General and Endoscopic Surgeon, Dr B

A Private Hospital

A Report by the

Health and Disability Commissioner

(Case 06HDC09771)

Parties involved

Ms A	Consumer
Dr B	Provider/General and Endoscopic Surgeon
Ms C	Registered nurse
Ms D	Registered nurse
Ms E	Registered nurse
Ms F	Consumer's daughter
Ms G	Consumer's friend
Dr H	Anaesthetist
Mr I	Registered nurse/the Hospital's Clinical Services Manager
Ms J	Charge nurse
Dr K	Psychiatrist
The private hospital	A private hospital

Complaint

On 30 June 2006 the Commissioner received a complaint from Ms A about the services provided by general surgeon Dr B and a private hospital (the Hospital). The following issues were identified for investigation:

Dr B

- *The adequacy of Dr B's preoperative investigation of Ms A before performing her surgery on 15 April 2005.*
- *The adequacy of the information Dr B provided to Ms A after her surgery on 15 April 2005.*
- *The adequacy and appropriateness of the Dr B's postoperative care of Ms A between 17 and 18 April 2005.*

The Hospital

- *The adequacy of the care provided by the Hospital between 15 and 18 April 2005; in particular the system for sharing and communicating information between the Hospital and Dr B.*

An investigation was commenced on 14 November 2006.

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Information reviewed

Information was received from:

- Ms A
- Dr B
- Ms F
- Ms G
- Regional Manager, the Hospital
- Quality Improvement Advisor, the Hospital

Ms A's medical records and ACC medical misadventure claim documentation were reviewed.

Independent expert advice was obtained from a general surgeon, Dr Andrew Connolly, and a registered nurse specialising in surgical care, Philippa Pringle (attached as Appendices 2 and 3 respectively).

This investigation has taken more than a year owing to the amount and complexity of the information involved and the need to obtain additional expert advice.

Information gathered during investigation

Overview
Ms A (aged 57 years) consulted general surgeon Dr B regarding elective surgery for varicose veins. At the pre-surgery consultation on 9 March she reported intermittent minor rectal bleeding. Dr B agreed to investigate the cause of Ms A's bleeding while she was anaesthetised for her vein surgery, scheduled for 15 April 2005. After performing the vein surgery, Dr B introduced a sigmoidoscope, which revealed a polyp, and a tumour in the rectal wall. He dissected the tumour from the wall of the rectum, which resulted in a visible hole. Dr B repaired the hole. The following day, he advised Ms A that a tumour had been found, dissected and sent for histological examination. On 17−18 April Ms A deteriorated and developed signs of peritonitis. She was returned to theatre for repair of a leaking anastomosis[1] and construction of a stoma.[2] When her condition did not improve, she was transferred to a public hospital's Department of Critical Care. On 21 April she was transferred to a surgical ward and

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[1] An artificial connection between two tubular organs or parts, especially between two normally separate parts of intestine.

[2] An artificial opening of a tube (eg, the colon or ileum) that has been brought to the abdominal surface.

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had additional surgery the following day to excise a short length of necrotic bowel and revise the colostomy.

December 2004 consultation
On 15 December 2004, Ms A consulted Dr B to talk about treatment for her varicose veins. Ms A was well known to Dr B as he had treated her on a number of occasions. That same day Dr B wrote to a dermatologist to whom he had written previously regarding Ms A's varicose vein treatments, to advise him that he had seen her that day regarding some "small residual veins on her left leg". Dr B stated that he had arranged to treat these under a "brief anaesthetic" early in 2005.

Dr B's experience
Dr B has been a Fellow of the Royal Australasian College of Surgeons (RACS) since 1977. He has over 30 years' service at a large public hospital, where he was the Clinical Director of General Surgery. Dr B resigned this position to concentrate on the development of a vascular service. He is an instructor in a number of RACS programmes. Dr B is a visiting surgical specialist at the Hospital.

March 2005 consultation
On 9 March 2005, Ms A saw Dr B to further discuss the surgery. She told him that for about two years she had experienced intermittent rectal bleeding. Dr B noted that the bleeding was of the "pan and paper" type and quite painless, but she had occasionally noticed clots. Ms A reported that there was no change in her bowel habits and that her general health was sound. She was aware of a small external or prolapsed haemorrhoid.

Ms A stated:

> "I also asked the surgeon whether I should have a physical examination at that time to rule out internal piles or whether there might be something more sinister. He said that it was not needed and did not undertake any physical or rectal examination, although he looked briefly at the Varicose Vein. … I should have undergone a colonoscopy and perhaps a gastroscopy procedure to exclude medical possibilities, as they were less invasive … and that would have highlighted the several polyps and extensive tumour. Given that I paid for a full preoperative consultation, I do not consider I received a thorough examination."

Dr B recorded the examination as follows:

> "Not examined today but for careful EUA [examination under anaesthetic] and possible bands or injections at the time of her vein surgery. Explained that further investigation and management would depend on the findings at the time."

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Dr B noted that he did not send a letter to the dermatologist regarding this consultation. Dr B advised that he does not recall Ms A specifically requesting an endoscopy. He said that it was "certainly discussed" and his recommendation was that as she was due to have an anaesthetic in about a week it was easier for her have an examination and any appropriate local procedure done at that time. Dr B stated that his other consideration when making this recommendation was that he believed this approach would cause her less distress.

On 9 March 2005, Ms A signed a "Patient Admission Form" signifying that she consented to the surgery and rectal examination Dr B had discussed with her. Ms A stated that she had originally intended to have her surgery in the early part of 2005; however, as she had just moved back into her house and was settling into a new job she decided to postpone the surgery until April. The admission date was noted to be 15 April 2005 and the length of her admission estimated to be between 24 to 48 hours.

Ms A believes that as the operation was not scheduled until 15 April, Dr B had "more than sufficient time to do a pre-examination".

On 21 March, Ms A telephoned Dr B to inform him that she had changed general practitioner. She also stated that she did not want morphine for pain relief postoperatively and that the new GP had recommended tramadol. Ms A also reminded Dr B that she had a heart murmur and asked about the need for antibiotic cover, and whether an intravenous or oral route was the most appropriate.

15 April 2005 surgery — the Hospital

On Friday 15 April 2005, Ms A was admitted to the Hospital for her surgery. A "Proposed Procedure" form recorded that her surgery was for left varicose veins and a sigmoidoscope examination under anaesthetic. Her previous history of rheumatic fever and asthma was noted. The form also noted that Ms A had requested not to have morphine as she had had a "bad experience last time". She was taken to theatre at 4pm. Anaesthetist Dr H started the general anaesthetic at 4.10pm.

Dr B recorded the procedures undertaken, noting that the previously marked veins on Ms A's left leg were carefully removed through a series of tiny incisions. The wounds were steri-stripped. Ms A was then positioned so that a sigmoidoscope could be inserted into her rectum. When the sigmoidoscope was inserted ten centimetres into the rectum a small adenomatous (benign epithelial) polyp, a few millimetres in diameter, was seen. Five centimetres further in, a "broad based villous tumour" could be seen on the anterior rectal wall. As there had been adequate preoperative bowel preparation Dr B decided that it was safe to excise this tumour. He dissected the tumour off the rectal wall using cautery. Dr B recorded, "At one point there was a visible hole into the Pouch of Douglas[3] and this was carefully repaired using a double layer of continuous 4/0 Monocryl [suture material]." Dr B considered that the closure

[3] Pouch of peritoneum occupying the space between the rectum and uterus.

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of the hole was satisfactory and decided not to remove the polyp or the peri-anal tags noted at the beginning of the procedure. He ordered intravenous antibiotics.

Dr B recalls:

> "The operation record is quite clear that a full thickness of bowel wall was performed with a breach into the Pouch of Douglas. … [R]esection of a bowel tumour should be complete to prevent recurrence or spread even if benign and if this entails full thickness resection then that is what should be done. It was clear to theatre staff that I was repairing the bowel after resection of the tumour but I do not recall whether I mentioned it to other staff — it is likely that I did so by way of explanation for not discharging [Ms A] on the Saturday morning as would normally be expected, as well as for the continuing prescription of antibiotics."

Ms A believes that if she had undergone a pre-surgical examination, the tumour would have been found and Dr B could have given appropriate time and thought to how best to proceed with "an appropriate medical intervention", and the subsequent events may not have occurred.

Postoperative care

Ms A returned to the ward at 6.45pm. Standard postoperative observations were taken and her condition was noted to be stable.

Ms F stated that she visited her mother on Friday evening and was present when she returned from theatre. Between 6pm and 8pm that evening Ms A was spoken to by the nurse caring for her mother, who told her that Dr B would be away for the weekend. Dr B left a message on Ms F's cell phone to advise her that "all went well".

The Hospital surgical records are standardised generic forms. The postoperative documentation used for Ms A was headed "Clinical Pathway for Various Veins". The form also noted "Additional surgery and/or change to surgery, which recorded that Ms A had "EUA [examination under anaesthetic] & exc. large rectal tumour". On the page headed "Day of Surgery", under the heading "Surgeon's & Anaesthetist's instructions", the postoperative instruction for Dr B's patients is "Bedrest postop day". Below this is a list of prompts for nursing staff for recording of medications, vital signs and other postoperative observations. The "Day One" form also has a list of the surgeon's and anaesthetist's routine standard instructions, such as "micropore to sutures, below knee TEDs [thrombosis/embolism deterrent stockings]". There is a section on the form for daily multidisciplinary notes and actions.

At 11pm Ms A expressed concern about Dr B not visiting. The nursing records show that Ms A became "very agitated". However, she was well enough to walk to the toilet and, after a cup of tea and something to eat, settled for the night.

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16 April 2005 — day one post surgery
Dr B states that he informed Ms A about the bowel resection on the morning following her surgery, but did not use the term "perforation". He explained that it is not his habit to discuss technical issues with his patients on the day of surgery. Taking account of the patient's anaesthesia and medication, Dr B normally waits until the following day when the patient is more alert and able to understand the explanations provided. He told Ms A that she had a "sizeable rectal tumour" that had been "hopefully completely" removed. He said that histology would confirm the nature of the tumour in a few days, and explained to Ms A that she would need a follow-up colonoscopy to deal with the small remaining polyps and to examine the entire length of her colon.

Ms A stated:

> "Whilst the surgeon probably has a better memory of the immediate postoperative events in relation to speaking with me about the excision of the tumour, I have a little less recollection (because of the heavy medicated state I was in). However, I do recall him saying he had taken out a tumour, he said 'something about a pouch', and some internal perineum hanging down, but he definitely did not say anything about him perforating the bowel."

Dr B stated that Ms A's postoperative care was managed with the bowel tumour in mind. She was advised about the findings and procedure and that she should stay in hospital, on antibiotics, until her bowels moved and her recordings were stable.

Ms A does not accept that Dr B's claim that her postoperative care was managed with the bowel tumour in mind. She said she was put on a full diet "almost immediately" and the type of food she was given was "very similar in quantity and portions" she received following other surgery. Ms A is concerned that Dr B did not provide her with information about bowel surgery or advise her of the potential risks associated with the procedure.

On Saturday 16 April, Ms A was well enough to go for short walks in the hospital corridor with the assistance of her daughter.

Histology report
Ms A understood that the tumour Dr B removed measured 15cm. It appears that Ms A was confused by the operation record noting that the tumour was found 15cm into the rectum. The histology report shows that the tumour was 45mm or 4.5cm at its widest point.

On 20 April 2005 the laboratory reported the result of the histology examination of the tumour Dr B removed from Ms A's rectal wall. The report stated:

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> "VILLOUS TUMOUR ANTERIOR RECTAL WALL 15–20 CM
>
> **Gross Description**
> The specimen consists of a light brown exophytic [growing outwards] tumour measuring 45 x 23 x 17 mm
>
> **Microscopy**
> All of the specimen has been processed for histological examination. Sections show a villous adenoma of the large intestine with low grade dysplasia. There is no evidence of malignancy."

