Opinion 22HDC00711
8 December 2025

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Removal of gallbladder during hemicolectomy

Introduction

1. On 20 March 2022, this Office received a complaint from Ms A (on behalf of the family) about the care provided to her father, Mr B, by Dr C at a private hospital. The complaint concerns inadequate care, information provided to Mr B, and communication with the family.

Background

2. In January 2021, Mr B underwent a partial cholecystostomy[1] at a public hospital (public hospital1), after experiencing acute cholecystitis.[2] Mr B suffered a prolonged bile leak from the gallbladder remnant[3] and subsequently underwent a magnetic resonance cholangiopancreatography[4] at another public hospital (public hospital2) in April 2021, which showed that Mr B had a gallbladder remnant with several small stones.

3. Alongside experiencing issues with his gallbladder, Mr B was overdue for a follow-up colonoscopy (relating to previous bowel surgery[5]). After undergoing the colonoscopy, Mr B was diagnosed with colon cancer. He was referred to Dr C[6] for a left hemicolectomy[7] in July 2021.

Surgical clinic appointment – 15 July 2021

4. Ms A told the Health and Disability Commissioner (HDC) that her father and family attended an initial surgical clinic appointment with Dr C, in which the following was discussed:

   a. Her father mentioned the recent partial cholecystectomy to Dr C, who offered to 'tidy up the gallbladder' during the scheduled left hemicolectomy.

   b. Her father and family informed Dr C that the gallbladder surgery and previous hemicolectomy had been complex and offered to provide previous surgical and outpatient notes, but Dr C declined.[8]

[1] During this procedure, half of Mr B's gallbladder was removed.
[2] Inflammation of the gallbladder.
[3] Gallbladder remnant is a rare complication of a cholecystectomy, resulting from an incomplete gallbladder removal. This can lead to residual gallbladder stones, which often causes pain, indigestion, and jaundice.
[4] Magnetic resonance cholangiopancreatography is a non-invasive imaging technique used to visualise the gallbladder and/or biliary tree using magnetic resonance imaging (MRI).
[5] Mr B underwent an ileocolic resection (also known as a right hemicolectomy) in 2001. This was a follow-up colonoscopy, which was overdue since 2018.
[6] Dr C is a colorectal and general surgeon.
[7] An operation where part of the colon (large intestine) is removed.
[8] In response to the provisional opinion, Ms A clarified that her father presented hard copies of previous surgical and outpatient notes to Dr C at this time, who declined to receive them.

c. Her father directly asked Dr C about his experience with gallbladder surgeries. Dr C replied, 'not very often, but they are straight forward'. This reassured her father about Dr C's capability to handle the partial cholecystectomy.

5. Dr C told HDC that he discussed the possible complications from the surgery during this consultation and that he would look at the gallbladder and remove it if it was straightforward. Dr C stated that he avoids difficult gallbladder surgery having operated on many difficult ones over 30 years.

6. Dr C recalled that Mr B mentioned he had acute cholecystitis in public hospital1 and that it had not been possible to remove all of the gallbladder and that he had a drain in. Dr C did not recall being advised that Mr B had attended public hospital2 and had further imaging and this was not in the referring doctor's notes. Dr C told HDC that, had he known this, he would have requested the notes and would almost certainly have left the gallbladder alone. Dr C told HDC that it can be difficult to get clinical notes from hospitals and, unfortunately, assumed they were not needed here.

7. Dr C's clinic letter outlined that Dr C discussed the surgery and complications with Mr B. A consent form was completed, but the complications or risks were not specifically documented in either the letter or the consent form.

8. Ms A stated that a week before the surgery, her father and family were concerned because they had not received the CT scan results (organised by Dr C previously) or admission details.[9] Ms A stated that her father telephoned Dr C for the CT results, and he 'thought he had already given the results'.

9. Ms A stated that, on 10 August 2021, Dr C briefly met with Mr B and herself. Ms A stated that Dr C said he would 'have a look when he got in there' and see if he could 'tidy up the gallbladder'.

Surgery

10. On 11 August 2021, Mr B underwent surgery at a private hospital. Clinical notes indicated that the procedure was for a 'left hemicolectomy for cancer' and 'cholecystostomy for chronic cholecystitis'. Ms A noted that, at this time, her father had no abdominal pain or symptoms consistent with recurrent cholecystitis.

11. Dr C accepted that there was little indication to operate on the gallbladder as a standalone procedure. However, as he was operating for the bowel cancer, he told HDC that it would be reasonable to have a look and see if removing it was feasible.

12. Dr C told HDC that the surgery was straightforward in relation to the colon cancer but that the gallbladder looked 'difficult'.[10] He started to remove the gallbladder in a

[9] Ms A stated that the family contacted the private hospital for admission details.

[10] The description of the gallbladder in Dr C's statements was of a scarred, 'rather shrivelled' gallbladder and that the gallbladder 'was extremely difficult to dissect out' (Dr C's operation note, 11 August 2021)

'retrograde fashion'[11] but, as it involved deeper structures, he called Professor D,[12] who completed the dissection and inserted a drain.

13. In response to the provisional opinion, Dr C told HDC that he only just started to dissect out Mr B's gallbladder when he found things difficult. Professor D was available and did most of the dissection from that point onwards.

14. Professor D advised that he attended surgery at the request of Dr C as Dr C was having difficulty with a cholecystostomy and required assistance. On arrival, Professor D advised that he could see that the dissection extended well above the gallbladder remnant and suggested that Dr C stop dissection. Although a bile duct injury could not be ruled out, there was no visible bile leakage. Professor D removed the gallbladder remnant before inserting a drain, and Dr C completed the bowel resection.

