Surgical Registrar, Dr C

A District Health Board

A Report by the

Health and Disability Commissioner

(Case 02HDC08735)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mr A	Consumer/Complainant
Dr B	Dr D's Registrar
Dr C	Surgical Registrar/Provider
Dr D	Urologist

Complaint

On 1 July 2002 the Commissioner received a complaint from Mr A about services he received at a public hospital on 30 November 2001. The complaint was summarised as follows:

At a public hospital on 30 November 2001, Dr C, a surgical registrar, did not use reasonable care and skill in attempting to insert a urethral catheter. He did not:

- *provide Mr A with adequate anaesthetic;*
- *correctly insert an introducer on two occasions;*
- *adequately prepare Mr A for a suprapubic catheter, which resulted in infections to the catheter wound and sutures.*

An investigation was commenced on 18 September 2002.

Information reviewed

- Complaint letter from Mr A, dated 25 June 2002
- Further letters from Mr A, dated 10 April 2003 and 17 May 2003
- Information provided by a District Health Board (DHB), including Mr A's records, dated 21 October 2002 and further letters dated 23 December 2002 and 28 May 2003
- Responses from Dr C, dated 23 September 2002, 13 January 2003, 10 April 2003, and 20 July 2003
- The Accident Compensation Corporation's (ACC's) medical misadventure file, dated 7 November 2002, and review decision, dated 14 July 2003
- Information provided by Dr D, dated 10 January 2003 and 21 July 2003

Independent expert advice was obtained from Dr Stephen Kyle, general surgeon.

Information gathered during investigation

Summary of events
On 30 November 2001 83-year-old Mr A had a trans-rectal biopsy, performed by Dr D at his private rooms. Following the procedure, Mr A experienced some discomfort and was unable to pass urine. Mr A contacted Dr D, who advised him to attend a public hospital's emergency department.

Dr D states that, having referred Mr A to the emergency department, he called the emergency department to discuss Mr A's care with the on-call registrar. He did not know which registrar was on call, as Dr B, his registrar, was not answering his pager. Dr D states that he left clear instructions with the emergency department reception, and the nursing staff, to ask the surgical registrar to insert a urethral catheter or, failing that, a suprapubic catheter. He asked that the registrar not do anything else and if there were any problems the registrar was to call him. There are no records of this message being taken or passed on to Dr C.

I accept that at the time that Dr C treated Mr A, he was not aware of any instructions that Dr D had left regarding Mr A's treatment. I also note that Dr C did not have access to Mr A's clinical records for his private urological treatment, although Mr A had attended the public hospital in 1997 with a similar problem, and those records would have been available at the hospital.

Mr A went to the emergency department later that evening. Dr C assessed Mr A and initially attempted to insert a urinary catheter. Prior to attempting to catheterise Mr A he applied anaesthetic gel. Unfortunately, he was unable to catheterise Mr A and was able to obtain only a small amount of blood-stained urine.

Dr C then obtained an introducer, a metal wire used to guide a catheter into place. Dr D states that in 1997 he removed introducers from the emergency department. They were locked away in the operating theatres and for Dr C to have obtained an introducer he would have to have gone upstairs to the theatre and asked a nurse to get one for him. The District Health Board (the DHB) has confirmed that, to discourage their general use, introducers are not kept in the emergency department.

Having obtained an introducer, Dr C used it to make at least two further attempts to catheterise Mr A. During these attempts Mr A became distressed and experienced chest pain. Dr C and the assisting nurses moved Mr A into the resuscitation area of the emergency department for treatment and further investigations.

There is evidence that Dr C and Dr D had a difficult relationship, which led Dr C to delay contacting Dr D. Dr C states that, following the unsuccessful attempts at catheterisation, he made two telephone calls to Dr D's cellphone. During the first call he discussed Mr A's care with Dr D, who advised him to insert a suprapubic catheter. The second call was to report that he had successfully catheterised Mr A using a suprapubic catheter. The telephone records from the public hospital indicate that two calls were made to Dr D's

cellphone from the emergency department at 6.35pm (lasting 42 seconds) and 8.15pm (lasting 3 minutes 20 seconds).

Dr D states that he was at his private rooms during that time and, as is his usual practice when at his private practice, he had his cellphone turned off. If hospital staff need to contact him they know to call through the telephone at his rooms. Dr D states that, as he had not heard from the emergency department, he went to see Mr A at around 7.55pm. He saw Mr A at around 8.10pm. He also saw Dr C, but Dr C walked away and they did not speak at all that night.

