

**Preoperative investigations and surgical standards for
laparoscopic cholecystectomy
(09HDC01505, 17 October 2011)**

General surgeon ~ Public hospital ~ District health board ~ Laparoscopic cholecystectomy ~ Preoperative investigations ~ Informed consent ~ Degree of care ~ Rights 4(1), 4(4), 6(2) 7(1)

A woman complained that a general surgeon operated on her to remove her gall bladder by laparoscopic cholecystectomy, when he had already removed her gall bladder 13 years earlier.

The year before the woman had her gall bladder removed she had suffered a stroke. The woman had a poor memory. She had had a number of admissions to hospital over the years with unresolved epigastric pain. Five years before the events complained about, the woman had a laparoscopic appendicetomy. The records of that surgery referred to the previous surgery to remove the woman's gall bladder.

As part of the preoperative assessments, the surgeon examined the woman on two occasions, in the Emergency Department and the surgical outpatient clinic, but failed to note scarring on the woman's abdomen that would have alerted him to the earlier laparoscopic cholecystectomy surgery. The woman was unclear what previous surgery she had undergone.

The surgeon organised for the woman to have an ultrasound scan and blood tests to assess her liver function. The gall bladder could not be visualised and the ultrasound scan report noted the possibility of a contracted gall bladder. The blood tests showed liver function within the normal range. The surgeon completed a referral form for an abdominal CT scan, and the referral form was placed in the woman's file. The surgeon did not intend the referral to be actioned at that time. However, clerical staff processed the referral and the woman had the CT scan which showed anatomy consistent with post-cholecystectomy and the presence of cholecystectomy clips.

The scan result was sent electronically to the surgeon. Although the surgeon viewed this report which contained the woman's name and details, he did not mentally connect the report to the woman. When the surgeon forwarded the report for printing, the report was sent to the wrong printer and the surgeon failed to retrieve it. At that time a recently introduced electronic result system was operating dually with the old paper system and he anticipated a paper copy would be attached to the file. However, this did not happen. The woman's earlier notes, which contained the records of her previous gall bladder surgery were not provided to the surgeon and he did not request them.

During the surgery, the surgeon initially believed that he had removed a shrunken gallbladder, but then found that a major duct injury had occurred. The woman was transferred to a tertiary hospital for review by a hepatobiliary/general surgeon. A post-surgical radiological examination confirmed the surgeon's concerns that a duct injury had occurred. The woman and her husband were advised of the error and corrective surgery was performed.

It was held that the serious consequences the woman sustained arose as a combination of individual error on the part of the surgeon, and district health board systems issues.

The surgeon failed to obtain full and accurate information about the woman's previous medical history, failed to carry out an adequate pre-operative assessment and failed to provide adequate information to the woman prior to her consenting to undergo the surgery. During the surgery the surgeon misread the anatomy. However, once the error was identified, the surgeon took prompt and appropriate action. The surgeon was found to have breached Rights 4(1), 4(4), 6(2) and 7(1) of the Code, and was referred to the Director of Proceedings. The Director decided not to take a disciplinary proceeding against the surgeon in this case or to bring a claim for damages before the HRRT (the consumer having ACC cover for treatment injury that would preclude an award of compensatory damages).

The district health board had a duty to ensure that the right information reached the right person at the right time. An incomplete set of the woman's clinical records was provided to the clinical team. The district health board breached Right 4(1) of the Code by failing to take reasonable steps to alert the woman's treating clinician to the existence of relevant clinical information, which adversely affected the care provided.