# General Surgeon, Dr B

## A Report by the

## Health and Disability Commissioner

## (Case 07HDC00329)

## Parties involved

| | |
|---|---|
| Mr A | Consumer |
| Mrs A | Complainant/consumer's wife |
| Dr B | Provider/General Surgeon |
| Dr C | Mr A's General Practitioner |

## References

The following references are made throughout this opinion:

| | |
|---|---|
| Hospital A | A medium-sized secondary hospital |
| Hospital B | A regional base hospital |
| Hospital C | A community hospital |
| Surgical day unit | The surgical day unit where Dr B performed the operation on Mr A |

## Complaint

On 12 January 2007, the Commissioner received a complaint from Mrs A about the services provided to her husband, Mr A, by Dr B.

The following issues were identified for investigation:

- *The appropriateness of the care provided by Dr B to Mr A in December 2006.*

An investigation was commenced on 12 February 2007, and on 28 May 2007 the investigation was extended to include the following issue:

- *The adequacy of the information Dr B provided to Mr A in relation to the surgery he performed in December 2006.*

## Information reviewed

Information from:

- Mr A
- Mrs A
- Dr B

Mr A's clinical records from:

- The surgical day unit
- The District Health Board
- General practitioner Dr C.

The following responses to the provisional opinion were received:

- Mrs A, on 27 September, 8 and 10 October 2007
- Dr B, on 11 October 2007.

Independent expert advice was obtained from general surgeon Dr Kenneth Menzies.

## Information gathered during investigation

*Background*
In December 2006, Mr A was 65 years old. His medical history included a cholecystectomy in February 2002, during which adhesions were found adjacent to an appendicectomy wound from some years before. In October 2005, Mr A had coronary artery bypass surgery. While in hospital recovering from the surgery, Mr A suffered a perforation of the sigmoid colon secondary to diverticulitis. He underwent a laparotomy and drainage. A few days following his recovery and discharge from hospital, Mr A was readmitted to hospital with a sub-acute bowel obstruction, which was treated without surgery.

*Chronology*
On 1 December 2006, Mr A's general practitioner, Dr C, referred him to general surgeon Dr B for the repair of an incisional hernia Mr A had developed on the left side of his abdomen.

On 7 December 2006, Mr A presented to Dr B at a surgical day unit. Mrs A accompanied her husband to the consultation. Prior to seeing Dr B, Mr A asked the receptionist where his surgery would be performed. Mr A was told that it would take place at the surgical day unit, which had a small operating theatre. Both Mrs A and her

husband were "surprised" to learn that surgical procedures were carried out within the surgical day unit's premises.

During the consultation, Dr B examined Mr A and noted:

> "While doing some heavy lifting in October this year, [Mr A] felt a 'pop' along an old midline abdominal incision of his. He therefore saw his GP who diagnosed an incisional hernia.
>
> On examination there is an incisional hernia present along the left side of the midline. This is about 4cm x 4cm and the contents are easily reduced."

Dr B advised Mr A that, without surgery, the hernia was likely to "get bigger" and that there was a risk of it becoming constricted. Mr A was told that surgery would reduce the risk of constriction to less than 0.5%. Dr B also advised Mr A that he could repair the hernia as a day procedure in a small operating theatre he had set up at the surgical day unit. Mrs A recalls Dr B mentioning that, as part of the procedure, he would administer intravenous anaesthetic into her husband's surgical wound to provide him with approximately 72 hours of pain relief following the operation.

*Preoperative discussion and documentation*
As part of the preoperative consultation on 7 December 2006, Mr A received written information about the nature and purpose of the hernia operation. Dr B also provided him with a Patient Information Booklet providing pre and postoperative advice about day surgery along with a two-page plan for Mr A's care after the surgery.

During the consultation, Mr A completed a Preoperative Assessment Questionnaire which included a "Consent to treatment or operation" section. The two-page form included a section requesting the patient to list major illnesses suffered during his or her lifetime. Mr A wrote "heart bypass — perforated — 12 months only [ago]" and beside this, Dr B documented "diverticulitis". The form also included a question on the patient's surgical history and the approximate dates of any procedures, under which was written "CABG [coronary artery bypass graft] / Colon Resection". No dates were listed for these procedures.

Mr A signed the consent form, which listed the common complications of the intended surgery as "bleeding, infection, recurrence [pain] and damage to the bowels". Dr B acknowledged on the form that these complications were discussed with Mr A during the preoperative consultation. Dr B recalls pointing out bowel damage as a possible risk of the operation, and reassuring Mr A that he "personally had not had this complication". Dr B also reassured Mr A that he had performed a number of incisional hernias as day cases and had "never had a problem". In contrast, Mrs A does not recall Dr B discussing any surgical complications during the preoperative consultation. However, she remembers asking him to refer to her husband's file for further information on his medical history.

In relation to whether there was any discussion with Mr A on the option of having the operation in hospital with an overnight stay, Dr B commented:

> "I was of the view that [Mr A's] operation would not be compromised by performing it as a day case. This was based on my past experience with such cases and as such I did not discuss an alternative option. I also took into consideration the fact that carrying out the operation as an overnight case would have meant treating [Mr A] in [another town].
>
> In conclusion, I have been a general surgeon for over 20 years during which I have never had a case in which I inadvertently perforated the small bowel without realising it. … [A]t all time[s] I am careful with patient selection at the [surgical day unit]. …"

*Surgical procedure*
On 15 December 2006, Dr B performed the operation to repair Mr A's incisional hernia at the surgical day unit. Dr B advised:

> "At 8.30am on the 15th of December I repaired [Mr A's] 3cm ventral hernia with a 7.6cm x 7.6cm Bard Composix Kugel hernia patch. As part of the operation I infiltrated local anaesthetic in his skin and rectus sheath [outer wall of the bowel]. The operation started at 8.35am and ended at 9.45am. I operated on [Mr A] first thing in the morning because of his age and the nature of his operation so he would have all day to recover if necessary.
>
> He had an uneventful postoperative course although the recovery nurse did tell me that he had one episode of abdominal pain that disappeared rapidly so she felt it was purely some wind pain. At 12.25pm he was quite alert, well, pain free and without assistance was able to walk out to the car and go home. He was given detailed discharge instructions which included a 24 hour phone number if there [were] any problems."

In his record of the operation, Dr B documented that the "small bowel was in the sac and there were adhesions to the small bowel surrounding the wound". He also noted that the adhesions were freed without difficulty.