17 April 2005 — day two post surgery
The clinical notes show that on Sunday 17 April, Ms A was concerned that her bowels had not moved. She believed she had a blocked bowel and was "probably going to die". Because her bowels had not moved and she knew that she would become constipated, Ms A telephoned a friend, Ms G, to ask her to bring some fruit when she visited. Ms G did not stay long at the hospital because Ms A's daughter was visiting and Ms A was in pain.

Dr B telephoned the hospital at 11.40am on Sunday. He recalls that "the responses to my enquiries were entirely reassuring", other than that Ms A's bowel had not yet moved. Under the circumstances he felt no action on his part was required and did not visit. Dr B stated, "I was led to believe she accepted this without any dissent." He said that he would try to visit later that day and instructed the nursing staff to continue with the intravenous antibiotic, Augmentin. The notes state that Ms A was being "very difficult and rude" to the nursing staff.

Ms A said that her deterioration began "during Sunday 17 April 2005 (from approximately 2.00 pm as I recall)". She "knew" things were not right. Her bowels had not moved, she was nauseated and bloated, and her urine output was low.

At 5.15pm, the agency nurse assigned to care for Ms A asked one of the registered nurses employed by the Hospital, Ms C, to talk to Ms A, who was distressed. Ms A told Ms C that she felt nauseated when her evening meal arrived. Ms C noted that although Ms A had not had a bowel movement that day, she had been up and about around the ward and had passed urine. Ms C advised Ms A not to have the full dinner she had ordered, but to have fruit and fluids instead until her bowels opened. Ms A told Ms C that she normally took Metamucil to help move her bowels. Ms C agreed to telephone Dr B to ask if Ms A could have some Metamucil.

Ms A stated that by this time she was clearly unwell and became "hysterical". She recalls that at 5.30pm she asked to be transferred by ambulance to the public hospital, but was advised that Dr B was "uncontactable".

The Hospital advised:

> "We have no record of [Ms A] making this request at this time.

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> Nonetheless, such a request is akin to a patient in a standard surgical ward at a tertiary hospital requesting a transfer to the Intensive Care Unit. These sorts of transfers are based on clinical need/considerations and not personal preferences. This may be difficult for patients to understand but we will always explain the rationale behind such decisions to patients and their families/whanau."

Ms A responded:

> "Although [the regional manager] may not find any written records, which clearly [shows] the nurses and supervisor failed to record, the reality is that the request was made (verbally and 'hysterically') and was ignored at some level (how many requests does a patient need to make?), and the action by the hospital to [Ms A's] requests was clearly outside [Ms A's] control as she was very unwell and was frightened. When a patient makes a request (whether it is deemed emotional, hysterical or outside the hospital 'parameters') a patient should, at the very least, expect in a hospital environment that it would be taken seriously enough. [The Hospital] should make every effort to contact the Surgeon to visit the patient at that time, or at the very least refer the patient to another Emergency Department at a Public Hospital whereby there would be better equipment and more skilled nurses to consider the intensity of [Ms A's] postoperative condition."

Ms C telephoned Dr B at about 6pm, advised him of Ms A's request and that she had "wind pains++". He agreed that she could have Metamucil.

Ms G said that at about 7.45pm she received a telephone call from Ms A, who was very upset. Ms A told her that she was very bloated, had not passed anything (which was not usual for her), and nobody was listening to her. She was very scared because her nephew had died of renal failure following septic shock and she feared that would happen to her. Ms A told her that an "Indian" nurse told her that she was "making a fuss". Ms G advised Ms A to "by-pass" the nurse — to "go round" her as she would normally do when she has a personality conflict with someone.

Ms A stated that despite the deterioration in her condition she continued to be monitored "only by [the Hospital] nurses" and despite asking to see a doctor this was refused and "my surgeon declined to visit at this time". She said:

> "I continued to deteriorate even further — there was almost a total cessation of urine output, I could not eat, I continued to vomit, I was delirious and the only actual intervention that occurred was the installation of a catheter by a nurse (at my suggestion) who appeared to have little experience placing a catheter within a patient."

During Sunday evening and night Ms A left three messages on her daughter's cell phone. Ms F stated:

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> "She was clearly screaming and upset about what was happening to her, said to come and get her and to take her to [the public hospital] emergency as, 'she said she was very sick and had vomited and the nurses were not looking after her or listening to her'."

Ms F did not retrieve her mother's messages until Monday morning owing to a problem with her cell phone.

Dr B recalls that he was contacted at about 8.20pm by the nursing staff to report that Ms A was "very agitated and becoming abusive". Her recordings remained stable but she was concerned that her bowels had not moved.

Dr B subsequently telephoned Ms A and spoke to her at about 10pm. He recalls:

> "[T]hat her bowel had still not moved … in itself was not to me a cause for alarm. I spoke to [Ms A] on the telephone and she expressed this to me, to which I advised her that she was not going to help by getting worked up and she seemed to accept this and my reassurance without question.
>
> It is certainly true that I prescribed a small dose of morphine at about 8.20pm on the Sunday evening on the basis that with normal recordings and significant agitation the morphine would help settle [Ms A] without masking any major developing problem — something which however I did not seriously consider at that time."

Ms A has no recollection of Dr B discussing morphine with her. As noted above, Ms A advised that her memory of the postoperative events is unreliable owing to her "heavy medicated state".

Ms A was very uncomfortable and upset that evening. Ms A said that the staff made "very inappropriate verbal comments" to her and that she was made to feel that she was "making a nuisance of herself". She stated:

> "During that period of despair (knowing I was close to death) it is possible the nurses may have been registered, but may not have had sufficient and previous professional competence/development/expertise in recognising the deleterious effects I experienced sufficiently and adequately to raise the alarm."

The Hospital has no record "to support or refute" Ms A's assertion that the nursing staff told her that she was making a nuisance of herself.

The Hospital stated:

> "Our nursing staff will always be vigilant for complications following bowel surgery as any procedures involving full thickness bowel wall excisions or bowel anastomoses carry a reasonable risk of developing an anastomotic leak (2–3% incidence on average).

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> The signs and symptoms of an anastomotic leak are initially representative of a number of differential diagnoses and are extremely hard to definitively diagnose early on. … Due to the difficulty in diagnosing this complication and the invasiveness of definitive treatment it is common practice to closely monitor such patients initially to see whether the patient's condition improves or deteriorates. The diagnosis usually becomes clearer with time."

A known side effect of morphine is nausea and vomiting. When prescribing the morphine Dr B also prescribed an antiemetic to be given at the same time (in line with accepted practice) to counteract nausea.

Ms D, the afternoon duty registered nurse, recorded:

> "2200pm [10pm] Very unsettled afternoon. Demanding to be seen by surgeon because BNO [bowels not open]. [Nurse in charge] spoke to surgeon — to have morphine and antiemetics as vomiting. Refused to let me do any observations on her, but temperature 37.3 at 10.25pm. C/o [complains of] nausea ++ — antiemetic given. Very abrupt with nursing staff. Surgeon has spoken to [Ms A] personally and she has calmed down a bit now. Still c/o nausea. BNO [bowels not open] yet — nil ordered from surgeon."

One hour later, the nursing record states:

> "2300 Pt appears uncomfortable c/o back & generalised abdo pain + nausea. IM Morphine 5mg given as ordered with little effect did not really settle, continues to complain with the pain. Also c/o discomfort on voiding + burning. On discussion pt states she is prone to UTI [urinary tract infections]."

18 April 2005 — day three post surgery
In the early hours of the morning of Monday 18 April, the nursing record states:

> "Unable to contact [Dr B] + Anaesthetist. [time not recorded] On discussion with staff + pt Noroxin i was given stat, pt was happy with this. Obs taken 2hrly O/N [overnight]. Pt continues to have spasms of abdo pain. IV Augmentin given + IV Tramadol & antiemetic, pt refuses to take o/[oral] pain relief. Voiding only small amts. Bladder scan done 400mls Residual. IN & OUT catheter done. Urine spec collected.
>
> 0400 Vomited 100mls digested fluid. Antiemetic given. Abdo examined now appears guarded & sluggish bowel sounds. Tried again to contact surgeon no reply.
>
> 0500 [Mr I] contacted will come in & see pt."

The Hospital policy on "Contacting Medical Specialists for Advice and/or Attendance" (authorised August 2004) is attached as Appendix 1. It states that if the patient's doctor is unable to be contacted on mobile or landline then the nurse is to contact an

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alternative doctor of the same specialty who has a "working relationship" with the doctor concerned. Failing that the senior nurse on call is advised of the situation. The hospital manager is to investigate immediately and seeks an explanation from the doctor involved.

At 6am on 18 April, registered nurse Mr I, the Hospital Clinical Services Manager, arrived and examined Ms A. Mr I noted that Ms A was complaining about generalised abdominal pain radiating to her back. Her pulse and respiration rates were elevated but her blood pressure was normal. When Mr I examined Ms A's abdomen he found guarding and an absence of bowel sounds. Ms A reported that she had a feeling of pressure and bloating and questioned whether she might have a urinary tract infection. Mr I recorded his impression that Ms A had developed an ileus[4] and that she needed hydration. He ordered that she have no further oral intake, and only ice to suck.

The Hospital advised that the diagnosis of an anastomotic leak becomes clearer with time:

> "This appears to be the case with [Ms A] and it was only between 0400hrs and 0630hrs on the 18th April that she appeared to develop more definitive signs indicating that she may have had an anastomotic leak (i.e. abdominal guarding, diminishing bowel sounds)."

At 7.40am, Ms A was seen by the anaesthetist, Dr H. Dr H noted that Ms A "looked miserable". Dr H examined her and found her abdomen to be distended, tender in the region of the right iliac fossa (area around hip bone) with no bowel sounds. Dr H ordered that Ms A's electrolyte balance be checked and for her to be started on intravenous fluids and sips of oral fluids only. She was also to have a urinary catheter introduced. Dr H contacted Dr B to advise him of the situation.

Dr B said that when he did not hear from the hospital overnight, he assumed that Ms A had settled. He was unaware of the deterioration in her condition until he received a call the next morning when he was travelling to the Hospital around 8.15am. His mobile phone had been on re-charge overnight. His landline at home did not ring — he has a telephone beside the bed and it did not ring overnight.

The Hospital's "Registration Guide for Visiting Practitioners" states under the "Conditions for Registration":

> "iv) Visiting practitioners must be both available and able to be contacted for the duration of their patient's stay in the hospital to attend call-outs

[4] Functional obstruction of the small intestine (ileum) due to loss of intestinal movement (peristalsis) which may be caused by abdominal surgery, peritonitis, and other conditions such as blood potassium deficiency.

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— in the event that the practitioner is not available to attend emergencies, it is the practitioner's responsibility to arrange appropriate cover

…

vi) Regardless of the arrangements for cover, the nurse in charge must be notified in advance of the non-availability of the visiting practitioner and details of the relieving practitioner."

The Hospital advised that it is the responsibility of the doctors to advise the hospital of any changes to their contact details. The hospital manager is responsible for maintaining an up-to-date record. "As far as we are aware the list was up to date. The night nurse tried the mobile number which is the usual number of first choice when contacting a doctor." Nursing staff are no longer able to recall why they did not contact Dr B on his landline.

Registered nurse Ms E was on duty on the morning of 18 April and accompanied Dr B to examine Ms A. Ms E stated:

> "The night staff had been extremely concerned about [Ms A] and reported they had telephoned the surgeon repeatedly during the night getting only an answer-phone on his mobile and 'no such number' on his home line. I remember there being quite a fuss when [Dr B] did arrive and that [charge nurse Ms J] dealt initially with him. [Dr B] looked into his mobile and said that it had logged only one call to him from the hospital. … He pointed out that whilst his home number in our internal directories was obviously out of date, the new number was in the telephone directory and he would have expected the staff to have thought of looking there."