Post surgery

15. Ms A stated that her mother (Mrs B) missed a post-surgery call from Dr C,[13] and a nurse contacted Dr C on her mother's behalf. Ms A stated that her mother recalled Dr C saying, 'I wish I hadn't touched the gallbladder'. However, Ms A stated that no one in the family, including her father, was advised about any significant or unexpected injury post-surgery.

16. Ms A stated that, on 12 August 2021, the physiotherapist and nurses appeared unaware of the significance of a bile leak and continued to mobilise her father, causing him significant pain and distress.

17. Ms A stated that later on 12 August 2021, she noticed bile in one of the surgical drains and overheard a nurse talking about a transfer to another public hospital (public hospital3) for an endoscopic retrograde cholangiopancreatography (ERCP).[14] Ms A stated that it was not until the evening that Dr C informed the family that a bile leak occurred during gallbladder surgery and that arrangements were being made to transfer Mr B to public hospital3.

18. Dr C told HDC that it is his usual practice to ring the relatives after surgery, and there was full discussion with the family at some stage that day. Dr C cannot recall the specifics, but he did mention how difficult the gallbladder dissection was and that he called in Professor D. Dr C did not mention anything about a major biliary injury because he did not think there was one at the time and he expected a reasonably quick recovery.

Transfer to public hospital3 – 12 August 2021

19. Dr C advised Professor D that Mr B had had a stable night but that there was bile in the drain. An urgent ERCP could not be arranged at the private hospital, so Mr B was transferred to public hospital3 under the care of Professor D on 12 August 2021. An ERCP confirmed a bile leak, and further surgeries were undertaken. Mr B's condition

[11] Refers to a process or procedure that is done in the opposite direction of the normal flow or progression.
[12] Hepatobiliary and Transplant Surgeon and Clinical Professor of Surgery.
[13] Ms A stated that Dr C left a voicemail to inform Mrs B that the surgery had been completed.
[14] ERCP is a specialised technique used to study the ducts or 'drainage tubes' of the gallbladder, pancreas, and liver.

subsequently deteriorated and, sadly, he died in early September 2021 from intra-abdominal sepsis.

SAC investigation and internal case review

20. A serious adverse event review (SAC investigation) was undertaken by the private hospital, and an internal case review was undertaken by Dr E, the Chief Medical Officer at the private hospital.

21. The SAC investigation highlighted that Dr C was not fully aware of Mr B's medical history before the operation. In particular, Dr C was not aware of Mr B's visits to public hospital2 as a follow-up from the public hospital1 admission that year (including imaging studies that showed abnormal anatomy) and did not request these notes; nor did he review Mr B's notes from public hospital1 before the operation. In addition, Dr C advised he had only undertaken cholecystectomies infrequently in recent years. The SAC investigation identified access to previous patient notes (public and private) at the private hospital as an area for improvement.[15]

22. Dr E's review[16] also concluded that Dr C did not fully acquaint himself with the surgical background of Mr B before surgery and that he failed to recognise that the surgery was outside his usual scope of practice, which led to serious harm. As a result, Dr E recommended that a review be undertaken of Dr C's approved area of practice and that the current restriction to undertaking gallbladder surgery remain in place.[17] Dr E acknowledged that Dr C has extensive surgical experience and that Dr C accepted that he should have obtained the full surgical background. Dr E did not consider that the lack of judgement and preparation is a systematic problem with Dr C's practice. However, Dr E recommended that Dr C make all efforts in future to obtain relevant clinical material on a patient before progressing for surgery.

[15] Dr C voluntarily stopped undertaking gallbladder surgery until the review was completed.

[16] Completed 4 July 2022.

[17] The Medical Council of New Zealand confirmed that Dr C currently has a voluntary undertaking in place since November 2022, stipulating that he must not undertake any gallbladder surgeries. Dr C has been compliant with this undertaking. A preliminary competence inquiry (PCI) report was finalised on 3 July 2023, and the PCI interviewer concluded that Dr C's practice was 'quite acceptable based on current standards in General and Colorectal Surgery.' However, Dr C has a tendency to omit documentation regarding the discussion of common complications in minor procedures. Although these discussions were likely to have occurred verbally, he emphasised that best practice would include reasonable documentation of these discussions. The interviewer also highlighted that this documentation 'deficiency' is common among Dr C's peers, and he did not consider Dr C to be a significant outlier in this regard. The Council's Medical Adviser reviewed Dr C's PCI report and was reassured about his standard of practice. The Deputy Registrar, acting under delegation, considered Dr C's PCI report and the Medical Adviser's advice and decided that no further action is required. Dr C's voluntary undertaking remains in place until the conclusion of the HDC process.

Dr C

18. Dr C acknowledged that he should have obtained more information about Mr B's gallbladder complaint before he operated on him for his bowel cancer and apologised to Mr B's family for his lack of thoroughness.

19. Dr C does not accept that he operated beyond his scope of practice and considers that he took appropriate action by stopping the procedure and calling in Professor D when he could see difficulties with the gallbladder.

20. Dr C stated that he is mindful of maintaining effective communication with patients and is sorry that Ms A felt that this did not occur.

Independent clinical advice

21. Independent clinical advice was provided by colorectal surgeon, Dr Shun-Jen Linus Wu (Appendix A), who advised that the following departures from the accepted standard of care occurred in relation to the care provided by Dr C:

    (a) Whether a cholecystectomy was indicated in this case – moderate departure;

    (b) Adequate review of history and documentation before surgery – severe departure; and

    (c) Attempted completion cholecystectomy – severe departure.