The telephone records and Dr C's recollection suggest that Dr D is mistaken in his recollection that he did not discuss Mr A's care with Dr C that night.

After treating Mr A's chest pain, Dr C prepared Mr A for a suprapubic catheter, which included applying an aqueous Betadine solution to the area. Dr C was then able to insert a small-bore suprapubic catheter, which relieved Mr A's urinary retention.

Subsequent to this treatment Mr A was diagnosed with a false passage. It appears that the false passage was created at the time of Dr C's first attempt to catheterise Mr A, and that this was a very likely outcome given Mr A's urological history. More recently, Mr A has been diagnosed with bilateral inguinal hernias.

The 1997 memorandum

In 1997, Dr D wrote a memorandum forbidding the use of introducers by junior staff at the public hospital. It was given to the Clinical Director, who wrote on it "Registrar file". This meant that the memorandum would have been placed in a file and it became the Clinical Director's responsibility to ensure that registrars were made aware of it. The memorandum was also copied to the Clinical Director, the Medical Director and the Emergency Department Charge Nurse.

Dr D also states that, while Dr C was employed at the public hospital, he spoke at the monthly general surgical audit meetings and warned all surgical registrars to refrain from using introducers under any circumstances. Dr D gives a talk to the registrars every year about urological emergencies; this includes telling them not to use introducers without him being present.

Dr C states that he was not aware of Dr D's 1997 memorandum and that he has never heard Dr D speak on the use of introducers at a general surgical audit meeting.

The DHB advised me that such memoranda are not subject to any particular process and it is left to the sender to decide how best to distribute them. It is also up to the sender to update, review and re-distribute the memorandum if it is to be of ongoing application. It is common for the sender to use a sign-off sheet to ensure that the memorandum reaches all of its intended recipients. The expectation of the DHB is that, where a memorandum is considered to be of particular importance or intended to be of wide and long-lasting application, the sender should endeavour to have it incorporated into a written policy or protocol. The DHB has a process for creating policies and protocols, and a Quality Team

to co-ordinate that process. There is no evidence to suggest that Dr D took any steps to update or review the memorandum after 1997.

Given the age of the memorandum, the fact that it was not incorporated into a policy, and the lack of any evidence, such as a sign-off sheet, to indicate that Dr C did see the memorandum, or attended a general surgical audit meeting at which Dr D forbade the use of introducers by registrars, I accept that when he treated Mr A Dr C was not aware of the memorandum or Dr D's instructions regarding the use of introducers.

ACC's medical misadventure investigation
During its medical misadventure investigation ACC obtained advice from two expert advisors, Dr Cadwallader and Dr Sexton. In their reports to ACC they made the following relevant comments.

Dr Jon Cadwallader, urological surgeon, stated:

> "Having recognised difficulty in the passage of a urethral catheter without an introducer, and the high probability of a bladder neck stenosis, and establishment of a false track, it was unwise to consider [using an introducer]. It would have been better to have proceeded further immediately to a suprapubic catheter to provide urinary drainage."

Dr Cadwallader concluded that there was "no issue with respect to medical error".

Dr Michael Sexton, general and endoscopic surgeon, stated:

> "When [the initial catheterisation] failed, an attempt to place a urethral catheter using an introducer was made. Instrumentation of the male urethra is hazardous and should only be attempted by those who have experience in its technique. The risk of creating a false passage is high especially in inexpert hands, but can occur with the most experienced urologist. It is important to recognise the risk and appreciate the possibility that it has occurred, since all attempts at blind intubation must cease."

Dr Sexton's opinion was that Mr A had not suffered additional morbidity as a result of medical misadventure.

ACC declined Mr A's claim for medical misadventure in November 2002 and his subsequent application for review in July 2003.

Independent advice to Commissioner

The following expert advice was obtained from Dr Stephen Kyle, general surgeon:

"***Sequence of Events***
[Mr A] had a trans-rectal prostatic biopsy on 30/11/02 by [Dr D], (Consultant Urologist) for investigation of the possibility of prostatic carcinoma. This biopsy was performed at [Dr D's] private rooms. [Mr A] had previously had a trans-urethral resection of the prostate in June 1997. He subsequently developed further difficulties with voiding for which he had a bladder neck incision, urethral dilatation and a further minor Prostatectomy in December 1997.

Following the trans-rectal prostatic biopsy [Mr A] could not pass urine and had bleeding from his urethra. [Mr A] contacted [Dr D] who referred [Mr A] onto the Accident and Emergency Dept at [the public hospital].