At midday, Mrs A was contacted by surgical day unit staff to collect her husband. She was not asked to bring another person to assist with transporting her husband home. When Mrs A arrived at the surgical day unit shortly afterwards, she found her husband lying down, dressed and ready to go home. She recalls the nurse asking if she had brought along another person. Mrs A responded that she had not been told to do so. Mrs A also recalls the nurse mentioning that they had "touched the bowel" and instructing Mr A to have only sips of water until he had passed wind. He was prescribed four different types of medication, including the analgesia Paradex. The nurse advised Mr A to rest in bed and to get up only to go to the toilet. A follow-up

appointment was scheduled for 21 December 2006, and Mr A was asked to contact Dr B if there were any concerns in the interim.

*Postoperative events*
On the afternoon of 15 December 2006, after arriving home from hospital, Mr A slept "on-and-off" until about 4.30pm when he awoke in severe pain, described as 10 on a scale of 1 to 10. Mrs A gave her husband two Paradex tablets and called Dr B, who attended Mr A. Dr B stated:

> "At 4.45pm I received a message from [Mrs A][1] that [Mr A] had developed sudden onset of severe abdominal pain. I went to his house thinking that this was most likely wind pain. He had a normal pulse but was clearly uncomfortable. He had minimal bowel sounds present. I gave him some intravenous Buscopan [anti-spasmodic] and Pethidine [narcotic] and this did not affect his pain. I then considered the possibility that the pain was from his wound and I injected some ½% Marcain [local anaesthetic] into the edges of the wound. This completely ameliorated his pain. I therefore put in a 16 gauge cannula just through the skin and superficial fascia and passed a 16 gauge epidural catheter into the wound and connected this to a continuous infusion pain buster pump containing 0.4% Naropin [local anaesthetic]."

Dr B stated that when he went to see Mr A, he was very uncertain about what was causing Mr A's abdominal pain. Because the injection of anaesthetic into the wound relieved Mr A's pain, Dr B said that he did not consider the possibility that he was dealing with an intra-abdominal catastrophe. He considered that intra-peritoneal pain would not be relieved by administering local anaesthetic in this manner.

The anaesthetic was injected using a long needle. According to Mrs A, Dr B experienced difficulty administering it and "stabbed" her husband "all over the place". Dr B left at about 7.15pm. Following that, Mr A continued dozing on and off and experienced "the odd pain". Mrs A recalls Dr B saying that her husband's pain was "most likely" owing to the original anaesthetic wearing off, along with "a bit of bowel wake-up". As part of the information he provided during the investigation, Dr B stated that he telephoned Mrs A at 9pm that evening and she informed him that her husband was "completely pain-free". In contrast, Mrs A does not recall Dr B making this call. She also stated that her husband was not completely pain free at this point.

Early the next morning, at about 1.15am on 16 December 2006, Mr A woke up in severe pain. Mrs A gave her husband a Tramal[2] pain relief tablet that Dr B had left him the previous evening. She telephoned Dr B, who asked her to check the analgesic pump to see if he had released the flow clip during his visit. Mrs A confirmed that he

[1] Owing to a power failure that afternoon (see footnote 3), Dr B retrieved Mrs A's message approximately 15 minutes after it was sent.

[2] Tramadol hydrochloride: a narcotic analgesic.

had, and Dr B asked her to release the clip further to increase its flow. Upon doing so, the anaesthetic leaked onto the bed. Mrs A informed Dr B of this and he instructed her to tighten the clip back up. He informed her that he would be "on his way" to review Mr A.

Dr B arrived at 2am. He said:

> "By the time I got to the house [Mr A's] pain was disappearing rapidly, further supporting that the pain was due to the pump not working. I checked the pump to make sure that the connection between the 16 gauge epidural catheter and the pump was not too tight and injected 20cc of 1% Xylocaine [local anaesthetic] down that tubing to make sure that it could be injected easily and also so that that would further ameliorate his pain. It did and the pain disappeared completely. I therefore reconnected the pump and went home."

In contrast, Mrs A stated that her husband's pain "did not disappear rapidly" during Dr B's visit. Her view is that by adjusting the anaesthetic pump, Dr B underestimated the level of pain relief her husband required. Mrs A stated that throughout that night, her husband experienced "tight pain", faintness and felt like "exploding" from his symptoms.

At about 4am, Mr A woke his wife to tell her that his wound was leaking. He was unable to get out of bed owing to his pain. She observed brownish fluid oozing out of her husband's wound, which had leaked onto the bed sheets. Towels were used to soak up the fluid. Mrs A recalls her husband being "quite concerned" about his symptoms and she telephoned Dr B again. He does not recall being told the colour of the fluid oozing out of Mr A's wound during this call. Dr B reassured Mrs A about her husband's symptoms and advised that the fluid was probably an overflow from the 20ml Marcain he had injected subcutaneously into Mr A's wound during his first visit. In light of his assumption about the leak and "because [he] had put a lot of local anaesthetic in the wound and had left a pump continuously infiltrating local anaesthetic into [Mr A's] wound", Dr B did not return to see Mr A. Instead, he informed Mrs A that he would change Mr A's wound dressing later that morning.

Two hours later, at 6am, Mr A started feeling sick and began vomiting "dark yellow/brown stuff" into a bucket every 15–20 minutes. Mrs A discussed with her husband whether to call an ambulance and to seek a second opinion from another doctor, but they agreed to wait a while as they understood that Dr B would be contacting them that morning. Approximately an hour later, Mrs A telephoned Dr B to report the recent developments. Dr B stated:

> "[Mrs A] called me again [at] approximately 7.15am to tell me that [Mr A] had vomited. This was concerning. My immediate impression was bowel obstruction. When I did [Mr A's] surgery I noticed that he had numerous small bowel adhesions and I had to move some of the small bowel around in order to place the hernia mesh. Sometimes that can cause an ileus (paralysis of the

> bowel) or a degree of obstruction. If it settled completely with some intravenous fluids and some anti-nauseants and he had good bowel sounds and started passing flatus, there would be no need to put him in hospital, but if it carried on or there was some other clinical concern he was going to need hospitalisation. As [Mr A] was not in pain I did not believe I needed to go to their home immediately and carried on with my plans to let the electrician in my rooms to fix the light at 9am.[3] As soon as I let the electrician in I telephoned [Mrs A] to see how [Mr A] was doing. She told me that he was sleeping and quite comfortable. I told her I would be over in about half an hour.[4]"

Dr B stated that he had contacted Mrs A at approximately 8.15am to enquire whether her husband was still vomiting. He was told that it had stopped and Mr A was sleeping.

Dr B acknowledged that "in retrospect, he should have gone [to their] home first" before going to his surgery that morning. However, with "[Mr A] comfortable and asleep, [Dr B] did not believe the delay was harmful". He lives on the other side of town, and it took approximately 30 minutes for him to drive to their home.