22. Dr Wu did not identify a departure in relation to communication with Mr B's family after surgery. Dr Wu was unable to comment on whether there had been open disclosure of a potential bile duct injury as Dr C did not think there had been an injury at the time.

Opinion: Dr C — breach

23. I take this opportunity to extend my sincere condolences to Mr B's whānau for their loss. I consider that there were deficiencies in the care provided by Dr C, and I have set out the reasoning for my decision below.

Whether a cholecystectomy was indicated and review of previous records

24. My advisor, Dr Wu, considered that there was no evidence to suggest that Mr B had ongoing gallstone-related symptoms that indicated a cholecystectomy was warranted in this case. In light of this, Dr Wu considered that proceeding with the procedure was a moderate departure from the accepted standard of care.

25. Dr Wu also noted that Dr C did not obtain any relevant notes relating to Mr B's gallbladder pathology, which might have alerted him to the potential difficulty of and risks associated with an attempt at completion cholecystectomy.[18] Dr Wu concluded that this was a severe departure from the accepted standard of care.

26. I accept this advice. Dr C acknowledged that he neither requested nor reviewed Mr B's previous clinical notes. I accept that there are differing recollections of what was

[18] Removing the remaining gallbladder tissue after a previous partial cholecystectomy.

discussed during the consultation on 15 July 2021. However, Dr C was aware that Mr B had previously had acute cholecystitis in public hospital1, that it was a complicated procedure and it had not been possible to remove all of the gallbladder, and that he had a drain. I am critical that, in these circumstances, Dr C not only proceeded with a cholecystectomy when there was little clinical indication it was required but that he also did not request the notes, which would have notified Dr C of the issues involved in the previous procedure.

Cholecystectomy surgery

27. Dr Wu advised that the cholecystectomy surgery performed by Dr C was not of an acceptable standard. The main issues with this part of the care were the inadequate preoperative work-up in obtaining further information in relation to the prior gallbladder surgery (as outlined above) and the decision to continue with gallbladder dissection when it was evident that it was not straightforward.

28. Dr Wu did agree with Dr C that it was not an 'incorrect' decision to assess the gallbladder remnant for suitability of a completion cholecystectomy at the time of Mr B's bowel cancer surgery, even though there was no clear indication to perform a completion cholecystectomy. An incidental cholecystectomy is considered reasonable in patients undergoing major abdominal surgery to reduce the possibility of having to perform subsequent abdominal surgery. However, when it was evident that the gallbladder surgery was difficult, Dr Wu considered that the most appropriate action would have been to abandon any attempts at dissection. I accept Dr C's response that as Professor D took over the surgery at the early stage once he realised how challenging it was, he did in fact abandon it and would have stopped the surgery at that point if Professor D was not available.

29. I acknowledge Dr C's response that he only just started to dissect out Mr B's gallbladder when he encountered difficulties. However, I note that Dr C previously told HDC that the gallbladder surgery looked 'difficult', with the gallbladder being described as shrivelled and scarred. I also note that Professor D advised that he could see that the dissection extended well above the gallbladder remnant when he attended surgery. In these circumstances, while I acknowledge that Dr C did request assistance from Professor D, I remain concerned that Dr C proceeded with the gallbladder surgery when there were indications it was not straightforward.

30. I accept that Dr Wu acknowledged that the bowel cancer surgery performed was done with an appropriate level of care and skill, and I am not critical of this aspect of care.

Conclusion

31. Accordingly, I find that Dr C breached Right 4(1)[19] of the Code of Health and Disability Services Consumers' Rights (the Code) for failing to obtain and review relevant clinical history to a procedure and for proceeding with the cholecystectomy surgery when it was apparent that it was not going to be straightforward and that there was no clinical indication that it was warranted.

[19] Right 4(1) states: 'Every consumer has the right to have services provided with reasonable care and skill.'

Documentation of risks – educative comment

32. I acknowledge that there are differing recollections about what was discussed at the meeting with Mr B and his family on 15 July 2021. Dr Wu stated that it is important to provide information openly and honestly to patients so that they can make a fully informed decision as to whether a patient wants to proceed with treatment. However, Dr Wu accepted that it is not possible to identify all the risks and complications of surgery but considered that general surgical risks, such as significant bleeding, injury to surrounding structures, and infection, as well as the specific risks of certain procedures, should be discussed.

33. Dr C did document that he had discussed the operation and complications in his clinic letter, and a consent form was completed, but there is no documentation outlining what complications were discussed in either the letter or the consent form. I take this opportunity to remind Dr C of the importance of keeping accurate and thorough documentation.

Changes made since events

34. Dr C told HDC that he has voluntarily chosen not to undertake gallbladder operations. He is now more diligent in talking about possible complications and ensures patients have a copy of the information outlining discussions.

Recommendations

35. In the provisional opinion, I recommended that Dr C complete the following:

    a) Provide a written apology to Mr B's family for the deficiencies identified in this report.

    b) Complete HDC's online learning course on informed consent (Module 2: what you need to know about informed consent).

    c) Provide a written reflection outlining the following:

        - The changes he has made to his practice as a result of this case, including any changes made in preparing for surgery, to minimise the chances of a similar situation occurring;
        - The importance of both listening to the patient and family and reviewing clinical history in clinical decision-making.

36. Dr C has since completed the above recommendations in response to the provisional opinion, and his apology has been provided to Mr B's family.

Follow-up actions

37. A copy of the report, with details identifying the parties removed, except the independent advisor who advised on this case, will be sent to the Medical Council of New Zealand and they will be advised of Dr C's name.