Dr B saw Ms A and discussed with her and her daughter the need for further surgery. Ms A signed an "Agreement to Treatment" form consenting to a laparotomy, drainage and colostomy.

Ms F stated that immediately she heard her mother's messages on the morning of Monday 18 April she telephoned the Hospital to find out her mother's condition and went in to sit with her. When Dr B assessed her mother on Monday morning he said that the situation "would go one way or the other", — she was "going to either get septicaemia (which clearly my mother already had) or get well".

Further surgery

Ms A was taken back to theatre at 11.05am on 18 April for repair of the bowel wall and creation of a temporary colostomy. By late afternoon there was concern about Ms A's condition. She was not maintaining a satisfactory blood pressure despite the administration of intravenous gelofusion (blood expander) and it was considered that

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she required more intensive monitoring than the Hospital was able to provide. Dr B explained:

> "Leakage from a bowel anastomosis … does invariably lead to septicaemia and septic shock which was the reason for the lifesaving Hartmann's procedure performed on the Monday morning. … [I]t was done promptly without risking the further delay involved in transfer to a public hospital. Incidentally during this operation a further resection of rectal stump was done removing the additional small polyps prior to closing off the rectal stump. Transfer to DCCM [Department of Critical Care Medicine] was discussed immediately on completion of this operation but deferred at the suggestion of the on-call DCCM consultant. Later that afternoon it became apparent that she was not able to be managed at the [Hospital] and transfer to DCCM was arranged."

The public hospital
Ms A was admitted to the public hospital DCCM at 5.46pm on 18 April 2005. She was intubated and ventilated. Ms A was discharged from DCCM to a surgical ward on 21 April. She required a further operation on 22 April to resect a short length of necrotic colon and revise her colostomy via her previous laparotomy wound.

Dr B visited Ms A while she was in hospital under the care of the colo-rectal service, and explained the course of events to her. He also advised her of the result of the histological examination of the dissected rectal tumour.

Ms A recalls that Dr B visited her only twice while she was a patient there.

Ms A's postoperative stay was prolonged by a significant wound infection, fever and a paralytic ileus. On 12 May she had a CT scan to exclude any further problems. Ms A was discharged on 12 May 2005.

Post-discharge problems
On 12 July 2006, an ACC case manager asked psychiatrist Dr K to assess Ms A in relation to her ongoing health issues. In her report of 3 August 2006, Dr K noted the circumstances of Ms A's surgery at the Hospital and transfer to the public hospital in April 2005. Dr K recorded that in September 2005 Ms A was readmitted to the public hospital for reversal of the stoma. Ms A found the preoperative preparation for this surgery distressing, as well as the postoperative phase. In April 2006 Ms A was again admitted, this time for an unrelated problem with her pancreas. She has also consulted a dentist about a tooth that was damaged when she was intubated at the public hospital on 18 April 2005.

Dr K noted Ms A's issues as:

- abdominal scarring, abdominal adhesions, tooth damage, previous colostomy
- bowel perforation and sequelae
- possibly some cognitive impairment secondary to hypoxia.

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Dr K noted that Ms A "fulfils the diagnostic criteria for post traumatic stress disorder". Dr K recommended six one-hour sessions of Eye Movement Desensitisation and Reprocessing (EMDR) by an appropriate and experienced EMDR practitioner. Dr K stated: "I would see [Ms A's] prognosis as being very good provided she has prompt and effective treatment."

Ms A stated that ACC declined to fund the recommended EMDR treatment because it does not fit their profile of intervention types. However, ACC provided funding for Ms A for post-traumatic stress disorder therapy with a clinical psychologist, from 1 August 2007.

Ms A's response
Ms A stated:

> "ACC have accepted medical misadventure for:
> (1) Septicaemia, Tooth Injury, Toxic Shock Syndrome, Peritonitis
> (2) Two hernias (consequential to the ongoing bowel surgeries)
> (3) Post Traumatic Stress Disorder
> (4) Critical Illness Syndrome caused by Hypoxia. …
>
> [B]oth [Dr B] and [the Hospital] have joint responsibility for her condition today that she will face for the remainder of her life, even though their roles are separate in terms of pre and post operative care. …
>
> During the time when [Ms A] was hospitalized (15 to 18 April 2005) at no time did she receive full disclosure of her condition from either the Surgeon or [the Hospital]? Second, she was not made aware of what was happening to her condition and how [the Hospital] was virtually 'playing a waiting game' — this type of experimental monitoring is neither ethical nor acceptable in a consultative, well-informed and transparent society that people live."

Dr B's response
Dr B advised that he is "most disappointed" by the outcome of Ms A's experience of care, but that he does "not feel that [she] received less than careful attention" from him. He stated:

> "This is clearly a most unhappy outcome for [Ms A]. Faecal leakage following rectal surgery is associated with severe morbidity as demonstrated here. The degree of soiling experienced here is more than is usual at such an early stage as also was the failure to exhibit significant fever or tachycardia in the presence of leakage. I do not believe that laparotomy could have been reasonably entertained at an earlier stage nor would the outcome have been significantly different."

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The Hospital's response
The Hospital advised:

> "[The Hospital] would like to reiterate how sincerely sorry we are that [Ms A] has continued to suffer serious complications following her surgeries and we acknowledge the significant impact this has had on her wellbeing."

Ms A's case was added to the Hospital 'Incident' database and presented to the Hospital's Clinical Medical Committee for discussion.

On 24 May 2005, the Hospital received a letter from the ACC Medical Misadventure Unit requesting a copy of Ms A's clinical records. The Hospital complied with this request on 26 May 2005.

On 8 June 2005, the Hospital received a letter from Ms A outlining several concerns related to her hospitalisation and the management of her complications. She stated that she wished to meet with the clinical and managerial representatives from the hospital to discuss her concerns. Ms A and Mr I had a number of telephone conversations before they reached an agreement that the meeting would take place on 15 July, attended by Dr B, the duty nurse and Mr I.

Prior to the meeting, a further internal investigation was undertaken. Written responses were requested from the nursing staff involved in Ms A's care, and those statements, the records and other documents were reviewed.

On 15 July 2005, Ms A was accompanied to the meeting by her support person, Ms G. Initially, Ms A and Ms G met privately with Dr B for an hour. The Hospital was not advised about the outcome of this meeting, and Dr B has not provided any detail about what was discussed. At 10.15am, Ms A and Ms G met with the duty nurse and Mr I. The meeting lasted for one and a half hours. The result of the meeting was an agreement by the parties to go away and review the information with the intention of meeting again, to work through Ms A's issues further.

On 23 July 2005, Ms A wrote to Mr I to acknowledge the meeting. She noted that there had been an agreement that the discussions were to be confidential and were not to be discussed outside the organisation. She also noted that Mr I would discuss with the Hospital's management "the appropriateness of a very small compensation, given that I have not been able to sustain my normal employment". Ms A advised that she would postpone any further meeting until after she had had the reversal surgery.

On 7 September 2005 Ms A and Ms G attended a further meeting with the Hospital's Chief Executive Officer and Chief Clinical Nursing Advisor. Ms A stated that her concerns were:

- The nursing staff failed to monitor her deteriorating condition and thus complications progressed beyond a reasonable period before the surgeon was called.

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- She was not listened to when she knew from 2pm on 17 April that things were going wrong.
- She had endured hardship and was seeking financial compensation. She stated that she did not intend to pay her hospital account and was seeking money for additional costs, such as having to change her travel plans.

The Hospital did not agree to provide Ms A with compensation. After a number of difficult communications, the Chief Executive Officer wrote to Ms A on 9 November stating: "[W]e consider that your most recent letters raise no new matters, but simply attempts to re-litigate issues to which we have already responded." Ms A was referred to the Health and Disability Commissioner.

Between 23 March and 10 April 2006 there was further correspondence between Ms A and the Hospitals regarding payment of her outstanding medical costs.

ACC

On 9 September 2005 ACC advised Ms A that her medical misadventure claim had been accepted as medical mishap, based on general surgeon advisor David Innes' advice that this case "satisfies both the mishap criteria of rarity and severity". Dr Innes advised:

> "The surgeon had two difficult decisions to make … and, in my opinion, the fact that, in hindsight, different decisions would have produced a better outcome, does not constitute medical error."

Dr Innes further advised that Ms A's injury was not caused by error on the part of an organisation, and that treatment had been "properly given". However, the injury met the criteria for medical misadventure because it was "rare":

> "The combination of sigmoidoscopy showing an unexpected rectal tumour, the transrectal excision leading to a perforation in the rectum, and the repair of the rectal perforation breaking down and leading to faecal peritonitis must be very rare and well below the threshold of 1%"

and "severe":

> "The patient was hospitilised for 24 days as a result of the injury, and will have significant restriction of activity for up to 6 months. She also faces further surgery to close her colostomy."

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Response to Provisional Opinion

The Hospital
The Hospital responded as follows:

> "**Standardised care plans**
> We do not believe that the nursing care provided was inappropriate in this case, and we have sought an expert opinion from Barbara Fox, Director of Nursing at St George's Hospital. … Ms Fox's view is that the nursing care was appropriate. [An excerpt of Ms Fox's advice is attached as Appendix 4.]
>
> Instructions from surgeons to the rest of the clinical team occur in a number of ways — standard instructions through the care plan, verbal instructions, and written instructions on the care plan or elsewhere in the notes. Additional instructions were added to [Ms A's] care plan, and these were carried out. The actual care provided was appropriate for both [Ms A's] varicose vein surgery and bowel surgery.
>
> We do not accept that [the Hospital] care plans are confusing if comments are added. … Standard instructions for surgeons are printed, but there is space in which further instructions can be, and are, recorded. [Ms A's] pathway pages dated 16 and 17 April show this space being utilised with both having verbal instructions from [Dr B] documented. The surgeon is also able to convey postoperative instructions by writing them on the Operation Record. [Dr B] did not provide any instructions.
>
> The nursing care was appropriate for both procedures, and would not have changed if another care pathway had been used. [Dr B] also provided instructions to the nursing staff during the postoperative period, which were implemented as instructed …
>
> ... It should be noted that [the Hospital] regularly reviews care plans with doctors to ensure that they continue to represent best practice.
>
> **Systems for contacting doctors**
> …
>
> [The Hospital] had the correct phone details for both [Dr B] and [Dr H] at the time [Ms A] was admitted. … There was no question that the hospital had [Dr B's] correct mobile phone number, and we do not know if his home line was actually tried. But if it was, the hospital staff had his current phone number. [Dr B's] current phone number is the same one that our records have shown since [Dr B's] registration at the hospital in 1998.
>
> [The Hospital] has a system in place where doctors are required to notify the hospital of any change in their contact details, and these details are confirmed

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each time a doctor's registration status with a hospital is renewed. … There is no basis on which to find that [the Hospital] did not have up to date details. …

An emergency situation?
We believe that your finding and proposed recommendations rest on a retrospective view that does not reflect the actual situation on the night of 17/18 April 2005. You suggest that nursing staff were so concerned about [Ms A's] situation that they considered they needed to speak to a doctor, but were prevented from doing so because they were unable to contact one. It is difficult so long after the event to determine what the nurses at the time were thinking. But the information that is available does not support a conclusion that (at least before 5am on 18 April) they considered it imperative that [Ms A] be promptly reviewed.

As Dr Connolly indicated, and as described in our initial response, [Ms A] had a poorly differentiated and slowly evolving postoperative complication. The slowly evolving and undifferentiated nature of her presentation warranted close monitoring which was done. [The Hospital] strongly believes that if the nurses considered that they needed to contact a doctor overnight they would have done so. This view is supported by the fact that when they became concerned and had no response to the mobile phone message left for [Dr B] they appropriately used [the Hospital's] back-up procedures and called in the senior nurse on call.