Dr B arrived at about 10.15am. He inserted a venous cannula and started intravenous fluids. According to Mrs A, he did not carry enough dressings with him during this visit. Dr B stated:

> "The vomiting in the morning started to change things. …
>
> …
>
> On arrival I put in a luer and I gave [Mr A] some Ondansetron and Dexamethasone for nausea and vomiting and started running in some IV fluids. … After I had given him the anti-nauseants and started the IV fluid, I took a look at his dressing. I could see very dark material coming out of the wound[5] that looked like bile. This was completely unexpected, as … his operation really had gone without incident. However, the problem is not uncommon and is identified in the patient consent form … I specifically mentioned this as a possible complication prior to surgery.
>
> As a consequence [Mr A] needed a laparotomy to suture the hole up as soon as possible as he was only going to get worse with any delay. I therefore phoned the Public Hospital and asked to speak [to the surgeon on duty]. I went over

---

[3] Dr B explained that on the night of 13 December 2006, a fluorescent light in the operating theatre blew while the room was being cleaned. This resulted in a small fire within the fluorescent light, which melted the diffuser. Dr B also stated that there was a power failure in his room on 15 December 2006 owing to the power outage in the central business district.

[4] Dr B estimated this timeframe based on the electrician informing him that "the job would not take very long". Dr B waited until the electrician finished before leaving his surgery for Mr A's home.

[5] According to Mrs A, the stained bed sheets were also seen by Dr B.

> the whole procedure of what happened with [the surgeon] and explained that [Mr A] had a small bowel fistula. I advised that I would be sending him straight up to the hospital. I then called the A&E department to let them know that [Mr A] was coming and wrote an admission note for him."

The process of transporting Mr A to hospital was difficult as Mrs A and Dr B had to assist him out of bed and carry him down a flight of stairs into the car. Dr B then requested paper from Mrs A to write the admission note before Mrs A drove her husband to Hospital A.

*Admission to Hospital A*
Mr A was admitted to Hospital A's Emergency Department at 11.50am on 16 December 2006. He was assessed, and the sutures from the previous day's operation were removed. A further 1–2 cups of brownish fluid leaked from Mr A at this time. A provisional diagnosis of bowel perforation secondary to hernia surgery was made. The follow-up plan included ordering an abdominal CT scan and administering intravenous fluids and antibiotics in the meantime.

At 4pm, Mr A had an abdominal CT scan, which showed a small collection of fluid between the small bowel and abdominal wall. That evening, Mr A underwent a laparotomy and oversewing of a perforation of his small bowel. Following surgery, Mr A was intubated and transferred to the Intensive Care Unit (ICU).

On 18 December 2006, Mr A was taken to theatre for removal of an abdominal pack and suturing of the rectus sheath. He had further surgery on 22 December 2006 for a delayed closure of his laparotomy wound. He was discharged from Hospital A on 28 December 2006.

For the next three months, a district nurse visited Mr A daily to review him and to change his dressings. According to Mrs A, her husband has "had a lot of trouble" since his initial surgery, requiring him to return several times to Hospital for reviews and further corrective surgery.

*Additional information from Dr B*
Following Mr A's surgery at Hospital A on 16 December 2006, Dr B unsuccessfully attempted to contact Mrs A. The next day, on 17 December 2006, Dr B telephoned the hospital and was told that Mr A had been on a ventilator overnight. During the day Dr B made further attempts to contact Mrs A. Finally, on the afternoon of 18 December 2006, Dr B spoke to Mrs A over the phone and apologised for "what had happened to her husband". He recalls Mrs A being "justifiably very angry … and had no desire to speak to [him]". Two days later, on the evening of 20 December 2006, Dr B visited Mr A in ICU. Dr B "sympathised with [Mr A] for the terrible time he was having" and "apologised for what had happened".

On 23 January 2007, Dr B took Mr A's file to his Unit Audit meeting. He stated:

> "[We] concluded that despite the fact that we have never had a complication with a Bard Composix Kugel mesh patch placed intraperitoneally before we are going to cease using them … [O]ur original conclusion was that we should not use them in cases like [Mr A] where there are dense adhesions and delicate small bowel secondary to previous peritonitis, as I assumed that in placing the patch I had accidentally torn the small bowel. Although this is still the most likely explanation for the hole in [Mr A's] small bowel, as stated in the Audit Report we have since been notified of a recall of all Composix Kugel mesh patches used in hernia repairs because the coil rings could break under stress during placement causing abdominal pain or a bowel perforation. We do not know if the hole in [Mr A's] small bowel was a result of inadvertent tearing of the bowel in the process of placing the patch or due to product failure, but in either case we will no longer be using Composix Kugel patches for ventral hernia repairs."

Dr B provided a copy of a document that supported his decision to perform Mr A's operation as a day case. He stated that Mr A's operation was a Category 2 case, described as "Procedures limited in their invasive nature, usually with minimal to mild blood loss and only mild associated risk to the patient independent of anaesthesia". The list of procedures given as examples of Category 2 cases includes inguinal and umbilical hernia repairs, but not the repair of incisional hernias.

In relation to his decision to perform Mr A's operation as day case, Dr B explained:

> "My decision whether or not a particular hernia repair should be performed at [the surgical day unit] as a day case is based primarily on the general health of the patient and the size of the hernia.
>
> It is my usual practice when deciding whether or not it is appropriate to undertake surgery at [the surgical day unit] to be careful with patient selection. At all times I comply with the selection criteria set out in Table II [Patient selection criteria for general anaesthetic surgery at the surgical day unit].
>
> …
>
> In [Mr A's] case he did not have any relative contraindications to outpatient surgery. He was experiencing no angina or heart failure, which indicated that his coronary artery bypass graft was working. I have discussed similar cases (coronary artery bypass surgery and no angina since the bypass) with cardiologists in the past. I have been advised that these patients are safer to operate on than patients who have not had a bypass since in the former you know they have functional coronary arteries where[as] in the latter they may well have a critical stenosis. For these reasons I did not view the fact that [Mr A] had coronary artery bypass surgery as a contraindication to day surgery provided my anaesthetist was happy with him, which [the anaesthetist] was.

> [Mr A] was classified as ASA II [6] … as he had no angina or heart failure since his cardiac bypass surgery and was otherwise well.
>
> In regard to [Mr A's] diverticulitis, although this can happen to anyone with diverticular disease after major surgery (approximately 60% of people in New Zealand over the age of 60 have diverticular disease), it is very rare after minor surgery. In my experience I have never had a case of post-operative diverticulitis in cases done at [the surgical day unit]."