38. A copy of the report, with details identifying the parties removed, except the independent advisor who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Independent clinical advice to Health and Disability Commissioner

Complaint:	**Mr [B] (dec) / Dr [C] at [private hospital]**
Our ref:	**22HDC00711**
Independent advisor:	**Dr Shun-Jen Linus Wu**

I have been asked to provide clinical advice to HDC on case number 22HDC00711. I have read and agree to follow HDC's Guidelines for Independent Advisors.

I am not aware of any personal or professional conflicts of interest with any of the parties involved in this complaint.

I am aware that my report should use simple and clear language and explain complex or technical medical terms.

Qualifications, training and experience relevant to the area of expertise involved:	My qualifications are Bachelor of Medicine, Bachelor of Surgery (MBChB, University of Auckland, 2001) and Fellow of Australasian College of Surgeons (FRACS, 2010). I am a Consultant General and Colorectal Surgeon and Endoscopist at Waikato Hospital.
Documents provided by HDC:	1. Letter of complaint dated 20 March 2022. 2. [Dr C]'s responses dated 28 June 2022 and 22 August 2024. 3. Statement from [Professor D] and enclosures. 4. Information from [private hospital], including statements from [Dr C] and [Dr F] made during internal review. 5. Clinical records from [Dr C] and [private hospital] covering the relevant period.
Referral instructions from HDC:	1. What information would usually be provided to a patient prior to a hemicolectomy and cholecystectomy. 2. Whether the preoperative assessment by [Dr C] of [Mr B] was of an acceptable standard. As part of this, please comment on whether a cholecystectomy was indicated for [Mr B] and the adequacy of review of relevant history and documentation by [Dr C] prior to the surgery. 3. Whether the surgery performed by [Dr C] on 11 August 2021 was of an acceptable standard. 4. Whether the information [Dr C] provided to [Mr B] after surgery was adequate. 5. Any other matters in this case that you consider warrants comment or amounts to a departure from accepted standards.

Factual summary of clinical care provided complaint:

Brief summary of clinical events:	The below summary of clinical events is based on documents provided to me by the Health and Disability Commissioner (HDC). These include letters, operation notes, and correspondence from [Dr F], and Professor [F], as well as the statement from [Ms A], Mr [B]'s daughter. **<u>Preoperative period</u>** Dr [C] first saw Mr [B] on 15 July 2021 after a colonoscopy had demonstrated a left colon cancer. The biopsy of this confirmed an adenocarcinoma. According to his letter dated 15 July 2021, [Dr C] stated that the surgery to treat the colon cancer "will be a laparoscopically assisted subtotal colectomy and if possible I will remove the rest of the gallbladder" and "I have explained the operation and the possible complications to him." It was mentioned in this letter that [Dr C] was aware that [Mr B] had acute cholecystitis and a partial cholecystectomy earlier in 2021, though [Dr C] incorrectly stated that this was done at [public hospital2]. In her statement, Ms [A] stated that [Mr B] was accompanied by his wife [Mrs B] and daughter […] to the appointment on 15 July 2021. She stated that "during the appointment, [Mr B] mentioned that he had a partial cholecystectomy secondary to acute cholecystitis at [public hospital1] on 27 March 2021 and had been followed up in outpatients at [public hospital2]. [Dr C] offered to 'tidy up the gallbladder' during the surgical time booked for the left hemicolectomy. [Mr B] had no abdominal pain or symptoms consistent with recurrent cholecystitis. At this time, [Mr B] and his daughter, […], identified to [Dr C] that his gallbladder surgery had been long and very complicated, requiring input from multiple surgeons. [Mr B] offered to provide the surgical and outpatient notes from both [public hospital1] and [public hospital2] outpatients, which [Dr C] declined. [Mr B] asked [Dr C] directly if he had much gallbladder experience and was reassured by [Dr C] who also commented 'not very often but they are straight forward.'" There appears to be no further formal interactions between [Dr C] and [Mr B] until the evening before surgery on 10 August 2021, when [Dr C] made a visit to [Mr B] at [private hospital] and indicated that he would "have a look when he got in there" and see if he could "tidy up the gallbladder" (according to the statement provided by Ms [A]).

Surgery

Consent: the surgical consent form appeared to have been signed by both [Dr C] and [Mr B] on 15 July 2021. The proposed operation was a laparoscopic subtotal colectomy and cholecystectomy. The section on the benefits and risks of the operation was left blank.

On 11 August 2021, Mr [B] underwent surgery for his colon cancer.

Operation note from [Dr C] stated that the colon was mobilised without incident, and before the colon was resected, he examined the gallbladder. He stated that the gallbladder "looked quite inflamed but initial inspection suggested that the cystic duct was free of adhesions. Slow dissection was done in a retrograde fashion with the harmonic scalpel and diathermy. Half the gallbladder was separated. However, at this stage the anatomy wasn't straightforward, and I wondered whether the right hepatic duct was visible in the base of the wound." At this stage, he asked for assistance from [Professor D] who attended. "[Professor D's] assessment was to leave the cystic triangle alone and take the top of the gallbladder off to remove the stones. This was done with the diathermy and the distal half of the gallbladder oversewn with 2/0 prolene sutures. No obvious stones left in the remaining gallbladder." Attention then turned to the colon, and the colon resection was completed.

In his statement dated 28 June 2022, [Dr C] stated that "I looked at the gallbladder and tentatively removed it in a retrograde fashion. I don't believe I undertook very much dissection when I came across a structure that looked abnormal. I wasn't prepared to go any further and planned to back off as I had discussed with the family. However, it seemed reasonable at the time to see whether any liver surgeons were available." [Dr C] stated that "His ([Professor D's]) report suggests that it was obvious that the dissection was well into the hilar plate. However, I don't believe that was so. My dissection had been along tissue outside the liver and seemed to both of us at the time a very stuck shrunken gallbladder."

