Dr C / A Private Hospital /

A District Health Board

A Report by the

Health and Disability Commissioner

(Case 00HDC03311)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Complainant / Wife of consumer
Mr B	Consumer (deceased)
Dr C	Provider / General Surgeon
Dr D	Anaesthetist at the second private hospital
Dr E	Intensivist at the public hospital

Complaint

On 5 April 2000 the Commissioner received a complaint from Mrs A concerning the services her late husband, Mr B, received from general surgeon Dr C. The complaint is that:

- *Dr C did not leave written instructions about food that Mr B could have, before bowel surgery. He gave verbal instructions to Mr B at the initial consultation on 6 December 1999. His instructions were contradicted by those given by the nursing staff at the first private hospital. Consequently, after his colonoscopy on 15 December 1999, Mr B was given a cup of tea and a sandwich before leaving the hospital. Later that evening, the night before surgery, he had a small meal.*
- *On the morning of surgery Dr C was advised by nursing staff of Mr B's food intake. He decided to proceed with surgery, after prescribing an enema for Mr B. Dr C has since acknowledged that Mr B's bowel preparation was inadequate.*
- *Dr C did not carry out the operation properly. Mr B's bowel was not stapled correctly. The anastomosis was left with an 18mm hole, which allowed bowel contents to leak into the peritoneum. This led to the eventual breakdown of the anastomosis.*
- *Dr C did not see Mr B for 12 hours after the operation. He failed to monitor Mr B's deteriorating condition.*
- *Mr B should have been transferred from the second private hospital to the Intensive Care Unit at the public hospital sooner. Had Dr C assessed Mr B during the initial 12 hours after the operation, he would have noted the deterioration in Mr B's condition and arranged the transfer. The decision to transfer Mr B, on the afternoon of 17 December 1999, was made by Dr D, the anaesthetist at the second private hospital, and not Dr C.*
- *Dr C did not come to see Mr B for 24 hours after his admission to the Intensive Care Unit.*
- *If Mr B had been taken to the operating theatre on 17 December 1999, as suggested by Dr E, the Specialist in charge of the Intensive Care Unit at the public hospital, he would have had a better chance of survival. Dr C ruled out that option. Mr B died on 21 December 1999, of septicaemia and multi-organ failure caused by the leaking anastomosis.*

- *When Mrs A raised her concerns with the public hospital about the care her husband received from Dr C, she was not informed about her right to complain to the Health and Disability Commissioner.*
- *When Mrs A met with the Medical Advisor of the District Health Board on 29 February 2000, and with the Medical Advisor, Dr C and the Head of Surgery at the public hospital on 17 March 2000, she was not given an adequate explanation to the answers she sought. Some information given was misleading and confusing to Mrs A. No validation was sought from Mrs A whether she was happy with the outcome of the meetings.*
- *Despite an undertaking by the Medical Advisor, at each of the meetings, that she would be sent a report on the findings of the hospital's internal inquiry into the matter, Mrs A did not receive a report.*

An investigation was commenced on 29 August 2000.

Information reviewed

- Information supplied by Mrs A
- Response from Dr C
- Response from the public hospital
- Response from the second private hospital
- Response from Dr D
- Mr B's medical notes from the two private hospitals and the public hospital
- Coroner's Findings and Notes of Evidence
- Post-mortem report by a pathologist
- Independent expert advice to ACC from a general surgeon
- Expert advice to Mrs A from a colorectal and general surgeon
- Summary of clinical competence concerns regarding Dr C, prepared by the Chief Medical Director of the District Health Board
- Expert advice to the second private hospital Audit Review Committee from colorectal and general surgeons
- Independent expert advice to Commissioner from Dr Robert Robertson, general surgeon

Information gathered during investigation

Overview

Following a consultation with his general practitioner and a general surgeon, Mr B, a 65-year-old man with diet-controlled diabetes, had a colonoscopy (examination of the bowel) at a private hospital. This examination revealed the presence of a single cancerous tumour, which was removed the following day at a second private hospital. Mr B's condition

deteriorated post-operatively and he was transferred to the Intensive Care Unit (ICU) at a public hospital where he remained in a critical condition and died four days later. A Coroner's inquest, hospital enquiries, an investigation by the Accident Compensation Corporation (ACC), and a competence review by the Medical Council have followed.

Consultation with Dr C – 6 December 1999
On 6 December 1999, Mr B was referred urgently to general surgeon Dr C, by his general practitioner, because of recent lower bowel discomfort and one episode of rectal bleeding. At 6.00pm that night Mr B and Mrs A attended a consultation with Dr C in his private rooms. Dr C examined Mr B and removed part of the tissue growth found in Mr B's rectum. A biopsy of the tissue sample was performed. Dr C confirmed Mr B's general practitioner's diagnosis of rectal cancer and recommended removal of the tumour via an anterior resection (where the affected part of the bowel is removed and then rejoined). He organised a pre-operative colonoscopy for 15 December, at the first private hospital. Bowel surgery to remove the tumour was arranged for 16 December at the second private hospital.

Dr C advised me that he gave verbal and written instructions to Mr B and Mrs A during the consultation on 6 December, about both the colonoscopy and the bowel surgery. In particular, Dr C stated that he told Mr B that he was not to consume food from 14 December until his bowel operation on 16 December. Dr C further advised that his usual practice was to give the patient the following three pieces of paper stapled together:

Prescription for 'Fleet' preparation
'Day stay Colonoscopy'
'Instructions for Bowel Prep for Colonoscopy or Surgery'

Mrs A advised me that she received the prescription and the first pamphlet but did not receive the pamphlet 'Instructions for Bowel Prep for Colonoscopy or Surgery' or any written instructions about what Mr B's food intake should be prior to his bowel surgery. Mrs A stated that Dr C gave verbal instructions to her husband prior to the colonoscopy that he was not allowed solid food but was allowed clear food and jelly. Dr C provided me with an example of a prescription for 'Fleet' and a copy of the two documents he provides to his patients. The 'Day Stay Colonoscopy', which Mrs A advised Mr B received, states that after the procedure "You may resume a normal diet unless instructed by the doctor." It also states that patients are to "Notify us if you have diabetes."

Colonoscopy – The first private hospital, 15 December
Mr B was admitted to the first private hospital at approximately 12.00pm on 15 December and a colonoscopy was undertaken shortly thereafter. The colonoscopy revealed no tumour additional to Mr B's known rectal cancer. Mrs A advised me that nursing staff told Mr B that he should have a cup of tea and a sandwich before returning home. Mrs A stated that she and her husband queried this instruction with nursing staff and told them that he was undergoing bowel surgery the next day. However, nursing staff assured them that provided Mr B did not eat anything after 6.00am on the morning of the bowel surgery, he could eat some food. The first private hospital later advised Mrs A by letter that it is "routine" to feed patients after a colonoscopy particularly if they are diabetic. Mr B was discharged at

approximately 2.30pm. Later that evening, Mr B ate a small piece of chicken and a small portion of potato and broccoli, and drank a cup of coffee.

Bowel surgery – The second private hospital, 16 December
At approximately 10am on 16 December, Mr B was admitted to the second private hospital. Mr B informed the nursing staff that he had eaten dinner the night before. His admitting nurse telephoned Dr C to discuss Mr B's preparation for surgery. As Dr C was unable to come to the phone, she informed his receptionist that Mr B had eaten dinner. The receptionist relayed this information to Dr C, who responded (through his receptionist) that Mr B should not have eaten the night before and that he should be given an enema. The admitting nurse checked whether this was to be a Microlax (a laxative) enema, and Dr C confirmed it was. Dr C also prescribed Fasigyn (an antibiotic for the prevention of post-operative infections). Mr B was given a Microlax enema and the Fasigyn. It is not recorded in Mr B's clinical notes whether he subsequently passed a bowel motion. Dr C advised, in his correspondence to ACC, that he had not specified a Microlax enema. Rather, he said he had expected Mr B to be given Fleet preparation (an enema commonly used for bowel x-ray and surgery of the colon, and more effective at cleaning the bowel than a Microlax enema).

Dr C advised me that he had been on call 24 hours a day for seven of the eight days prior to Mr B's operation, and had been "very busy". He believes that this was an "unreasonable workload" and resulted in him "becoming fatigued".

Records show Dr C started Mr B's bowel operation at about 3.45pm, and finished it approximately two hours later. The anaesthetist, Dr D, administered Mr B's general anaesthetic and inserted an epidural (a cannula inserted into the lining of the spinal column to administer medication) to provide Mr B with post-operative pain relief.

Dr C's notes of Mr B's operation record the following:

> "Lower interior resection with ileostomy. No obvious metastasis.
> Uneventful op."

The typed operation note gives a full report of the operation. The cancer was described as being 9cm on the anterior rectal wall. A double stapling technique was undertaken with the assistance of Dr D, who fired the staple gun. Dr C stated that this produced a tension free, well profused anastomosis (procedure of joining the bowel with staples) with two intact donuts (circular staple sites). Dr D advised me that he thought that one donut was satisfactory; the other was equivocal. He offered to show Dr C, but his offer was declined. Dr C diverted the faecal stream with a temporary loop ileostomy, and a large pelvic drain was inserted. A second drain was inserted to collect wound ooze. Mr B was administered 400 milligrams of the antibiotic gentamicin. An indwelling catheter was inserted to drain and measure Mr B's urine output.