Dr B also stated:

> "… I am deeply sorry for what happened and also for the considerable pain and anxiety caused to both [Mr and Mrs A] as a consequence. At all times I was doing my utmost best for [Mr A] and I was both saddened and shocked at the unexpected complication."

## Independent advice to Commissioner

*Initial advice*
The following expert advice was obtained from Dr Kenneth Menzies, colorectal and general surgeon:

> "I have been asked to provide an opinion to the Commissioner on Case No 07/00329. I confirm that I have read and agreed to follow the Commissioner's Guidelines for Independent Advisors.
>
> I graduated with MB BS from the University of New South Wales, Sydney, Australia, in 1967. I subsequently undertook training in general surgery and qualified with the Fellowship of the Royal College of Surgeons of England and Fellowship of the Royal Australasian College of Surgeons. I obtained vocational registration in General Surgery with the Medical Council of New Zealand in 1975. I am currently employed as a General Surgeon at Wellington Hospital. I have been a member of the American Society of Colon and Rectal Surgeons since 1994. I have been accredited by the New Zealand Conjoint Committee for recognition of training in gastrointestinal endoscopy to practice gastroscopy and colonoscopy.

[6] American Society of Anesthesiologists Class II. Patients under this surgical category may undergo "outpatient procedure with local, regional or general anaesthesia" and "must be watched carefully".

**Expert Advice Required**

To advise the Commissioner whether, in your professional opinion, the care provided to [Mr A] in December 2006 by [Dr B] was of an appropriate standard.

1. Please comment generally on the standard of care that was provided by [Dr B] to [Mr A].

*If not covered above, please answer the following questions and include reasons for your views:*

2. Please advise whether [Dr B] performed the hernia operation to an appropriate standard. Please include in your discussion [Dr B's] use of a Bard Composix Kugel hernia patch.

3. Please advise whether it was appropriate for [Dr B] to discharge [Mr A] several hours after surgery on 15 December 2006.

4. Please comment on the adequacy and appropriateness of the postoperative care that [Dr B] provided to [Mr A] including:

    (a) The management of [Mr A's] pain.

    (b) The management of [Mr A's] surgical wound.

    (c) The management of [Mr A's] vomiting.

    (d) Whether [Dr B] reviewed [Mr A] in a timely manner on 15 and 16 December 2006.

5. According to [Dr B], the perforation in [Mr A's] small bowel could have been the result of 'inadvertent tearing of the bowel in the process of placing the mesh patch or due to product failure'. Please comment on the appropriateness of [Dr B's] assessment.

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

    If, in answering any of the above questions, you believe that [Dr B] did not provide an appropriate standard of care, please indicate the severity of his departure from that standard.

    To assist you on this last point, I note that some experts approach the question by considering whether the provider's peers would view the conduct with mild, moderate, or severe disapproval.

7. Are there any other aspects of the care provided by [Dr B] to [Mr A] that you consider warrant additional comment?

8. Are there any other aspects of the care [Mr A] received that you consider warrant additional comment?

**List all sources of information reviewed**

- Copy of [Mrs A's] complaint form dated 9 January 2006, with 3 supporting statements, and 4 photographs, marked 'A' (Pages 1–9).
- Copy of HDC's notification letter to [Dr B] dated 12 February 2007, marked 'B' (Pages 10–12).
- Copy of [Dr B's] response dated 16 February 2007, marked 'C' (Pages 13–20).
- Copy of [Mr A's] clinical records from [Dr B] dated 7–16 December 2006, marked 'D' (Pages 21–50).
- Copy of [Dr B's] audit records, marked 'E' (Pages 51–55).
- Copy of [Mr A's] clinical records from [Dr C's] clinical records dated 3 November–7 December 2006, marked 'F' (Pages 56–59).
- Copy of [Mr A's] clinical records from the [District Health Board] dated 16–29 December 2006, marked 'G' (Pages 60–189).
- Copy of [Mr A's] clinical records from the [District Health Board] dated 23–24 January 2007, marked 'H' (Pages 190–212).
- Copies of clinical records provided by [Dr C] (General Practitioner).

**Background**

[Mr A], age 65, developed an incisional hernia on the left side of his abdomen after some heavy lifting in October 2006. On 7 December 2006, he attended a preoperative consultation with [Dr B] and surgical repair of the hernia was scheduled for 15 December 2006.

At 8.30am on 15 December 2006, [Dr B] repaired [Mr A's] ventral hernia with a 7.6cm x 7.6cm Bard Composix Kugel hernia patch. [Mr A] had an uneventful postoperative course, and was discharged home at midday.

That evening, at approximately 5pm, [Dr B] reviewed [Mr A] at home and prescribed intravenous analgesics. Naropin was also injected in the subcutaneous tissue around [Mr A's] wound and [Mr A] remained relatively pain free throughout the evening.

In the early hours of 16 December 2006, [Mr A's] pain returned. [Dr B] returned to see [Mr A] at approximately 2am and injected more Naropin. At approximately

4am, Mrs A informed [Dr B] that there was fluid coming out of her husband's wound. He advised her to pad the dressing and stated that he would review [Mr A] again later that morning.

From approximately 6am, [Mr A] began vomiting and [Dr B] was contacted at approximately 7.15am. As [Mr A] was not in pain at that time, [Dr B] made a decision to proceed with a prior appointment that morning, and arrived at [Mr A's] home at approximately 10.15am. He observed 'very dark material' coming out of [Mr A's] wound which was indicative of a small bowel fistula, and referred [Mr A] to [Hospital] for a laparotomy.

Later that evening, [Mr A] underwent a laparotomy. On 18 December [2006], the sutures were removed and the wound was closed and washed with saline on 22 December [2006]. [Mr A] made good recovery, and was discharged from [Hospital] a week later on 29 December 2006.

**Past Medical History of [Mr A]**

- [Mr A] was known to have chronic obstructive pulmonary disease, a high cholesterol level and hypertension.

- He had had an appendicectomy operation performed prior to 1992.

- An open cholecystectomy was performed in [Hospital C] on 3 February 1992. He had been admitted prior to that date with acute cholecystitis. At operation it was found that he had adhesions adjacent to the lower paramedian appendicectomy wound.

- Three colonoscopies were performed between November 2001 and October 2002 for colonic polyps. It was noted on each occasion that he had severe sigmoid diverticula disease.

- He was admitted to [Hospital B] with crescendo angina on 27 September 2005.

- Cardiac catheterisation was performed and he was found to have critical left main stem coronary artery disease.