[Ms A's] condition deteriorated at about 8.25pm on 17 April when her pain score increased to 10. [Dr B] was contacted at that stage and he ordered a dose of intramuscular morphine, with a further dose in two hours time if required. [Dr B] obviously did not consider it necessary that he review [Ms A] at this time. …

The nursing notes stated that neither [Dr B] nor [Dr H] were able to be contacted. The time at which this contact was attempted is not recorded, but the notes also indicate that [Ms A's] condition was discussed with [Ms A] and other staff, and that treatment appropriate for a urinary tract infection was commenced. Those records do not suggest that there was an appreciation of a requirement to contact [Dr B]. Rather, they suggest that a call was being made to update him. …

The notes also suggest that this view of not requiring [Dr B] may have been a reasonable thought at the time. [Ms A's] condition was no different through the night of 17/18 April than it had been at the time when [Dr B] had last been contacted. … However, when [Ms A] vomited at around 4am the nurses became concerned about [Ms A's] condition and called for assistance. …

The true context on the night is that nursing staff were keeping a close watch on [Ms A] since the previous afternoon through the undifferentiated

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> development of her condition. Calls to [Dr B] were not emergency requests for his immediate presence, they were to update him. The on-call procedure and the procedures for contacting medical specialists [were] followed as soon as [Ms A's] condition started to present itself more clearly. The nurses then acted according to the hospital's safety back-up by calling the senior nurse on call.
>
> A finding that [the Hospital] systems for obtaining medical assistance are inadequate is not justified. When the system was initiated, it responded appropriately. [The Hospital] is at a loss to explain why [Dr B] responded to a message left for him within about half an hour after 7.30am, but not to any message left for him overnight.
>
> With the benefit of hindsight, it may appear that the conclusions about [Ms A's] condition overnight were delayed. However, we believe that this assessment would be unfair given that [Dr B] had been informed of [Ms A's] condition at around 8.30pm and he felt it unnecessary to review her, and even when [Ms A] was reviewed by a doctor at 7.30am there was not an immediate diagnosis of her complication. There was a further three and a half hours before she returned to theatre. The time it took before [Ms A] actually returned to theatre also suggest that even if the nurses had sought [Dr B's] attendance earlier, that the actual treatment provided, and [Ms A's] outcome would have been no different. This is consistent with the expert opinion provided by Dr Connolly. …
>
> In this case it is inappropriate to find that nurses should have made a difficult diagnosis in a gradually emergent condition when a doctor that later saw [Ms A] when even more signs were present seemingly [Dr H] did not appreciate the significance of her condition."

The Hospital also commented on the report provided by independent nurse expert Ms Philippa Pringle (Appendix 3) in relation to the adequacy of the Hospitals' generic postoperative instruction forms, nursing documentation and the nursing assessment, monitoring and reporting of Ms A's condition. It stated:

> "We note that Ms Pringle's opinion was that there was an acceptable standard of care delivered. The exception was … where she suggested a concern that the nursing staff did not report to another medical practitioner at approximately 4am and were remiss in not following [the Hospital's] (reporting) policy. We wish to address that point.
>
> [The Hospital] believes that the night nurses were not remiss in following the contacting doctors policy and that the suggestion that they were, is unduly influenced by the benefit of hindsight. At the time the acts occurred, the registered nurses were exercising their clinical judgement appropriately and making reasonable decisions based on those judgements. The professional responsibility of a nurse is governed not only by following an organisation's

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policies and procedures, but also by their own body of professional knowledge and nursing skills, key to which is the nurse's complex clinical judgement and decision making.

In the context of [Ms A's] emerging clinical condition the nurses exercised their clinical judgement appropriately (having attempted to make an 'update call' to the surgeon earlier.) At approximately 4am on 18 April 2005, having assessed [Ms A's] now changing clinical condition (vomiting around 4am, abdomen appeared 'guarded' with 'sluggish bowel sounds') the night nurses attempted to make a second call. When the surgeon (and off duty anaesthetist) did not respond to their message they acted absolutely appropriately (clearly again having judged the situation not critical enough to call an alternative surgeon) they activated the senior nurse on call policy for assistance. …

The final point we wish to make is that [Ms A] developed a serious complication which is well recognised as being insidious in onset and hard to initially diagnose, and once diagnosed requires prompt attention. Even when the anaesthetist assessed [Ms A] it appears the diagnosis was not entirely clear, when it did become clear further treatment progressed promptly.

We remain of the view (and we believe this has not been challenged) that surgery did occur in a timely fashion and that the complications experienced by [Ms A] could not have been avoided."

Code of Health and Disability Services Consumers' Rights

The following Right in the Code of Health and Disability Services Consumers' Rights is 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.

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Opinion

Introduction

Ms A complained that the standard of care provided to her by general surgeon Dr B and the Hospital was not appropriate. Ms A consulted Dr B on 9 March 2005 for a preoperative examination for elective varicose vein surgery (scheduled for 15 April 2005). At this appointment Dr B and Ms A discussed the issue of her intermittent rectal bleeding and they agreed that Dr B would perform a rectal examination after he had dealt with the varicose veins. On 15 April, after completing the vein surgery, Dr B resected a 4.5cm tumour from the anterior rectal wall. Postoperatively Ms A suffered a catastrophic complication when the anterior rectal wall broke down. Ms A developed peritonitis, requiring emergency surgery and transfer to the public hospital Intensive Care Unit.

Breach — the Hospital

Deterioration

The key issue in this case is the adequacy of the Hospital's response to Ms A's deterioration. It is therefore necessary to determine when Ms A's deterioration was detected. My expert surgical advisor, Dr Connolly, advised that the clinical record indicates that the deterioration occurred a number of hours before 4am on Monday 18 April. The greatest deterioration appears to have occurred over the late evening of 17 April. Ms A's stable vital signs did not mean that she had not begun to deteriorate. Dr Connolly advised that, in an otherwise healthy patient, the cardiovascular signs of sepsis are often not evident until some hours after the onset of infection. Ms A's increasing nausea and worsening pain along with the low-grade fever (37.3°C at 10.25pm on 17 April) were early indications of the development of sepsis. At this time Ms A was demanding to speak with Dr B, and the nursing notes describe her as "very difficult and rude". Dr Connolly commented that it was unlikely that Ms A would have demanded to speak to her surgeon if her condition was unchanged and she was feeling reasonable.

Ms A's observation chart from the time of her admission recorded her pain and sedation scores, oxygen saturation, respiratory rate, temperature, blood pressure and observations of her wound site. These observations were satisfactory until 10.30pm on 17 April. My expert nursing advisor, Ms Pringle, advised that Ms A's slight increase in heart rate and blood pressure were not in themselves sufficient to cause concern; however, her pain score of 10/10 was a concern.

Contact with surgeon or medical colleague

When the nurses became concerned about Ms A's condition, they tried to contact Dr B on his mobile (at midnight and 4am). They also tried to contact the anaesthetist, Dr H, at midnight. At 6am the Clinical Services Manager, registered nurse Mr I, was notified about Ms A's deteriorating condition and that Dr B and Dr H could not be contacted.

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It is not clear why Dr H was not able to be contacted. In relation to Dr B, it appears that when the nurses tried to contact him during the night, his mobile was on answer-phone (while being recharged) and his home number (the number in the hospital's internal directory) gave a "no such number" message. Dr B's new telephone number was not listed in the hospital's internal directory, but was in the telephone book.

The Hospital has a policy on contacting medical specialists for advice and/or attendance on patients, which states that if the designated doctor or specialist cannot be contacted, staff are to contact an alternative doctor in the same specialty who has a working relationship with that doctor or could be of assistance. The Hospital "Conditions of Registration" state that "Visiting specialists must be both available and able to be contacted for the duration of their patient's stay to attend call-outs".

The Hospital stated that, in the circumstances, the nurses exercised appropriate clinical judgement, by attempting to make an "update" call to Dr B at midnight and then at 4am when Ms A displayed the concerning symptoms of abdominal guarding and sluggish bowel sounds. When the nurses were unable to contact the surgeon, they again acted appropriately when they judged the situation not critical enough to call an alternative surgeon and instead called the senior nurse on call at 6am. The Hospital submitted that Ms A's complication is well recognised as being insidious in onset and difficult to diagnose in the initial stages, and that when the condition was diagnosed, further treatment progressed in a timely fashion.

Dr Connolly advised that there was enough reason in the clinical notes over the night of 17/18 April to justify contacting Dr B and/or Dr H or another doctor. He said:

> "In my opinion, the inability of the hospital to contact [Dr B] and [Dr H] or any other medical officer represents a serious failure on behalf of the hospital. ... I find it extraordinary that there appears to have been no attempt to phone [Dr B] on his landline. I find it equally concerning that the hospital did not seek alternative medical input once the staff failed to contact either the surgeon or the anaesthetist."

Ms Pringle stated that although she found that the nursing assessment and monitoring of Ms A's condition was appropriate and of a generally accepted standard, she was concerned about the lack of reporting of Ms A's abdominal pain and discomfort to another medical practitioner when they could not contact Dr B. A pain score of 9/10 for 12 hours would certainly have warranted re-contacting the surgeon.

As noted in a previous HDC report:[5]

> "Nurses are more than simple recorders of observations. Observations should be interpreted and acted upon."

---

[5] Opinion 00HDC04656, 24 October 2003.

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Ms Pringle advised that the nursing staff were remiss in not following their own policy for contacting medical specialists and ensuring that Ms A had access to appropriate and timely care. In her opinion, this was a moderate departure from accepted standards.

Transfer to ICU
Ms A believed that she should have been transferred to ICU before she had the second surgery. Dr Connolly advised that the drainage of faecal contamination in Ms A's abdomen and the creation of a colostomy was essential to her recovery and it was not surprising that she required transfer to the public hospital ICU. However, the issue of the timing of her transfer was best left to the clinicians. It is preferable to have the patient in a stable condition before transfer. He said that while the timing of the operation may not have altered the need for intensive care support, any delay caused by the inability of the hospital to obtain an appropriate timely medical review "could be regarded as significant".

Standard of care
When patients have a surgical procedure requiring an overnight stay in a private hospital, they naturally expect that their surgeon or anaesthetist (or medical back-up) will be contactable and available if needed overnight. The Hospital clearly set itself the same standard, as evidenced by its own policy on contacting medical specialists for advice and/or attendance. Although I have no concerns about the overall standard of care provided by the Hospital to Ms A, at one crucial juncture — her deterioration overnight on 17−18 April — the Hospital did not provide care of an appropriate standard.

It was not unreasonable for the surgeon, Dr B, to have his mobile on charger overnight. He had recently changed his landline number. While it is the doctor's responsibility to inform the hospital of any contact changes, it is the responsibility of the hospital manager to ensure that this information is logged. It appears that this was not done and the nursing staff were unable to contact him. Furthermore, they were also unable to contact the anaesthetist, Dr H. As noted above, it is not clear why the nurses were not able to contact Dr H during the night.

I accept that nurses should use their own judgement and skills as well as their employer's policies and procedures. In my view, the nurses took their professional judgement and skills to the outer limits when they decided that Ms A's condition was not sufficiently critical at 4am to consult another surgeon, after they failed a second time to contact Dr B. They waited another two hours before calling for a senior nursing review. When a medical assessment was conducted at 7.40am by Dr H there was still no sense of urgency. However, when Ms A was seen by Dr B at about 9am prompt action was taken.

I accept my experts' advice that even if Dr B had been contacted earlier Ms A may not have had her surgery earlier and, even if she had, it may not have altered the need for her to be transferred to ICU. It is not clear whether the delay contributed to her

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complications and slow recovery. Dr Connolly advised, “It is not to say that the effects of the infection would have been the same had the operation been performed earlier.” But the critical safety net of surgical/medical back-up was not activated when she needed it. Accordingly, in my opinion, the Hospital did not provide Ms A with care of an appropriate standard and accordingly, breached Right 4(1) of the Code.