Dr C advised me that immediately after the operation he checked the integrity of the anastomosis by digital examination and it seemed intact. Dr D confirmed that Dr C carried

out a digital rectal examination, something he had not observed Dr C do at this stage during previous operations. Dr C did not check the anastomosis by use of a sigmoidoscope (an instrument used for visualising the rectum and sigmoid flexure of the colon). There is no record in the operation note of Dr C visually sighting the anastomosis and Dr D confirmed (at the Coroner's inquest) that he did not see Dr C visually check the anastomosis with a sigmoidoscope. Dr C informed me that digital palpation would detect a defect such as the 18mm anastomotic defect subsequently revealed at autopsy. Dr C said that if the defect was not present during the operation it would not have been detected by other methods, such as submerged sigmoidoscopic insufflation.

Post-operative care – 16 December

Following surgery, Mr B was transferred to the ward at 7.10pm. The ward nursing notes describe him as "cold and shivering", with 250mls in the Redivac drain and scant drainage in the silicone drain. His oxygen saturation was normal, as were his blood pressure and pulse rate. Dr D ordered the continual delivery of Marcain with fentanyl (analgesia) via an IV (intravenous) drip, with provision for Mr B to obtain more pain relief through a PCEA (patient controlled epidural analgesia) pump if required.

Dr D saw Mr B at about 8.15pm. He noted Mr B's shivering and his raised blood sugar level (12.0). (Normal blood sugar level is between 4 and 7.) He queried the need for Mr B to have an insulin infusion.

Dr C advised me that at about 9.00pm he was contacted by nursing staff about Mr B's shivering. Dr C suggested that Mr B needed close monitoring. There is no record in Mr B's notes of Dr C's discussion with nursing staff. Dr D advised me that he visited Mr B at approximately 9.30pm as part of a routine visit and was not concerned about Mr B's condition so did not make a record of his visit. Mr B's epidural record shows that he requested and received 3mls of additional analgesia at approximately 10.00pm. Nursing notes record that at 10.00pm nursing staff, concerned about Mr B's shaking, telephoned Dr D. Dr D saw Mr B at about 11.45pm and commenced an insulin infusion. Dr D recorded that Mr B was hyperventilating, had tachycardia (rapid heartbeat) and his pulse rate was up to 150/minute. An electrocardiogram (ECG) showed sinus rhythm (normal heartbeat). Dr D advised me that he thought that infection so soon after surgery and the administration of gentamicin was unlikely. He was suspicious that spasm, or colicky abdominal pain or possibly gut ischaemia was causing Mr B's symptoms. Accordingly, Dr D ordered blood gas tests, the results of which were normal. He also ordered a top-up of the epidural Marcain with fentanyl.

The nursing notes record that at 10.10pm Dr C was also contacted in relation to Mr B's left-sided pain and shivering. However, Dr C denied that he was contacted again that night and said that he was unaware of further concerns about Mr B until the next morning.

17 December

Nursing notes record that Mr B was stable until 4.30am when Dr D was notified of Mr B's decreased blood pressure (69/33) and low urine output. Dr D prescribed additional IV fluids and recommended the epidural be turned off until Mr B's blood pressure improved

from 69 to over 90 systolic. The epidural was recommenced at 5.30am. Nursing notes record that at 6.00am Mr B was "more settled".

Dr D advised me that he had considered contacting Dr C about Mr B's condition but decided against it, as he knew Dr C would be reviewing Mr B first thing in the morning. Dr D said that he stressed to nursing staff that they should make Dr C aware of the pain that was proving difficult to treat, as well as the circulatory instability, and the fact that these concerns had prompted him to visit during the night.

Dr C reviewed Mr B at 7.00am. At that time, Mr B's blood pressure was 105/45. He had reduced urinary output. Dr C advised me that although Mr B was unwell when he saw him, it was unclear what was causing his problem. Dr C said that it was possible that Mr B's condition was caused by an over-reaction to his epidural pain block.

Nursing staff contacted Dr D at 8.40am when Mr B's blood pressure dropped to 70/40. Dr D ordered Mr B's epidural to be reduced and intravenous fluids given. At 10.00am nursing staff again contacted Dr D concerned about Mr B's blood pressure (90/40), which was still low. Dr D ordered the epidural to be discontinued until Mr B's blood pressure improved to over 90 systolic.

At approximately 11.15am nursing staff advised Dr D of Mr B's blood test results. His white blood count was depressed at 2.4 (normal range is between 4.0 to 11.0) and the nurses documented that his results showed a "toxic looking picture". Dr D said he would visit Mr B at lunchtime. A message was also left for Dr C advising him of Mr B's blood test results. Dr C phoned the ward at 11.50am. It is documented in the notes that Dr C commented that Mr B's bowel preparation had not been good, and that contamination was likely. Dr C prescribed Mr B IV ceftriaxone (an antibiotic) 12 hourly.

Dr C advised me that he was committed to carrying out two major operations at the public hospital on the morning of 17 December, and had an operating list in the afternoon.

Dr D saw Mr B again at 12.50pm. At the Coroner's inquest Dr D stated that despite Mr B's adverse blood tests (indicating infection), his appearance did not necessarily reflect this, as he seemed alert and could answer questions. However, there were additional symptoms that concerned Dr D. Mr B's pulse oximeter (equipment that records the pulse) reading had gone down slightly and his fingers were cooler than they had been. Dr D spoke to Dr C at around 1.30pm and they discussed Mr B's condition and management plan. Dr D's recommendation was that Mr B be transferred to the public hospital for intensive care support; he felt it was "imperative at that stage for transfer to occur quickly and for inotropic support to continue". Dr D could not recall discussing in detail with Dr C whether consideration should be given to further surgery; any decision to re-operate would primarily be a surgical call. However, Dr D recalled stressing to Dr C his view that Mr B was "very sick, much sicker than outward appearances suggested".

Dr C said he discussed with Dr D his plan to continue with conservative management (antibiotic therapy and drainage) and the need for Mr B to have intensive care support. Dr

C was concerned that further surgery would be risky as it could disperse a localised pelvic infection throughout the abdominal cavity. Dr D said (at the Coroner's inquest) that at the time he agreed with Dr C's plan to manage Mr B conservatively.

Dr C advised me that it was only at this stage that the need to transfer Mr B to the Intensive Care Unit (ICU) at the public hospital was apparent. As Dr D was already at the second private hospital, he offered to make the arrangements for Mr B's transfer. He telephoned Dr E, intensivist at the public hospital. Dr D then telephoned Mrs A about her husband's deterioration and arranged for Mr B to be transferred to ICU at the public hospital.

Dr E stated that Dr D's description of Mr B's history and clinical condition was consistent with an anastomotic leak with generalised sepsis and multi-organ dysfunction. Dr E said he discussed with Dr D the role of definitive surgical management either pre- or post-ICU admission and they agreed that the safest course was first to admit Mr B to The public hospital. Dr D suggested that Dr E discuss the need for further surgery with Dr C. Dr E then advised the on-call anaesthetist at the public hospital to expect a patient for exploratory laparotomy later that day.

Dr D's notes, written at 1.50pm, describe Mr B's blood pressure as low, his peripheral perfusion poor, his white blood cell count low, and his creatinine (a waste product of protein) rising. He noted that Mr B required "HDU/ICU inotropes" (drugs that regulate heart contractions) and that he had discussed his transfer with Dr E of The public hospital. At 2.20pm Dr C telephoned the second private hospital and nursing staff updated him about Mr B's condition.

The public hospital ICU

At 2.30pm Mr B was transferred via ambulance to ICU at the public hospital. Dr E examined Mr B on his arrival at the unit. Dr E noted Mr B to be a previously fit man with no history of cardiac or respiratory disease, and mild diabetes controlled by diet. His entry in the ICU notes reads:

> "Post operative sepsis with multi-organ failure (MOF) – respiratory failure – renal failure – shock. 24 hours ago anterior resection (low) and ileostomy, uneventful anaesthetic, ? incomplete donut on anastomosis."

Dr E telephoned Dr C and informed him of the outcome of his assessment and diagnosis. Dr E stated (at the Coroner's inquest) that he made Dr C aware of the gravity of Mr B's deteriorating condition; in particular, profound sepsis shock that would necessitate inotropic support, respiratory failure that would require artificial ventilation, a depressed white blood count and extensive 500mls Redivac drainage of faecal material. He asked Dr C about an exploratory laparotomy and washout but Dr C said that it was not indicated. Dr C told Dr E that he would visit Mr B the next day and would contact the surgical registrar on call. Dr E recorded his conversation in Mr B's notes:

> "D/W Surgeon ([Dr C]) – Critical state, massive drain losses (500 mls in < 1 hour). ? need for operative intervention. ➔ Not required, drain and Abs. He will contact Surg reg on call."

Dr E stated that approximately two hours after their initial conversation, Dr C telephoned ICU. Dr E advised him that Mr B's condition was now critical. There is no record of this conversation in Mr B's medical notes. Dr C advised me that "if the ICU staff were truly concerned Mr B needed urgent re-operation that afternoon they could readily have sought a second opinion from the surgeon on call".

Dr C advised the Coroner that he telephoned ICU again at approximately 5pm and said that he was "assured" that Mr B had a satisfactory urinary output. He said he discussed Mr B's condition with the on-call surgical registrar, and told him that he wanted to be notified of any deterioration. There is no record in Mr B's hospital notes of Dr C's telephone call at 5pm or his discussion with the surgical registrar.

The surgical registrar advised me that although he could recall Mr B's case, he could not recall (owing to the amount of time that has passed) whether he had had a conversation with Dr C in relation to Mr B's care. He advised that it is his practice to record any conversations with consultants in the patient's notes.