- An urgent coronary artery by-pass graft was performed in [Hospital B] on 4 October 2005. He went into atrial fibrillation two days later on 6 October.

- On 9 October 2005, while still in hospital following the CABG operation, [Mr A] complained of severe left-sided abdominal pain. A CT of the abdomen was performed which showed free intra-abdominal air.

- An urgent laparotomy was performed that day. He was found to have a perforation of the sigmoid colon secondary to diverticulitis and a peri-

diverticula abscess. A sigmoid colectomy was performed together with a primary anastomosis.

- A few days following his discharge from [Hospital B] he was admitted to [Hospital A] with sub-acute bowel obstruction. This was treated conservatively and the obstruction resolved. He was noted at that time to have a discharging sinus from the lower end of his laparotomy wound.

**Expert Advice**

"I wish to make some relevant general remarks before proceeding to answer the specific questions put to me by the Commissioner.

The operation of *Repair of Midline Abdominal INCISIONAL Hernia* is a major operation compared to that of repair of an inguinal hernia. The risk profile is much higher.

A midline abdominal incisional hernia occurs through the wound of a previous LAPAROTOMY incision. Of necessity it involves opening into the peritoneal cavity (i.e. the abdominal cavity).

There is a significant likelihood of there being adhesions within the peritoneal sac and adhesions to the anterior abdominal wall. These adhesions, when present, frequently involve loops of small intestine.

It is necessary to divide and free up these adhesions before proceeding to the actual repair. It is not uncommon for the small intestine to be perforated during the process of freeing of adhesions. Usually this is recognised at the time and immediate repair is performed. In these cases there is usually no further problem.

Occult perforation (i.e. injury to the intestine which is not seen and hence not repaired at the time) is a recognised but uncommon complication of division of adhesions. In these cases the diagnosis is often delayed because it is unexpected.

[Mr A] had a coronary artery By-Pass Graft operation performed in [Hospital B] in 2005. This was followed in October 2005 by an acute perforation of the sigmoid colon secondary to DIVERTICULITIS. He had emergency surgery at [Hospital B] which involved a *Laparotomy, Peritoneal Toilet and Sigmoid Colectomy*. There was subsequently infection in the laparotomy wound and delayed wound healing. Not surprisingly he later developed an incisional hernia.

When there has been a bowel perforation and peritonitis it is almost inevitable that adhesions of small bowel will develop.

When [Dr B] operated on [Mr A] on 15 December 2006 to repair his incisional hernia, the Operative Findings were 'there was small bowel in the sac and there were adhesions to the small bowel surrounding the wound'.

It was therefore necessary to free up these adhesions and mobilise the small intestine from the anterior abdominal wall before repair of the incisional hernia could be undertaken.

At the operation, which was performed on [Mr A] in [Hospital A] on 16 December 2006 by [the duty surgeon], it was found that there was an opening (or enterotomy) in a loop of ileum measuring 1cm in diameter.

This had resulted in leakage of bile stained intestinal fluid from the intestine into the peritoneal cavity. A collection of this fluid was found within the wound. The evidence provided to me, including photos and the statement provided to the Commissioner by [Mrs A], indicates that small intestinal fluid was discharging out from [Mr A's] abdominal wound at 4am on 16 December. This was only 18 hours after the operation performed by [Dr B] to repair the abdominal incisional hernia.

In my opinion, the only feasible explanation is that when [Dr B] was freeing up the adhesions by 'sharp dissection' (refer operation report of 15/12/06) he inadvertently made a full thickness perforation of a loop of ileum. This was not recognised at the time. The perforation may have been temporarily walled off for some hours, however at about 4pm on 15 December when gut content was expelled into the peritoneal cavity its irritating effect resulted in the sudden onset of very severe central abdominal pain. The fluid was contained within the abdominal cavity for a time, but later that evening it started to discharge through the wound, thus soaking the dressings and surrounding bedding.

I felt that this background explanation was necessary before I commenced to answer the specific questions posed to me by the Commissioner.

In answer to Questions 1, 3 and 7, I wish to state the following:

In my opinion (which is supported by that of several colleagues with whom I have discussed this case in general terms) it was INAPPROPRIATE to perform the operation of repair of the midline abdominal incisional hernia on [Mr A] in a stand alone *Day Surgery Unit*.

In his submission to the Health & Disability Commissioner dated 16 February 2007, [Dr B] states 'over the last five years I have done approximately 175 hernias including a number of ventral hernias as day cases without any significant problem and have never had to have one admitted to the public hospital before'. Despite this, in my opinion, it was unwise of [Dr B] to undertake this operation on [Mr A] as a day case.

As I have explained in the foregoing, this is not minor surgery. [Mr A] had previously had major abdominal surgery complicated by wound infection. It was likely that he would have significant adhesions. He was known to have ischaemic heart disease. There was always the potential for complications to develop, either during the operation or in the postoperative period. These can be dealt with expeditiously in the hospital setting but can, as in the case of [Mr A], be very distressing when they occur at home.

In my opinion [Mr A] should have been kept in hospital for at least 24 hours postoperatively. This was not possible in the [surgical day unit].

In other words, in my opinion, it was NOT appropriate for [Dr B] to discharge [Mr A] several hours after surgery on 15 December 2006.

[Dr B] was called at 4.30pm that afternoon and notified that [Mr A] had suddenly developed severe central abdominal pain. After he had received the message he attended [Mr A] at home promptly. However in my opinion it was not appropriate to set up the continuous infusion local anaesthetic pump. The sudden onset of severe central abdominal pain should have alerted [Dr B] to the possibility of a serious intra-abdominal catastrophy. I feel the best option, at that time, would have been to arrange for [Mr A] to be admitted to hospital for careful observation, nursing care and parenteral analgesia.

Mrs A had a telephone conversation with [Dr B] on 4am on 16 December. [Mrs A] states that when she 'turned on the light … *yuk* was everywhere, all over the sheets and under him … found it was coming from the bottom of the wound, a *brownish colour*. I then phoned [Dr B] again and said what had happened.'

[Dr B] failed to appreciate the potential serious implication of this development. He presumed that the fluid discharge was the result of the continuous infusion of local anaesthetic even though [Mrs A] states that the fluid coming out from the wound was brownish in colour.

Similarly when [Dr B] was advised that [Mr A] was 'vomiting dark yellow/brown stuff into a bucket on and off' he gave priority to seeing the electrician. If [Mr A] was vomiting repeatedly he would have required an intravenous saline infusion to maintain his fluid balance.

All these problems (i.e. the management of the abdominal pain, the wound discharge and the treatment of the vomiting) would have been much better dealt with if [Mr A] had been an inpatient in hospital for at least 24 hours following his incisional hernia operation.