No breach — Dr B

Preoperative assessment

Ms A alleges that she first discussed the issue of her rectal bleeding with Dr B in December 2004 when she saw him to discuss surgery for some small residual varicose veins in her left leg. She believes that she should have “undergone a colonoscopy and perhaps a gastroscopy procedure to exclude medical possibilities”. Ms A stated that if Dr B had performed a pre-surgical examination the tumour would have been found, he would have had time to consider the most appropriate medical intervention, and the subsequent events would not have occurred.

Dr B did not record any discussion about rectal bleeding in his letter to Ms A’s general practitioner about this consultation. It is therefore not possible to conclude what was actually discussed. However, I accept Dr Connolly’s advice that it would be “extraordinary for [Dr B] to have ignored rectal bleeding symptoms”.

Dr B first documented his awareness of the rectal bleeding when Ms A saw him on 9 March 2005 for her preoperative examination. He noted the symptoms she described and the treatment options. He recommended that a rectal examination be performed at the time of her vein surgery, in four weeks. Dr B knew Ms A well as he had treated her on a number of occasions. He considered that combining a sigmoidoscopy with the vein surgery would cause her less distress.

Dr Connolly stated that Dr B had three options available to him on 9 March: to examine Ms A at that time, to recommend colonoscopy, and to plan for an examination at the time of the vein surgery. It was unlikely that Dr B could have performed a totally satisfactory examination in his rooms that day because Ms A would not have had bowel preparation — an enema. Dr Connolly advised that Dr B’s best choices lay with a preoperative colonoscopy or an examination under anaesthetic, with the need for subsequent investigations depending on the findings.

Colonoscopy is not without risk. The risks include bleeding and perforation. A preoperative colonoscopy would have detected the tumour. However, Dr Connolly advised that if removal of a tumour was feasible during colonoscopy, there was still the risk of perforation. Although a preoperative colonoscopy may have altered the type of information Dr B provided to Ms A prior to the surgery, it may not have avoided any of the subsequent complications she experienced.

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Dr Connolly stated that while some surgeons would have decided to perform a colonoscopy first, most general surgeons would agree with the course of action Dr B chose. He advised that Dr B's "lack" of preoperative investigations was reasonable given that he planned to perform a thorough bowel investigation within a month of the March consultation.

Surgical care
When Dr B performed the sigmoidoscopy on Ms A on 15 April following the vein surgery, he found a large but "grossly benign" tumour 15cm into the rectum. Dr Connolly advised that Dr B's local excision of Ms A's tumour was "perfectly acceptable".

Local excision of a rectal tumour can be performed in two ways, via a trans-anal approach (as in this case) or via colonoscopy. Neither procedure is free from the risk of bleeding or perforation. The technical ability and clinical experience of the surgeon is "paramount" when considering a trans-anal excision. Dr B had the training and experience to perform trans-anal procedures to remove tumours situated as high in the rectum as Ms A's tumour.

Dr Connolly advised that although varying opinions would be given by various surgeons about the choice of operative strategy to employ when excising a rectal tumour, Dr B's peers would not find his surgical decision in this case to be negligent. Dr Connolly stated:

> "It is important to stress that complications following an operation are not axiomatic of poor judgement or performance. I find no areas of concern in the technical conduct of the operation as described by [Dr B] in his operation note of 15 April 2005."

Postoperative care and information
At 6.45pm on 15 April, Ms A was transferred from the theatre suite to the ward. Her condition was stable and her postoperative recordings were satisfactory, although she appeared anxious. Ms A does not recall Dr B mentioning anything about a perforated bowel. She did not know the serious nature or the possible consequences of what had happened during her surgery.

Dr B explained that it is not his usual practice to discuss technical issues with his patients when they are still affected by anaesthetic and pain control drugs and that he waits until his patients are able to understand the explanations provided. Dr B saw Ms A the following morning and described the surgery but did not use the term "perforation". He told Ms A that he had located and removed a sizeable benign rectal tumour that had been "hopefully completely" removed and explained she would need a follow-up colonoscopy after her discharge from hospital to remove the remaining polyps and examine the full length of her bowel. Dr Connolly has no concerns about the type of information Dr B provided to Ms A on the day following her surgery.

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Dr Connolly further advised that Dr B's orders on 16 April for Ms A to start to mobilise and take a normal diet as tolerated were appropriate because dietary and movement restrictions after rectal surgery may promote complications. Dr Connolly stated, "I do not believe there are any grounds for criticism of the initial post-operative information supplied [by Dr B] to either [Ms A] or to the nursing staff."

On 16 April, Ms A was able to mobilise, was self-caring and eating a little — factors that suggest she was making a satisfactory recovery at that time. During the morning of 17 April, Ms A became anxious about developing constipation. She believed she had a "blocked bowel" and that she was "probably" going to die. Early that evening she asked to be transferred to the public hospital but was told that Dr B was "uncontactable".

Dr Connolly advised on 17 April that there were indications of a developing clinical problem. Ms A reported nausea and became very anxious. Dr B was notified about her anxiety regarding her "blocked bowel" and that she feared she would die. He said that he would try to visit Ms A later in the day and instructed staff to continue her intravenous morphine. Ms A continued to be very unsettled and worried about her lack of bowel movement. At 6pm a further telephone call was made to Dr B. He instructed that she could be given a mild laxative.

There is discrepancy in the times that the nursing staff spoke with Dr B that evening in relation to Ms A's anxiety. He recalls that the call was at 8.20pm. The nursing notes record that the charge nurse spoke with Dr B around 10.25pm.

Dr B was informed that Ms A's recordings were stable but she was very anxious about her lack of bowel movement. He believed that this "in itself" was not a cause for alarm. He asked to speak with Ms A and advised her that she was not helping herself by getting "worked up". The record notes that following her talk with Dr B, Ms A "calmed down a bit". Dr B did not receive a further call from the hospital that night.

Dr Connolly had no concerns about Dr B's care of Ms A on 17 April.

The nursing staff did not manage to contact Dr B in the early hours of 18 April when they became concerned about Ms A. Dr B became aware that Ms A had deteriorated only when he received a call from the hospital at 8.15am on his mobile phone. He assessed Ms A and advised her that she needed further surgery. Following the laparotomy, drainage and colostomy surgery, Ms A did not recover as expected. Dr B organised her transfer to the public hospital ICU.

Dr Connolly commented that it is impossible to know whether Dr B would have taken Ms A to theatre earlier if he had been given the opportunity. However, it was "perfectly reasonable" for the operation to take place at the Hospital on 18 April. Given the nature of Ms A's complications it was highly likely that she would have required intensive care support even if her surgery had been performed earlier. Dr Connolly stated:

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> "Despite the subsequent breakdown of the rectal repair and the development of peritonitis, in my opinion, the judgement shown by [Dr B] was of a standard acceptable to surgeons in New Zealand."

Conclusion
I conclude that Dr B's management of Ms A's care was appropriate. He took into consideration his knowledge of Ms A when recommending that she have a bowel examination while anaesthetised for her vein surgery. Dr B advised Ms A of the outcome of the surgery and responded to her concerns. When he became aware that Ms A's condition had deteriorated and she required additional surgery he responded appropriately. Dr B treated Ms A with reasonable care and skill, and communicated with her appropriately. Accordingly, Dr B did not breach the Code.

Actions taken

Dr B
Dr B advised that he will endeavour to ensure that he provides written instructions for postoperative management of secondary procedures in future.

Recommendation

The Hospital
I recommend that the Hospital provide a written apology to Ms A for its breach of the Code. The apology should be sent to the Commissioner's Office and will be forwarded to Ms A.

Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand, the Ministry of Health and the District Health Board.

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

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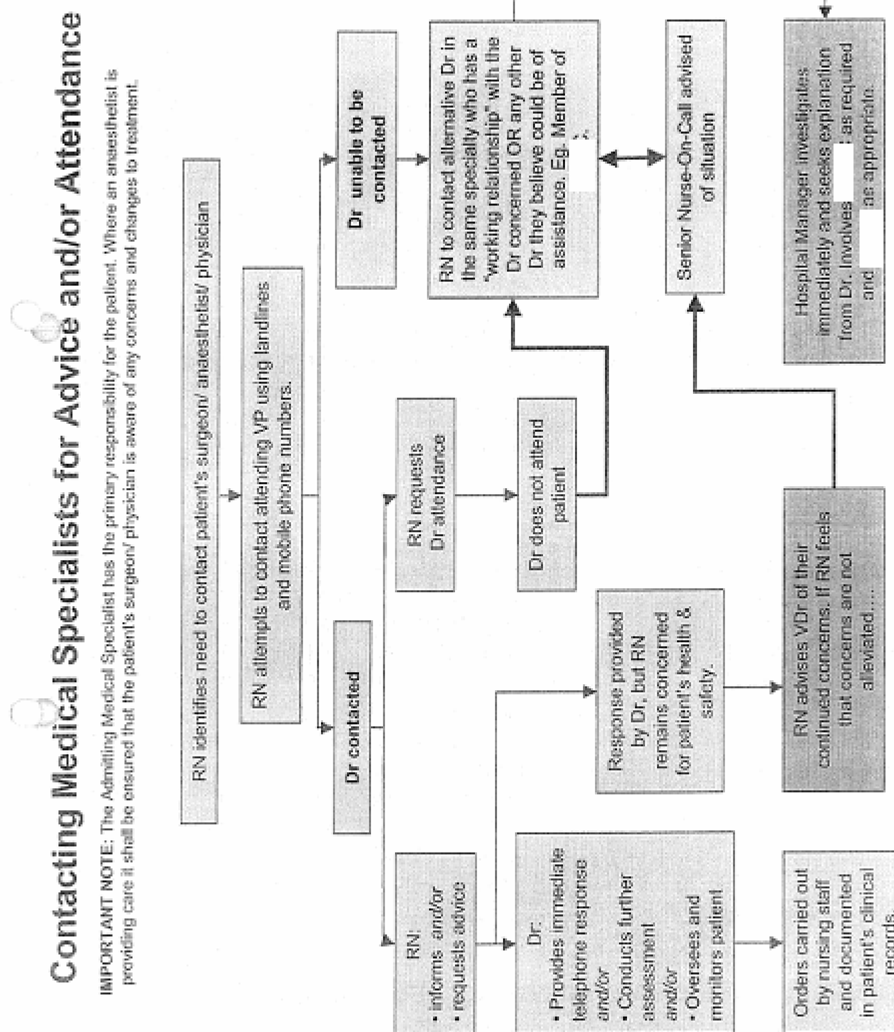
Appendix 1

8.9 CONTACTING MEDICAL SPECIALISTS FOR ADVICE AND/OR ATTENDANCE



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Appendix 2

Independent surgical advice
The following independent expert advice was obtained from general surgeon Andrew Connolly:

> "Thank you for requesting expert advice on the complaint laid by [Ms A]. The complaint refers to aspects of the care she received by [Dr B], Surgeon, and [the Hospital] in April 2005.
>
> **Professional Qualifications**
>
> I hold a medical degree (MBChB) form the University of Auckland (1987). I am a Fellow of the Royal Australasian College of Surgeons (1994). I have formal post-fellowship training in colorectal surgery in the United Kingdom. I am vocationally registered with the Medical Council of New Zealand in General Surgery. I am a full member of the Colorectal Surgical Society of Australia and New Zealand. I am employed (fulltime) as a General & Colorectal surgeon by the Counties Manukau District Health Board. I am the Head of the Department of General Surgery at CMDHB. I am the acting Clinical Director of Surgical Services at CMDHB. I have had a formal 18-month period of clinical research investigating the effects of, and treatment options for, severe intra-abdominal infection and I have had a number of papers published in peer-review journals on this and related topics. I have served on the Board of Basic Surgical Training, Physiology subcommittee, for the Royal Australasian College of Surgeons. I have served on the national Advisory Board regarding the screening of at-risk groups for colorectal cancer.
>
> **Statement on Conflict of Interest**
>
> I was an Advanced Surgical Trainee under [Dr B] for a six-month period ending June 1994. I declared this relationship (verbally) to … HDC in March 2007.
>
> I do not perform private surgery although the Department of General Surgery at CMDHB does periodically contract public elective operations to be performed at [the Hospital]. This process does involve me in an administrative capacity as Head of Department, but I do not perform operations at [the Hospital], nor do I receive any financial or other benefits for my administrative input.
>
> I do not believe either of the issues raised above impair my ability to give a fully independent expert opinion.
>
> **Issues Raised by the Commission**
>
> I have been asked to address a number of specific issues surrounding:

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(i) The adequacy of preoperative investigations of the bowel.
(ii) The adequacy of postoperative information supplied by [Dr B].
(iii) The adequacy and appropriateness of postoperative care provided by [Dr B].
(iv) The adequacy of care provided by [the Hospital]; in particular the systems of communication between the hospital and the surgeon.