18 December

At 3.00am a medical emergency team was called in response to a cardiac arrest call concerning Mr B. His blood pressure had dropped suddenly from 80 systolic to between 30–40 systolic. His heart rate dropped from 140 beats per minute to 20 beats per minute. However, by the time the emergency team reached ICU Mr B's heart rate and blood pressure had returned to his "baseline" following the administration of IV noradrenaline. The medical emergency team recorded that Mr B was deeply sedated, with a heart rate of 170 beats per minute and blood pressure of 180/95.

In the morning Dr E recorded the following:

> "Imp moribund, unlikely to survive.
> Plan continue current Rx (treatment)
> ↓ K+
> [Dr C] and family aware of grave prognosis
> Not for resus in event of cardiac arrest."

Dr C informed me that he was unaware of Mr B's deterioration until he rang ICU that morning at 8.30am. He visited Mr B later that morning but did not document his visit in Mr B's notes. His visit to Mr B was, however, documented by the nurses. During the evening Mr B's condition was "relatively unchanged but critical", with a heart rate of 145–155 and blood pressure of 80/40–105/50. Clinical notes record that his urine output of 0–30ml per hour was "poor".

19 December
Mr B remained seriously unwell. His clinical notes record that at 2.30pm there was a "slight improvement" in Mr B's condition with blood pressure of 108/50–120/55 but a heartbeat that remained "tacky" (fast) at 126–136 beats per minute.

20 December
There was no improvement in Mr B's condition. He was seen by a cardiologist, who commented that although Mr B had significant ventricular impairment, there was no evidence of a primary myocardial (heart) problem.

21 December
On the morning of 21 December Mr B was diagnosed with acute renal failure. Dialysis was not considered a practical option given Mr B's extremely grave prognosis. Mr B's condition continued to deteriorate. He died at 11.25am that day.

Dr C's communication to family
In the days following Mr B's death, Dr C sent Mrs A and her family a hand-written card expressing his "deepest sympathy" on their loss, but noting: "At autopsy [Mr B] had severe coronary artery disease and a very enlarged heart. This severely reduced his ability to cope with infection present." Dr C offered to discuss the matter and gave his work and home telephone numbers. Dr C advised me that he intended his comments to be of comfort to Mrs A, and sincerely regrets that his card "may have been regarded as misguided".

The public hospital
Mr B was admitted to the second private hospital as a private fee paying patient and was under the care of Dr C. However, upon transfer to the public hospital, Mr B's status changed to that of a patient within the public system. He was admitted as an acute patient under the care of Dr C who, as well as treating patients in his private capacity, also worked as a part-time surgeon employed at the public hospital. Dr C did not treat patients at the public hospital in his private capacity.

In his response to my provisional opinion, Dr C informed me that he was not the surgeon on call at the public hospital on the evening of 17 December. He further commented that asking the on-call registrar to "keep him in touch" was not evidence of his acceptance of Mr B's ongoing care.

The public hospital informed me that there is an unwritten understanding that when a private patient transfers to the public hospital the patient remains the responsibility of the private surgeon, if that surgeon has clinical privileges at the hospital. If the surgeon is unable to attend for some reason, then care for that patient is transferred to the acute duty team for management. There is no record of Dr C transferring Mr B's care to the on-call consultant surgeon at the public hospital.

Post-mortem
A pathologist conducted a post-mortem examination of Mr B at the second public hospital, on 22 December 1999. Her report, dated 2 February 2000, concluded that Mr B's cause of

death was post-operative sepsis with multi-organ failure. She noted that Mr B had triple vessel coronary artery disease, which may have also contributed to his death. An 18mm defect in the bowel anastomosis was also noted and that approximately 150mls of brown stained fluid and mixed faecal material was present in his abdominal cavity. At the Coroner's inquest the pathologist stated that the staples appeared to have been correctly placed, but had come apart (resulting in the leak).

Coroner's inquest
The Coroner's inquest, held on 11 August 2000, determined Mr B's cause of death to be "Post-operative Sepsis due to a failure in a rectal anastomosis, a complication of lower rectal surgery".

Accident Compensation Corporation
Mrs A made a claim to the Medical Misadventure Unit of Accident Compensation Corporation (ACC), on behalf of Mr B, about the treatment provided to him by Dr C. In October 2000 ACC recommended that a finding of medical error be made, arising from a failure to exercise a standard of care and skill that was reasonable to expect in the circumstances. The ACC finding was made on the basis of the following expert advice from a general surgeon:

> "…
>
> There are two areas which appear to be critical in this claim:
>
> 1. There is an issue with the donuts. The leak occurred within hours of the operation and since the anastomosis was formed without tension and after mobilization of the splenic flexure, it seems reasonable to assume that the anastomosis was deficient when it was stapled. The anaesthetist who operated the stapling gun stated at the inquest that the donuts were equivocal. If the donuts were not intact then, by definition, the anastomosis is deficient and the defect should be sought and closed. Other means of checking the anastomosis in the pelvis include insufflation under water or saline, a visual check with a sigmoidoscope and a peranal digital check. Apart from the donuts, (and with a 3 centimeter distal clearance I do not agree that a histological check of the donuts is necessary), the other checks are available but could not be regarded as mandatory. However, in the presence of 'equivocal' donuts, it is the responsibility of the operating surgeon to confirm the integrity of the anastomosis before closing the abdomen.
>
> 2. The other issue relates to the management of the anastomotic leak. The surgeon's view is that the drain was doing its job in clearing the leakage from the anastomosis and that there was a significant risk in re-operating. This view is not supported by the colorectal surgeon. At the autopsy there was evidence of faecal contamination of the wider peritoneal cavity. I believe that the balance of surgical opinion would support resuscitation and re-operation particularly if there was a question over the adequacy of the bowel preparation, as in this claim. A diverting stoma, of course will not prevent an anastomotic leak and is felt to be of value where the leak occurs

> from anastomotic breakdown as a failure of healing rather than in the immediate post-operative period. Once the decision to manage conservatively was made, the chances of surviving a re-operation diminished with time. The elevation of cardiac Troponin has been raised as part of the explanation for his rapid deterioration. Troponin is released by damaged heart muscle fibres and is elevated with myocardial infarction. It is also elevated in other conditions where the heart muscle is damaged such as sepsis.
>
> I think, on balance, that there would be sufficient concern amongst surgical peers regarding the two areas that I have outlined, to support a finding of medical error as defined in the Act.
>
> …"

The second private hospital

The Hospital Audit Review Committee of the second private hospital reviewed Dr C's treatment of Mr B and, taking into account expert advice from colorectal and general surgeons, concluded that "the attention given to this patient by [Dr C] was not up to the standard expected of a consultant general surgeon". They were very critical of Dr C's post-operative management of Mr B's deteriorating condition, and noted that in a private hospital setting, although a surgeon can ask a colleague (eg an anaesthetist, as in this case) to assist and to add expertise, "the final responsibility must always be with the surgeon".

In responding to my provisional opinion, the second private hospital stated:

> "In our view, no reasonable responsible surgeon operating in our hospitals could (by telephone only) monitor a patient whose condition was deteriorating critically, and whose only other expert was the anaesthetist (who has no surgical expertise as such and who does not have ultimate responsibility for the patient)."

Dr C's registration with the second private hospital was terminated by the private hospital's management in November 2000.

Medical Council of New Zealand

The Medical Council of New Zealand has undertaken a review of Dr C's competency to practise surgery. Following an initial review in 2001, a detailed audit was undertaken by two advisors of all major colorectal surgery performed by Dr C from 1 January 1997 to 31 December 2001. In July 2002, the Council resolved that Dr C's practice was deficient in the area of colorectal surgery and that he should undertake an educational programme to enable him to return to unrestricted practice, while ensuring patient safety is not compromised.

Independent advice to Commissioner

Original advice
The following independent expert advice was obtained from Dr Robert Robertson, general surgeon:

> "Thank you for your request to advise the Commissioner whether, in my professional opinion, services were provided to [Mr B] with reasonable care and skill. In addition too you ask what were the specific standards and were they followed? Were [Dr C's] instructions to [Mr B] about food intake prior to the colonoscopy procedure adequate knowing that [Mr B's] bowel preparation was not ideal? Was [Dr C's] decision to proceed with surgery appropriate? Was [Dr C's] decision to conservatively manage [Mr B's] sepsis with antibiotics appropriate? Was [Dr C's] monitoring of [Mr B] postoperatively adequate? Was [Dr C's] decision to not operate once [Mr B] was in ICU appropriate? Whose responsibility was it to make that clinical decision? Are there any other matters you consider relevant in relation to the standard of care provided to [Mr B]?
>
> [Mr B] saw [Dr C] as a patient on 6 December 1999 because of rectal bleeding. He was examined at that time and found to have a tumour in the rectum which was biopsied. Arrangements were made for him to have a colonoscopy on 15 December 1999 at [the first private hospital] and to have surgery the following day at [the second private hospital], 16 December 1999. He was given written information with respect to colonoscopy and a prescription for Fleet preparation to clear the bowel. There is some debate as to how much information he received with respect to maintaining clearance of the bowel and this has been one of the issues raised during the complaint. According to the records available from the [first private hospital], this colonoscopy was undertaken on the morning of 15 December 1999. He was noted to be a borderline diabetic which was diet controlled and he had last had anything by mouth at 8.00 that morning. He returned to the ward at 12.45 hours and was seen by [Dr C] and was to be admitted to [the second private hospital] on the 16 December 1999 for bowel resection and he was for discharge from the [first private hospital] that evening. He was given Pethidine, Hypnovel (Midazolam) and Fentanyl as part of his sedation medication. It is understood from information supplied although not specifically stated in the record that he was given a cup of tea and a sandwich before leaving the hospital. (I would expect this to be relatively normal practice for patients having had a colonoscopy once they have awoken.)
>
> That evening, according to his wife, he ate a small piece of chicken and a small portion of potato and broccoli and drank a cup of coffee. In the anaesthetic record of [the second private hospital] it stated that his last oral intake was at 07.45 hours that morning but there is no other record of this or what he may have had then. There was little else recorded preoperatively on 16 December 1999 and it does not state at what time he arrived at the hospital although his wife states he came in at 10.00am and waited until a room was made ready for him. (A summary of his stay at [the second private hospital] has also been provided. I note this was signed by the Ward Manager on 22 March 2000

and this obviously would have been done subsequent to the events.) Also close to the time, [the admitting nurse], who presumably was the nurse who admitted [Mr B] on Thursday, 16 December 1999, wrote a report form to discuss antibiotics, anticoagulation (Fragmin) and bowel preparation with [Dr C].