**Bard Composix Kugel Hernia Patch**

In my opinion it was acceptable for [Dr B] to use a Bard Composix Kugel Hernia Patch to repair [Mr A's] abdominal incisional hernia. The Composix Kugel Patch has been designed for use in the repair of abdominal incisional hernias. One side of this patch is smooth and shiny. This side of the patch is placed on the deep (or peritoneal) aspect. The nature of this surface minimises the risk of adhesions developing between the intestine and the patch. The technique used by [Dr B] to position and secure the patch, as described in the operation report dated 15 December '06, was correct and in accordance with the manufacturer's instructions.

The Bard Composix Kugel Hernia Patch product comes in various sizes. [Dr B] used the smallest size patch which was circular in shape with a diameter of 7.6cm. It has the catalogue number 0010203. I have been provided with photos of the abdominal wound taken following the surgery which was performed at [Hospital A]. It appears to extend vertically from the level of the umbilicus to the level of the symphysis pubis. I am surprised therefore that such a small patch was used.[7]

I wish now to address Question No 5 which is as follows:

According to [Dr B], the perforation in [Mr A's] small bowel could have been the result of 'inadvertent tearing of the bowel in the process of placing the mesh patch or due to product failure'. Please comment on the appropriateness of [Dr B's] assessment.

[Dr B] has described in the operation report the technique which he used in placing the mesh patch. In my opinion the placing of the patch could not have resulted in inadvertent tearing of the bowel.

In his report to the Health & Disability Commissioner dated 16 February 2007, [Dr B] raises the possibility that the perforation of the bowel may have been 'due to product failure'. He has subsequently provided a copy of a Reuter's health information bulletin dated February 1 2007 which advises a product recall of Composix Kugel Mesh Patches.

I have had a meeting with the regional sales manager for BARD New Zealand. She has provided me with information on the device recall and I enclose copies of this information with my report. The recall was in relation to product codes

[7] In response to my provisional opinion, Dr B stated that he used a 7.6cm piece of mesh during the operation as Mr A's original hernia was "only approximately 3cm". Dr B also clarified that the photographs Mrs A supplied of her husband's hernia were taken after Mr A underwent surgical repair for his perforated bowel at Hospital. Hence, the photographs showed Mr A's incision from the umbilicus to the pubis, and the hernia itself appeared to look larger than 3cm.

0010202 and 0010204. The product used in [Mr A's] operation had the product code 0010203 and this was not included in the recall. The reason for the recall was the reported breakage in several batches of the recoil ring. There were a total of six ring breaks reported from approximately 25,835 units manufactured between January 1 2004 and September 30 2005. The reported occurrence rate is therefore 0.023%. Of these, there were two inconclusive incidents where bowel perforation and broken ring were noted at the time of explant. In my opinion it is extremely unlikely that the small bowel perforation sustained by [Mr A] was the result of product failure. As I have stated earlier in this report, it is most likely that the full thickness perforation of a loop of small intestine was the result of inadvertent damage to the intestine during mobilisation of adhesions.

Question No 6:

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

In my opinion the answer to this question is yes.

In conclusion therefore I wish to reiterate that my major criticism in relation to the care provided by [Dr B] to [Mr A] is that it was inappropriate to perform the operation of repair of the midline abdominal incisional hernia in a stand alone *Day Surgery Unit*."

*Further expert advice*
Dr Menzies provided the following additional advice:

"Thank you for your letter dated 17 July 2007 requesting further expert advice on the care that [Mr A] received from Dr B, General Surgeon.

I wish to confirm that you have provided me with:

1. Copy of HDC's extension of notification letter to [Dr B] dated 28 May 2007

2. Copy of [Dr B's] response dated 9 June 2007

You have requested the following:

'I would appreciate it if you could review the above documents and advise the following:

1. Did [Dr B] provide [Mr A] with adequate information in relation to the surgery he performed in December 2006? Please provide reasons for your view.

2. In the light of the additional information from [Dr B], are there any amendments you wish to incorporate into your report of 30 April 2007?

3. Any other aspects of [Dr B's] care which you consider warrant additional comment.'

My response to Question 1 is as follows:

[Dr B's] letter dated 8 June 2007 indicates that he did discuss with [Mr A] the possible complications which could occur following repair of his ventral abdominal incisional hernia. However, in his response to Question No 3 did you discuss with [Mr A] the option of having the operation in hospital with an overnight stay? [Dr B] states 'I did not discuss an alternative option'. In other words [Dr B] did not give [Mr A] the option of having his surgery performed as an inpatient. In other words he did not discuss with [Mr A] the pros and cons of day surgery as opposed to inpatient surgery for the repair of the incisional hernia. In my opinion this is a significant omission and therefore I would conclude that [Dr B] did NOT provide [Mr A] with adequate information in relation to the surgery beforehand.

My response to Question No 2 is as follows:

[Dr B] appears to have misunderstood the significance of part of Question No 2 in the letter from the Deputy Commissioner dated 28 May 2007. He was asked to include in his response any consideration he may have given to [Mr A's] previous surgeries including emergency surgery following an acute perforation of the sigmoid colon secondary to diverticulitis in October 2005. [Dr B's] response was that postoperative diverticulitis was very unlikely following the hernia repair.

The significance in this context of the previous emergency surgery for perforated diverticulitis is, as I stated in my report dated 30 April 2007 'when there has been a bowel perforation and peritonitis, it is almost inevitable that adhesions of small bowel will develop'. In other words it was very likely that there would be significant adhesions involving small intestine within and around the sac of the incisional hernia. This indeed proved to be the case. The postoperative complications which occurred resulted from inadvertent perforation of the small intestine during the freeing up of these adhesions.

In other words it was inevitable from the outset that there would be adhesions within the hernial sac and therefore, as a consequence, repair of this hernia was not going to be a simple exercise. In my opinion this case did not fit into Category No 2 of Surgical Categories in Table V as provided by [Dr B].

I would therefore reiterate that, in my opinion, [Dr B] made an error of judgement in deciding to repair the ventral abdominal incisional hernia of [Mr A] in a Day Surgery Unit.

My response to Question No 3 Any other aspects of [Dr B's] care which you consider warrant additional comment is no."

Dr Menzies was asked to provide further clarification of his advice:

"You have asked me to comment on the severity of [Dr B's] departure from an appropriate standard of care in relation to the following specific points:

1. [Dr B's] decision to operate on [Mr A] as a day case rather than as an inpatient.

2. [Dr B's] decision to commence analgesia on the afternoon/evening of 15 December 2006 rather than readmit [Mr A] to hospital.