In addition, I have been asked for my expert opinion as to when the bowel began to leak following the 15 April 2005 operation as well as my opinion on aspects of the nursing care and the timing of [Ms A's] transfer to an intensive care unit. I have also been asked to address whether or not I believe the (operative) approach adopted by [Dr B] was reasonable.

I have read the considerable correspondence supplied by the Commission.

[In his expert advice, Dr Connolly referred frequently to documents that the Commissioner had provided to him for the purposes of his expert advice. These references have been removed to improve the readability of this anonymised opinion.]

[Ms A] has raised a number of issues in her complaint that are not, to me, of clinical relevance — such as concerns regarding some aspects of her interaction with ACC. Whilst these issues are clearly of importance, I have not considered or commented on them.

Summary of the Clinical Background to the Complaint

[Ms A] had residual/recurrent varicose veins on her left leg. She had previously had surgery for this condition and returned to consult with [Dr B] regarding further treatment options for the residual veins. This consultation was on 15 December 2004. [Dr B] recommended surgery.

[Dr B] next saw [Ms A] on 9 March 2005. This consultation was timed to precede the intended operation date of 15 April 2005. At this consultation, [Ms A] mentioned she had had intermittent rectal bleeding. [Dr B] did not perform a rectal examination at this visit, but noted that he would perform an examination at the time of the vein surgery.

On 15 April 2005, [Ms A] was admitted to [the Hospital]. [Dr B] performed surgery that day. He dealt with the varicose veins; then he performed an examination of the rectum. His findings were of a tumour at 15 cm on the anterior rectal wall as well as a small polyp at 10 cm. [Dr B] removed the tumour.

Postoperatively, [Ms A] suffered a catastrophic complication. The anterior rectal wall repair broke down and [Ms A] developed signs of peritonitis. She

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required emergency surgery and transfer to [the public hospital]. There she required further surgery and an extended period of recovery. [Ms A] required further surgery to reverse the colostomy, but that operation was complicated by significant bleeding, necessitating further emergency surgery.

[Ms A] also subsequently required surgery for a cystic mass of the pancreas incidentally detected on CT scanning whilst at [the public hospital].

Specific Issues Raised in this Complaint

(i) Preoperative Investigations

According to [Dr B], he first became aware of the rectal bleeding at the 9 March 2005 consultation. [Dr B] chose to investigate this issue at the time of surgery and intimates in his clinical notes of that time that he planned to manage any (minor) pathology he detected.

[Ms A] states that at the December 2004 appointment with [Dr B] she mentioned the rectal bleeding. It is impossible for me to conclude what actually was stated at the December 2004 consultation, however I note [Dr B] did not comment about anything other than the varicose vein issue in his letter of 15 December 2004 to [Ms A's] General Practitioner.

It would be extraordinary for [Dr B] to have ignored rectal bleeding symptoms at the 15 December 2004 consultation.

There is no doubt [Dr B] was aware of the rectal symptoms at the March 2005 consultation. [Dr B] had a number of options available to him on 9 March. These include:

(a) Examine [Ms A] at that time
(b) Recommended a colonoscopy
(c) Plan for an examination at the time of the veins operation.

[Ms A] presumably would not have had an enema preparation for the 9 March consultation. Therefore it is unlikely that [Dr B] could have performed a totally satisfactory examination in his rooms that day. Therefore in my opinion the best choices lay either between a preoperative colonoscopy and an examination under anaesthetic with the need for subsequent investigations dictated to a large extent by the findings at surgery. [Dr B] chose the latter.

Colonoscopy is not without some risk. The risks include bleeding and perforation. Whilst a preoperative colonoscopy would have detected the tumour at 15 cm, it is still likely, given the operative findings, that surgical removal would have been necessary. Even if at colonoscopy the tumour could have been fully removed, there would have been a (comparable) risk of rectal perforation.

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The logic behind performing the examination under anaesthetic prior to a colonoscopy is that should the surgeon find a categorical explanation for the bleeding, the patient may not necessarily require the colonoscopy, thus avoiding any of the risks of that procedure. Of course the converse is also true; the operative findings may simply reinforce the need for a colonoscopy (as they did in this case).

I do not, however, accept [Ms A's] analogy of the 'X-ray and the broken arm'. It is not that simple a question.

In my opinion the 'lack' of preoperative investigations was reasonable given that [Dr B] planned to perform a thorough examination at the time of the veins surgery within a month or so of the March consultation. I believe whilst some surgeons (including me) would adopt a 'colonoscopy first' approach most General Surgeons would agree the course of action chosen by [Dr B] was an acceptable one.

A preoperative colonoscopy may not have avoided any of the subsequent complications experienced by [Ms A]. This point is very important. Of course, it may have altered the type of information given to [Ms A] if surgery for the rectal tumour was still required. In other words, preoperative colonoscopy may have altered the emphasis in certain areas of the consent process. I note that [Ms A] recalls [Dr B] discussing prior to the surgery the potential removal of any lesion.

(ii) Operative Strategy

Given that [Dr B] elected to perform an examination at the time of surgery, the key issue regarding this aspect of the complaint is 'was it clinically reasonable to excise the tumour once it was detected?'

[Dr B] chose to remove the tumour. This is, in my opinion, the key issue that would generate debate amongst surgeons. As a rule of thumb, if the tumour looks clearly malignant, it would be unwise to attempt a full excision without considerably greater preoperative information (colonoscopy, histology, radiology). However, when the tumour has the appearances of a large, but grossly benign tumour, local excision is perfectly acceptable. Such local excision could be attempted in two ways — surgically via a trans-anal approach or via colonoscopy. Neither is free of risk, including bleeding or perforation.

Trans-anal surgical removal of rectal masses is an area where personal experience plays a large and important role. No two tumours are the same, with surgical 'access' to the tumour being of paramount importance. Factors that preclude the safe removal of one tumour may not be significant in the next. Surgery in this area often relies on the technical ability of the surgeon to both see tumour and 'control' the excision.

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The clinical experience of the surgeon is paramount when considering this specific issue of trans-anal excision. Surgeons of [Dr B's] generation were trained to tackle large rectal tumours situated quite high in the rectum (as this tumour was). In my opinion, such training and experience is not something many younger surgeons have a lot of, simply because the vast majority of such resections are now done at the time of colonoscopy or are concentrated in the hands of a few colorectal specialists. A similar analogy could be drawn with gallbladder removal. Many of today's surgical trainees have very little experience with removal of the gallbladder through a 'traditional incision' given almost all are now removed via telescopic (laparoscopic) means. This does not, however, make it 'old fashioned' or 'negligent' to remove a gallbladder via an open incision.

If [Dr B] had not removed the tumour at the time of the operation, [Ms A] would have required a colonoscopy and still faced the risks of perforation. Alternatively, [Ms A] may have had the colonoscopy and then subsequently needed a trans-anal excision of the lesion if the colonoscopist had been unable to (fully or partially) remove the tumour.

In my opinion, as long as [Dr B] had an adequate view of the tumour and could confidently repair the surgical defect in the rectal wall, the decision to remove the tumour was perfectly justified. I believe, as with preoperative colonoscopy, varying opinions would been given by various surgeons as to the operative strategy each would employ. However, *I do not believe a group of surgical peers would find the decision taken by [Dr B] to have been negligent.*

It is important to stress that complications following any operation are not axiomatic of poor judgement or performance. I find no areas of concern in the technical conduct of the operation as described by [Dr B] in his operation note of 15 April 2005 although I note a discrepancy between the operation note and the letter to ACC of 15 July 2005 regarding the choice of suture material for the repair of the rectal wall. I do not believe this difference is clinically relevant.

I must specifically emphasize that I agree with [Dr B's] use of the term 'breach' — this is an expected part of many trans-anal operations and does not indicate a technical complication. It is a term used by surgeons to describe aspects of the operation.

(iii) Postoperative Care

This area is considerably more complex than the preoperative and operative issues addressed above. There are issues relating both to the individual care given by [Dr B] and to the wider issues of the care delivered by the hospital itself. I will try to avoid repetition, but there is considerable overlap between surgeon and hospital in some areas.

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(a) Initial Postoperative information.

[Dr B] visited [Ms A] on Saturday 16 April and discussed the operative findings. There is some debate between [Ms A] and [Dr B] as to exactly what was said. I do not have any way of concluding what information was or was not passed on by [Dr B], nor what information may subsequently have been forgotten by [Ms A] given the significant complications she was about to experience. It is well documented in the medical literature that memory of clinical discussions can be poor particularly when a patient suffers a life-threatening complication requiring amongst other things a period of intensive care support.

In my opinion, it is important to consider what information the staff at [the Hospital] should have been aware of to enable them to care fully for [Ms A]. Such information would have included the extent of the rectal surgery and any specific postoperative restrictions secondary to this surgery. I cannot find any specific notation as to the extent of the resection, although the fact a trans-anal excision of a large tumour occurred is clearly recorded on the relevant notes from 15 April. The word 'large' should have been sufficient to alert staff to the potential for postoperative complications from the excision. I note [Dr B] prescribed ongoing intravenous antibiotics — this is appropriate after the type of rectal excision surgery [Ms A] had.

As for postoperative restrictions, there is in fact no clinical benefit from dietary restriction after this type of surgery. Whilst many surgeons do restrict food intake, it is totally without foundation in the surgical literature. Therefore I do not believe there are any grounds for criticism of the initial postoperative information supplied either to [Ms A] or to the nursing staff. Similarly, bed rest would not have prevented or minimised any risk of perforation of the rectal repair. In fact, both dietary and movement restrictions after rectal surgery may promote some complications.

Of some concern, I note that the nursing record for 16 April 2005 is on a template referring to the postoperative preferences of various surgeons for a patient post-varicose vein surgery. Whilst the excision of the rectal tumour is noted at the top of the page there is no specific post-rectal surgery 'surgeon-specific' plan on this page. Nor does the hand written note 's/b (seen by) [Dr B]' make any mention of the plans or progress regarding the bowels. This note is presumably written by a nurse.

(b) Clinical Deterioration — Timing

Other than the issue of preoperative investigations, the identification and reaction to the clinical deterioration experienced by [Ms A] is the key to this complaint.

As is often the case, it is unclear exactly when [Ms A] began to significantly deteriorate, thus indicating a likely perforation of the rectal wall. However,

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from the notes, I believe there was no cause for concern on 16 April, but over 17 April, there were indications of a developing clinical problem. Naturally I am approaching this with the considerable benefit of hindsight, but I will endeavour to eliminate that advantage in reaching my opinion.

The clinical notes of 16 April reveal [Ms A] was eating a bit, able to mobilize, and was 'self caring' by the afternoon /evening. These factors suggest she was making a satisfactory recovery on Saturday 16 April. Added to this, [Dr B] had no concerns when he reviewed [Ms A] that morning.