She reports that her advice to the receptionist in [Dr C's] rooms was that [Mr B] had eaten dinner the night before, after the colonoscopy. [Dr C] apparently stated to her that the patient should not have eaten and asked to give [Mr B] an enema. The nurse questioned as to whether this was a Microlax enema and it was confirmed with [Dr C's] receptionist. She also states that she was not to give him Fragmin (anticoagulant) but was to give Flagyl as part of the pre-medication antibiotic. The nurse states that [Dr C] used Fasigyn so she called the rooms back and this was checked with [Dr C] and the drug corrected to Fasigyn. (These drugs are similar anti-anaerobic agents.) She states that [Dr C] saw [Mr B] prior to surgery but did not mention anything about the bowel preparation to her. This was dated 20 December 1999 after the event but prior to the time [Mr B] died.

The record of the operation in the [the second private hospital] notes was rather skimpy and had been written and signed by [Dr C] stating surgeon notes – Lower Anterior Resection with Ileostomy. No obvious mestastasis. Uneventful op. (While this may convey the sentiments of the operation in a broad sense, I believe it is inadequate for hospitals to have such abbreviated operation note records and this may be an issue the hospital should address.) The subsequently produced typed operation notes give a full report of the operation stating the cancer was at 9 cms on the anterior rectal wall and the patient was given thrombo-prophylaxis with intermittent calf compression, antibiotic prophylaxis with Gentamicin, 5 mgs per kilogram, and I note in the hospital record, five ampules of Gentamicin were dispensed indicating at least 400 mgs could have been given together with the Fasigyn. Analgesia with Marcain wound infiltration was given and the patient had a general anaesthetic and epidural anaesthetic.

The tumour was confirmed as being extraperitoneal involving the rectum beyond the peritoneum and there was no evidence of spread from the tumour. The operation reads as one which appears relatively straightforward other than having some difficulty mobilising the splenic flexure which in the case of a low anterior resection may need to be fully mobilised to achieve an anastomosis without tension which apparently it was. A double staple technique was undertaken and the comment that this produced a tension-free well perfused anastomosis with two intact doughnuts is stated. A defunctioning loop ileostomy was constructed and I note that in the preoperative assessment at [the second private hospital] this was expected. Two drains were used to the pelvis; one a suction drain and the other a silicone tube drain. It does not state in the operation note that the anaesthetist fired the gun at the lower end and it does not state if an assistant was otherwise used for the procedure. These may be issues that could be discussed in the form of more broad recommendation.

The anaesthetic record written by [Dr D], anaesthetist, appears unremarkable. It would seem the procedure commenced some time shortly after 1530 hours and was completed

around 1730 hours making the procedure overall two hours in duration which would be a standard type of time for this kind of operation. There was nothing remarkable about the recovery room report which covers the time from approximately 1800 hours to 1850 hours and I note the patient returned to the ward at 1910 hours. At the time the patient returned to the ward it was noted he was feeling cold and shivering, there was 250 mls in the redivac drain and there was scant drainage from the silicone drain. His saturations were normal as was his blood pressure and pulse rate.

He was seen by the anaesthetist, [Dr D], at 2015 hours, he was aware of the shivering and noted then his blood sugar level was 12 and the need for an Insulin infusion was raised. Two hours later the blood sugar level was 12.9 and [Dr D] was telephoned with respect to the shaking and [Dr C] was contacted with respect to the pain he had experienced in his left side together with the shivering. He was seen by [Dr D] at 2345 hours and an Insulin infusion was commenced. [Dr D] wrote in the notes that he was hyperventilating, he had a tachycardia with his pulse rate up to 150/minute and the ECG showed sinus rhythm. He was given some analgesic medications which helped improve his general state. Blood gases were taken and these were normal. Changes were also ordered to his intravenous fluids at this point. Overnight his urine was measured carefully on an hourly basis and ranged from 10 mils in one hour and up to 50 at others. It was probably in the marginal level of around 30 mls/hour most of the time. During this time his blood pressure had dropped and intravenous fluids were increased to try and overcome this together with improvement to his urinary output. It was noted at 0430 hours on 17th that his urine output had dropped to 10 mls of concentrated urine. It was 20 mls in his ileostomy, 50 mls in the silicone drain and 480 mls in the redivac drain with no faecal incontinence rectally. He was seen by [Dr C] at 0700 hours who changed some of the medication to include Fragmin plus antibiotics and also charted some Ativan. [Dr D] was contacted at 0840 hours as his blood pressure was again low and ordered the epidural to be reduced and to give some more intravenous fluid. At 1000 [Dr D] was notified again regarding the blood pressure and the epidural was turned off until the blood pressure returned to 90 systolic. Blood tests were arranged to include Gentamicin levels at 1115 hours and the result of the white cell count was returned which showed his white cell count was only 2.4 and according to the notes shows (a toxic looking picture). [Dr D] was contacted regarding this and advised he would visit.

At 1150 hours [Dr C] phoned aware of the lab results and it is stated that the patient's bowel preparation wasn't very good and he would add IV ceftriaxone 12 hourly and he would ring back. This was given at 1200 and 1205 hours and at 1250 hours, [Dr D] saw the patient and apparently he was unhappy with his condition and discussed this with [Dr C] and the Intensive Care Unit at [the public hospital]. He also spoke to [Mrs A] and stopped the epidural. At this point arrangements were made for transfer of [Mr B] to the Intensive Care Ward, [the public hospital]. At 1420 [Dr C] phoned in and was updated about the patient's condition. The other blood tests done at this time included a creatinine of 0.129 and urea of 6.5. Both of these are within the normal limit although the creatinine was the upper limit of normal. During this time his urinary output remained at the just acceptable level of between 40 and 25 mls/hour and the patient obviously was in considerable pain and was restless at times.

[Dr D] wrote in the notes at 1350 hours that blood pressure was low, peripheral perfusion was poor, his white blood cell count was low, his creatinine was rising and that he required HDU/ICU inotropes and that he had discussed with [Dr E] finally leaving the developments awaited. Another comment made by a nurse, signed […], states redivacs 460 mls. No increase. Silicone drain scant in bag but looks faecal in tubing. The patient was transferred at 1430 hours and in the notes recorded at [the public hospital] on his arrival, the initial diagnosis is post-op sepsis with multi organ failure, renal dysfunction, shock. A comment is made ? incomplete doughnuts from the anastomosis.

In his past history it is noted that he had excellent exercise tolerance. He had diet controlled non-insulin dependent diabetes mellitus for eight years and there was no cardiac respiratory or hypertensive problems. He was noted to be tender in the abdomen with no bowel sounds, ileostomy was satisfactory and there was a comment of drainage of faecal material from redivac 500 mls in less than one hour. A naso gastric tube was placed and 500 mls of fluid drained and that his creatinine had gone from 0.09 preoperatively to 0.13 12 hours postoperatively. His white cell count had gone from 7.1 to 2.4 to 1.8. The impression was of a critically ill man with postoperative sepsis (presumed anastomotic leak). This produced multiple organ failure and this was discussed with the surgeon, [Dr C], with respect to this critical state and questioned the need for operative intervention. It stated that this was not required, drain and antibiotics, and he will contact the surgical registrar on call. This implies from [Dr E's] report that [Dr C] would undertake this.

Further reports in the notes that afternoon and evening noted that the redivac drain continued to drain moderately large amounts describing the material as dark brownish red and a small amount of brownish red drainage from the silicone drain. During this time he was paralysed for ventilation and he continued to have difficulty with his blood pressure as it remained very low. By 10 o'clock that evening the redivac had drained altogether 1100 mls of reddish brown discharge but after that time the drainage tailed off and there was 100 mls drained in the following few hours.

At 3.00am on 18 December a cardiac arrest call was made as he was haemodynamically unstable but this corrected reasonably quickly. At this point it was decided that if such a dramatic event should recur, he should not be resuscitated and [Mr B's] wife was notified of this. They were also given a full explanation about the physiological effects of sepsis but if he did have further bradycardiac hypotensive episodes, when inotropes had been switched on or off then a 2 mg IV bolus of Adrenaline could be given. This occurred during change over of the inotropic medication pumps. By 18 December 1999 [Dr E's] impression was that he was moribund and unlikely to survive but they would continue with their current treatment. Both the surgeon and the family were aware of the grave prognosis and on this day it was noted there was 60 mls of brown fluid from the abdominal redivac and 250 mls of faecal drainage in drain 2 which, I presume, is the silicone drain. He was also seen by [Dr C] on this day as is recorded in the notes. On 19 December 1999 he remained deeply unconscious and sedated, requiring the ventilatory and inotropic supports, he continued to drain fluid from his redivac drain and

tube drain and it was felt that he had had an anastomotic leak from his anterior resection causing a faecal peritonitis leading to overwhelming sepsis and multi organ failure.