The Surgical Registrar on Call, [Dr C], assessed [Mr A] and attempted to relieve his problem of urinary retention. [Dr C] initially tried attempting passing a wide bore Urethral Catheter into the bladder which was unsuccessful. He then tried 'a number of times', to pass a Catheter using an Introducer. This is a stiff wire instrument designed to negotiate a Catheter into the Urinary bladder. It can be useful when a previous Prostatectomy has been performed. [Mr A] became very distressed with this procedure, which was terribly painful for him. He developed chest pain and concern was raised that Mr A might be having a cardiac event which transpired to not be the case.

[Dr C] then tried to pass a large bore Suprapubic Catheter directly into the bladder through the abdominal wall. This also failed. [Dr C] was subsequently then able to successfully place a narrow bore Suprapubic Catheter which appeared to provide satisfactory urinary drainage.

[Mr A] was admitted and subsequently discharged with the Suprapubic Catheter in situ on 2.12.01. Pathological examination of the biopsies revealed that [Mr A] had Prostatic Cancer.

Examination by [Dr D] on 16.01.02 revealed a false passage through the Prostate which was probably a consequence of the attempted urethral catheterisation. There was also narrowing of the bladder neck, which was surgically widened. [Dr D] has continued to manage this problem along with [Mr A's] prostatic cancer.

Commission Questions:
Please comment on the use of anaesthetic gels when inserting Urinary Catheters.

It is entirely standard practice to use Anaesthetic gels prior to urethral catheterisation. These Gels are made up in a convenient syringe applicator that also contains antiseptic. It would be extremely difficult if not impossible to pass a Urinary Catheter without the lubrication provided by the Gel. As this is such a standard part of Catheterisation, it would seem inconceivable that this step could be ignored. Typically a trolley or tray is

readily available with the necessary equipment for Catheterisation. If in a moment of forgetfulness, this step were omitted, then it would quickly become apparent due to the difficulty and pain produced in passing the Catheter. Hence in my opinion, it is extremely likely that Anaesthetic Gel was used and that the pain [Mr A] experienced would have been from the general difficulty of the procedure and probable creation of a false passage.

Was Dr C qualified to use an Introducer in these circumstances?

However experienced [Dr C] was with the use of Introducers, had he been cognisant of [Dr D's] protocol for Junior Staff not to use these instruments, it was inappropriate for him to use one, as [Dr D] is responsible for his patient's overall management.

General Surgical Registrars should be well qualified in performing basic Urethral and Supra-Pubic Catheterisation. Using an Introducer is a more advanced procedure. Many surgical Registrars would have been trained in this procedure particularly if they had had a period working in Urology. From [Dr C's] letters, he does not appear to have had any formal Urological attachment in his training. He does however, state that he has used Introducers on numerous occasions before. As it appears he has not had formal Urological training, it probably would have been wise to consult [Dr D] prior to using an Introducer. Lack of consultation under these circumstances would probably invoke mild disapproval from General Surgical Peers.

Assuming [Dr C] was not aware of the instructions against using Introducers, were his actions in Catheterising [Mr A] reasonable in the circumstances?

General opinion for a case such as [Mr A's] would probably vary between not using an Introducer at all to having a solitary gentle attempt with this instrument if adequately trained. Suprapubic Catheterisation would be a good option.

[Dr C's] use of the Introducer to pass the Urethral Catheter seems to have exceeded standard practice. He admits to having multiple attempts in his letter to […] 14.01.02. I note however in his letter to Mr Paterson dated 23.09.02 that [Dr C] states only two attempts were made. [Dr C's] seemingly excessive use of the Introducer probably would invoke moderate disapproval from Colleagues. It must be appreciated that the same trauma could arise in the most experienced of hands.

Did [Dr C] adequately prepare [Mr A] with regards to infection control prior to inserting a suprapubic catheter?

Standard practice for Suprapubic Catheter placement would be to use sterile technique and disinfect the area. This is so basic and standard I believe it was performed as [Dr C] claims. [Dr C] also gave [Mr A] antibiotics intravenously. Despite these measures superficial infection around the appliance is not uncommon.

Additional Comment

In our smaller hospitals many specialties have to be covered by a General Surgical Registrar. Twenty four or even forty eight hour periods of call are frequent along with a very busy non urgent workload. It is common to work twelve consecutive days, four of which would incorporate twenty four hour periods of call. At [the public hospital] when on call, [Dr C] would probably have been the first Registrar contact with any patient with a urological, general surgical, paediatric surgical, vascular, traumatic neurosurgical, traumatic cardio-thoracic, or plastic surgical emergency. At a larger hospital, specialist consultant staff and Registrars would cover these additional specialties. Registrars are often put in a difficult position of assessing and performing immediate management on patients that are not in their area of training or future career aspirations. This can be very stressful. Sometimes, despite the best of intentions, in retrospect, problems will be deemed to have been managed inappropriately.

