylori and she was prescribed the triple therapy regime.
>
> [Dr B] did not see [Mrs A] after that until [2003] when she once again presented with abdominal pain, nausea and anorexia. Diverticulitis was raised as a possible diagnosis. A CT scan was organised which showed gallstones. At that time [Mrs A] was apparently diagnosed as a 'borderline diabetic'. Physical examination continued to demonstrate tenderness in the right iliac fossa and [Dr B] had a 'strong impression of inflammatory process in the RIF' however in the absence of a definite diagnosis he discussed with [Mr and Mrs A] the need for a diagnostic laparoscopy. He raised caecal-diverticulitis, Meckel's diverticulitis or appendicitis as possible diagnoses. Accordingly an exploratory laparoscopy was organised for [Day 5]. The consent process acknowledged the high likelihood her gallbladder and appendix would be removed at the surgery.

**Operation and postoperative**

The surgery took place on [Day 5]. From the documents provided there is some conflicting evidence as to the time of the surgery. On [Dr B's] handwritten operation report the operation is said to have started at 8 minutes past eleven and finished at 1744. I presume this is a mistake as it would indicate a six hour operation. The more likely time of the operation was late in the afternoon at about 1600 as is indicated on the anaesthetic sheet. Surgery appears to have taken approximately one hour and a half to complete. The hand written operation note reports normal findings within the abdominal cavity particularly the small bowel, appendix, right colon, right ovary and gallbladder. The gallbladder was excised with clips applied to the cystic duct and cystic artery. The appendix was also excised and the small bowel examined from end to end using atraumatic Babcock forceps. The surgery finished at approximately 6 o'clock in the evening. [Mrs A] spent the next hour and a quarter in the recovery ward before returning to the ward.

In recovery she was reported as awake and comfortable with no nausea. She was given 100mg of tramadol orally. At 1840 her blood pressure was noted to be low and 1 unit of haemaccel was given intravenously. She returned to the ward at 1915 hours with a blood pressure of 85/57 and an instruction if the BP remains low to be given further haemaccel. She was complaining of severe abdominal pain, light headedness and nausea. The nursing notes report she was given pethidine and tramadol although I cannot establish from the notes the exact time of the administration of these drugs nor the amount given.

[Dr F], the anaesthetist, phoned in at 2200 hours and it reports he requested the nursing staff to try and avoid giving pethidine. At 2330 hours the night staff nurse reported [Mrs A] to be very distressed with pain mainly on the left side of her abdomen. She was restless and peripherally cold and clammy. She was complaining of nausea. The resident medical officer [Dr C] was contacted and on hearing her blood pressure was 89/60 he advised giving a unit of IV haemaccel stat and 100mgs of IM pethidine. She responded well to that treatment and began taking a few sips of ice orally. She slept until 0300 (on [Day 6]) but once again was troubled by severe right sided abdominal pain and was restless and clammy. [Dr C] was contacted again (at 0445 hours) and once more he suggested giving a unit of haemaccel IV and a further 100 mgs of IM pethidine. An indwelling urinary catheter was inserted at that stage with 650mls of urine drained. At 0530 her blood pressure was 120/80 and [Mrs A] reported feeling dizzy and 'scared to close her eyes'. [Dr B] was notified of her condition at 0540 hours on [Day 6] and in response to her abdominal pain problem he suggested using buscopan. [Dr B] was asked whether or not it was necessary for the patient to be seen by the resident medical officer and he did not feel that was necessary. At 0620 on [Day 6], [Dr F] rang in and prescribed 5mgs of IV frusemide. At 0700 [Mrs A] reported feeling better and had a heart rate of 100 and a BP of 110/70. Her oxygen saturation was 97% on 2 litres of

oxygen. Shortly after that time she was seen by [Dr B]. He suggested decreasing the intravenous fluid, giving a diet as tolerated and mobilising her with encouragement of chest physio. The staff nurse covering the night shift on [Day 5] was so concerned about [Mrs A's] clinical situation and for her need to seek advice that she reported these facts in an incident report detailing the night's activities.

Throughout the late morning of [Day 6] the nursing notes report [Mrs A] complaining of a lot of abdominal pain and nausea. She was mobilised by the nurses to the edge of the bed but could not tolerate walking due to the pain. Blood results from [Day 6] at 1130 hours showed a haemoglobin of 122, WBC count 6.1 (neutrophils 86.2%, lymphocytes 8.2%), sodium 143, potassium 5.1, creatinine 74, total protein 52 (60–83), albumin 28 (34–50), C-reactive protein 97 (0–7) and her AST/ALT were increased. Perhaps significantly the blood film reported a left shift of the neutrophils.[14] Later on in the afternoon of [Day 6] she was seen by [Dr B] and prescribed buscopan for pain at 1835 hours. It was documented at that stage she could only get out of bed with the help of a physiotherapist and two nurses and the use of a walking frame. Her pain was mainly in the right side of her abdomen but also in the right shoulder tip and suprapubic. At 2000 hours on [Day 6] she was given a 100mgs of IM pethidine and 10mgs of maxalon orally. It was reported she was tolerating oral fluids but needed encouragement to take them. The covering resident medical officer for the night of [Day 6], [Dr J] was called to see [Mrs A] at 2230 hours on [Day 6]. He took a history from [Mrs A] who was complaining again of abdominal pain mainly in the right side and also shoulder tip. She apparently had had some marginal benefit from pethidine. Her bowels had not yet opened and she had not passed wind. On examination he found her in discomfort with a tender abdomen and scant bowel sounds. Her temperature was 37.4 with a pulse of 100–108. Respiratory rate was 16–18 per minute. He prescribed further IM pethidine and recommended that she be reviewed in the morning by the surgeon.

On the morning of [Day 7] [Mrs A] was seen by [Dr B] and the blood results from the previous day were discussed. In particular the raised liver function tests were noted. At that visit [Mrs A] had not passed any flatus, her abdominal pain was discussed with [Dr B] and the conclusion was that this was the same pain as her 'preoperative pain'. Oral tramadol was given. After [Dr B's] round [Mrs A] was assisted to a chair using a frame and noted to be in some discomfit. She was then assisted in the shower but because of severe increased pain especially in the right flank she was assisted back to bed at

[14] The left shift of neutrophils on blood film was reported on Day 7. Dr Stewart subsequently stated: "This does not alter the fact that some blood tests (not the white cell count) were abnormal on [Day 6] (protein, albumin, C-reactive protein) and whilst these are relatively non-specific abnormalities and not diagnostic, they may be relevant when looked at in the context of a patient who is not progressing."

0940 hours and given 50mgs IM pethidine. At that time her respiratory rate was noted to be 34 per minute, oxygen saturation of 97% on 3 litres of oxygen and a blood pressure of 110/80. The resident medical officer [Dr L] replaced her intravenous leur and at 1025 intravenous tenoxicam was given along with maxalon. [Dr L] made no comment on [Mrs A's] clinical situation.[15]

At 1100 hours her abdominal pain continued and further IM pethidine was given along with tenoxicam and oral panadol. [Dr F], the anaesthetist, arrived (it is unclear whether he examined [Mrs A]) and apparently altered the medication. With the pain continuing tramadol was given at 1200 hours. Registered Nurse [Ms K] and the physiotherapist were concerned about [Mrs A's] ongoing pain and rising respiratory rate (at this stage approximately 36 resps/min). In the early afternoon it was noted [Mrs A] had passed only 15mls of urine since the catheter had been removed approximately 8 hours earlier.

Nurse [Ms K] and Charge Nurse [Ms D] discussed the deteriorating signs and symptoms and at 2pm rang [Dr B]. He was told about the increased pulse (129/min), her increasing oxygen requirements and her decreased urine output.

[Dr B] requested an ultrasound to be done and was waiting to hear the morning blood results. He said he would review [Mrs A] after his clinic in […]. Some time around mid-afternoon, Nurse [Ms M] rang [Dr B][16] with the blood test results (increased creatinine) and the ultrasound report. He said he would be in to see her soon and to give her IV saline.

Later in the afternoon (1630 hours) [Mrs A] clearly deteriorated, low blood pressure, increased pulse and peripherally cold, all signs of worsening septic shock. Both Nurse [Ms M] and the Staff Nurse summoned doctors including surgical registrar [Dr M], and [another surgeon]. They tried contacting [Dr F] the anaesthetist, but he was unavailable. [Another] anaesthetist who was in the hospital, arrived. [Dr B] arrived after 5 o'clock and [Mrs A] was immediately taken to theatre for a laparotomy.

**Observations**

(1) Every nursing report from immediately postoperative to late in the afternoon on [Day 7] when [Mrs A] returned to theatre states concerns about the degree of pain and discomfort [Mrs A] was enduring.