In the notes it states ARDS (Adult Respiratory Distress Syndrome), renal failure, septic shock and DIC (Disseminated Intravascular Coagulopathy) which may be grouped in the condition known as SIRS (Systemic Inflammatory Response Syndrome) and during this day and the next he remained critical but stable. He had become febrile with a temperature of 40 degrees, his heart rate remained elevated at 165/minute, with the blood pressure just adequate at 115/45 on both Dopamine and Noradrenaline infusions. His urinary output remained minimal with his creatinine having risen to 0.51 and his potassium was up at 5.1 and urea at 23.7. This indicated he was in established acute renal failure and also at this time he was seen by a cardiologist who commented on the state of his heart and that he had significant ventricular impairment but there was no evidence of a primary myocardial problem as it was felt, at that point, that TNT was normal but he did require cardiac supports to enable the heart rate to be maintained more normally. By the following day, 21 December 1999, he was in an extremely poor state and that dialysis for his acute renal failure was not a practical option and following that he slowly but gradually deteriorated and died at 1125.

[The] Pathologist undertook a post-mortem examination, at [the second public hospital] on 22 December 1999. She noted an ileostomy in the right lower abdomen with an associated bag containing approximately 2 mls of brown coloured fluid. There were two drains in the abdomen; the upper had drained 100 mls of brown fluid and the lower had drained 20 mls of brown coloured fluid. The report on the gastrointestinal system notes that in the region of the rectum there is an 18 mm defect which has surrounding staples. There are fibrous adhesions in the lower abdominal cavity. Approximately 150 mls of brown stained fluid and mixed faecal material are present in the abdominal cavity. The mesentery showed peritonitis with friable and degenerate neutrophils (pus cells). In summary, in her opinion, the cause of death was postoperative sepsis and multi organ failure. There is triple vessel coronary atheroma which may have also contributed. I note that there was some clarification with respect to this report asked for by the [the second private hospital] investigating team which I don't believe added anything further to her report.

What were the specific standards and were they followed? In the work up of this patient the explanation of the operation, the expectation there would be an ileostomy that he had a cancer and the bowel needed to be checked for further disease and overall assessment of him appeared to be straightforward. He had a fairly standard bowel preparation for a colonoscopy which was undertaken and failed to show other significant abnormalities but it is regrettable that he was fed twice after the colonoscopy with apparently normal food as it would have been more appropriate to have kept him on fluids to perhaps complement his colonoscopy preparation with a rectal washout of some form prior to his surgery the following day. This, in fact, did happen and possibly could have been appropriate enough.

The other major issue is the management once the leak had been recognised and, to some extent, the events were so rapid and overwhelming that time to follow a conservative line and assess its outcome never became an option. This is unfortunate because he had a covering ileostomy to divert the faecal stream and if it had been a small leak that remained contained, it may have subsequently healed with the simple conservative measures put in place. Unfortunately, with hindsight we know it was a large leak, 18 mms in diameter at post-mortem and although it must have been moderately contained in the sense that most of the drainage came out via the drains his response to the septic complications caused by this [was] overwhelming. This may have been exacerbated by him being a diabetic and it certainly gave him a rapid downward course.

Comment was made in the Coroner's report by the anaesthetist who gave the initial anaesthetic that the patient's recordings were satisfactory at around midday on 17th but he did not look all that well particularly with his poor peripheral perfusion and this may have been the clue to intervene then and bring out the end of the bowel as an end stoma and drain the pelvis and oversew or staple the rectum, if possible. With hindsight this may have saved his life but I believe after this, with his rapid deterioration, any operative intervention would have killed him more quickly.

Were [Dr C's] instructions to [Mr B] about food intake prior to the colonoscopy procedure adequate? The instructions for food intake with respect to the colonoscopy were satisfactory but those instructions after the colonoscopy should have been cleared and probably should have been made to his caregiver, in this case, [Mrs A], as [Mr B] would have still had the effects of Midazolam and therefore would not have remembered anything he was told. If [Mr B] or [Mrs A] had been told he should not eat solid food after his preparation, they were subsequently misled by the production of a sandwich at [the first private hospital] and by him subsequently eating a small meal that evening. This, in itself, would not have caused the problem, [Mr B] subsequently suffered from but it is much safer to keep away from solid food in preparation for an operation such as this.

Knowing that [Mr B's] bowel preparation was not ideal, was [Dr C's] decision to proceed with surgery appropriate? I believe, in the circumstances, it was; especially as he had prescribed an enema (rectal washout prior to surgery to keep the distal bowel clean).

Was [Dr C's] decision to conservatively manage [Mr B's] sepsis with antibiotics appropriate? With hindsight obviously not, but at the time if one had felt this was a small leak and with an upstream diverting ileostomy, it would seem appropriate as a first step given that if an end colostomy was then constructed, this may mean he would never be joined up again and thereby have a permanent colostomy for the rest of his life and in many cases, if the leak remains contained and controlled with drains and the sepsis controlled with antibiotics in respect to its systemic effects then one could anticipate a more satisfactory outcome.

I believe that the diverting ileostomy will sometimes give the surgeon a false sense of security in this situation because there is still a large bowel with usually fluid material within it that may continue to leak and if the site of anastomotic dehiscence or break down is large, as in this case, it will keep leaking and will not, however, be corrected until complete diversion of the lower bowel is undertaken. (In my own hospital in the last 12 months a similar incident occurred where initial conservative management was undertaken using the belief that the bowel had been diverted with an ileostomy but subsequently the patient had to have the anastomotic site taken down and converted to an end colostomy to stop the ongoing sepsis.) This sometimes will be done reluctantly because the initial procedure is to try and maintain a functioning ano rectum and if the anastomosis is low this option may have to be abandoned.

Was [Dr C's] monitoring of [Mr B] postoperatively adequate? The monitoring at the [the second private hospital] was appropriate and I believe [Dr C] was kept fully informed of the events and the patient was visited on four occasions by the anaesthetist and once by [Dr C] in the 20 hours or so after his surgery. At that particular time there would have been considerable debate as to whether the problem was due to the epidural and the effect of epidural analgesia in the postoperative phase especially as it may affect the patient's blood pressure as much as any impending surgical complication which may also contribute to this. I believe, however, it would have been appropriate for [Dr C] to see [Mr B] in the Intensive Care Ward at [the public hospital] on 17 December because at that time clinical examination may have altered his management options.

It is recorded in the notes that the surgical registrar was to keep him informed but there is no record written that this happened and also in a case such as this with the benefit of hindsight if [Dr C] was not immediately available, it may have been useful to consult the surgeon on call or another surgeon with a colorectal interest to review the case as their input could have been valuable while there may still have been time to consider surgical intervention. Certainly by that evening, I believe surgical intervention was probably not an option. This also answers your next question.

Was [Dr C's] decision to not operate once [Mr B] was at ICU appropriate? Whose responsibility was it to make that clinical decision?

Are there any other matters you consider relevant in relation to the standard of care provided to [Mr B]? I would like to reiterate that I believe that [Mr B's] outcome was tragic and I believe the primary event was the failure of the anastomosis which has occurred at an extremely early time. There is no record in the notes that the anastomosis was adequately checked using the sigmoidoscope and inflating the lower bowel while the pelvis was filled with some form of fluid or visually inspecting it with the sigmoidoscope or from above at the operation site at the time of the operation and I believe this is critical. I believe also, that an experienced assistant should, wherever possible, be used in such cases, as this particular anastomosis is one that is always fraught with the risk of break down, particularly in the modern age where mesorectal excision is undertaken and the blood supply to the distal rectum may be marginalised.

I also feel it is appropriate that the surgical service, wherever possible, should work as a team and not rely wholly on the single surgeon to make all of the decisions although ultimately the surgeon-in-charge will have to take the majority of the responsibility and there may be a place for some better co-ordination at [the public hospital] in this respect. Finally I feel that the outcome from the leak with the subsequent sepsis was extreme and overwhelming and not what might be normally expected in such circumstances and this unfortunately did not give the medical staff caring for [Mr B] much of an option to exercise choices in their decision making. This, in itself, may have been the single most significant contribution once the complication had occurred and the time frame made so short as to herald the outcome regardless of whatever treatment may have been instituted."

Further advice

The following further independent expert advice was obtained from Dr Rob Robertson, who was asked to review his original advice in light of the responses to the provisional opinion:

"Thank you for your recent letter and copy of both [Dr C's] and [the second private hospital's] response to your provisional opinion. You have asked for clarification on a number of points.

Firstly, do I revise my original advice in light of the above responses?
The answer to this is no … having gone carefully through my report I don't see any other need to revise or change it. I do not have the full notes to refer back to with respect to my report but I believe the last paragraph sums up my feelings and I think many of these issues are covered both by [the doctor] for [the second private hospital] and [Dr C].

It is extremely difficult to know when a patient is transferred if the transfer is to the Acute Team on Call or to the surgeon continuing the care and one can only make assumptions about this from the notes. He was, of course, transferred to the Intensive Care Ward and I am not familiar with the structure – this is managed at [the public hospital]. I can refer to my experience in [a city] where the patients transferred to Intensive Care are admitted under the Intensive Care Consultant who then 'calls the shots'. If a patient is transferred from a surgical service either within the hospital or without there is normally a line of communication established. Within the hospital this would always be the team responsible for the patient but when transferred from outside the hospital this may be to the Acute Team unless the Specific Consultant who is employed at the public hospital carries on the care. In the case of [Mr B] I am not entirely sure who was ultimately responsible from a surgical perspective when he was in Intensive Care and you may wish to establish that with the Intensive Care Service and [the public hospital] policy. I did make a point that when such complications arise it may be appropriate for the Acute Surgeon of the day in [the city] to be involved and this is an issue the surgical services there would need to address.