In a further statement dated 22 August 2024, [Dr C] stated that "it looked difficult at the time of surgery, and I started removing the gallbladder slowly in a retrograde fashion. As soon as I saw it involved deeper structures I called in [Professor D]. He actually did more dissection before putting a drain in the area and finishing."

[Professor D's]'s account of the surgery on 11 August 2021 was provided in his written statement on 16 August 2024.

	He stated that he received a call from an anaesthetist at [private hospital] on behalf of Dr [C], requesting his assistance with a cholecystectomy that he was having difficulty with. He recalled that, when he arrived in the theatre, [Dr C] explained that he was undertaking a laparoscopic left hemicolectomy for cancer. The patient had a previous partial cholecystectomy for cholecystitis and apparently had stones in the gallbladder remnant so [Dr C] was attempting to remove the gallbladder remnant at the time of elective bowel surgery. This was proving difficult due to fibrosis in the area, and he had not been able to identify the medial attachments of the gallbladder remnant in order to complete the cholecystectomy. [Professor D] could see on the video monitor that the dissection extended well above the gallbladder remnant into unsafe anatomical territory. He suggested that [Dr C] stop dissecting while he scrubbed up. After scrubbing, he was able to confirm that the dissection extended a long way superior to the cysto-biliary triangle, well into hilar plate region at the liver hilum (containing vital anatomic structures including hepatic ducts and major vascular structures). It was evident that diathermy had been used to dissect this area. A bile duct injury was considered at this stage, but without proper equipment, it was not thought to be safe to proceed to explore the area. [Professor D] extended the incision and removed the gallbladder remnant and placed a drain in proximity to the hilar plate. He left [Dr C] to complete the bowel resection and asked [Dr C] to call him the next morning with an update. **<u>Postoperative period at [private hospital]</u>** [Mr B] was transferred to the HDU [high-dependency unit] postoperatively as planned. An attempt was made by [Dr C] to contact Mrs [B], but the phone call was not answered, and a voice message was left. According to Ms [A], a nurse subsequently phoned [Dr C] on behalf of Mrs [B], who recalled [Dr C] saying "I wish I hadn't touched the gallbladder." [Ms A] stated that no one in the family, including [Mr B], was advised about any significant or unexpected injury. [Dr C]'s statement dated 28 June 2021 mentioned that he "would have rung [Mr B]. Again I do not remember the specifics. [Ms A] suggests I did not tell them any details. However, I would have mentioned how difficult the gallbladder dissection was and mentioned that I called in [Professor D]. My view and [Professor D]'s I believe at that time was that we had dissected the outer half of the gallbladder, found it too stuck, placed a drain in the area and came out. I suspect I didn't mention anything about a major biliary injury because I didn't think there was one."

	In the statement by [Dr F] (anaesthetist caring for [Mr B]) dated 18 February 2022, she stated that she phoned [Mr B]'s daughter […] and explained that [Mr B] had "emerged well from anaesthesia. She was then aware that [Professor D] had been called in to assist with the gallbladder operation." [Mr B] appeared to have a stable night. The observation chart shows that his vital signs were within normal range. [Mr B] was reviewed by [Dr C] and [Dr F] in the morning of 12 August 2021, and from their clinical notes entries, [Mr B]'s condition appeared satisfactory with satisfactory observations and urine output, and pain was well controlled at that stage. [Dr F] stated in her statement on 18 February 2022, that "[Mr B] spent a largely uneventful night in HDU and after reviewing him the following morning I was happy that he was transferred to the surgical ward." Nursing staff entry at 1430 hours on 12 August stated that [Mr B] required 2 litres of oxygen, and pain score of 4 to 5 out of 10. It was documented here that there was bile in the right upper abdominal drain. Subsequent entries had noted that [Mr B] had vomited, but his observations appeared stable. The entry at 1715 hours on the same day by the nursing staff stated that "surgeon met with [Mr B] with daughter […] present. Advised plan is to transfer to [public hospital3]." Ms [A] stated that [Mr B] developed significant pain on mobilisation that resulted in him becoming distressed and tearful. Later this day, [Ms A] noticed bile in one of the surgical drains and heard a nurse talking about transfer to [public hospital3] for ERCP, and it was not until later that evening that [Dr C] informed them a bile leak had developed when he was operating on the gallbladder and that transfer to [Public hospital3] was being arranged. **<u>Care at [Public hospital3]</u>** [Mr B] was transferred to [public hospital3] under the care of [Professor D] on 12 August 2021. He underwent an ERCP the day after (13 August 2021), which demonstrated a significant bile duct injury in the region of the biliary confluence. [Professor D] performed urgent surgery on [Mr B] to repair the injury on 14 August 2021. The findings at this surgery were: moderate amount of bile-stained fluids in the abdomen; a large longitudinal anterior defect of the wall of biliary confluence, several centimetres in length; extensive diathermy artefact/eschar of the hilar plate, the right

	posterior section duct, and possibly the right anterior section duct. [Professor D] undertook debridement and Roux-en-Y hepaticojejunostomy to repair the bile duct injury. [Mr B]'s clinical notes at [public hospital3] were not available to me. [Professor D] stated [Mr B]'s postoperative course was complicated by further bile leakage from non-healing of the hepaticojejunostomy repair. The ongoing bile leak was controlled by the drain. Unfortunately [Mr B] developed a life-threatening complication of bleeding from a right hepatic artery pseudoaneurysm on 23 August 2021. This was investigated and confirmed by a gastroscopy then a CT angiography. The bleeding was not considered suitable for endovascular management. [Professor D] undertook an emergency operation on 23 August 2021. The findings were: a large defect in the side of the right hepatic artery as it entered the liver; further evidence of thermal injury at the porta hepatis; no identifiable viable ducts to the right lobe to reconstruct. [Professor D]'s opinion was that there was no option but to perform a right hepatectomy. This surgery was complicated by hepatic insufficiency and intra-abdominal abscess. The abscess was drained under radiological guidance on 31 August. However, [Mr B]'s overall condition did not improve and, despite maximal support in Critical Care, he died [in early] September 2021.

