Failure to provide full information; postoperative bleeding and delay in re-operating (12HDC01488, 10 March 2015)

General surgeon ~ District health board ~ Cholecystectomy ~ Postoperative bleeding ~ Death ~ Surgery ~ Informed consent ~ Delay ~ Rights 4(1), 4(4), 6(1)

An elderly man who had significant medical co-morbidities was reviewed by a general surgeon in the surgical outpatient clinic of a public hospital.

The surgeon explained to the man that he required a cholecystectomy (removal of his gallbladder) and a hernia repair operation, and that because of certain previous surgery, he would need an open operation, which would be more significant than a laparoscopic approach. There is no record of any information regarding possible alternative treatment options having been provided. At the time, the surgeon was subject to voluntary restrictions on his surgical practice, which the man was also not informed of.

Following the operation the man's condition was initially unremarkable, but his blood pressure started to drop about an hour after surgery. Over an hour later, the surgeon arranged an ultrasound scan, which showed internal bleeding. The surgeon decided to re-operate to control the bleeding. During surgery, the wall of the portal vein was damaged, causing further blood loss. Despite extensive resuscitation efforts, sadly, the man died.

The post-mortem found that the cause of death was hypovolaemic shock secondary to ongoing blood loss. The source of blood loss was damage to the left hepatic artery, which appeared to have been damaged during the initial cholecystectomy, and from damage to the portal vein, which occurred during the second surgery.

The information about the voluntary restrictions on the surgeon's practice may have influenced the man's decision to undergo the surgery at that time and place, and to have had it performed by that surgeon. By not providing that information, it was held that the surgeon breached Right 6(1). The surgeon's decision to proceed with a full cholecystectomy meant he did not provide services to the man with reasonable care and skill, breaching Right 4(1).

Following the surgery, the man's prolonged hypotension and marked drop in haemoglobin was consistent with significant postoperative bleeding. The delay before re-operating placed him at risk of harm. Accordingly, the surgeon was found to have breached Right 4(4). During the second operation, the surgeon made a serious error when he damaged the portal vein, breaching Right 4(1). The surgeon was referred to the Director of Proceedings, who decided not to issue a proceeding.

The DHB was held responsible for the lack of critical thinking and proactivity of its staff when the man deteriorated postoperatively. The DHB therefore failed to provide services to the man in a manner that minimised the risk of harm and, accordingly, breached Right 4(4).