The clinical record of 17 April suggests that [Ms A] deteriorated sometime during that day/evening. I base on the fact that the night record 16–17 April does not raise concerns, but the day/evening record of 17 April does. In particular I note [Ms A] began to experience nausea and the nurse caring for her noted the patient felt she would 'probably die'. This record is not timed, but it precedes a note timed at 2200 hours 'very unsettled afternoon'. This note also goes on to record that the patient was increasingly nauseated over the night shift.

In my opinion there is little doubt that [Ms A] was deteriorating over the evening/night of 17 April. At some point on this day, I believe the rectal wall perforated. This is further supported by the nursing notes of 18 April. [Ms A] was still nauseated, and she was experiencing increasing back and abdominal pain in the early hours of 18 April. It would seem that the greatest deterioration was over the late evening/night of 17 April given the degree to which the nursing staff have documented their clinical concerns, supported by the comment timed at [2200] hours that the patient was demanding to speak to the surgeon — something unlikely to have occurred if [Ms A] was feeling reasonable/unchanged.

I do not agree with the summary from the hospital that the deterioration occurred between 0400 and 0630 hours on 18 April. The clinical record, in my opinion, supports deterioration over a number of hours preceding this time. The 'stable' nature of her recordings (pulse, blood pressure) does not mean she had not begun to deteriorate. Following the onset of infection the cardiovascular signs of sepsis are often delayed by some hours, particularly in an otherwise healthy patient. I believe the increasing nausea and the onset of worsening pain along with a low-grade fever were early indications of the development of sepsis.

By the morning of 18 April it is clear from the clinical notes that [Ms A] had peritonitis and urgent surgery was arranged. Subsequent to this, [Ms A] was transferred to the [public hospital], Department of Intensive Care Medicine. The timing of the transfer to the intensive care unit at [the public hospital] is discussed below.

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(c) Clinical Deterioration — Response of the Medical & Nursing Staff
This is a very complex point in the complaint. [Dr B] phoned and spoke with the nursing staff at 1140 hours on 17 April. It would appear that there were no major points of concern at that time as [Dr B] is noted to have planned to visit either later that day or early the following day. Clearly if there was concern, he would not have suggested the timing of his next visit as recorded here.

The [2200] hours record refers to the patient wanting to speak to the surgeon. The nursing staff contacted [Dr B] at approximate 2220 hours on 17 April. He prescribed a small amount of morphine analgesia. [Dr B] also had a discussion, via telephone, with [Ms A], but it is unclear to me what time this occurred (I note the report by [the Hospital] refers to this occurring at 2200 hours).

After the consultation via the telephone, there is a significant point of concern. [Dr B], according to the hospital, could not be contacted over the night of 17–18 April. However, [Dr B] has clearly described that his telephone did not ring. The nursing note for the night shift 1–18 April reports that neither [Dr B] nor the anaesthetist could be contacted. It then is recorded that '[…]' was contacted to see the patient. This is apparently the senior nurse manager on call for the hospital (see pg 41, summary)

At 0740 hours [Dr H], anaesthetist, saw [Ms A] and instigated further treatment. [Dr H] also spoke with [Dr B].

In my opinion, the inability of the hospital to contact either [Dr B] or [Dr H] represents a serious issue. It seems extraordinary that neither was contactable. The response of [the Hospital] to the enquiry from the Commission states that the hospital twice tried to contact [Dr B] on his mobile phone between 2300 hours and 0400 hours on the night of 17–18 April 2005.

There is no indication of how attempts were made to reach [Dr H].

There is no record to suggest the hospital tried to contact [Dr B] on his home landline. [Dr B] has stated that he was recharging his cell phone overnight thus explaining why he did not hear it ring.

In my opinion, the inability of the hospital to contact either [Dr B] or [Dr H] or any other medical officer represents a serious failure on behalf of the hospital. I have no doubt from the clinical notes that there was enough reason for clinical concern over the night 17–18 April 2005 to justify attempts to contact the surgeon and/or the anaesthetist. I find it extraordinary that there appears to have been no attempt to phone [Dr B] on his landline. I find it equally concerning that the hospital did not seek alternative medical input once the staff had failed to contact either the surgeon or the anaesthetist. I do not have a copy of [the Hospital's] contact processes alluded to, but I would be most

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surprised if the policy was to simply leave messages on cellular telephones when the staff clearly had justifiable clinical concerns about [Ms A].

(d) Was there a clinically relevant delay in the timing of the Medical review?

Given in my opinion there was a delay in contacting the medical staff, was this delay significant? It is very important to note that had [Dr B] (or [Dr H]) seen [Ms A] over the night of 17–18 April the need for urgent surgery and a colostomy would not have been altered. Nor likely would the complications experienced at [the public hospital] of needing the stoma revised.

It is impossible to know if [Dr B] would have taken [Ms A] to theatre earlier than he did on 18 April, as [Dr B] was not given the opportunity to do so.

Given the nature of the complication, in my opinion [Ms A] was highly likely to require intensive care support for the effects of severe sepsis even if her surgery had been some hours earlier. That is not to say the effects of the infection would have been the same had the operation been performed earlier.

The generalised effects of intra-abdominal sepsis are related in part to the duration of the infection. I believe all abdominal surgeons and intensive care specialists would agree that early drainage of intra-abdominal sepsis and control of the underlying cause are crucial to the recovery of the patient.

Therefore in my opinion, whilst the timing of the operation on 18 April may not have altered the need for intensive care support, any delay caused by the inability of the hospital to obtain an appropriate medical review could be regarded as significant.

I do not believe there were sufficient clinical grounds to suggest surgery should have been performed on 17 April even if [Dr B] had seen [Ms A] on the evening of the 17th.

(e) Transfer to Intensive Care

[Ms A] has raised the issue of the timing of her transfer to intensive care. In my opinion the decision as to whether or not to transfer [Ms A] preoperatively was best made by [Dr B] and [Dr H].

In my opinion it was perfectly reasonable to operate at [the Hospital] on 18 April as the key to [Ms A's] recovery was the drainage of the faecal contamination in her abdomen and the creation of the colostomy. Postoperatively, [Ms A] initially appeared to be stable and hence returned to the ward. Ultimately by late afternoon on 18 April she required transfer to intensive care at [the public hospital].

Whilst I doubt any clinician would be surprised that [Ms A] required transfer to an ICU, I do not think the standard of care provided at [the Hospital] following

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the operation on 18 April was anything other than of a high standard. The timing of transfers between hospitals is an imperfect art as opposed to a science. The clinical record from Recovery indicates a stable clinical picture, albeit with a reduced blood pressure. The nursing record from later that afternoon suggests a stable, but unwell, patient. It is just these circumstances — sick, but stable, which constitute the safest set of circumstances under which to transfer a sick patient from one hospital to another.

Conclusions

Clearly, [Ms A] suffered a severe complication of the trans-anal excision of the rectal tumour. Despite the subsequent breakdown of the rectal repair and the development of peritonitis in my opinion the judgement shown by [Dr B] was of a standard acceptable to surgeons in New Zealand. I believe [Dr B] acted appropriately when he advised an examination and appropriate treatment at the time of the varicose vein surgery. Whilst others may have adopted a different pathway to investigate the rectal bleeding symptoms, I believe [Dr B's] choice was one of a number of acceptable paths to follow.

I have no concerns over the type of information [Dr B] imparted to [Ms A] on 16 April.

I have no concerns over [Dr B's] care on 17 April.

I have a small concern about the nursing record being 'dominated' initially by the preferences for veins surgery and I wonder if it would be more appropriate to clearly indicate when patients have had a second significant procedure and to insist on specific instructions from the surgeon. I accept that the clinical pathway document (reverse of pg 64) states the additional surgery, but there is no subsequent guidance to the nursing staff.

The area of major concern that I have revolves around the inability of the hospital to contact [Dr B] (or any other doctor) when the nursing staff clearly had concerns for [Ms A]. I believe this 'failure' requires a definitive solution, be it a 'one off' problem or representative of a more systemic risk.

I have considerable empathy for [Ms A] who has obviously been through a very stressful and prolonged period of ill health."

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Appendix 3

Independent nursing advice

The following independent expert advice was obtained from registered nurse Philippa Pringle:

> "My name is Philippa Pringle and I have been asked to provide an opinion to the Health and Disability Commissioner on case number 06HDC09771. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.
>
> I am the Director of Nursing at Mercy Hospital Dunedin, a position I have held for the past 2½ years. Mercy Hospital provides elective surgical services for a wide range of surgical specialties including colorectal surgery. Prior to my working at Mercy Hospital I worked in the public sector for 25 years, the last 14 years as Nurse Manager of Dunedin Hospital's Intensive Care Unit. During my nursing career I have been involved in the care of a large number of patients undergoing colorectal surgery in both the pre-operative and post-operative phases of their care. I have also co-ordinated both the Emergency Management of Severe Trauma (EMST) and the Care of the Critically Ill Surgical Patient (CCrisp) courses for the past six years.
>
> **<u>Background (as supplied by the office of the HDC)</u>**
>
> On the 15th of April 2005, [Ms A] was admitted to [the Hospital] for minor varicose vein surgery and an exploration of her lower bowel while under general anaesthetic to follow up on her report of intermittent anal bleeding.
>
> The sigmoidoscopy revealed a moderate size full-thickness benign tumour which was excised. [Dr B] noted that he could see into the pouch of Douglas when excising the tumour. When [Ms A] returned to the ward, the instructions to the nursing staff regarding post-operative care was noted on a standardised generic form headed 'Clinical Pathway for Varicose Veins'. The form also noted 'Additional surgery and/or change of surgery', which in [Ms A's] case, recorded 'EUA & exc. Large rectal tumour.'
>
> On the afternoon of day-two post-surgery [Ms A's] condition started to deteriorate. She complained of abdominal pain, nausea and vomiting. There is discrepancy about when the nursing staff spoke to [Dr B] about [Ms A] during the evening of 17 April. [Dr B] recalled that he was consulted and ordered 'a small dose of morphine' at 8.30pm, the nurses recorded that they spoke to him at 10pm.
>
> At 11pm [Ms A] was complaining of back pain, generalized abdominal pain and nausea. She was given intramuscular morphine, 5mg, with little effect. The

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nursing records note that the staff tried but were unsuccessful in contacting [Dr B] and the anaesthetist about this time, but the time was not recorded.

[Ms A] vomited around 4am. Her abdomen appeared guarded with 'sluggish bowel sounds'. A further attempt was made to contact [Dr B].

At 5am the nursing staff called out Clinical Services Manager, registered nurse [Mr I]. [Mr I] considered that [Ms A] had developed an ileus.

At about 7.30am the anaesthetist, [Dr H], was contacted. [Dr H] examined [Ms A], started her on intravenous fluids and called [Dr B].

[Ms A] was returned to theatre for repair of the bowel wall and creation of a temporary colostomy at 11.05am on 18 April. However, her condition continued to cause concern and she was transferred to [the public hospital] Intensive Care Unit. She had further follow-up surgery and … ongoing complications.

Supporting Information

- [Ms A's] complaint to the Commissioner, dated 1 July 2006, marked 'A'. (Pages 1 to 13).
- [Dr B's] responses to HDC, dated 3 August 2006, marked with a 'B'. (Pages 14 & 15).
- [Dr B's] response to HDC and accompanying documents, dated 25 November 2006, marked with a 'C'. (Pages 16 to 30).
- [The Hospital's] response to HDC, with supporting documentation, dated 16 August 2006, marked with a 'D'. (Pages 31 to 256).
- Notes taken during a telephone call to [Ms A's] friend, [Ms G], on 10 November 2006, marked with an 'E'. (Page 257).
- Notes taken during a telephone call to [Ms A's] daughter, [Ms F], on 10 November 2006, marked with an 'F'. (Page 258).
- [The Hospital's] response to HDC, dated 4 December 2006, marked with a 'G'. (Pages 259 to 266).
- Additional information provided by [the Hospital's] [Quality Improvement Advisor] on 23 July and 2 August 2007, marked with an 'H'. (Pages 267 to 272).
- Provisional opinion dated 6 August 2007, marked with an 'I'. (Pages 273 to 301).