Question 1: What information would usually be provided to a patient prior to a hemicolectomy and cholecystectomy.	
List any sources of information reviewed other than the documents provided by HDC:	• Medical Council of New Zealand statement: Informed Consent: Helping patients make informed decisions about their care. June 2021 • Royal Australasian College of Surgeons Position Paper on Informed consent. 2021 (https://www.surgeons.org/about-racs/position-papers/informed-consent-2019) • Code of Health and Disability Services Consumers' Rights (the Code)
Advisor's opinion:	The information usually provided to a patient prior to a hemicolectomy by a surgeon include: • Indication for surgery • Benefit of surgery

	• Risks of surgery o Intra operative ▪ Bleeding ▪ Damage to surrounding structures ▪ Conversion to open surgery (if done with minimally invasive techniques) o Early postoperative ▪ Pain ▪ Infection including intra-abdominal, respiratory tract, urinary tract, wound ▪ Anastomotic leak ▪ Ileus ▪ Medical complications such as pneumonia, pulmonary embolism, deep vein thrombosis, stroke, cardiac complications such as arrhythmia or myocardial infarct o Possibility of a stoma, temporary or permanent The information usually provided to a patient prior to a cholecystectomy by a surgeon include: • Indication of surgery • Benefits of surgery • Risks of surgery o Intraoperative ▪ Bleeding. Significant bleeding being rare but possible, from the liver or the blood vessels ▪ Injury to the surrounding structures ▪ Bile duct injury. The estimated incidence is around 1 in 500 to 1000. However, it is important to inform the patient [of] the significance of bile duct injury in terms of morbidity and mortality, as well as the possibility of major reconstructive surgery required to repair the injury ▪ Conversion to open o Early postoperative ▪ Pain ▪ Bile leak, which could be minor (e.g. from cystic duct stump) or major (e.g. from bile duct injury) ▪ Infection – wound, intra-abdominal, respiratory, urinary tract ▪ Medical complications such as stroke, cardiac complications such as arrhythmia and myocardial infarct, deep vein thrombosis, pulmonary embolism

	I do not believe that surgeons should be expected to cover all potential complications when discussing the risks of a procedure. However, I believe that it is important to cover the general surgical risks of significant bleeding, injury to surrounding structures, infection, as well as the specific risks of certain procedures, for example ureteric injury and anastomotic leak for bowel resection, and bile leak and bile duct injury for cholecystectomy. While these complications and risks may have all been discussed by [Dr C] with [Mr B] and his family, it had not been specifically documented in his letter on 15 July 2021 ([Dr C] mentioned that he had "explained the operation and the possible complications to him") or on the consent form for the procedure.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	When entering into a therapeutic relationship with a patient, it is important to provide information openly and honestly to the patient, so that they can make a fully informed decision whether they want a treatment. The information may include: an explanation of their conditions, the options available, the results of tests and procedures, and the risks and benefits of the treatment. Right 6 of the Code states that every consumer has the right to be fully informed. It is also important to document in the clinical notes and on the consent form that the discussion regarding the procedure had taken place.

Question 2: Whether the preoperative assessment by [Dr C] of [Mr B] was of an acceptable standard. As part of this, please comment on whether a cholecystectomy was indicated for [Mr B] and the adequacy of review of relevant history and documentation by [Dr C] prior to the surgery.	
List any sources of information reviewed other than the documents provided by HDC.	• Goldstein J, et al. Risk of gallbladder cancer with increasing gallstone size: a systematic review and meta-analysis. *American Journal of Gastroenterology*. 2020;115(1):S57. • Concors SJ, et al. Resection of gallbladder remnants after subtotal cholecystectomy: presentation and management. *HPB (Oxford)*. 2018;20(11):1062–66.
Advisor's opinion	Indications for a cholecystectomy are: • Symptomatic gallstones such as biliary colic • Complications from gallstones o Acute or chronic cholecystitis o Bile duct stones which can cause biliary obstruction or cholangitis o Gallstone pancreatitis