(2) Throughout the entire 48 hour period from the first operation until the second procedure [Mrs A] required regular IM pethidine. Evidence from

[15] Dr M's notes were written retrospectively on Day 8.

[16] Dr Stewart subsequently acknowledged that Dr B phoned the nurses, but stated that "it is not crucial or relevant who initiated the conversation".

the notes indicates at least 5 doses of pethidine given during that period. This is in addition to other analgesics particularly tramadol and tenoxicam.

(3) The night shift immediately after the surgery (in the early hours of [Day 6]) is of concern. Registered Nurse [Ms H] was so concerned over the severity of [Mrs A's] symptoms (pain and hemodynamic instability) she called the RMO ([Dr C]) twice. The level of concern she had is illustrated by the fact she filled out an incident report immediately following that shift.

(4) On consecutive days (the morning of [Day 6] and the morning of [Day 7]) [Mrs A] was not mobilising freely. Just to get to the bedside chair or the bathroom required the assistance of more than one nurse.

(5) At no stage during the immediate 48 hours postoperatively did [Mrs A's] gut function return. There are notes from the nurses and confirmed by [Dr B], that after longer than 24 hours post operatively (on the morning of [Day 7]) [Mrs A] had not passed flatus. Throughout this time she had minimal oral intake. On the morning of [Day 7] she ate yoghurt and a mandarin, prior to that some water.

(6) [Mrs A's] blood test results on [Day 6] were not normal. Her serum total protein was 52 (normal 60–83) and serum albumin was 28 (normal 34–50), both significant decreases. The C-reactive protein was elevated and a left shift of neutrophils was reported on the blood film.

(7) [Dr B] maintains that:

a) There was no obvious peritonitis or concerning abdominal signs

b) Her complaints of pain were consistent with her pre-op symptoms

c) Blood tests were normal

d) Her behaviour (mobilisation and eating) was normal.

Before addressing the specific questions, I emphasise the fundamental problem in this case was a small bowel perforation (perhaps several) with contamination of the peritoneal cavity by small bowel content and subsequent overwhelming sepsis. The initial complication arose from a traumatic perforation caused by the Babcocks forceps during the small bowel examination. I note [Dr B] and [the expert witness who provided expert advice on behalf of the family at the Coroner's inquest] have raised the possibility the cause of the perforation may have been drug (tenoxicam) induced. I believe that explanation is highly unlikely. There are reports (ANZ J. Surg 2001 71, 255–256) of non-steroid anti inflammatory drugs (NSAIDS of which tenoxicam is an example) causing small bowel perforation. NSAID-induced small bowel ulceration is also recognised and uncommon, but perforation is rare and usually associated with long term usage and all perforations recorded

have been in the ileum, not the jejunum. [Mrs A's] perforations were multiple; in jejunum and prior to the surgery she had not been a regular user of NSAIDS. I maintain her perforations were secondary to the procedure and nothing to do with her postoperative tenoxicam. The entire case and opinion hinges on the performance of [Dr B] and other medical attendants including the nursing staff recognising that this complication had occurred and adequately responding to it.

**Expert advice required**

***1. Please comment generally on the standard of care provided to [Mrs A] by:***

***a) [Dr B]***

The standard of care provided to [Mrs A] by [Dr B] during the **postoperative** period was deficient. Before elaborating on this I emphasise my criticism of his care only applies to the postoperative period. The preoperative consultations, the investigations and decision making processes preoperatively were satisfactory and these aspects would be seen by his ([Dr B's]) peers as reasonable.

[Mrs A's] preoperative symptoms and minimal signs were difficult to elucidate. Whilst resorting to exploratory laparoscopy is a relatively rare event, it is an accepted course of action providing it is fully discussed with the patient and acknowledged by both surgeon and patient, that there may be no significant findings and postoperatively symptoms may persist. [Dr B's] operating technique to examine the small bowel by 'running' it was appropriate. ('Running' the small bowel means examining the entire length of small bowel, approximately 5 metres, by passing or feeding the bowel tube from one gasping forcep to another). The small bowel is very mobile and can be passed between instruments. The grasping forceps, called Babcocks, take hold or grasp the bowel on its outside surface. These forceps are called atraumatic and are designed to minimise the risk of perforating or tearing the bowel wall during the grasping process). A disease of the small bowel, such as a tumour, inflammatory process or a narrowing would probably be apparent by this examination. Having found the small bowel to be normal, he then proceeded with cholecystectomy and appendicectomy, both reasonable options, particularly cholecystectomy as the preoperative CT scan had showed a gallstone in the gall bladder.

***b) [The private hospital]***

The general standard of care provided by [the private hospital] to [Mrs A] is largely limited to an opinion on the postoperative care. The initial admission process and theatre routines are appropriate and there is nothing in the submitted documents to suggest inadequate nursing staff levels or inadequate

provision of resident medical officer cover. There were problems with communication which will be discussed under 6.

***2. Please comment generally on the standard of postoperative care provided to [Mrs A] by:***

***a) [Dr B]***

Referring to [Dr B's] assertions outlined in '7' under **observations**, I believe the evidence in the provided documents would challenge some of these.

- During the first 24 hours postoperatively, [Dr B] did not recognise peritonitis or any concerning abdominal signs. It is clear by [Mrs A's] reluctance to mobilise (requiring nursing and physio assistance, using the walking frame) that movement caused considerable pain ('unable to tolerate walking due to pain'). This was severe pain as shown by her analgesia requirements including the need for regular IM pethidine. Throughout this period [Dr B] attributed [Mrs A's] ongoing pain to a continuation of her preoperative pain. Whilst initially this is possibly a plausible explanation, it became a highly unlikely scenario, particularly when other factors were becoming readily apparent. I refer to her unstable and low blood pressure recordings, her reluctance to mobilise (she was not restricted in her mobility **pre**-operatively), her absence of gut function and the abnormal blood findings. By the end of [Day 6] I believe [Dr B] had a responsibility to doubt his initial hypothesis that all he was seeing was a continuation of her preoperative symptoms. Preoperatively she was not requiring narcotic medication, she was not troubled with mobilising, she was not reluctant to eat and drink. It was a convenient explanation for her pain for the first 24 hours but after that [Dr B] should have been considering alternatives. By late on [Day 6] (at his evening visit) he should have recognised the amount of medication [Mrs A] was requiring to control pain was clearly excessive. This finding should have alerted him to the possibility of a postoperative complication.

  Mitigating factors (her preoperative abdominal pain, the difficulty diagnosing small bowel perforation, suppression of inflammatory response by NSAIDS) have been put forward by expert witnesses to explain or rationalise the failure to make a timely diagnosis. In my opinion some of this reasoning is 'clutching at straws'. Whilst NSAIDs are anti-inflammatory, I am unaware of the literature indicating **significant** infection is 'masked', particularly infection as severe as would occur following enteric perforation. I think it highly improbable that the short term tenoxicam given to [Mrs A] would have had any role in 'suppressing inflammation' to the extent her symptoms and signs were masked. Also, these mitigating factors have been used on the assumption [Mrs A's] recovery was proceeding 'normally'. She clearly was not. I am not suggesting [Dr B] should have diagnosed a small bowel (jejunal)

perforation, but 24 hours and certainly 36 hours following this type of laparoscopic surgery, if the patient is not progressing then the suspicion of a complication having occurred has to be high. Probably the commonest complication following this type of surgery causing ongoing pain and failure to progress would be a collection of either blood or bile in the upper abdomen. Acceptable standards of care in this situation demand further investigations (? CT scan, repeat laparoscopy? laparotomy) either at 24 hours or certainly at 36 hours postoperation (ie early on [Day 7]).

Surgeons practising regular laparoscopic procedures particularly laparoscopic cholecystectomy and laparoscopic appendicectomy would not expect their patients to be still requiring regular intramuscular pethidine 24 hours after the surgery. In one study of laparoscopic cholecystectomy as a day case procedure (BJS 2004: 91; 312–316) an analgesia pack given on discharge consisted of paracetamol, ketoprofen (a non steroidal anti-inflammatory) and tramadol (an opoid-like analgesic). 96% of patients felt happy with this regime. As in that study [Mrs A] also had NSAIDs (tenoxicam) and tramadol, but this was not helping and she required in addition several doses of IM pethidine during the first 24 hours post operation. This was a clue that the recovery was not proceeding smoothly, indicating a level of concern requiring closer investigation.