You next asked for me to comment specifically on the responsibility of surgeons for monitoring patients in private hospitals postoperatively.

My understanding of this, according to the [private hospital] agreement with visiting practitioners, is that the surgeon is primarily responsible for surgical patients as such. I believe, however, this particular case illustrates an issue where some aspects of this responsibility need to be looked at slightly differently. [Mr B] had an epidural catheter for postoperative analgesia which is becoming an increasingly common phenomenon in New Zealand surgical practice. It is meant to give patients better pain relief postoperatively and allow earlier discharge from hospital and greater ease for the patient's welfare.

There is a lot of debate about the benefits of epidural anaesthesia particularly from those with a surgical bias. When they work well they can be extremely good and beneficial but when they do not work well, they can be quite a challenge for people looking after postoperative patients. In particular they will mask important postoperative events and mislead those people looking after the patients that nothing is too much amiss. This may well have happened in this case. They also change some of the physiological behaviour of the patients in the postoperative phase again leading to a misjudgement of the patient's status. In the public hospital setting where I work, there are on call anaesthetic specialists and technicians who solely monitor the After Hours Epidural Service to maintain the integrity of this form of analgesia. The monitoring of [Mr B] at [the second private hospital] in the early postoperative phase was undertaken by the anaesthetist responsible for that epidural catheter and I would feel this is appropriate. I have not the notes to refer to but I do not recall [Dr C] being specifically requested to visit [Mr B] and assess him having been written or discussed on that first postoperative evening. He did see the patient the next morning which one would expect would be the normal procedure for a surgeon caring for a post surgical patient.

[The doctor for the second private hospital] makes significant criticism of [Dr C] that he did not monitor the patient closely but it may have been assumed that the initial problems could be epidural related rather than purely surgical and I don't believe that it is appropriate to be overly critical especially if [Dr C] had not been requested to visit the patient by those who were immediately present at his bed side … If [Dr C] was tied up in the operating theatre the day following surgery as he states, it would be virtually impossible for him to see [Mr B] and during that time [Dr D], the anaesthetist, did see him and arrange the transfer. [Dr C] did seem to be informed and did communicate with the hospital during this morning but I did note that the epidural analgesia was not stopped until after 12 midday and I suspect, reading through my report it was probably between 0840 hours and 1250 hours that it became apparent that there was something major going on in [Mr B's] abdomen that was probably unrelated to the epidural. Up until that time, I suspect nobody really fully appreciated the intra abdominal complication and this may well have been because the epidural had masked it. While one would not wish to stop the use of epidural analgesia, one can certainly see that its role can have a major effect on the patient especially if such a complication as [Mr B] suffered occurs so early.

Your next point was whether [Dr C] met his responsibility on this case while [Mr B] was at [the second private hospital].

I believe he did but given the proviso that if all the information we now know and they knew by 12 midday had been available to him earlier in the morning, I imagine he would have arranged transfer earlier. I think one has to recognise that a dynamic process is taking place while the various information is collated, ie the examination of the patient, the tests that are undertaken and the results of those tests are all brought together. This takes time and in [Mr B's] case I believe while he still had his epidural going, some of this information would have been hard to assess.

…"

Code of Health and Disability Services Consumers' Rights

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

RIGHT 4
Right to Services of an Appropriate Standard

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

Opinion: No breach – Dr C

In my opinion Dr C did not breach the Code of Health and Disability Services Consumers' Rights in the following areas:

Right 4(1)

Instructions about eating prior to surgery
Mrs A alleged that Dr C did not provide her husband with adequate information about food intake prior to his bowel surgery. Mrs A recalled Dr C's verbal instructions about food intake prior to the colonoscopy. She also advised that Dr C gave her husband two pieces of paper at the 6 December 1999 consultation: a prescription for 'Fleet' preparation and a document about day stay colonoscopy. Mrs A denied that she and Mr B were given the pamphlet 'Instructions for Bowel Prep for Colonoscopy or Surgery'.

After Mr B's colonoscopy at the first private hospital nursing staff told him to eat a sandwich and have a cup of tea before being discharged. Mr B and Mrs A queried this advice with the nursing staff, and told them that Mr B was having bowel surgery the next morning. However, the nursing staff assured them that Mr B could eat food up until 6am the next day. Consequently, Mr B consumed two small meals before his surgery.

Dr C advised me that he gave Mr B and Mrs A adequate instructions about food intake, covering both the colonoscopy procedure and the bowel surgery, at his consultation on 6 December 1999. He described to me his 'usual practice', which is to give the patient three pieces of paper stapled together: a 'Fleet' prescription, a pamphlet about day stay colonoscopy and a third document called 'Instructions for Bowel Prep for Colonoscopy or Surgery'.

Dr C provided me with a copy of the documents he gives to patients who are to undergo a colonoscopy and/or bowel surgery. I note the document concerning 'Day Stay Colonoscopy' states that the patient may resume a normal diet after the procedure. It also requests patients to inform staff if they have diabetes. Ensuring diabetics receive sufficient food intake to maintain their blood sugar levels is a key factor in managing such patients. I am advised that it is usual to provide some food and a drink to patients following a colonoscopy, particularly if they are diabetic and therefore likely to have an even lower blood sugar than normal from fasting prior to the procedure. I note that my advisor commented that providing a cup of tea and a sandwich to a patient following colonoscopy is a relatively normal practice.

In the case of Mr B, however, it was necessary for him not to consume food following his colonoscopy because of his impending bowel surgery the next day. The third document, 'Instructions for Bowel Preparation for Colonoscopy or Surgery', states that patients are not to consume food prior to surgery and that only clear fluid is permitted.

Mrs A alleges that her husband did not receive this document. Dr C, on the other hand, states that it is his usual practice to provide all three documents stapled together to patients. It is not clear exactly what happened in the case of Mr B, but I am satisfied that Dr C did provide some instructions about Mr B's food intake. This is supported by Mrs A's evidence that when Mr B was offered a sandwich after his colonoscopy, Mr B and Mrs A questioned the nursing staff whether this was appropriate, in light of the impending bowel surgery the next day.

It was unfortunate that Mr B and Mrs A were incorrectly advised about food intake by the first private hospital nursing staff. I understand that since this incident the first private hospital requires written instructions from surgeons about patients' food intake, post colonoscopy. However, I am satisfied that Dr C did give Mr B and Mrs A adequate instructions about food intake prior to the colonoscopy and bowel surgery.

In my opinion, Dr C did not breach the Code in relation to this matter.

Decision to proceed with surgery

Mrs A was concerned that, despite knowing that her husband had eaten the night before surgery, Dr C decided to proceed with surgery as planned.

Dr C has acknowledged that he was advised by nursing staff on the morning of the surgery about Mr B's food intake the night before. He ordered an enema, prescribed antibiotics,

and proceeded with the surgery as planned. He advised me he expected the enema to be Fleet preparation.

There is some discrepancy concerning the conversation between Dr C's receptionist and the admitting nurse on the morning of Mr B's surgery about the need for additional bowel preparation. Dr C was unavailable to speak directly to the admitting nurse, who telephoned to advise him that Mr B had eaten the night before. She questioned Dr C's receptionist as to whether the enema was to be a Microlax enema, which was confirmed. Dr C has denied that he ordered a Microlax enema. I note that the report form written by the admitting nurse recording her discussion with Dr C's receptionist is dated 20 December 1999, four days after the event. The pre-operative record completed prior to Mr B's surgery recorded that a Microlax enema had been given.

Although Dr C acknowledged in his report to ACC that Mr B's bowel preparation was not ideal, he considered that it was still appropriate to proceed with the surgery. Dr C advised me that he believed it was reasonable to proceed with the surgery after Mr B had received an enema.

The Coroner found that adequate steps were taken prior to surgery to ameliorate the effect of poor bowel preparation and that it was appropriate for Dr C to proceed with the surgery as he did.

My advisor agreed that it was reasonable for Dr C to proceed with surgery in the circumstances. He stated that, although the eating of two small meals in itself would not have caused the problem that Mr B suffered, it was safer to keep away from solid food prior to bowel surgery because of the risk of infection. However, in the circumstances, "especially as [Dr C] had prescribed an enema (rectal washout prior to surgery to keep the distal bowel clean)", Dr C's decision was appropriate.

Having considered all of the information available to me, I accept that Dr C's decision to proceed with Mr B's surgery was reasonable in the circumstances and that he did not breach the Code in relation to this matter.

Post-operative monitoring

Mrs A complained that Dr C failed to adequately monitor her husband following his surgery at The second private hospital, and did not see him for 12 hours after his surgery; it was Dr D, not Dr C, who monitored Mr B and arranged for his transfer to ICU. The second private hospital advised me that Dr C did not monitor Mr B adequately following surgery.

Dr C was the surgeon who booked Mr B for surgery at the second private hospital and the final responsibility for post-operative care rested squarely with him. However, the anaesthetist, Dr D, was actively involved in Mr B's initial post-operative care. Dr D inserted an epidural line during surgery to provide Mr B with post-operative pain relief. (An epidural line removes the need for regular intra-muscular injections.) As anaesthetist, Dr D, was responsible for inserting the epidural line and was primarily responsible for monitoring the line.