	• Gallbladder cancer • In some cases, biliary dyskinesia In general, cholecystectomy is not recommended for asymptomatic gallstones, except in the case of large stones, or presence of a porcelain gallbladder, both of which are associated with an increased risk of gallbladder cancer (1). In some instances, an incidental cholecystectomy is considered reasonable, in patients undergoing major abdominal surgery where you would like to reduce the possibility of having to perform subsequent abdominal surgery. Obviously, the risks and benefits of this need to be carefully weighed up, and the priority is to treat the primary pathology. With all the available documents, I could not find any evidence that [Mr B] had suffered from ongoing gallstone-related symptoms. I do not have access to the [public hospital2] outpatient records and can only assume that the surgeon at [public hospital2] did not recommend a completion cholecystectomy due to the lack of significant symptoms, as well as the potential risks involved. Furthermore, a completion cholecystectomy following a subtotal cholecystectomy is associated with increased risks and is technically challenging. A subtotal cholecystectomy is done instead of a standard cholecystectomy at the time of the index operation, usually due to significant inflammation at the hepatocystic triangle that prevents safe dissection. Due to the severe inflammation and subsequent scarring, as well as scarring from the index operation, a completion cholecystectomy is technically challenging. There are no large case series in the literature on this topic. One article (2) with 14 patients undergoing completion cholecystectomies reported that all required an open procedure, with one patient sustaining a major bile duct injury requiring a hepaticojejunostomy repair. The rate of major bile duct injury in this series is thus 7% (1/14), higher than the reported rates in standard cholecystectomies, acknowledging that this was a small series of only 14 patients. It was clear that [Dr C] did not obtain any relevant notes relating to [Mr B]'s gallbladder pathology, which in this case, might have alerted him of the potential difficulty and risks associated with an attempt at completion cholecystectomy. In summary, I do not believe that a cholecystectomy was indicated in this case, and I do not believe that there was adequate review of

	history and documentations regarding the history relating to the gallbladder pathology.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	1. A completion cholecystectomy was not indicated in this case, due to a lack of significant symptoms. 2. A thorough review of past history and clinical records, including operation note, imaging reports, and clinical letters, relating to [Mr B]'s gallbladder pathology was essential. 3. If a completion cholecystectomy is indicated, a referral to, or involvement of, a specialist hepatico-pancreatico-biliary (HPB) surgeon prior to surgery would be appropriate.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	1. Indication for cholecystectomy in this case – Moderate departure. 2. Adequate review of history and documentation prior to surgery – Severe departure
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	I did not consult with my peers
Please outline any factors that may limit your assessment of the events.	I acknowledge there was a significant time lapse between the incident and the subsequent responses, and my opinion is formulated based on the available information.
Recommendations for improvement that may help to prevent a similar occurrence in future.	• Thorough review of relevant history and documents prior to any treatments • Preoperative involvement of a specialist HPB surgeon when indicated

Question 3: Whether the surgery performed by [Dr C] on 11 August 2021 was of an acceptable standard.	
List any sources of information reviewed other than	

the documents provided by HDC:	
Advisor's opinion	**<u>Bowel Cancer Surgery</u>** I believe that the bowel cancer surgery was performed with appropriate level of skills and standard. **<u>Gallbladder Surgery</u>** I am of the opinion that [Dr C] has the necessary skills to perform a <u>routine</u> gallbladder surgery. In this case, [Mr B]'s gallbladder surgery was not routine. While there was no clear indication for a completion cholecystectomy, I believe [Dr C]'s original plan of assessing the gallbladder at the time of [Mr B]'s colonic surgery and proceed to a completion cholecystectomy if it was deemed straightforward, was not necessarily incorrect. I also agree with his original plan of "backing off" if the gallbladder looked difficult to dissect. I do, however, believe that his decision to continue with the gallbladder dissection deviated from his original plan. The description of the gallbladder in his statements was that of a scarred, "rather shrivelled" gallbladder and that the gallbladder "was extremely difficult to dissect out" ([Dr C]'s operation note, 11 August 2021). Surgery is a discipline that requires both good technical skills as well as sound decision-making. Decision-making occurs in all facets of the care – preoperative, intraoperative, and postoperative. Therefore, when judging whether the surgery performed is of an acceptable standard, we must consider both the technical as well as the decision-making aspects. It is my opinion that the gallbladder surgery performed by [Dr C] was not of an acceptable standard. The main issues with this part of the care were the inadequate preoperative work-up in obtaining further information in relation to the prior gallbladder surgery (as outlined above), and the decision to continue with gallbladder dissection when it was evident that it was not straightforward. This decision ultimately led to a major bile duct injury from which [Mr B] did not recover. I would like to acknowledge that [Dr C] did obtain help from a specialist HPB surgeon intraoperatively when he became concerned with the gallbladder dissection, which was the correct action to take.
What was the standard of care/accepted	In this case, I believe that the standard of care/accepted practice are:

practice at the time of events? Please refer to relevant standards/material.	1. Review the indication, and risks and benefit of completion cholecystectomy 2. Do not commence dissection or to cease dissection when it was evident that the gallbladder dissection was difficult 3. Obtain assistance from a specialist HPB surgeon, either preoperatively, or intraoperatively, when it is anticipated, or one has encountered, a difficult dissection.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	• Left hemicolectomy – No Departure • Attempted completion cholecystectomy – Severe Departure • Obtain assistance from an HPB surgeon intraoperatively – No Departure
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	I did not formally consult with my peers
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	• Thorough review of history and relevant documents (as outlined above) • Request subspecialty opinion appropriately. In this case, a preoperative consult with an HPB specialist would be tremendously beneficial in reviewing the indication and potentially formulating an operative strategy • Do no harm – abandon attempt of difficult dissection, or seek a second opinion early, when encountering difficulty during surgery, particularly if it is not related to the primary pathology.

Question 4: Whether the information [Dr C] provided to [Mr B] after surgery was adequate.