- The blood tests on [Day 6] were not normal. In particular, serum protein and albumin levels were decreased and whilst not diagnostic this is a significant finding indicating a catabolic state. I note in the evidence from [the witness who provided expert advice on behalf of the family at the Coroner's inquest] (point 4 of his evidence) he acknowledges the blood tests on [Day 6] were abnormal but could reasonably be interpreted as a 'normal post surgical effect'. I strongly oppose that view. The main advantage of minimally invasive surgery is to avoid the traumatic catabolic effects of open surgery. Most patients go home within 24–36 hours of laparoscopic procedures, particularly the operation [Mrs A] had. Whilst reductions in serum protein and albumin occur after open abdominal surgery, (particularly major surgery involving bowel resections or for acute inflammatory disease such as appendicitis/cholecystitis), similar falls in the serum protein and albumin following laparoscopic surgery (particularly if there has not been an acute inflammatory problem) should be viewed with concern. I have reviewed the last 9 laparoscopic cholecystectomy procedures I have done, 8 of these cases had blood tests done on the first postoperative day. The protein and albumin levels were normal in every case. Whilst I accept that comparing laparoscopic cholecystectomy to [Dr B's] operation (laparoscopic cholecystectomy/appendectomy and examination of the small bowel) is not exactly equivalent, I would expect the recovery of both these procedures to be similar and a significant reduction of protein/albumin levels postoperatively is cause for concern.

The blood film on [Day 6] reported a left shift of the neutrophils. Admittedly, this is also not diagnostic and toxic changes were not noted. The absolute white count of 5.4 (4–11) was within the normal range, but the left shift comment should have raised some concern particularly when taken in context of other abnormal findings. The elevation of C-reactive protein again is a relatively non specific finding, but interpreted in the context of other abnormal findings may be significant.

***b) [The private hospital]***

The observations and documentation by the nursing staff on the various shifts for the first 48 hours post-operatively were appropriate and correct. Staff Nurse [Ms H] was very concerned about the level of pain and distress [Mrs A] displayed on the first (the night of [Day 5]). Staff Nurse [Ms M] was concerned about the level of pain on the morning shift on [Day 6]. General Nurse [Ms I] worked the afternoon on [Day 6] and was so concerned about the level of pain [Mrs A] displayed that she rang the anaesthetist at 8pm who prescribed more intramuscular pethidine. The clinical coordinator (Charge Nurse) [Ms D] was working during the day on both [Day 6 and 7]. She was aware of the continuous pain [Mrs A] was having; she heard the concerns Staff Nurse [Ms H] had had on the night of [Day 5], she discussed the pain problem with [Dr B] on the morning of [Day 7] and in the middle of the day she was alerted to the ongoing pain and hemodynamic problems of [Mrs A], by comprehensive Nurse [Ms K]. I will comment further on these issues under question 6.

***3. Please advise whether [Dr B] performed the laparoscopic surgery on [Day 5] to an appropriate standard.***

I consider [Dr B's] performance with the laparoscopic surgery on [Mrs A] was satisfactory. She sustained a severe and subsequently catastrophic complication of instrument induced small bowel perforation and whilst this is a very rare event, it is well recognised and documented.

***4. Please comment on the adequacy of [Dr B's] supervision of [Mrs A's] care postoperatively.***

[Dr B's] supervision and care of [Mrs A] post-operatively was not satisfactory. The following factors below, taken together should have alerted [Dr B] to recognise a possible problem and respond appropriately.

a. her persistent complaints of severe pain

b. her narcotic requirements over the 36 hours postoperative period (at least 4 intramuscular doses of pethidine given)

c. relevant abnormalities in the blood test done on [Day 6] (low serum protein/albumin, elevated CRP)

d. he failed to recognise/acknowledge her lack of mobilisation

e. he claimed she was tolerating a 'normal diet'.[17] There is nothing in the submitted hospital notes to support that claim. She was only tolerating liquid and little of that.

Whilst any of these 'factors' taken in isolation perhaps could be rationalised or explained as a variation that possibly would resolve or correct, but taken together, these findings and observations all strongly indicate [Mrs A's] immediate postoperative progress was not satisfactory. At the very least, the events of [Day 6] should have alerted him to a possible problem, and with her still not progressing by early on [Day 7], he should have urgently investigated her at that stage, including considering laparotomy.

***5. Please comment on the adequacy of [Dr B's] cover arrangements.***

I am not critical of his cover arrangements. The hospital provides night resident doctor cover which is more than many private hospitals provide. For this type of surgery (minimally invasive laparoscopic procedures) there is no requirement to have a resident doctor in attendance either day or night. Private hospitals in this country would generally accept that provid[ed] the surgeon was available by phone, then 'extra' cover for patients recovering from laparoscopic procedures (or indeed most open operations) was not needed. Should the operating surgeon be unavailable then there is a responsibility on him (her) to arrange satisfactory cover.

***6 Please comment on the standard of communication between clinical staff.***

In my opinion, the submitted documents indicate communication problems between clinical staff, a situation that is below acceptable standards. There was communication breakdown at several levels — between the nurses, from nurses to [Dr B], from the RMOs to [Dr B] and between RMO ([Dr C] particularly) and the nurses.

Registered Nurse [Ms H] was so concerned during the early hours of [Day 6] she filled out an incident form. The Director of Nursing [Ms E] was aware the form had been completed, but did not see the content of the form until after [Mrs A] had been transferred to [public] Hospital (2 days later). I believe both Nurse [Ms E] and the Charge Nurse [Ms D] should have been fully aware of this incident form and its contents. It is not clear from the documents whether [Ms D] was aware of the incident form; she was aware that [Mrs A] had had a bad night on [Day 5] and of Nurse [Ms H's] concerns.

If that incident form was to have any impact, it had to be seen and actioned on [Day 6], not some days later.

[17] Dr B did not use the exact words, "normal diet".

It is also not clear whether [Dr B] was aware of the incident form. Had he been aware, it may have led to heightened concern by him that [Mrs A's] progress was poor.

Virtually all nursing shifts in the immediate 48 hours postoperative period were commenting on the degree of distress and pain being endured by [Mrs A]. These observations were documented in the nursing notes. The notes also record how these concerns were relayed to [Dr B] (always at his visits, but he was also rung on several occasions[18]). On 4 occasions the nurses called the resident medical officer. I find it unacceptable that these concerns were not actioned by [Dr B] or possibly [Dr B] was not given the full picture. It is likely both these scenarios existed.

In my opinion there was a responsibility on Charge Nurse [Ms D], who is in a position to get an overview of the situation, to perhaps have acted more decisively and reinforced to [Dr B] the persistent and increasing concerns of the nursing staff.

[Dr C] was the night resident medical officer on duty on the night of [Day 5] and the early morning of [Day 6]. He was called twice by Staff Nurse [Ms H] during the night, once at 2330 and a second time at 0445. On both occasions he was told [Mrs A] had low blood pressure (86/50), she was in a lot of pain and she was restless and clammy. His response on both occasions was to order more IV fluid (haemaccel) and more intramuscular pethidine. In [Dr C's] evidence point 5, he states such symptoms are not unusual in the immediate post-operative period. I would dispute this statement and it either reflects his ignorance of how patients should be a few hours following a laparoscopic procedure, or, by not attending the patient, he is making a risky assumption that despite these findings, the patient is well. I would be concerned with these symptoms/signs in a patient after any operation let alone a laparoscopic procedure. I am critical of RMO [Dr C] not attending [Mrs A] after the first call, and I am very critical of him not attending after the second call. This lack of action by not attending after the second call is below acceptable standards, even taking into account he is a junior doctor with little surgical experience.

[Dr C] in point 9 of his evidence says that his criteria for attending a patient are:

1) Observations suggesting need for assessment
2) Nurses ask him to attend
3) If there is any concern.

[18] Dr B was in fact rung on two occasions.

I maintain even a junior doctor should interpret what he was told by Nurse [Ms H] as 'observations needing further assessment' and secondly getting twice called about the same problem is cause 'for concern'.

There was an onus on Nurse [Ms H] to have been more decisive and ask [Dr C] to appear especially on the second occasion. However, in my opinion [Dr C] is not exonerated because the nurse did not specifically ask him to come.