3. [Dr B's] decision not to attend [Mr A] immediately, having been contacted at approximately 4am on 16 December 2006.

4. [Dr B's] decision not to attend [Mr A] immediately, having been contacted at approximately 7.15am on 16 December 2006.

In response to Question No 1 — I would view with moderate disapproval [Dr B's] decision to operate on [Mr A] as a day case rather than an inpatient. In particular I would view with moderate disapproval that [Mr A] was not given an option to decide whether to have his surgery in the [surgical day unit] or a facility providing inpatient care.

In response to Question No 2 — [Dr B] misdiagnosed the aetiology[8] of the abdominal pain which [Mr A] developed on the afternoon of 15 December 2006. As I have stated previously, in my opinion it would have been wise at that stage for [Dr B] to have arranged for [Mr A] to be admitted to hospital. If he had done so then subsequent events would have been able to be managed more appropriately. I would view [Dr B's] decision to commence analgesia rather than admit [Mr A] to hospital with moderate disapproval.

In response to Question No 3 — [Dr B] obviously did not appreciate the nature of the fluid which was discharging from [Mr A's] wound when he was contacted at 4am on 16 December 2006. This may have been because the events which were occurring were not adequately explained to him over the phone. I would therefore view his decision not to attend [Mr A] immediately with mild disapproval.

[8] The causes and origins of diseases.

> Likewise, in answer to Question No 4, I would view with mild disapproval [Dr B's] decision not to attend [Mr A] immediately when he was contacted at 7.15am on 16 December."

## Responses to provisional opinion

Responses to my provisional opinion were received from the following parties:

*Mrs A*
Mrs A clarified several aspects of her husband's care in relation to the preoperative consultation, surgery performed and Dr B's management of the postoperative symptoms and complications. The relevant points have been incorporated in the "information gathered" section of this report.

*Dr B*
In response to my provisional opinion, Dr B stated:

> "I have reviewed the analysis of the [couple's] complaint against me and believe that the analysis has been very detailed and fair, and I agree with the analysis. But in retrospect things can seem quite different than they really were so I would like to make a few comments ..."

Dr B's response included clarification about aspects of his management of Mr A's postoperative care, which have been incorporated in the "information gathered" section of this report.

In relation to the appropriateness of performing Mr A's surgery as a day case, Dr B stated:

> "In retrospect one can easily conclude that [Mr A] was a disaster waiting to happen and therefore he should never have been done as a day case. I saw a small (3cm) midline hernia in a man who had had a successful cardiac bypass operation, and had no angina and no evidence of heart failure. He was ASA2, he had a small hernia, he needed a short operation, and our experience with ventral hernias told me that I could do his as a day case. What I was proposing was also consistent with published criteria for doing day surgery. I have since done a literature search on day case incisional hernia repairs and found papers in which they were done quite successfully both open and laparoscopic.
>
> The range of procedures which people are doing as day cases has constantly expanded since its inception nearly 30 years ago. When I attended the Australian Day Surgical Conference in November 2006, I was quite taken aback at some of the procedures which people are doing as day cases such as thyroidectomy and transurethral resection of the prostate. The published

> criteria focus in the ASA rating of the patient (1 or 2, [Mr A] was ASA2), the duration and type of operation and the normal post op course of the procedure being consistent with home care. These criteria do not explicitly list 'risk of complications' although it is implicitly implied in the ASA, the duration and the type of operation. 'Type of operation' can be a bit nebulous and depends on what the surgeon and unit are comfortable with. Where many units do laparoscopic cholecystectomies as day cases, I have personally never felt comfortable doing so. On the other hand where your reviewer is not happy with even small incisional hernias being done as a day case, I have been quite comfortable with these, but not the larger ones which I have done as overnight cases. Where adhesions are part of every incisional hernia repair (by definition they have had a previous operation), it is true that I could have expected [Mr A's] to be worse than the average because of his previous peritonitis. This did not concern me because over the years I have freed up adhesions from over 100 abdomens [and] have made the odd hole in the small bowel (as have most general surgeons), but I have always seen this and repaired it at the time. In fact [Mr A's] adhesions freed up very easily under direct vision and thus my conviction that the hole was made when I placed the mesh. … Thus for me the problem in [Mr A's] case was not the fact that I did him as a day case (I would have done exactly the same operation as an overnight case), but the technique I used and the fact that I tore the bowel.
>
> Looking at it in retrospect it is impossible to argue with your reviewer's conclusion, that it would have been much less distressing to the [couple] if [Mr A] had had this complication as an inpatient instead of at home. … [V]irtually any surgical procedure can have a complication which would be less traumatic to the patient and their family if they were an inpatient and not at home when it happened. …"

[Dr B] also stated:

> "… [W]hat has really shaken me in this case is not that I did [Mr A] as a day case but that I made a hole in the bowel and did not recognise it. As a result of this I will never again do an operation which involves opening the peritoneal cavity as a day case. … I had my reasons why I felt doing [Mr A] as a day case was quite acceptable but I have certainly taken on board what your reviewer has said. I have also given up doing this type of operation as an inpatient. This decision has been in part due to my loss of confidence as a result of this episode, but in part it is also that I know emotionally I could not face a complication like that again. …
>
> …
>
> As with all complications in my practice this one was reviewed extensively at a Unit Audit Meeting as well as at a Peer Review Audit. Recommendations were made on how to avoid this in the future, but this complication and the

subsequent enquiry have hit my confidence very hard. I have therefore significantly limited the scope of my surgery and have decided to retire earlier than planned."

## 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.*

*RIGHT 6*

*Right to be Fully Informed*

*(1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including —*

*…*

*(b) an explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; …*

## Opinion: Breach — Dr B

### Standard of care

*Preoperative care*

Dr B decided to perform Mr A's operation as a day procedure, rather than as an inpatient, which would have involved Mr A staying in hospital at least overnight. In explaining his rationale for his decision, Dr B referred to the operation as a Category 2, described as a procedure "limited in [its] invasive nature, usually with minimal to mild blood loss and only mild associated risk to the patient independent of anaesthesia". However, I note that the surgical procedures listed under this category do not include incisional hernias. I also note that Mr A had a significant medical history of having

developed adhesions following previous surgery, along with perforation and sub-acute obstruction of the bowel.

Dr B considered it appropriate for Mr A's operation to be performed as a day case, and supplied several documents to support his view. He also commented in response to my provisional opinion that the published criteria "do not explicitly list [the] risk of complications" for different surgical categories, and that the type of operation suitable to be performed as a day case "depends on what the surgeon and unit are comfortable with".