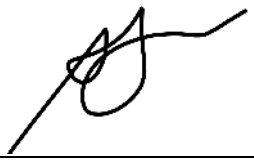
List any sources of information reviewed other than the documents provided by HDC:	• Disclosure of Harm. New Zealand Medical Council Statement. January 2024
Advisor's opinion:	The accounts from [Dr C], [Dr F], and [Ms A] regarding the communication after surgery are summarised below. I acknowledge the time lapse between the event and when the statements were prepared. **[Dr C]'s Account** In his statement dated 28 June 2021, [Dr C] stated that "at the end of the operation I would have rung [Mr B]. Again I do not remember the specifics. [Ms A] suggests I did not tell them any details. However, I would have mentioned how difficult the gallbladder dissection was and mentioned that I called in [Professor D]. My view and [Professor D]'s I believe at the time was that we had dissected the outer half of the gallbladder, found it too stuck, placed a drain in the area and came out. I suspect I didn't mention anything about a major biliary injury because I didn't think there was one." **[Dr F]'s account** In her statement dated 18 February 2022, [Dr F] stated "I then phoned [Mr B]'s daughter ([…], Consultant Anaesthetist) and explained that her dad had emerged well from anaesthesia. She was then aware that [Professor D] had been called in to assist with the gallbladder operation." **Ms [A]'s account** In her statement to the HDC on 20 March 2022, [Ms A] stated "[Mrs B] was phoned by [Dr C] after surgery but missed the call and a message was left on the answering service saying that the surgery had been completed. [Mrs B] went to HDU to see her husband postoperatively. A nurse phoned [Dr C] for [Mrs B], when he heard she had not spoken to him directly. [Mrs B] recalls [Dr C] saying "I wish I hadn't touched the gallbladder." No one in the family, including [Mr B], was advised about any significant or unexpected injury." From the available information, it can be concluded with reasonable certainty that communication did take place between [Dr C] and [Mr B]'s family after surgery (although not clear whether [Mr B] himself was involved directly in the communication), that they were informed about [Professor D's] involvement in the case, and that the gallbladder part of the surgery was difficult. [Dr C] stated that, at that time, he was not suspicious of a bile duct injury,

	therefore this possibility was not communicated to the family. [Professor D] stated in his letter to Dr [E], that he "considered the possibility of bile duct injury, and while they could not rule out a bile duct injury, there was no visible bile leakage, which provided some reassurance." The key question is whether there was an open disclosure of what had occurred during surgery. From what is available to me, it appeared that there was a disclosure of i) difficulty of the gallbladder part of the procedure and ii) attendance of [Professor D] to assist in the gallbladder surgery. It also appeared that neither [Dr C] nor [Professor D] was certain at the time that a bile duct injury had occurred. Obviously, it is impossible to know what was conveyed by [Dr C] to [Mr B] and his family on the day of surgery, but I assume that the bile duct injury was not suspected at the time by [Dr C], therefore not stated explicitly by him to the family.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	The standard of care is open disclosure. Open disclosure is the transparent communication and honest discussion with a patient and/or their family about an incident that resulted, or **could have** resulted, in harm or injury to the patient. In this instance, the difficulty of gallbladder dissection, and the involvement of [Professor D] were disclosed. As a bile duct injury was not confirmed, this was not disclosed. I believe most surgeons would be mindful of the possibility of this complication in this situation, and would have suggested that this was a possibility, and that close observation is required and a prompt intervention is undertaken for any suspicion of an actual injury. I am unable to conclude with certainty whether a potential harm has been disclosed in this case.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	• Open disclosure of difficulty encountered during gallbladder dissection, and involvement of an HPB surgeon – No departure • Open disclosure of a potential bile duct injury – Unable to comment
How would the care provided be viewed	I did not consult with my peers

by your peers? Please reference the views of any peers who were consulted.	
Please outline any factors that may limit your assessment of the events.	My opinion was based solely on statements provided.
Recommendations for improvement that may help to prevent a similar occurrence in future.	• Open communication • Disclosure needs to include any potential harms, and reassurance that any serious complications will be promptly addressed

Question 5: Any other matters in this case that you consider warrants comment or amounts to a departure from accepted standards.	
List any sources of information reviewed other than the documents provided by HDC:	
Advisor's opinion:	I do not have any further comments
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	
How would the care provided be viewed by your peers? Please reference the	

views of any peers who were consulted.	
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	

By signing this report, I agree to HDC correcting any formatting, spelling, or grammar issues on the proviso that the substance of the report and any quoted material remains unchanged.
Signature 
Name: Dr Shun-Jen Linus Wu
Date of Advice: 24 July 2025

Thank you for asking me to comment on [Dr C]'s response. Below is my reply:

I acknowledge that significant time has passed since the original surgery and therefore the recollection of the conversations between parties would have been challenging. My opinion was based on the documentation and the statements provided. I do not believe the differences in the recollections can be reconciled.

As per my original report, I do agree with [Dr C] that it was not an "incorrect" decision to assess the gallbladder remnant for suitability of a completion cholecystectomy at the time of [Mr B]'s bowel cancer surgery, even though there was no clear indication to perform a completion cholecystectomy. An incidental cholecystectomy is considered reasonable in patients undergoing major abdominal surgery where you would like to reduce the possibility of having to perform subsequent abdominal surgery. However, when it was evident that the gallbladder surgery was difficult, I believe the most appropriate action would have been to abandon any attempts of dissection.

I had access to some information of [Mr B]'s stay at [public hospital3], mainly via a statement provided by [Professor D], which was comprehensive. I was aware that [Mr B] seemed to be making progress until further complication of the significant bleeding from the hepatic artery pseudoaneurysm. In my opinion, the formation of a hepatic artery pseudoaneurysm is secondary to a non-healing hepaticojejunostomy repair of the bile duct injury. The failure of the repair was most likely due to the severity of the bile duct injury. I do not believe that the remnant gallbladder is likely to cause this complication.

I acknowledge the changes that [Dr C] had made to his practice after this case, and I believe that the bowel cancer part of the surgery that he had performed was done with an appropriate level of care and skills.

Kind Regards

Linus Wu