In summary, evidence of communication breakdown is alarmingly obvious:

1) The nurses report severe abdominal pain, … [Dr B] says it is just her preoperative pain.
2) The nurses report minimal oral intake, … [Dr B] says 'she is eating her dinner' (see paragraph 28 in [Dr B's] evidence)
3) All nursing notes comment on [Mrs A's] mobilisation difficulties. [Dr B] interprets the nurses' comments on mobilisation [that the] nurses also 'thought there was no obvious illness present' (see paragraph 31 in [Dr B's] evidence).[19]

***7. [Dr B] was telephoned at approximately 2pm on [Day 7] by RN [Ms K]. She stated that she informed [Dr B] of [Mrs A's] clinical signs (increased pulse, low oxygen saturation, decreased urine output) and requested that he review [Mrs A]. [Dr B] stated that '[n]othing in the conversation made me believe that there was a need to see [Mrs A] prior to getting imminent results.'***

I interpret Registered Nurse [Ms K] telephone call to [Dr B] on the afternoon of [Day 7] as a final call for help. For nearly 2 days nurses had been informing [Dr B] of [Mrs A's] symptoms. The nurses from late morning on [Day 7] recognised how sick she was. They should have been more forceful in requiring [Dr B] to come and review the situation at that time. [Dr B] responded to the afternoon call by ordering an ultrasound scan and waiting on blood results. The relevant information he received however came from Registered Nurse [Ms K] who told him about [Mrs A's] unrelenting abdominal pain, her oxygen requirements increasing, her increased pulse rate and her poor urine output. There is enough in that message (and particularly taking into account the fact that [Dr B] knew [Mrs A's] progress to that point had been very slow) to expect an immediate response, by coming to the hospital himself and if he was going to be held up in traffic he had an obligation to ring a senior

[19] Commissioner's note: Dr B stated at paragraph 31 of his response:
"The nurses commented that there was difficulty mobilising [Mrs A]. That turn of phrase was consistent with them expressing that they also thought there was no serious illness present. Normally [the nurses] would use other phrases if they had concerns about a patient's condition."

doctor at the [private hospital] (another surgeon, an anaesthetist) and get them to review the situation without delay.

***8. Was [Dr B's] documentation of an appropriate standard?***

[Dr B's] documentation was satisfactory. His handwritten operative note was legible and explained the procedure. It is usual for this handwritten note to be followed by a more formal typed note which is not only for the notes but also for other interested parties particularly the referring GP. Ideally he should have regularly written in the clinical notes, particularly documenting the outcome of his visits. However, these visits (and their outcomes) were recorded by the nursing staff, which is a practice widely used in private hospitals. Unless there are complications this practice (of allowing the nurse to record the surgeon's visit) is never questioned, but in the complicated patient the surgeon him/herself should document the issues. In defence of [Dr B], he clearly did not recognise there were complications.

**Summary**

It is my opinion that [Dr B's] poor response to [Mrs A's] deterioration and the communication demonstrated between staff at [the private hospital] falls below acceptable standards. This opinion is based on the evidence submitted indicating an overwhelming awareness by the nursing staff and [Mrs A's] family, of her concerning postoperative symptoms and signs and yet for much of the time, particularly the first 36 hours, [Dr B] appears oblivious to what seemed obvious to everyone else. I concede [Dr B] was not supported by the RMOs (particularly [Dr C] and [Dr L]) and there was poor communication to [Dr B] from both the nursing staff and from his anaesthetist [Dr F]. Despite that I believe there was enough clinical evidence apparent by late on [Day 6] or certainly by early on [Day 7] for [Dr B] to have acted more decisively at that time, which may have saved [Mrs A's] life."

*Further advice*

Dr Stewart was asked to elaborate on the nature of his criticism of Drs B and C. He stated:

*Dr B*

"On [Day 6] [Mrs A's] situation was perhaps difficult to diagnose … The evidence however was there and by either late on [Day 6] or certainly [Day 7] it was clear the likelihood of a complication occurring was high. I believe most surgeons would have been worried by the [Day 7] (about the possibility of a complication) and intervened early on that day; certainly once he had received the first call on the [Day 7] from the nursing staff, [Dr B] should have responded immediately and come to the hospital. Operating a few hours earlier on [Day 7] may have saved her life. For failing to act more decisively (emergency investigations, [possibly] CT scan or re-look surgery), early on [Day 7] constitutes falling below acceptable

standards which, particularly because the outcome was catastrophic, I view with severe disapproval.[20]

*Dr C*

"I believe it was completely unacceptable for [Dr C] not to attend [Mrs A] after the 2nd call (from the nurses) on the night of [Day 5]. He will argue the nurse didn't request him to come. In his evidence he outlines his criteria for attending and I believe the situation described to him fits those criteria, particularly his, 'if there is any concern', criteria. By this criteria he should have attended and his failure to do so after the 2nd call falls below acceptable standards which I regard with severe disapproval."

Dr Stewart subsequently advised:

"The first failure to attend would be viewed with moderate disapproval, on the second occasion with severe disapproval."

*The private hospital*

"I regard the failure of senior nurses … to combine all their concerns (the repetitive reports detailing the problems with [Mrs A] postoperatively) and therefore act more assertively (impress on [Dr B] the need to act) as a fall below acceptable standards. I regard this with mild to moderate disapproval."

*Dr B's response*

Dr B, through his lawyer, commented on Dr Stewart's initial report. Dr B questioned Dr Stewart's advice as Mrs A's blood pressure was stable in theatre recovery; the blood pressure and pulse were stable on the ward; the "concerning" clinical observations at 5.30am were "consistent with the pain recorded" and "consideration of her post-operative BP in light of her sex and low pulse rate".

Dr B also stated that abdominal pain was the "primary complaint" when Mrs A consulted him, and that there was a recent preoperative description of the pain as "severe". Dr B also contended that the use of anti-inflammatory drugs can mask severe infection.[21]

Dr B's lawyer submitted:

"Mr Stewart quotes a paper from BJS indicating that 96% of patients were happy with a certain analgesia pack after laparoscopic cholecystectomy. It is hard to reconcile his use of these cases which involved patients coming in for a particular operation with a very high probability of curing their pain and with an almost certain diagnosis of biliary colic), and the case of [Mrs A]. It is submitted that with

[20] Dr Stewart was asked to clarify this comment. In an email dated 11 February 2008, he stated:

"I severely disapprove of [Dr B's] lack of action on [Day 7] irrespective of the outcome."

[21] *Paediatrics* vol 103 783–90, and *NZMJ* 2001, January 26 114, 3–6.

those patients it would be expected that they would have an uncomplicated post-op course with normal postoperative pain. Yet even in these circumstances, 15% of those day patients were admitted overnight because of their pain. Those patients are very different from [Mrs A's] case. Her surgery having regrettably not cured her pain meant that there was an expectation that her preoperative pain would continue.

…

Mr Stewart's use of his own last nine cases of cholecystectomy is, it is submitted, misleading and concerning. His patients did not have the same clinical picture, but had not even had the same operation.

…

[Dr B] instructs that the left shift of neutrophils could be due to anything and most often would be due to some totally insignificant factor. Of relevance is that a blood test on 8 April 2002 had shown a neutrophil leucocytosis. In American Journal of Surgery, 186 (1) 40–44, the authors note a drop in albumin and rise in liver enzymes after laparosopic surgery and a rise in CRP was noted by authors in Surgical Endoscopy 20 448–451.

…

Mr Stewart has referred to five factors which he says indicate the need to 'consider laparotomy'. Putting to one side whether these factors are truly five separate factors, it is submitted that this is pure retrospective analysis, made without due consideration to the total clinical picture, namely an undiagnosed severe abdominal pain. No other expert has claimed that pain alone is sufficient evidence to warrant laparotomy. He has, it is submitted, failed to show due consideration to factors including the absence of evidence of disease such as fever, hypoxia or other signs, usually present where there is a complication requiring laparotomy.

…

Mr Stewart shows no appreciation of the established reported literature on the difficulty in diagnosing bowel perforation after laparoscopy. The literature shows that many cases are not diagnosed in the immediate postoperative period.

Mr Stewart does not take into account that four doctors examined [Mrs A] postoperatively and came to the conclusion that there was no peritonitis or cause for alarm. These included [Dr F], an experienced intensivist […] so not available to provide a report.

…

> It is submitted that the claim [that an earlier operation may have saved [Mrs A's] life] is emotive and unjustified. The evidence shows that [Dr B] received the first call on [Day 7] from the nursing staff. That call was at 2pm. The evidence also shows that [Dr B] operated at 6pm. Had he acted immediately on [Day 7] after the call, then it is submitted the earliest the operation could have taken place would have been 4pm … [Dr B] instructs that the theatre was immediately available at 6pm because the elective lists on that day were finished. At 4pm, that may not have been the case. It is submitted that one could not realistically say that it would have made a significant difference."

[Dr B] also stated:

> "The case of [Mrs A] has been continually on my mind now for over three years. I have made efforts to further improve my practice:
>
> … I consult my colleagues more widely and frequently for the management of cases. Failure of any patient to recover as expected, results in seeking a second opinion to ensure there is the opportunity for consideration by another doctor, who is able to look fresh at all the information."