Did [Dr D] act appropriately in informing junior staff of his instructions for the use of Introducers?

[Dr D] has produced a protocol which was sent to the A&E Dept in 1997 requesting that Introducers not be used for Urethral Catheterisation. While it might be expected that with publishing a protocol, this would become widely known and followed, this is often not the case in our Public Hospitals. There is frequent turn over of staff, including medical, nursing and administration. It is extraordinarily difficult to maintain knowledge and compliance of protocols for the literally hundreds of varying procedures that can be performed. From the reports and letters I have read, [Dr D] has endeavoured to standardise management for urological emergencies by Junior Staff more than any hospital that I have been associated with. As far as [Mr A's] case is concerned, ideally [Dr D] would have personally spoken to [Dr C] prior to [Mr A's] arrival at the A&E Dept.

[Dr D] did phone A&E informing them of [Mr A's] impending arrival which was reasonable."

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

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

…

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

Opinion: Breach — Dr C

Lack of reasonable care and skill
There are a number of significant factors that influenced Dr C's decision to use an introducer on Mr A. As general surgical registrar in a smaller hospital, he was required to urgently assess and manage patients, like Mr A, whose conditions were outside of his area of training or future career aspirations. In Mr A's case, urology was not Dr C's specialty area, he had no access to Mr A's private treatment records, and he was unaware of Mr A's complicated urological history. Dr C was, however, aware that Mr A was under the care of a consultant urologist, Dr D, who had referred his patient to the emergency department because of a urological problem.

I note Dr C's comments that he considered that he was left unsupported in a difficult clinical situation when he saw Mr A on 30 November 2001. I accept that this was clearly a difficult situation. Dr C was acting without direct guidance from Dr D, and was not made aware of any instructions Dr D had left with the emergency department about Mr A's care. It appears that Dr C and Dr D had a difficult relationship, which led Dr C to delay seeking Dr D's advice until after he had encountered problems catheterising Mr A. I note my expert's comments that, ideally, Dr D should have spoken to Dr C personally prior to Mr A's arrival, although it was reasonable that Dr D called the emergency department to advise them of Mr A's imminent arrival.

In Dr C's response to my provisional opinion he stated that he had used introducers previously in a number of hospitals, including the public hospital, and been instructed in their use by consultant surgeons. Dr C also accepted that he lacked knowledge about this specialised procedure. However, at the time, he felt that there was an expectation that it was an appropriate procedure for a registrar in an emergency department to carry out.

I note that Dr C was not a urological registrar and had only informal training in the use of introducers. In order to use an introducer, he had to obtain one from theatre, where they are kept specifically to discourage general use. However, Dr C chose to attempt a difficult and potentially dangerous procedure using an introducer, rather than inserting a suprapubic catheter or contacting Dr D for further instructions. I accept my expert's comments that, in the circumstances, using a suprapubic catheter would have been a good option and that, given his level of experience and apparent lack of formal urological training, Dr C should have contacted Dr D prior to using the introducer. I note my expert advice that Dr C's decision not to contact Dr D would attract mild disapproval from his peers. I also note Dr Cadwallader's comment that Dr C was "unwise" to consider using an introducer, and Dr Sexton's comment that "instrumentation of the male urethra is hazardous and should only be attempted by those who have experience in its technique".

I accept that Dr C was placed in a difficult situation and had to make a decision about how he could best relieve Mr A's distress. In my opinion, while it was far from ideal, Dr C's initial attempt to catheterise Mr A using an introducer was not an unreasonable course of action in the circumstances. However, I accept my expert advice that the use of an introducer is an advanced procedure, and that an adequately trained surgeon would not have persevered beyond a single gentle attempt to insert a catheter using an introducer. I note that Dr C had only informal training in the use of introducers and yet he made at least two attempts.

In Mr A's case, Dr C needed to be especially careful, as he was not aware of Mr A's full urological history and he had already obtained a small amount of blood-stained urine when trying to insert the catheter. I note my expert advice that it is likely that Dr C caused the false passage with his first attempt to catheterise Mr A. I also note Dr Sexton's comments that "it is important to recognise the risk [of a false passage] and appreciate the possibility that it has occurred since all attempts at blind intubation must cease".

In response to my provisional opinion, Dr C stated that the use of an introducer is not "in and out", but requires gentle and repetitive direction and redirection of the catheter tip. Thus, the fact that he withdrew the catheter on one occasion between these multiple gentle attempts has little relevance.