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- Response to PO from [Ms A], marked with a 'J'. (Pages 303 to 314).
- Response to PO from [the Hospital], dated 19 September 2007, marked with a 'K'. (Pages 315 to 325).

I have been asked to:

1. Advise the Commissioner whether, in my opinion, [the Hospital] provided surgical services to [Ms A] of an appropriate standard.

It is not appropriate for me to comment on whether [Ms A] received medical care to an appropriate standard while at [the Hospital]. I will however comment on the nursing services provided to [Ms A].

[Ms A] was admitted to [the Hospital] as already stated on the 15th of April 2005 where she underwent surgery for both varicose vein surgery and an EUA which resulted in resection of a large bowel tumour.

Her recovery was uneventful until the 17th of April when she developed increasing nausea, vomiting and abdominal pain that did not improve nor respond to prescribed pain relief. Her nursing care up to that time, in my opinion, was appropriate, irrespective of the fact that her plan of care was based on a varicose veins pathway. I will discuss the appropriateness of this when answering questions 2 & 4.

From the evening of the 17th April until the morning of the 18th April nursing staff noted deterioration in [Ms A's] condition, evidenced by her increasing agitation, abdominal pain, nausea and vomiting. They appropriately contacted [Dr B] for advice regarding control of her pain. They also appropriately increased the frequency of her observations as recorded on [Ms A's] observation chart.

The nursing notes reflected the nursing staff's awareness of [Ms A's] deteriorating condition, although her vital signs remained relatively stable. As noted by Dr Connolly (pg 288) a leaking anastomosis is not always manifested by changes in cardiovascular signs.

The inability of the nursing staff to contact [Dr B] is, I believe, an area of concern in [Ms A's] care. I shall elaborate on this further.

The return to theatre and subsequent transfer of [Ms A] to [the public hospital] Critical Care Unit was entirely appropriate. Following [Ms A's] second operation [the Hospital] recognised that they were unable to provide the level of tertiary care required by [Ms A] at that stage.

Other than the issue of the failure to contact [Dr B] I believe that [Ms A] in my opinion received nursing care to an appropriate standard at [the Hospital].

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2. The adequacy of the standardised generic post-operative instruction forms in directing an appropriate plan of care.

3. The standard of nursing documentation.

I have combined Questions 2 and 4 in the following opinion:

Critical pathways can be defined as problem-specific management plans that delineate key steps along an optimal timeline to achieve a set of described intermediate and ultimate patient goals. While clinical pathways may also be called care paths, integrated clinical pathways, care maps, and anticipated recovery pathways all attempt to increase efficiency by organising the care delivery process into individual and analysable steps (1).

While the pathway acts as a template of the care to be provided to a chosen group of patients, it is not intended to compromise clinical judgement (2) which I believe is an important point to make in this case. Variations from a pathway in my experience occur relatively frequently and these are dealt with to meet the needs of the individual patient.

The choice of a varicose veins clinical pathway on admission (pg 00049) I believe was clinically appropriate as that was seen as her primary procedure. The EUA may have been simply that with no resultant procedure undertaken. Unfortunately that was not the case for [Ms A] as following the EUA the surgeon went on to perform an excision of a large rectal tumour requiring a repair to the rectal wall. This additional procedure was noted on [Ms A's] clinical pathway.

The post operative observations and recording of vital signs stated on the care plan were appropriate to both surgical procedures (pg. 51). I note, however, that in the line adjacent to the 'Care as per relevant protocols' (Pg 51) no notation was made.

There was a notation next to this objective on subsequent days however which could lead to the assumption that protocols for both varicose vein excision and rectal excision were being adhered to. There is, however, no expanded comment to confirm this assumption. I note that in the NHS Rotherham General Hospital's care pathway provided that other than stoma care, urinary catheter care and NGT care, none of which were applicable to [Ms A's] situation, the care received by [Ms A] at [the Hospital] post operatively was in accordance with the guidelines outlined in the NHS pathway. The only other variation were diet and ambulation needs. These are, as outlined by Dr Connolly, often contentious issues and practice varies among surgeons as to how quickly to allow patients to ambulate and how soon patients are able to eat and drink.

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A 2002 study (1) of 41 hospitals in the USA found that most pathways were in fact similar in content, including incorporation of guidelines, measurement of clinical outcomes. Many hospitals do not use disease or procedure specific pathways but use generic care plans.

The only other comment I would make is that the pathway on the afternoon of the 17th and following night shift did not reflect [Ms A's] deteriorating condition. This was, however, captured in the written notes. I also note that the surgeon had written no additional instructions post surgery for [Ms A's] second procedure.

I do not believe that [Ms A] being on a varicose vein pathway was inappropriate given that this was the primary reason for her admission. I believe that pathways are a guide only and are no substitute for nursing knowledge and skills. In my opinion the standard of the nursing documentation was adequate.

Other than the issue of the failure to contact [Dr B] I believe that [Ms A] in my opinion received nursing care to an appropriate standard at [the Hospital].

1) Nursing assessment, monitoring and reporting of [Ms A's] condition during the afternoon, evening and night of April 17th 2006. Was there anything else that they should have done?

2) I note from [Ms A's] observation chart that from the time of her admission she had observations of her:

- Pain and sedation score;
- Oxygen saturations
- Respiratory rate
- Temperature
- Blood Pressure
- Wound Site
- CWMS — presumably of her left leg as this is not stated.

These observations are appropriate for both types of surgery that [Ms A] underwent. Her observations were satisfactory until 10.30pm on the 17th of April 2005.

At 7.45pm it is noted on [Ms A's] observation chart that she refused to have her observations taken then and at 8.30pm, although at 8.30pm her temperature was taken and was slightly raised at 37.3. Both times a respiratory rate could

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have been taken without interacting with the patient. An elevated respiration rate is often the first sign of a patient's deteriorating condition.

From 12.00am onwards her observations were taken 2/24 which is an appropriate level of monitoring given the degree of concern noted in the nursing record.

The slight increase in HR and the negligible change in BP, which had been lowish other than on admission were not sufficient in themselves to cause concern and certainly the elevated HR could have been attributed to the pain [Ms A] was experiencing. Of greater concern are the observations that record a pain score of 10/10. I note, however, that there was actually very little change in [Ms A's] condition following [Ms A's] conversation with [Dr B] at 8.25pm on the 17th of April. It may be reasonable to expect therefore that [Dr B] was aware of [Ms A's] condition at that time. What could not be reasonably expected, however, was that [Dr B] would be aware of [Ms A's] sustained abdominal pain that did not respond to the prescribed pain relief.

A score of 9/10 for 12 hours would certainly have warranted re-contacting the surgeon. I note that there were two attempts to contact the surgeon which was certainly appropriate. They were, however, unable to make contact with [Dr B]. I am unsure why they did not follow their hospital policy (pg 302) which states that if the doctor is unable to be contacted you contact 'a doctor in the same specialty who has a working relationship with the doctor concerned or another doctor'. I also cannot comment as to why they did not contact the surgeon on his landline. They did, however, as part of their policy appropriately contact their senior nurse on call.

In my opinion the nursing assessment and monitoring of [Ms A's] condition during her admission to [the Hospital] were appropriate and of a generally accepted standard of care.

Where I have a concern was the lack of reporting of [Ms A's] abdominal pain and discomfort to another medical practitioner when they were unable to contact [Dr B].

The Registered Nurse utilises nursing knowledge and complex nursing judgement to assess health needs, provide care, and advise and support people to manage their health. The Registered Nurse also provides comprehensive nursing assessments to develop, implement and evaluate an integrated plan of health care, and provides nursing interventions that require substantial scientific and professional knowledge and skills (Nursing Council Competencies for the Registered Nurse scope of practice).

Many of the nursing interventions rely upon relaying important clinical information. Domain 1, competency 1.4 in the domains of competence for the

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Registered Nurse scope of practice requires a nurse to promote an environment that enables client safety, independence, quality of life and health. An indicator for this competency states that the nurse will ‘identify and report situations that affect client or staff members’ health or safety’.

I am unable to comment on whether if [Dr B] had been contacted earlier he would have taken [Ms A] to Theatre any earlier and whether this lack of reporting impacted on [Ms A’s] ultimate outcome.

In my opinion the nursing staff were remiss in not following their own contacting medical specialists’ policy (pg 302) and ensuring that [Ms A] had access to appropriate and timely care. I believe this to be a moderate breach of Right 4 of the [Code of] Consumers’ Rights.

Summary

Other than the issue of the failure to contact [Dr B] I believe that [Ms A] in my opinion received nursing care to an appropriate standard at [the Hospital].

I do not believe that [Ms A] being on a varicose vein pathway was inappropriate given that this was the primary reason for her admission. I believe that pathways are a guide only and are no substitute for nursing knowledge and skills. In my opinion the standard of the nursing documentation was adequate.

I am unable to comment on whether if [Dr B] had been contacted earlier he would have taken [Ms A] to Theatre any earlier and whether this lack of reporting impacted on [Ms A’s] ultimate outcome.

In my opinion the nursing staff were remiss in not following their own contacting medical specialists’ policy (pg 302) and ensuring that [Ms A] had access to appropriate and timely care. I believe this to be a moderate breach of Right 4 of the [Code of] Consumers’ Rights.

Bibliography

1) ‘Use and Evaluation of Critical Pathways in Hospitals’, Effective Clinical Practice, May, June 2002, Dr Darer, J., Dr Pronovost, P., Dr Bass, E.

2) ‘What is an integrated care pathway’, Sue Middleton, Jane Barnett, David Reeves. www.evidence-gased-medicine.co.uz Volume 3, No.3, February 2001.

3) Competencies for the Registered Nurse Scope of Practice. Approved by the Council: June 2005.”

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Appendix 4

Nursing advice obtained by the Hospital
Southern Cross Hospital obtained expert advice from registered nurse Barbara Fox. Ms Fox advised:

> "My name is Barbara Fox. I am the Director of Nursing at St George's Hospital, a position I have held for the past 13 years. St George's Hospital provides elective surgical services spanning a wide range of specialties including approximately 2,800 general surgical cases. A significant number of these cases include colorectal surgery.
>
> Responsibilities in my current role include the oversight of nursing and clinical services and clinical risk management at St George's Hospital. This involves at times, the review of clinical notes, including the care and treatment of patients as requested by outside agencies, for clinical audit and internal clinical reviews.
> …
>
> **Standard of Nursing Care**
>
> In my opinion, considering the situation where there was difficulty in accessing the surgeon, the care provided to [Ms A] by the nursing staff at [the Hospital] was appropriate. The variation in the patient's condition was monitored, her care adjusted and nursing interventions, (ie observations, analgesia and antiemetic administration) as far as was possible, within the registered nurse scope of practice, were implemented.
>
> It appears that the nurses, after failing in their efforts to access medical advice attempted to assess the cause of [Ms A's] increasing pain. Regular abdominal examination revealed initially, sluggish bowel sounds and later cessation of bowel sounds. Consideration was given of a urinary tract infection initially as suggested by [Ms A].
>
> From the nursing notes, it appears that as the nursing staff became aware that [Ms A's] condition was not progressing as expected, the nursing interventions implemented were congruent with the guidelines on a colorectal surgical pathway. It is my opinion that failure to utilise a specific pathway overnight would not have significantly altered the outcome for [Ms A].
>
> I am unable to comment on the significance of the delay in notification of the surgeon, or if earlier notification could have changed the outcome for this patient. The medical expert is of the opinion the second surgery was not delayed.

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These comments are based on the paper review of the documentation provided only and do not take into account other factors that may impact on nursing practice during the period of [Ms A's] admission to [the Hospital]."

Barbara Fox
RN, BA (Nursing Studies, Massey University), Dip App. Sci., FCNA.

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