*The private hospital*

The private hospital commented on Dr Stewart's comments about the responsibilities of nursing staff in communicating concerns to Dr B:

> "The ability of a nurse to challenge a doctor's view and his approach to care for his patient is fraught with difficulties. Ultimately, if information is provided to a doctor concerning a patient's care, then for the most part the nurses involved act on the doctor's decisions (or indecisions or inaction). The nursing staff in this case were already guiding and suggesting further action to [Dr B] and were proactive in the management of [Mrs A's] case. This was an unusual situation which has not been repeated with other surgeons in the Hospital. Nursing staff do not usually take such an active role in challenging a surgeon's decisions and it is revealing in terms of [Dr B's] management.
>
> In this case, the nurses' view of [Mrs A's] condition varied significantly from [Dr B's] view. The nurses regret in hindsight that they did not manage [Dr B's] decision making more aggressively to force a change. However, to now criticise them for this aspect brings with it an aspect of hindsight which would be unfair given the overall circumstances."

*Additional surgical advice*

Dr Stewart provided further expert advice:

> " … I have reviewed the correspondence you enclosed and have replied under three headings
>
> a. [Dr C]

b. Reply to submission [from [Dr B's lawyer]
c. Communication issues (with reference to interviews with [Ms E] and [Ms D]).

**a. [Dr C]**

I am not suggesting he would have (or could have) diagnosed the complication sustained by [Mrs A]. The role/obligation of the night resident is to respond to the nurses calls, in most instances, by attending the patient. Perhaps for 'minor' issues (eg prescribing sleeping tablets, confirmation of normal recordings etc) then the phone call alone will suffice. I emphasise however that doctors who are called by the nursing staff reporting postoperative symptoms (and significant symptoms as they were with [Mrs A]), are taking 'risks' by not seeing and examining the patient. In [Dr C's] submission he states he learned from the first phone call (from S/N [Ms H]) on the night of [Day 5] that [Mrs A] was 'somewhat cool peripherally'. That could be a very significant observation in a patient a few hours following an abdominal surgical procedure. It requires confirmation and at the very least a detailed examination of the abdomen. It is arguably acceptable (many surgeons would say it is not acceptable), not to attend after **one (1)** call; it is unacceptable to not attend after the **second** call.

It seems very unlikely that had [Dr C] attended [Mrs A] on the night of [Day 5] he would have diagnosed a postoperative complication. However, the ultimate unfortunate outcome for [Mrs A] makes his failure to attend worse. [Dr C] stood no chance of making a significant diagnosis if he did not see her and carry out an examination.

The fact that [Dr C] was not specifically asked to attend by S/N [Ms H] is not a mitigating factor. His failure to attend on the first occasion I regard with disapproval. Having been called a second time about the same patient with similar symptoms and not attending is considerably below acceptable standards.

**b. Reply to submission [from Dr B's lawyer]**

Addressing the comments of [the lawyer]. In her submission she has addressed various points. I have used her paragraph headings in my reply.

1. Possibility of diagnosing a complication on the first post-operative day.
   There was enough concern during the first post-operative night ([Day 5]) over [Mrs A's] condition (including low blood pressure) for the night house surgeon to be called twice and such was the concern of the night nurse that the following morning she felt compelled to complete an incident report. In the submitted documents there are references to pain and blood pressure management (the recently submitted interview with [Ms D] confirms that) during the first 24hrs post-op. I emphasise I am not suggesting that a diagnosis was obvious during the first 24hrs; I am

suggesting that there was (or should have been) concern that her ([Mrs A's]) recovery was not proceeding normally and by late on the first post-operative day ([Day 6]) or certainly by early on [Day 7], that concern should have heightened to a level indicating the need for more intensive investigation. With respect to the blood tests, my original reports say they were not diagnostic but in combination with her failure to progress, they were significant and cause for concern. It is wrong to take the blood test (or indeed any of [Mrs A's] clinical parameters) in isolation. Taking **all** factors into account during the first 36 hours post-op, there were real concerns. Incidentally, I am not sure what the significance of point '4' in [the lawyer's] notes is … 'consideration of post-operative BP in the light of her sex and low pulse rate'!!!

2. Comments about the level of pain pre-operatively

   Whilst [Mrs A's] pre-operative pain symptoms need to be taken into account, it was unfortunately given far too much 'weight' in her postoperative assessment. It is worth noting that although [Mrs A] almost certainly had preoperative functional abdominal symptoms including pain, she was able to live normally. I do not subscribe to the view that her postoperative pain symptoms were likely a continuation of her pre morbid state but even if that was the case, her failure to show any improvement (in mobility, alimenting and pain) during the first 24 hours should have led to consideration of other causes for her lack of progress.

3. Pre-operative reluctance to eat

   There is huge difference between a patient with functional gastrointestinal symptoms (including eating irregularities), and a severely ill postoperative patient who, because of the severity of their illness, will not (or physically cannot) either eat or drink. The contrast or difference between these two scenarios should be apparent to trained clinical personnel and in [Mrs A's] case her reluctance to eat (and drink) was clearly a response to her clinical situation. All nursing reports (of [Mrs A's] eating drinking and mobilisation), further reinforced by the current submission from [Ms D] ('this lady needs two nurses and a physio to help get her out of bed') are in contrast to [Dr B's] version of her condition. The nurses state she was unwell, in pain, reluctant to mobilise and at best taking small amounts of fluid (a yoghurt substance was referred to in the original documents). According to [the lawyer], [Dr B] portrays an entirely different scenario … [Mrs A] was 'sitting up in a chair eating her dinner'. These scenarios are inconsistent (or if she was sitting up it took considerable physical assistance to get her there and I doubt she was contentedly eating her dinner) and the weight of evidence would favour the situation described by several of the nursing staff.

4. Anti-inflammatory Drugs

   If the masking properties of the anti-inflammatory drugs (which I submit in this case is just a convenient theoretical explanation) was relevant, then I am mystified why the various nurses who attended [Mrs A] throughout her stay were not equally (as [Dr B]) impressed with the lack of clinical signs.

5. Blood Tests

   As I have alluded to above, the blood test abnormalities (left shift of neutrophils, low albumin and low protein), are not diagnostic but in the context of [Mrs A's] poor post-op progress they are significant.

6. Postoperative care

I presume [the lawyer] is questioning whether the 5 factors I referred to in my original document are 'truly five **separate** factors'. My statement in that document clearly says that these factors are **not** separate and should be (or should have been) taken together. [The lawyer] seems to support that view; I am unclear of the point she is trying to make. She goes on to note concerns that my 'analysis' is retrospective and made 'without due consideration to the total clinical picture'. It is very much the contrary. [My] criticism of [Dr B] largely rests on the fact that the **whole** clinical picture was not considered. He only ever considered that her ongoing post-op pain (and other symptoms and signs) was a continuation of her pre-operative symptoms, rather than considering more widely and asking whether the post-op symptoms may well have had nothing to do with her pre-morbid state and instead were due to a complication.

A previously well middle aged lady 24–36 hrs following a minimally invasive laparoscopic procedure is still requiring regular narcotic pain relief, has not moved out of bed without the help of several assistants, has not had a resumption of gut function and has eaten and drunk very little, is cause for concern. If any 'experts' were to review that situation and deny they would consider doing further investigations (note in my original document I talked of urgent further investigations **including** considering laparotomy), I would be very surprised. The answer in a surgical fellowship exam to that clinical scenario would insist laparotomy be considered, possibly not the first thing to do, but if CT scan for example was not available, laparoscopy/laparotomy would be the only option. There is an old surgical adage, 'more harm is usually done by **not** considering (or doing) a laparotomy than doing one'.

7. Difficulty of Diagnosis

I am not critical of [Dr B] not diagnosing an iatrogenic small bowel perforation. I am critical of him not recognising the likelihood that a surgical complication may have occurred and particularly not taking timely steps to investigate such a possibility. I stress the cause of the complication whilst important is not the main point. Recognising there possibly **was** a complication and instituting measures to diagnose it and manage it, was required and not done to a satisfactory standard given the evidence available.