Despite Dr B's comments and the documents he supplied, I have concerns about his decision to perform Mr A's operation as a day case. Dr Kenneth Menzies, my independent surgical expert, advised that it was "likely that Mr A would have significant adhesions". Having noted Mr A's heart disease and previous major abdominal surgery compounded by infection, Dr Menzies considered it inappropriate for Mr A to have been managed as a day case. Dr Menzies advised that Mr A's operation did not fit into the Surgical Category 2, as "it was inevitable from the outset that there would be adhesions within the hernial sac and … repair of this hernia was not going to be a simple exercise".

Put simply, given Mr A's previous medical history, Dr B should not have performed Mr A's operation as a day case, and the subsequent complications would have been better managed had Mr A been an inpatient and stayed overnight in hospital. However, this did not occur as Mr A was not offered the option of having his hernia operation done as an inpatient (discussed below).

Dr B accepts that, in retrospect, Mr A was "a disaster waiting to happen" but at the time of the events in question, he considered it appropriate to perform Mr A's surgery as a day procedure. In light of Mr A's case, Dr B will no longer perform as day cases any operations that involve opening the peritoneal cavity.

*Postoperative care*

Several hours after his operation on 15 December 2006, Mr A was discharged home and developed a series of complications. This would undoubtedly have been very distressing for Mr A and his wife. I agree with Dr Menzies that the complications would have been better managed had Mr A been in hospital. The first hint that all was not well was when Mr A suddenly developed severe central abdominal pain the afternoon following his discharge home. Although Dr B attended promptly, he decided to keep Mr A at home, commencing local anaesthetic through a pump. His did so based on an incorrect assumption that the local anaesthetic infiltrated in Mr A's wound during the operation had worn off. I share Dr Menzies' view that keeping Mr A at home was an unwise decision even though the anaesthetic provided Mr A with immediate relief.

Early the next morning, at approximately 1.15am on 16 December 2006, Mrs A informed Dr B that her husband was in severe pain. Dr B attended a second time and

adjusted the anaesthesic pump. However, no decision was made to admit Mr A to hospital.

At 4am, Mrs A telephoned Dr B again to report that brownish fluid had leaked from her husband's surgical wound. This was the third indication that all was not well. However, Dr B mistakenly assumed that the liquid was merely an overflow of the local anaesthetic he had injected into Mr A's surgical wound the previous evening, and decided not to visit until later that morning.

Mrs A called Dr B again at 7.15am to inform him that her husband was vomiting. Although it was Dr B's "immediate impression" that Mr A had bowel obstruction, Dr B decided not to attend at that point as Mr A was not in pain. Instead, Dr B proceeded with a 9am appointment with the electrician to repair the lighting at the surgical day unit. His decision was partly influenced by Mrs A's report that her husband had stopped vomiting and was asleep when Dr B telephoned her at approximately 8.15am. A second telephone call to Mrs A shortly after 9am reassured Dr B that it was unnecessary to attend to Mr A immediately when Dr B learnt that Mr A was "still asleep and comfortable". In my view, Dr B was falsely reassured by Mrs A's reports of her husband's condition, and made an unwise decision to allow the electrician to finish his job before attending to Mr A at about 10.15am. Dr B acknowledges that "in retrospect, [he] should have gone to [their home] first".

Dr Menzies advised that Dr B should have arranged for Mr A's admission to hospital when he experienced severe abdominal pain at 4.30pm on 15 December 2006, and considered Dr B's failure to do so a moderate departure from an appropriate standard of care. In addition, having been alerted by Mrs A at 4am and 7.15am the following morning to further complications, Dr B should have attended immediately. I note Dr Menzies' comment that Dr B's peers would view both omissions with mild disapproval.

Although I have reviewed this case with the benefit of hindsight and knowledge of the ensuing postoperative complications, I am concerned that Dr B failed to act appropriately when faced with Mr A's deterioration in condition. Dr B was well aware of his patient's previous medical history of postoperative complications (since they were documented in the consent form). I endorse my expert's view that Mr A should have been admitted to hospital sooner.

I am particularly concerned that Dr B did not attend Mr A immediately when he was contacted again by Mrs A at 7.15am on 16 December 2006 regarding her husband's vomiting. This was a new symptom, which developed following a series of other complications from the previous afternoon. Taking all of them into account, it was apparent that Mr A was clearly unwell and required expedient attention. Although Dr B has explained his reasons for not attending immediately, his actions seem inconsistent with his "immediate impression" of bowel obstruction when contacted by Mrs A.

*Summary*
I am concerned that Dr B considered it appropriate for Mr A to be operated on as an outpatient despite his past medical history and presentation.

Having discharged Mr A home several hours following surgery, Dr B was responsible for ensuring that any subsequent complications were appropriately managed. Having been alerted by Mr A's wife on two occasions to significant changes in her husband's condition, Dr B failed to readmit Mr A to hospital. He also failed to attend to Mr A when his surgical wound leaked at 4am the following morning. Finally, Dr B delayed attending to Mr A that morning as he was falsely reassured by Mrs A's reports (at 8.15am and 9am) that her husband's vomiting had ceased and he was "asleep and comfortable".

Taking into account all of these factors, I conclude that Dr B did not provide Mr A with an appropriate standard of care and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).

**Information provided about the operation**

Under Right 6(1) of the Code, patients have the right to receive full information about their care and treatment, including an explanation of the treatment options available.

I acknowledge that Mrs A and Dr B differ in their recollection of whether Dr B discussed the possible surgical complications during the preoperative consultation. From reviewing Dr B's records, including the consent form that he and Mr A signed, I am satisfied that there was some discussion of the common surgical complications. However, Dr B should have specifically discussed with Mr A the option of having his operation in hospital with an overnight stay. He failed to do so. Consequently, Mr A was not given the opportunity to evaluate the pros and cons of day surgery as opposed to inpatient surgery for his hernia operation. Dr Menzies considered this a significant omission. I agree that Dr B did not provide Mr A with adequate information prior to performing the surgery. In my view, Dr B breached Right 6(1) of the Code.

## Actions taken

Following Mr A's surgical repair at Hospital A, Dr B contacted Mrs A to apologise for what had happened to her husband. He also apologised in person to Mr A when he visited Mr A in hospital four days later. In addition, during the investigation, Dr B supplied information to my Office that included a written apology to Mr and Mrs A. I commend Dr B on his prompt and unreserved admission of responsibility.

Dr B advised that he has reflected on and reviewed his practice in light of this case.

## Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand, with a recommendation that the Council undertake a review of Dr B's competence.

- 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 Association of General Surgeons, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.