While I accept that it may not be a simple matter of one attempt or two, I am satisfied that, given all the circumstances of Mr A's referral, including Dr C's lack of training, the lack of information about Mr A's condition or instructions from Dr D, and the results of the initial attempt at catheterisation, Dr C exceeded reasonable practice in his attempts to catheterise Mr A using an introducer. Accordingly, Dr C failed to provide services with reasonable care and skill and breached Right 4(1) of the Code.

Opinion: Breach – The District Health Board

I am concerned about the public hospital's reliance on a four-year-old memorandum as the only apparent means of documenting what Dr D has described as "fundamental teaching" – that the use of introducers by inexperienced hands is "forbidden". It appears that Dr D did not avail himself of the opportunity to have his instructions about introducers more formally incorporated into a policy or procedure. I note that, had he wished to do so, the DHB had a system in place for creating and reviewing such documents.

I also note that the DHB does not appear to have made any attempt to standardise the use of memoranda as a means of communicating important information. Nevertheless, I accept that the DHB has taken adequate steps to provide guidance for junior staff regarding the management of urological emergencies at the public hospital.

I note the following comment made by ACC's expert, Dr Michael Sexton:

> "The conflicting statements from the principals in this claim … indicate a disturbing lack of communication and support between the consultant and registrar and confusion regarding protocols. These issues clearly need to be addressed as a matter of urgency."

I share Dr Sexton's concerns. The District Health Board, as a provider of health services at the public hospital, is required under Right 4(5) of the Code to ensure co-operation and effective communication between its staff, so that the quality of patient care is not compromised. In my opinion, Dr C should not be the scapegoat in this case, and the Board must accept its share of responsibility for what happened to Mr A. In the circumstances, the District Health Board breached Right 4(5) of the Code.

In my provisional opinion I stated that I intended to recommend that the DHB review practices at the public hospital in light of the communication and support issues raised by this case, and that it hold an internal debrief with Dr D in light of my report. The DHB has responded, stating that it accepts my findings and recommendations.

Opinion: No breach – Dr C

Anaesthetic
Dr C states that he did apply anaesthetic gel before attempting to insert the urinary catheter. I accept my expert advice that the use of such gels is entirely standard practice; if Dr C had not used the gel it would have been immediately obvious when he attempted to catheterise Mr A.

I consider it probable that, in accordance with standard practice, Dr C did use anaesthetic gel prior to attempting to catheterise Mr A, and that the pain he experienced is likely to have been due to the general difficulty of the procedure and the creation of the false passage. Accordingly, in relation to this matter Dr C did not breach the Code.

Preparation for suprapubic catheter
Dr C states that, prior to inserting the suprapubic catheter, he prepared the skin with an aqueous Betadine solution. He also considered that Mr A had had a dose of oral antibiotics earlier in the day to cover his prostate biopsy. Dr C used three antibiotics, including intravenous gentamicin and metronidazole, in preparing Mr A for catheterisation.

I accept my expert advice that these steps were in accordance with standard practice, and that superficial infection around a suprapubic catheter appliance is not uncommon. In my opinion Dr C acted with reasonable care in preparing Mr A for a suprapubic catheterisation, and did not breach the Code.

Other comments

Communication issues
During the course of this investigation it has become clear that there were considerable communication problems between Dr C and Dr D, and that this affected Mr A's care. While I have found the DHB in breach of the Code for failing to ensure that its doctors worked together effectively, I consider that some responsibility must also fall on the doctors involved. I encourage both Dr C and Dr D to reflect on their approach to communicating with other providers and ensure that they provide services in a professional manner.

Dr C's response to my investigation
In response to my provisional opinion Dr C advised me that he has learnt from this incident, but that as he does not intend to develop his career in the field of urology, he will not undergo any further training in this area. He has stated that he does not intend to use introducers in the future and, if faced with a similar situation, he would request that the patient be managed by a consultant urologist.

I also note that Dr C wrote to Mr A on 17 September 2002, apologising for the pain he suffered during the procedure and expressing his sadness in learning of Mr A's ongoing symptoms related to this incident. Dr C has also co-operated fully with the hospital's internal investigation and with my investigation.

Recommendations

I recommend that the District Health Board review practices at the public hospital in light of the communication and support issues raised by this case, and hold an internal debrief with Dr D in light of my report.

Further actions

- Copies of my final report will be sent to the Medical Council of New Zealand and to the Accident Compensation Corporation's Medical Misadventure Unit.

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