[The lawyer] submits 4 other doctors 'examined' [Mrs A] postoperatively. She states that all of them concluded there was no peritonitis. I take issue with that conclusion. Leaving out [Dr B] who saw [Mrs A] on 3 occasions, the other doctors [the lawyer] refers to are probably [Dr F], [Dr J] and [Dr L]. There is no evidence from the submitted documents that [Dr F] even

examined the abdomen let alone was in a position to comment on peritonitis. [Dr J] (the resident on the night of [Day 6]) found her 'in discomfort with a tender abdomen'. From the submitted notes the only time [Dr L] saw [Mrs A] was in the middle of the afternoon on [Day 7] only 2–3 hours before her emergency surgery. It is not clear from the notes whether [Dr L] examined [Mrs A's] abdomen; he can not comment on peritonitis if he has not examined her! What [Dr L] did say to the nursing staff was that she ([Mrs A]) was in pain and was hyperventilating and if the pain was brought under control then other things would settle down (I have quoted [Ms D]). I doubt Drs [L and F] made any attempt to arrive at a diagnosis, they seem to have simply responded to her symptoms and recommended pain relief. In the documents I received there was nothing I saw indicating that 2 of these doctors ([L and F]) even looked for peritonitis and the other doctor ([Dr J]) found her ([Mrs A]) to have a tender abdomen. Apart from [Dr B] and perhaps [Dr J], other doctors who saw [Mrs A] were not focussed on establishing a diagnosis to explain her clinical situation and responded to her symptoms (mainly pain) by prescribing analgesia. I have little doubt that once it was promulgated (by [Dr B]) that [Mrs A's] postoperative pain was simply a continuation of her pre-op symptoms, that none of the subsequent doctors (particularly [Drs L and F]) chose to formally examine her abdomen and challenge the working diagnosis.

**c. Communication issues (with reference to interviews with [Ms E], [Ms D])**

The transcripts of the interviews with [Ms E] and [Ms D] whilst a little hard to decipher and understand (because they are word for word what was said in the interviews and unedited in order not to destroy exactly what was said) are revealing and contain considerably more information and evidence of aspects of the nursing perspective on [Mrs A's] post-operative care than what was in the original documents.

I wish to rescind or at least modify what I stated in my previous submission under No. 6 ('Please comment on the standard of communication between clinical staff'). I am now convinced there was little more the nursing staff could have done to impress upon [Dr B] how ill [Mrs A] was during the immediate 48 hours post-op. As [Ms E] put it [in her interview with HDC] she was responding to an assertion (by me) that the nurses could have been stronger in raising their concerns with [Dr B], 'I still can't believe, that with all that evidence, constantly being described, um, and I think to the nurses' credit as objectively as they could they were becoming hysterical.'

There is a consistent theme coming through in both the [Ms E] and [Ms D] interviews that all the nursing attendants were well aware [Mrs A] was not progressing and did all they could to impress upon [Dr B] that something (further investigations) needed to happen. C/N [Ms D] took the relatively unprecedented

step of suggesting doing a CT scan (page 00363 … 'so I was saying to [Dr B] well have we done a CT scan because this lady had unrelenting pain …' and then finally took it upon herself (correctly I believe) to organise an ultrasound scan on the morning of [Day 6]. These are the actions of desperate nurses who fully understood the seriousness of the situation but could not convince [Dr B] to act.

There is a further important comment in [Ms D's] interview that surely should have indicated to [Dr B] the lack of progress by [Mrs A]. On the morning of [Day 7] (on page 00366) [Ms D] said: 'I don't remember saying those words exactly to him but when he said we were going to get her up and going, I, I said to him this lady needs two nurses and a physio to help get her out of bed, she's got unrelenting pain.'

I now accept the nursing communication was satisfactory and I am of the view the nurses did all they could to alert [Dr B] of [Mrs A's] deterioration. I probably overstated the importance of the incident report. I accept those reports are generally written not for any immediate action but as a document to discuss at a later date when procedural matters are being looked at to improve. Had [Dr B] been aware of the incident report I doubt it would have changed much particularly taking into account everything written in that report had already been conveyed at [Dr B's] early [Day 6] ward round."

## Responses to provisional opinion

*The private hospital*
The private hospital responded to the provisional opinion as follows:

"The problems in communication between [Dr B] and the other staff at the Hospital were not obvious at the time prior to [Mrs A's] operation. …

[Dr B] was operating at [the private hospital] on a relatively infrequent basis. He was operating in the public hospital and also carrying out private operations at [another] Hospital.

The first clear sign of an important communication issue arose in relation to the investigation of [Mrs G's] death.[22] The first provisional opinion in relation to [Mrs G] was dated 18 March 2003. This identified a conflict between a nurse who stated she had rung [Dr B] and his response that this did not happen. Unfortunately the call was not recorded in the clinical notes. It was not until the records from

[22] See Opinion 00HDC04656.

Telecom were obtained that the call could be proven. This detail was provided to [HDC] and the second provisional opinion was released on 1 September 2003.

It is possible to identify the communication issue with some clarity now. But it is suggested this is with the benefit of hindsight. The objective material available to [the private hospital] at the time of [Mrs A's] operation in [2003] was limited and was still developing.

[The private hospital's] management dealt directly with [Dr B] and recorded their discussions in writing. This approach had proved successful with similar problems with other consultants in the past. [Dr B's] response to such approaches was unique amongst the consultants at the Hospital.

We have attached copies of the relevant correspondence for your information.

*Summary*
[The private hospital] is committed to providing high quality healthcare. [The private hospital] accepts some concerns had been identified involving [Dr B] prior to [Mrs A's] operation. However, it took action to investigate those concerns and attempted to resolve them where this was possible with [Dr B]. There was limited evidence available at the relevant time to take any decisive action.

The evidence of serious communication problems had not been clearly identified at this time. We consider that in the circumstances, [the private hospital] did all that could be done to deal with the issues that had presented.

Our approach (and [Dr B's] response) can also be seen in the actions we took following [Mrs A's] death. Management sought to discuss her care with [the] District Health Board. This approach was not accepted. The Hospital also instigated a Mortality and Morbidity review in 2004. In addition … [the private hospital] arranged for the independent review of [Dr B's] cases to be carried out by [two doctors].

…

[W]e can advise now that [the private hospital] has no opportunity or need to audit [Dr B] further because he no longer has clinical privileges to work at our hospitals."

*Dr B*
In response to the provisional opinion, Dr B reiterated his concerns about Dr Stewart's advice. Dr B also noted, in relation to communication difficulties, that the nurses were "a significant common denominator", and that "in all likelihood from the evidence", the difficulties were "caused by the nurses' communication".

Dr B submitted that the public interest does not require him to be referred to the Director of Proceedings, since the case relates to "historic conduct relating … to

issues of communication". He also noted that the case "has already been the subject of extensive scrutiny before the Coroner".

*Dr C*
In response to the provisional opinion, Dr C submitted that Dr Stewart's criticism of his failure to attend Mrs A was coloured by outcome bias. Dr C noted that neither the anaesthetist nor surgeon altered his management of Mrs A.

Dr C obtained expert advice from consultant anaesthetist Dr J.

Dr J advised:

> "[After the second telephone call from a nurse, at 4.45am on [Day 6], [Dr C] should probably have assessed the patient himself and discussed the situation subsequently with [Dr B] [and] obtained advice about further management because he was a house officer and not a consultant surgeon.
>
> …
>
> I … believe that [Dr C's] conduct does not fall beneath the standard expected of a registered medical practitioner working as a house officer in a private surgical hospital providing care for consultant surgeons' patients."

Dr C accepts that his actions "may not have been optimal on that evening" (though he believes they were reasonable) and, "looking back on the night in question, he regrets not having attended [Mrs A]".

## 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*

*Right to Services of an Appropriate Standard*

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

…

*(5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.*

## Opinion: Breach — Dr B

*Introduction*
Mrs A developed a serious complication following routine surgery. Postoperatively, Mrs A suffered from significant pain and distress. The nursing staff caring for her were concerned about her condition and on several occasions notified her surgeon, Dr B. Tragically, despite emergency surgery and aggressive management from intensive care units in two hospitals, Mrs A died. The question for determination is whether Dr B should have recognised her postoperative complications at an earlier stage, and acted sooner.

For the reasons set out below, I have concluded that Dr B failed to provide Mrs A services with reasonable care and skill, and failed to cooperate with other clinical staff to ensure quality and continuity of services. Accordingly, he breached Rights 4(1) and 4(5) of the Code of Health and Disability Services Consumers' Rights (the Code).

*Response to complications*
Mrs A experienced a significant amount of pain soon after surgery, requiring four different analgesic drugs in the 14-hour period after surgery until she was reviewed by Dr B.

The nurse on duty during Mrs A's first postoperative night was sufficiently concerned about her condition that she called for medical support on three occasions and completed an incident form. These are the actions of a nurse who is very concerned about her patient. Dr B was aware that the nurse had contacted the RMO. While he was not aware of the incident form, the information on the form was also available to

him from the nursing notes, including the three reviews that had occurred overnight (once by Dr J, twice by Dr C).[23]

Dr B appears to suggest that Mrs A's recovery was progressing "normally" either because she had suffered such pain prior to surgery, or because it was expected postoperative pain.

However, I note that from immediately after surgery on Day 5 to 4.15pm on Day 7, Mrs A was administered analgesia on 25 occasions: pethidine six times; Panadol seven times; tramadol six times; Tilcotil three times; and Buscopan three times. This is a significant amount of pain relief.