Mr B was a diet-controlled diabetic. Following his surgery and return to the ward at 7.10pm, Mr B was seen by Dr D at approximately 8.15pm, and at 11.45pm, when he commenced an insulin infusion. Between those visits, nursing staff contacted Dr C, who requested that Mr B receive close monitoring. At 4.30am, Dr D was contacted by nursing staff about Mr B's low blood pressure and decreased urine output. Dr D gave verbal orders for Mr B to receive further fluids and for his epidural to be turned off until his blood pressure improved.

When Dr C saw Mr B at 7am the next day, his blood pressure had improved, although his urine output was still low. Dr C was concerned that Mr B's earlier low blood pressure and reduced urine output was caused by an overreaction to the pain relief administered via the epidural. Dr C gave no new orders at that time. I note that my advisor commented:

> "At that particular time there would have been considerable debate as to whether the problem was due to the epidural and epidural analgesia in the post operative phase especially as it may affect the patient's blood pressure as much as any impending surgical complication which may also contribute to this."

My advisor noted that although epidurals can be beneficial, in some cases they can mask a problem that may be developing.

Some time after he was seen by Dr C, Mr B's blood pressure dropped again. At 8.40am nursing staff contacted Dr D, who ordered a reduction in the epidural rate and further intravenous fluids. Dr D was contacted again at 10am as Mr B's blood pressure was still low. By 11.15am Mr B's blood tests had returned and both Dr D and Dr C were informed of the results, which showed that an infection was likely. Dr C ordered further antibiotics.

The decision to transfer Mr B to the public hospital was made after Dr D had seen Mr B again at 12.50pm and following consultation with Dr C. Dr D and Dr C agreed that although it was necessary to transfer Mr B to the public hospital, it was appropriate at that stage to manage Mr B conservatively and not to conduct further surgery.

I accept that Dr D's active role in Mr B's post-operative monitoring, as anaesthetist, was appropriate. I am left in some doubt whether Dr C's level of monitoring, given Dr D's involvement and the concern that Mr B's symptoms may have been related to the epidural, was reasonable. Dr C did not see Mr B until 7am the next day, but he had not been asked to attend earlier by either the nursing staff or Dr D. Both Dr C and Dr D appear to have been kept well informed by nursing staff about Mr B's condition post-operatively. Dr C was tied up in the operating theatre on the day of Mr B's deterioration (17 December) and it would have been difficult for him to see Mr B. He relied on Dr D to arrange Mr B's transfer to the public hospital, after their telephone discussion at 1.30pm.

Mrs A's allegation that had Dr C seen Mr B within 12 hours of his surgery, transfer would have been arranged sooner, does not appear to be sustainable. As discussed above, Mr B was closely and appropriately monitored. Both nursing staff and Dr D contacted Dr C to discuss their concerns about Mr B. There were a number of critical factors that impacted

on the decision to transfer Mr B to the public hospital at the time – his continuing low blood pressure, decreased urine output, blood test results showing evidence of infection, and his drop in pulse rate. These occurred over a period of hours and, in totality, indicated that Mr B's condition was deteriorating. Throughout this time, he was closely monitored. I am satisfied that transfer to the public hospital was made at the appropriate time and was not delayed by the fact that Dr C did not personally review Mr B.

On balance, although I have some concerns about Dr C's 'hands-off' approach, I am satisfied that Mr B was appropriately monitored while at the second private hospital, and that Dr C did not breach the Code in relation to this matter.

Opinion: Breach – Dr C

Right 4(1)

Standard of surgery
Mrs A alleged that Dr C did not carry out her husband's bowel surgery properly.

Dr C stated that Mr B's operation resulted in a "tension-free, well perfused anastomosis with two intact donuts". The pathologist who performed Mr B's post-mortem, advised the Coroner that the staple sites seemed to have been correctly placed, but had come apart subsequently as a result of traction (resulting in the hole). The Coroner noted that failure or leakage of an anastomosis is a known complication.

I have received no information to indicate that the surgery performed by Dr C was inadequate or inappropriate, except in one key area, and that is Dr C's checking of the anastomosis. Having joined the anastomosis using staples, Dr C then checked the integrity of the anastomosis digitally. There are a number of ways to check that an anastomosis has been effectively formed and that there are no leaks. Digital examination is one method, but I am advised that it is not the most effective method and that use of a sigmoidoscope is more reliable. My advisor stated:

> "There is no record in the notes that the anastomosis was adequately checked using the sigmoidoscope and inflating the lower bowel while the pelvis was filled with some form of fluid or visually inspecting it with the sigmoidoscope or from above at the operation site at the time of operation and I believe this is critical."

Although there may be occasions where digital examination may be sufficient, it was not the case with Mr B. My advisor noted:

> "… [T]his particular anastomosis is one that is always fraught with the risk of breakdown, particularly in the modern age where mesorectal excision is undertaken and the blood supply to the distal rectum may be marginalised."

Dr C did not check the anastomosis with a sigmoidoscope. Dr D advised the Coroner that he did not see Dr C visually check the anastomosis with a sigmoidoscope.

Dr C stated that the low position of the anastomosis made it more difficult to check the site. That being the case, I consider that it was all the more important to ensure that the anastomosis was properly checked. Leakage from a newly formed anastomosis is a recognised complication of bowel surgery. Dr C also informed me that it was not necessary for him to have used a sigmoidoscope, and that he would have felt an 18mm hole (which was subsequently revealed at autopsy) by digital palpation. However, Dr C would not have detected a smaller defect. Although we do not know exactly when the defect occurred, it is possible that it started as a small defect that could have been detected by examination with a sigmoidoscope after the operation. It is no answer for Dr C to say that, *if* the defect was not present during the operation, it would not have been detected by other methods, such as submerged sigmoidoscopic insufflation.

The independent general surgeon who advised ACC, noted that "it is the responsibility of the operating surgeon to confirm the integrity of the anastomosis before closing the abdomen". The colorectal surgeon who advised Mrs A, commented that "there was an early leak in the bowel … [t]his technical failure should have been picked up at the operation". The surgical advisors to the second private hospital's Audit Review Committee, considered that taking steps to visualise the integrity of the anastomosis is "a required part of the accepted technique".

In my opinion, in failing to take adequate steps to check the integrity of the anastomosis, Dr C did not provide surgical services to Mr B with reasonable care and skill and breached Right 4(1) of the Code.

Management of anastomotic leak
Mrs A alleged that Dr C did not appropriately manage her husband's sepsis. In particular, Dr C did not operate on 17 December to repair the leak in Mr B's anastomosis.

Dr C advised me that, in hindsight (knowing that Mr B's leak was large, not small) he wished he had managed Mr B differently. However, he maintained that his decision to manage Mr B's symptoms conservatively was reasonable in the circumstances, given that he believed it was a small leak that could be managed through drainage and antibiotic therapy.

My advisor commented:

> "… [Mr B] had a covering ileostomy to divert the faecal stream and if it had been a small leak that remained contained, it may have subsequently healed with the simple conservative measures put in place. Unfortunately, with hindsight we know it was a large leak, 18 mm in diameter at post mortem and although it must have been moderately contained in the sense most of the drainage came out via the drains his response to the septic complications caused by this [was] overwhelming."

Dr D discussed Mr B's management with Dr C at 1.30pm on 17 December, prior to Mr B's transfer to ICU. However, Dr C believed that surgery at that time could well have placed

Mr B at greater risk, by spreading any infection present into his abdominal cavity. Intensivist Dr E telephoned Dr C and raised the possibility of further surgery after his assessment of Mr B in ICU, but Dr C considered that surgery was inappropriate at that time and maintained his decision not to operate. This discussion is confirmed in Dr E's entry in Mr B's notes.

Dr C did not see Mr B following his transfer to ICU in the early afternoon of 17 December until the morning of 18 December. Dr C spoke to Dr E by telephone soon after Mr B's arrival in ICU and again later in the evening, and it appears also he had a telephone conversation with the on-call surgical registrar, although no record of this discussion was kept.

Dr C informed me that he was not the surgeon on call at the public hospital. He was busy with his own operating schedule within the hospital. The public hospital advised me that there was an "unwritten understanding" that a private patient transferring to the public system remained the responsibility of the private surgeon if they had operating rights at the hospital. Dr C had clinical privileges at the public hospital. There is no record of Dr C transferring responsibility for Mr B's care to the on-call consultant surgeon or advising staff that he was unavailable to continue his care. There seems to have been no question in the minds of all the staff involved in Mr B's care that Dr C was the responsible surgeon. When Dr E informed Dr C about Mr B's deterioration, Dr C gave advice on his further management. I am satisfied that Dr C was in fact the responsible surgeon for Mr B at the public hospital.

Mr B's immediate post-operative medical monitoring at the second private hospital was undertaken mainly by Dr D, the anaesthetist. Dr D made Dr C aware of Mr B's serious and deteriorating condition at 1.30pm on 17 December, and they discussed whether further surgery was necessary. Following Mr B's transfer to ICU, Dr C spoke to Dr E, who specifically asked whether further surgery was indicated. Dr C made a decision not to re-operate, even though he had not personally reviewed his patient, despite two experienced colleagues discussing with him the seriousness of Mr B's condition. Both of those clinicians had seen Mr B and, in the case of Dr D, had observed first-hand the deterioration in Mr B's condition.

I note the following comment of my expert advisor:

> "I believe, however, it would have been appropriate for [Dr C] to see [Mr B] in the Intensive Care Ward at [the public hospital] on 17 December because at that time clinical examination may have altered his management options."