Dr Stewart advised that, by late on Day 6, when Dr B reviewed Mrs A:

> "[Dr B] should have recognised the amount of medication [Mrs A] was requiring to control the pain was clearly excessive."

When Dr B ordered the nurse to give Buscopan at 6.35pm on the evening of Day 6, it was the 12th administration of analgesia since her operation 24 hours earlier. Dr B advised the Coroner that Mrs A was not needing much narcotic analgesia, and referred to the two administrations of pethidine at 4am and 8pm on Day 6. However, I note that tramadol is also a narcotic analgesic, and review of the drug chart shows that Mrs A was administered either pethidine (six times) or tramadol (five times) on 11 occasions from 6.30pm on Day 5 to 9.40am on Day 7.

I am not convinced by Dr B's submission that Mrs A's pain was not abnormal. I accept Dr Stewart's advice that Mrs A's pain and distress should have alerted Dr B to the possibility of postoperative complications.

Mrs A's blood test of Day 6 was abnormal. Dr Stewart advised that, on its own, the results were not diagnostic of the specific postoperative complications that Mrs A was suffering from. However, the information was important in the context of the patient's general condition, and other presenting features.

The nursing staff recorded in their notes, and state that they reported to Dr B, that Mrs A was having extreme difficulty walking — on the first day after surgery she required the assistance of two nurses, the physiotherapist and a walking frame to get out of bed. In addition, the nurse recorded that Mrs A was tolerating only small amounts of fluids, taking no more than sips by the afternoon of Day 6. Yet Dr B advised the Coroner in his letter dated 24 March 2004 that, until late on Day 7, Mrs A "seemed able to mobilise and eat satisfactorily postoperatively". This is in striking contrast to the nurses' records, their recollection, and the fluid balance chart.

[23] Dr C reviewed Mrs A twice overnight on Day 5/Day 6. Dr J reviewed Mrs A on the night of Day 6.

Mrs A's blood test, like her postoperative pain, difficulty mobilising, nausea and clinical observations were pieces of a jigsaw from which Dr B should have appreciated the need for further investigation of Mrs A's symptoms. I endorse Dr Stewart's summary view:

> "Whilst any of these 'factors' taken in isolation perhaps could be rationalised or explained as a variation that possibly would resolve or correct, … taken together, these findings and observations all strongly indicate [Mrs A's] immediate postoperative progress was not satisfactory. At the very least, the events of [Day 6] should have alerted him to a possible problem, and with her still not progressing by early on [Day 7], he should have urgently investigated her at that stage, including considering laparotomy."

*Communication*

It is vitally important for members of a clinical team to work together to ensure a patient gets the best possible standard of care. In particular, the relationship between a surgeon and the nurses on the ward is vital.

In this case, I have been provided with evidence that despite significant concerns about Mrs A being raised with Dr B by nursing staff, this did not prompt any action from him. In particular, Ms D stated that, on the morning of Day 7, she discussed the need for further investigation of Mrs A's condition with Dr B. In his responses, Dr B appears to suggest that Mrs A's postoperative condition was not unexpected given her preoperative pain, and therefore further investigation was not required. Yet he had not provided the nursing staff with any information about the nature of Mrs A's preoperative pain.

The telephone call at 2pm on Day 7 was significant. The call was made by Ms K, and witnessed by Ms D. Ms D is clear that Ms K communicated to Dr B that Mrs A's condition was of concern, yet he did not seem to comprehend what was being said. Ms K recorded, at the time, that she "strongly verbalised the need for him to come and review [Mrs A]".

Dr B stated:

> "The nurse suggested that I might like to review [Mrs A] again as there had been a deterioration. She had not passed any urine that morning and she had become tachycardic."

In my view, even if Ms K had merely "suggested" that Dr B consider whether he would like to review Mrs A, the critical facts were that his patient had not passed urine for some hours, was tachycardic, her oxygen saturations were deteriorating, and she had unrelenting pain.

I endorse Dr Stewart's view that there was enough information in Ms K's call to expect an immediate response from Dr B, either by coming himself, or asking another

doctor to attend in his stead. He did neither, choosing to complete his clinic. Although it cannot be said that Mrs A would have survived had Dr B attended immediately, her chances of survival would have been greater.

It is hard not to reach the conclusion that Dr B discounted the nurses' concerns in the postoperative stage of Mrs A's care. Certainly, given what Dr B was told about Mrs A's condition at 2pm on Day 7, he should have been concerned enough to take immediate action.

*Summary*
Dr B failed to respond to Mrs A's worsening condition and the concerns of the nursing staff. When called by the nursing staff on Day 7, in what Dr Stewart called a "final call for help", Dr B neither attended himself, nor asked a colleague to attend in his place. In his response, Dr B appears to suggest that he is being judged with the benefit of hindsight. Dr Stewart advised:

> "A previously well, middle aged lady, 24–36 hrs following a minimally invasive laparoscopic procedure, is still requiring regular narcotic pain relief, has not moved out of bed without the help of several assistants, has not had a resumption of gut function and has eaten and drunk very little, is cause for concern. If any 'experts' were to review that situation and deny they would consider doing further investigations … I would be very surprised. The answer in a surgical fellowship exam to that clinical scenario would insist laparotomy be considered, possibly not the first thing to do, but if CT scan for example was not available, laparoscopy/laparotomy would be the only option. There is an old surgical adage, 'more harm is usually done by **not** considering (or doing) a laparotomy than doing one'."

On 23 October 2003, I released my report into the care provided to Mrs G (00HDC04656). Dr B performed a laparoscopic cholecystectomy on Mrs G at the private hospital on 26 February 1999. I found that Dr B failed to respond adequately to Mrs G's deteriorating postoperative condition, including a call or calls from concerned nursing staff. In my investigation report, I noted Dr B's assurances:

> "[Dr B] has advised that as a result of this incident he has reviewed his practice and now, whenever he is the sole specialist responsible, makes a point of visiting every patient twice daily or telephoning the nursing staff and asking for full details of the patient if he is only able to visit once a day."

It could be argued that Dr B satisfied his previous assurances by visiting Mrs A or telephoning nursing staff; however, such contact is irrelevant if inadequate clinical care is provided as a result of those contacts. Dr B's errors of clinical judgement and his failure to act on the communication from the nursing staff were significant.

Dr B was on notice that he needed to improve his communication with nursing staff. I find it very concerning that he did not take steps to do so. It is incumbent upon health

professionals to learn from tragic cases such as that of Mrs G and improve their practice. Dr B shows very little insight into how his poor communication with nursing staff contributed to the tragic outcome for Mrs A. Instead, he points the finger at the nurses as the cause of the communication difficulties. He compounds his own failings by his lack of insight and unwillingness to accept any personal responsibility.

I note Dr Stewart's view that the postoperative care provided to Mrs A by Dr B would be viewed with severe disapproval by his peers. In my view, Dr B breached Rights 4(1) and 4(5) of the Code, as he failed to provide services with reasonable care and skill, and failed to co-operate with the nursing staff to ensure quality and continuity of care. His failings are of sufficient gravity to warrant referral to the Director of Proceedings, to consider whether further proceedings should be taken against Dr B.

## Opinion: Breach — Dr C

As the RMO on duty during the night of Day 6, Dr C was responsible for responding to any calls for assistance from the nursing staff. Overnight, he was called twice because of concerns about Mrs A's condition.

At 11.30pm, he was called by Nurse Ms H, as Mrs A was very distressed, restless, in pain, nauseous, with a low blood pressure, and "cool and clammy". Dr C did not assess Mrs A in person; he ordered pethidine and intravenous fluids to be administered, and to be called back "if this pain relief was inadequate".

Dr C was called for a second time almost five hours later, at 4.45am. Mrs A was in considerable pain ("Disabled by pain"), "restless and clammy", and her blood pressure had dropped. Again, Dr C did not attend in person, and instructed that pethidine and IV fluids be given, but added that a urinary catheter be inserted to rule out either urinary retention of low circulatory volume (hypovolaemia).

Dr C stated that these calls were "routine postoperative pain management enquiries", and that he would have attended Mrs A if the nurse had asked him to. However, I note that Mrs A's low blood pressure was also discussed between Dr C and the nurse, which resulted in Dr C twice ordering IV fluid replacement. Also, as a result of the nurse's concerns expressed in her second call, Dr C ordered a catheter to be inserted to observe for a low circulatory volume or urinary retention. It is of note that Mrs A's preoperative blood pressure was recorded (midday on Day 5) at 140/80mmHg; when Dr C was called the first time, Mrs A's blood pressure was 90/60mmHg, and 95/65mmHg when called the second time.

Dr C has not suggested that he was too busy to attend on either of these occasions. It appears that he chose not to attend because he did not believe that there was any clinical need for him to assess Mrs A's condition in person. However, I am satisfied

that Ms H's calls to Dr C were not just routine postoperative pain management calls — they were calls from a nurse concerned about the condition of her patient. I note that when she needed medical advice a third time, she contacted Dr B rather than Dr C.

Dr C advised that he would have attended "if there [was] any concern". In my view, Mrs A was described to him by Ms H as a patient whom Dr C should have attended: Mrs A's blood pressure was low (twice requiring volume expanding fluids), she was in significant pain, and the nurse had called twice. Dr C suggests that, as the nurse had not specifically asked him to attend, there was therefore no need for him to do so. However, my view, supported by my expert, is that with the symptoms as described by Ms H in her contemporaneous clinical record, Dr C should have assessed Mrs A in person.

Dr C obtained expert advice from consultant anaesthetist Dr J. I note, however, that Dr C was employed as an RMO, not an anaesthetist, and the purpose of his role was:

> "[t]o assist with the care and treatment of patients at [the private hospital] as directed by the medical consultants and provide immediate patient care in the event of emergencies".

Ms H contacted Dr C not because he was an anaesthetist, but because of his role to support ward staff "in the event of emergencies".

Dr Stewart advised that it was "arguably acceptable" for Dr C not to attend on the first call from Ms H, but this would still be viewed with moderate disapproval by his peers. However, in relation to the second call, Dr Stewart considered that it was "unacceptable" that Dr C did not attend, and that his peers would view this failure with severe disapproval.

[The consultant anaesthetist who provided expert advice to Dr C] was less critical of Dr C's failure to attend, advising that his conduct "does not fall below the standard expected of a registered medical practitioner working as a house officer in a private surgical hospital providing care for consultant surgeons' patients". However, even [he] accepted that Dr C "should probably have assessed the patient himself and discussed the situation subsequently with Dr B", having been telephoned a second time by the nurse.

I note that the private hospital has amended its policy subsequent to this incident to state specifically that an RMO should personally assess a patient if called twice. In my view, the fact that this is now an explicit requirement does not excuse Dr C from failing to review Mrs A in person on the night of Day 6.

By failing to assess Mrs A in person when called, Dr C failed to provide services with reasonable care and skill, and consequently breached Right 4(1) of the Code.

## Opinion: No breach — The private hospital

*Credentialling*

Credentialling supports patient safety by clearly defining and monitoring practitioner competence within a given scope of practice.[24] All hospitals should have rigorous processes in place for credentialling clinical staff. The need for effective credentialling was highlighted in my *Tauranga Hospitals Inquiry* report[25] and more recently in my *Wanganui Hospital Inquiry* report.[26] The private hospital had a well-established credentialling/privileges process in place in 2003, but it is not clear how rigorous it was.

I note with some concern that Dr B's privileges were renewed without restriction in 2003. I appreciate that the Medical Council competence review was reassuring and, given Dr B's assurances, concerns may have been allayed. However, an employer or a hospital granting clinical privileges should undertake a broader assessment of a clinician's performance, taking into account any issues that have arisen in the workplace. The Medical Council's competence review process is no substitute for a rigorous credentialling process.

I discuss below the private hospital's responses to communication difficulties involving Dr B, and to other concerns raised about his practice.

*Communication*

It appears that there were no difficulties experienced by nursing staff in *contacting* the medical staff caring for Mrs A. What proved difficult for the nurses was having their concerns appreciated by Drs B and C.

Dr B stated that he expected to be informed by the RMO of any concerns about his patients, but on the two occasions when Dr C attended Mrs A, Dr B was not contacted directly by the RMO. I note, however, that the nurse on that occasion did call Dr B and discuss Mrs A's care overnight, so Dr B would have been aware of Dr C's involvement in Mrs A's care. Dr B would also have been aware of Dr J's review, from the notes.

Although Dr Stewart has criticised the standard of communication at the private hospital, I am satisfied that the problem was that Dr B was not "hearing" what he was

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[24] Credentialling a process used to define specific clinical responsibilities (scope of practice) of health professionals on the basis of their training, qualifications, experience, and current practice, within an organisational context. The context includes the facilities and support services available in the service the organisation is funded to provide. Credentialling is part of a wider organisational quality and risk management system designed primarily to protect the patient. It is an employer responsibility with a professional focus that commences on appointment and continues throughout the period of employment. Ministry of Health, *Toward Clinical Excellence — A framework for the credentialling of senior medical officers in New Zealand* (March 2001) 1.1.

[25] http://www.hdc.org.nz/files/hdc/opinions/04hdc07920surgeon.pdf (18 February 2005).

[26] http://www.hdc.org.nz/files/hdc/opinions/ (26 February 2008).

being told. Nor has Dr B provided any evidence that he had clarified or documented his expectations about being contacted, for the benefit of nursing staff and RMOs.

Dr B had a history of communication problems with nursing staff at the private hospital. It appears that nursing staff had modified their practice to take into account these problems. An example is the fact that the telephone call to Dr B on the afternoon of Day 7 was made by two nurses.

Nursing staff may have modified their practice, but the key issue is whether the private hospital did enough to remedy problems with Dr B's communication. Although there is no employment relationship between Dr B and the private hospital — he is granted "visiting privileges" — that does not allow the private hospital to abrogate itself from a responsibility to ensure that its visiting specialists are providing an appropriate standard of care, particularly when a significant risk (poor communication with nursing staff) is identified.

In its response to the provisional opinion, the private hospital advised that it was not aware of the communication problems between Dr B and nursing staff until after the release (in September 2003) of the HDC second provisional report of an investigation into Dr B's care of another patient at the private hospital. With some reservations, I accept that the private hospital did not have reason to be concerned about Dr B's communication with nursing staff at the time of these events.

*Previous concerns*
The private hospital commented that there had been rumours circulating about Dr B's clinical practice, but that they were unsubstantiated and it had proved impossible to obtain any further information because of "privacy concerns".

In my view, if concerns have been raised (even informally) about an individual practitioner's practice, then all reasonable attempts should be made to ascertain the validity of those concerns. The private hospital has a Medical Advisory Committee that could have discussed the issue. An audit of his practice could have been considered. Obviously, in fairness to Dr B, the concerns needed to be put to him so that he could respond. However, any concerns about the clinical competence (including communication skills) of a visiting specialist must be taken seriously by the private hospital that grants him or her visiting privileges.

The private hospital has provided correspondence to and from Dr B which shows that it did seek to clarify whether there was any need to be concerned about his practice. The Medical Council was also contacted but said that it could not provide details of a competence review it had undertaken on Dr B in early 2003. Ultimately, the private hospital was informed by Dr B that the Medical Council had written to him on 15 May 2003, advising that there were no concerns about his clinical practice.

*RMO staff*
The private hospital employs five RMOs who provide support out-of-hours. Dr Stewart advised that this level of staffing is more than many private hospitals provide. I am satisfied that Dr C's breach of the Code was as a result of his own poor clinical decision-making, and that the private hospital could not have predicted or prevented his actions. I note, however, that the private hospital has subsequently introduced guidelines that require a doctor to attend the patient, in person, if called on a second occasion. In this case, I do not feel that the absence of those guidelines contributed to Dr C's failure to act appropriately.

*Summary*
Undoubtedly, the private hospital had to deal with a difficult set of circumstances with Dr B over a lengthy period of time. A picture emerges of a hospital that endeavoured to address the issues fairly and firmly. The legal issue is whether the private hospital took reasonable actions in the circumstances to ensure that Dr B was competent to practise, and to protect patients. This is a finely balanced decision. It is easy with hindsight to see that the private hospital failed to promptly identify the extent of Dr B's shortcomings. When management became aware of concerns about Dr B's practice, it probed the concerns but was unable to substantiate them. On balance, I accept that the private hospital took reasonable actions in the circumstances to ensure that Dr B was competent to practise. Accordingly, the private hospital did not breach the Code in its care of Mrs A.

## Recommendations

I recommend that Dr B apologise to Mr A for his breaches of the Code, review his practice in light of this report, and confirm that he has provided a copy of this report to the Chief Executive of any hospital where he currently works.

I recommend that Dr C apologise to Mr A for his breach of the Code, and review his practice in light of this report.

## Follow-up actions

- Dr B will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

- A copy of this report will be sent to the Medical Council of New Zealand and the Coroner.

- A copy of this report, with details identifying the parties removed except the name of Dr B, will be sent to the Royal Australasian College of Surgeons.

- A copy of this report, with details identifying the parties removed, will be sent to the New Zealand Private Surgical Hospitals Association and the New Zealand Nurses Organisation, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.



*Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.*