The failure of Dr C to review Mr B in person was a significant failure. It underpinned his critical decision not to operate. I note my advisor's comments that "the directing ileostomy will sometimes give the surgeon a false sense of security" and that, with hindsight, surgery (a complete diversion of the lower bowel) may have saved Mr B's life.

Mr B was denied that opportunity because of Dr C's decision – made without having personally reviewed his patient – to maintain conservative treatment. As noted by the general surgeon who advised ACC, "the balance of surgical opinion would support resuscitation and re-operation particularly if there was a question over the adequacy of the bowel preparation", as in Mr B's case. "Once the decision to manage conservatively was made, the chances of surviving a re-operation diminished with time."

The advisor who advised Mrs A, considered that Dr C made "a severe error of judgement" in speculating how much further faecal contamination of the peritoneal cavity would occur as a result of the anastomotic leak; to assume that his drains were adequate to deal with the leak was an "extremely dangerous assumption" in light of the considerable amount of faecal material coming through the Redivac drain.

Mrs A's advisor summarised his views:

> "In conclusion, the window of opportunity in retrieving complications such as occurred in [Mr B's] case in relation to sepsis is very small, and quick decisive action is needed by a surgeon to deal with an anastomotic leak. In my opinion, [Dr C] did not address the severity of [Mr B's] condition. He should have recognised that his symptoms were sufficiently serious to indicate a further laparotomy was essential. This was not a situation where the infection would be adequately addressed by any conservative treatment."

I note that the Coroner stated that "[i]t is not for this Inquest to second guess a surgeon". I am also conscious of the risk of the benefit of hindsight. However, unlike the Coroner, I am required to make a finding about whether Dr C exercised reasonable care and skill in the circumstances at the time. I have carefully considered all the expert evidence available to me. Each of the advisors casts doubt on the adequacy of Dr C's management of the anastomotic leak. I have formed a clear view that Dr C did not meet the standard reasonably expected of a surgeon in such circumstances. (Although it is not determinative of my decision, I believe that Dr C's mismanagement may well have cost Mr B his life.) Accordingly, in my opinion Dr C breached Right 4(1) of the Code.

Opinion: No breach – The Second Private Hospital

Right 4(1)

Dr C was an independent surgeon who had clinical privileges at the second private hospital. The second private hospital advised me that it is the responsibility of the surgeon to arrange for the booking of patients for admission to its hospitals and that although it provides "… all the usual hotel and nursing services, theatre, equipment and staff etc … the patient remains under the medical management of the visiting practitioner, who is entirely independent of [the second private hospital]".

Visiting practitioners, such as Dr C, apply to be registered with the second private hospital. Registration includes submitting written references and naming three referees. Registration is renewed on an annual basis and can be suspended or terminated. Visiting practitioners are required to follow the policies and procedures of the second private hospital.

In my opinion, although a private hospital does not employ the surgical and other specialist consultants who treat private patients at its facilities, the hospital does have a legal responsibility to ensure that its consultants are competent to practise (within their scope of practice at the facility) and that appropriate policies and procedures are in place and followed by the consultants (and by nursing staff).

For present purposes, it is not necessary to determine whether such legal responsibility arises as directly or vicariously (on the basis that consultants are the ostensible agents of the hospital, since they are 'held out' to the public as authorised to operate at the facility). Having considered the submissions of the second private hospital, I am satisfied that it had taken adequate steps to ensure that Dr C was competent to practise and that appropriate policies and procedures were in place.

In these circumstances, the second private hospital fulfilled its legal responsibility and did not breach Right 4(1) of the Code.

Opinion: No breach – The District Health Board

Right 4(1)

In addition to any direct liability for a breach of the Code, employers are vicariously liable under section 72(2) of the Health and Disability Commissioner Act 1994 for ensuring that employees comply with the Code of Health and Disability Services Consumers' Rights. Under section 72(5) it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the employee from doing or omitting to do the thing that breached the Code.

Dr C was employed at the public hospital by its management (now a District Health Board). Any failure on the part of Dr C, including any breach of the Code, while he was acting as an employee at the public hospital, raises issues as to the liability of the District Health Board.

Although Dr C was not the on-call consultant surgeon at the public hospital when Mr B was transferred to ICU, he was recorded on Mr B's patient label as the surgeon under whom Mr B was to receive care. Dr C did not take any steps to formally transfer Mr B to the care of the on-call consultant surgeon or the surgical team. Accordingly, Dr C remained the responsible surgeon.

The public hospital confirmed that when a private patient transfers to the public hospital, the patient remains the responsibility of the private surgeon if that surgeon has clinical privileges at the hospital (as did Dr C), unless and until care is transferred to the on-call consultant surgeon. No such transfer occurred in Mr B's case.

I have found that Dr C breached Right 4(1) of the Code by his management of Mr B's anastomotic leak, which included a failure to review his patient in person at the public hospital ICU. However, I have reviewed the history of steps taken by the public hospital to address clinical competence concerns in relation to Dr C, from June 1994 onwards. I am satisfied that the District Health Board acted responsibly and took active steps to identify and respond to concerns about Dr C's colorectal surgery. In these circumstances, the District Health Board fulfilled its legal responsibility as employer and is not vicariously liable for Dr C's breach of Right 4(1) of the Code.

Other comment

Co-ordination of care

Eating prior to surgery
Mr B received conflicting information from nursing staff and from Dr C about what he should eat after the colonoscopy and prior to his bowel surgery. There was a clear lack of communication between Dr C, who had ordered the colonoscopy and was to perform the bowel surgery, and nursing staff at the first private hospital, where the colonoscopy was performed.

In my opinion, it was the responsibility of Dr C as surgeon to ensure that nursing staff were properly briefed about what Mr B could eat after his colonoscopy. I have received no evidence that Dr C fulfilled this responsibility.

The public hospital
Continuity of care for hospital patients, with multiple staff involved and changing shifts of nurses and doctors, makes it imperative that there is effective communication, co-operation and co-ordination at all levels. My advisor has referred to the need to work as a team.

The critical point in Mr B's case was the time of his transfer from a private to a public hospital. Where there is such a transfer, the surgeon may or may not be the admitting surgeon in the public hospital. There is a potential for a breakdown in the co-ordination of care. Dr C was the surgeon under whom Mr B was admitted to the public hospital. It is possible that review by another surgeon at the public hospital may have persuaded Dr C to reverse his decision not to operate or, at least, have prompted him to review Mr B in person. However, there appears to have been a reluctance to consult with other clinicians about 'Dr C's patient'.

This is a matter that my advisor commented upon. Dr Robertson noted:

> "I also feel it is appropriate that the surgical service, wherever possible, should work as a team and not rely wholly on the single surgeon to make all of the decisions although ultimately the surgeon-in-charge will have to take the majority of the responsibility and there may be a place for some better co-ordination at [the public hospital] in this respect."

It is possible that the medical staff in ICU did not want to "second guess" the decisions of Dr C. Perhaps they were mindful of the fact that Dr C had initially operated on Mr B as a private patient. Yet from the time of his admission to ICU, Mr B was completely reliant on the public hospital staff to care for him appropriately and take all necessary steps to save his life. Co-ordination of care, and consultation between his admitting surgeon and other experienced clinicians, was absolutely critical.

Dr C did not see his patient on his transfer to ICU, and did not arrange for another surgeon to see Mr B. Staff in ICU did not take steps to obtain further surgical input into the decision not to operate on Mr B. I am left with the impression that Mr B fell between the cracks of the private and public systems.

I note that the District Health Board has advised me that, in light of this incident, a written policy is being developed at the public hospital to clarify the co-ordination of care in private/public interface situations.

Duty of candour

Following the death of a patient because of complications of surgery, a surgeon owes a bereaved family a duty of candour. The surgeon should offer to meet the family in person, and should provide an explanation and a commitment to provide further information as soon as it becomes available. Although an apology may not be appropriate (because the contributing factors may not yet be understood), empathy and sincere condolences for the family's loss should be forthcoming.

I have read the card that Dr C wrote Mrs A and her family in the days following Mr B's death. In my opinion Dr C's specific mention of Mr B's "severe coronary artery disease and very enlarged heart" as "severely reduc[ing] his ability to cope with infection present" was inappropriate and misguided, and could be interpreted as an attempt to focus the family's

attention on causal factors other than Dr C's own role as surgeon. To make such statements in a bereavement card shortly after Mr B's death was insensitive in the extreme.

Actions

- A copy of this opinion will be sent to the Medical Council of New Zealand, the Accident Compensation Corporation, the Director-General of Health, the Chair of the Board of the first private hospital and the Chair of the New Zealand Committee of the Royal Australasian College of Surgeons.

- An anonymised copy of the opinion will be sent to the Royal Australasian College of Surgeons and the New Zealand Private Hospitals Association, and published on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

- I will refer this case to the Director of Proceedings to determine whether any further action should be taken.

Addendum

The Director of Proceedings laid before the Medical Practitioners Disciplinary Tribunal a charge alleging inadequate bowel preparation, failure to adequately assess postoperatively, failure to appropriately respond to clinical presentation (by failing to re-operate), failure to consult with and/or transfer care to a specialist surgeon, and inadequate notes. The Tribunal found Dr C guilty of professional misconduct in relation to the second, fourth and fifth particulars of the charge, and imposed a fine of $12,500 plus $37,825.94 costs. The Tribunal also ordered publication of the orders in the *New Zealand Medical Journal*. Decision No 247/03/99D may be viewed at www.mpdt.org.nz.