Gynaecologist, Dr B

A Private Hospital

A Report by the

Health and Disability Commissioner

Case 09HDC00816

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Complaint

On 29 January 2009 the Health and Disability Commissioner (HDC) received a complaint from Mrs A about the services provided by gynaecologist Dr B. The following issues were identified for investigation:

- *Whether gynaecologist Dr B provided Mrs A with reasonable treatment and care between 24 November and 4 December 2008.*
- *Whether Dr B provided adequate information to Mrs A about laparoscopic hysterectomy and postoperative care in November and December 2008.*
- *Whether the private hospital provided Mrs A with reasonable treatment and care between 24 and 30 November 2008.*

An investigation was commenced on 13 February 2009.

Parties involved

Mrs A	Consumer/Complainant
Dr B	Provider/Gynaecologist
A private hospital	Provider/Private Hospital

Information reviewed

Information was provided by:

- Mrs A
- Dr B
- Registered nurse, Mrs C
- Ms D, Hospital Manager, the private hospital

Mrs A's private and public hospital clinical records were obtained and reviewed. ACC provided a copy of Mrs A's treatment injury claim documents. Independent expert advice was obtained from gynaecologist Dr Michael East, who specialises in laparoscopic surgery, and is attached as **Appendix A**.

Information gathered during investigation

Overview

In April 2008, Mrs A, aged 54 years, consulted gynaecologist Dr B at her private practice to discuss treatment options for her prolonged heavy menstruation. After investigations and consideration of various options, Mrs A decided to have a laparoscopic hysterectomy. Dr B performed the hysterectomy on Mrs A on 24 November 2008 at a private hospital. Dr B advised Mrs A postoperatively that the surgery was complicated by abdominal adhesions. Following the surgery Mrs A experienced pain and distension of her abdomen. Dr B suspected that Mrs A had a paralytic ileus that would settle in time. She did not undertake any further investigation of the symptoms that Mrs A continued to experience. On the fourth day post-operation, Dr B examined Mrs A noting her distended abdomen, and the lack of bowel sounds. Mrs A was recommenced on IV fluids and nil per mouth.

Mrs A was discharged on Sunday 30 November, on a light diet and with a prescription for four-hourly Panadol for pain and daily Losec for nausea. Her abdomen was still distended and she was nauseated and vomiting. On Thursday 4 December, Mrs A consulted Dr B with continued nausea and vomiting. Dr B ordered blood tests and an abdominal X-ray, and on seeing the results urgently admitted Mrs A to a public hospital. Mrs A had surgery at the public hospital on 5 December for repair of a perforated bowel and was transferred to another public hospital on 14 December for repair of a perforation of her left ureter.

Key events

Initial consultation — 7 April 2007
On 7 April 2007, Mrs A, who lived in another region, consulted gynaecologist Dr B. Mrs A was troubled by prolonged vaginal bleeding. Dr B took a cervical smear and arranged for Mrs A to have an ultrasound scan. They discussed the options available for management of the problem, including a Mirena intrauterine device, endometrial ablation[1] or hysterectomy.[2] No decision was made at the initial consultation, although Mrs A expressed interest in endometrial ablation.

17 April consultation
On 17 April, Mrs A returned to see Dr B to discuss the results of the cervical smear and ultrasound. The smear was mildly abnormal with some atypical cells. The ultrasound showed no fibroids or polyps. However, Mrs A had a bicornuate uterus,[3] and a condition of the lining of the uterus, which indicated that she would not be a good candidate for endometrial ablation. Dr B noted that Mrs A had had three children, born by Caesarean section.

[1] Removal of the lining of the uterus.
[2] At this consultation or a subsequent consultation, Dr B provided Mrs A with a copy of the standard hysterectomy information sheet provided by the Royal Australasian and New Zealand College of Obstetricians and Gynaecologists.
[3] The bicornuate or double uterus is a rare malformation due to developmental error, and in some cases there is complete duplication of the uterus, cervix and vagina.

Dr B suggested trying a Mirena IUD, but Mrs A stated that she would prefer to go straight to hysterectomy. However, she had arranged to travel overseas in June for a month. Dr B advised that if she had surgery in May she would still be recovering while on her trip, and it is common in the first few weeks of having a Mirena fitted to have minor bleeding. Dr B suggested a temporary solution of a high dose of progesterone. Dr B gave Mrs A a prescription for the progesterone, norethisterone, and Cyclokapron, in case she had a heavy bleed while away. The plan was to review her when she returned from holiday.

August–October — further consultations
Mrs A saw Dr B on 6 August and informed her that the norethisterone had not been effective in controlling the bleeding. Treatment options were once again discussed. Dr B recommended a laparoscopically assisted vaginal hysterectomy (LAVH), as this is minimally invasive, but allows good views of the uterus and ovaries, management of adhesions, and the ability to dissect the bladder from the uterus while directly visualising it. Dr B advised HDC that she was aware that Mrs A had an increased risk of bladder perforation because of her three Caesarean sections, which would have caused some scar tissue around the bladder. She had also had surgery to repair an incisional hernia, which would contraindicate an abdominal hysterectomy.

Dr B booked Mrs A to have the surgery on 13 August 2008 at the private hospital. However, on 7 August Mrs A telephoned Dr B's rooms and asked for the surgery to be rescheduled for 24 October. Mrs A continued to take norethisterone to control her heavy bleeding.

On 4 September, Mrs A telephoned Dr B's rooms to postpone her surgery. She was undecided about surgery as the norethisterone was controlling her symptoms. She said that she would consider her options and contact Dr B again when she had decided whether to go ahead with surgery.

On 8 September, Mrs A telephoned Dr B's rooms and spoke with the practice nurse and asked to be booked for a hysterectomy for 24 November 2008. Dr B asked Mrs A to make an appointment for a review, because she had not seen her for several months, and Mrs A needed to sign a fresh surgical consent form.

Dr B saw Mrs A on 15 October and they discussed the effects of the norethisterone and details of an LAVH. Mrs A signed a new consent form. She was booked for surgery on 24 November.

Admission — 24 November
Mrs A was admitted to the private hospital on the morning of 24 November. Shortly after her admission, Dr B visited Mrs A on the ward to discuss her surgery that afternoon. Dr B told Mrs A that if any difficulties arose that could not be managed laparoscopically, she might have to perform an open procedure. Dr B told Mrs A that she would return to the ward with a catheter in her bladder, a wound drain and an intravenous drip.

Surgery — 24 November
Dr B advised HDC that the only notable findings during the surgery were some adhesions which involved the small bowel and omentum.[4] Two adhesions were released by dissecting a small amount of the peritoneum from the anterior abdominal wall. There were other similar adhesions that did not require dissection because they did not obscure Dr B's view of the ovaries or uterus, and there were no adhesions between these organs and the bowel. Dr B advised that the remainder of the surgery was straightforward, and at the end of the surgery the urine was running clear indicating that there had been no injury to the bladder or ureters.

Dr B spoke to Mrs A in Recovery and told her that the surgery appeared to have gone well.

Day 1 post surgery — 25 November
Dr B saw Mrs A on the morning of 25 November and explained the operation and her findings. Dr B checked the level of the Redivac draining Mrs A's wound (130mls) and, as the wound was satisfactory, she ordered that the drain could be removed. Mrs A's observations were normal and she was tolerating oral fluids. The ward nurse reported that Mrs A had audible bowel sounds. Dr B told the nursing staff to remove Mrs A's urinary catheter and start to mobilise her, and said that she could have a light diet.

Mrs A recalls that Dr B told her that the operation "had been 'a bit more tricky' as the bowel was 'hung up like curtains' and she had to sort that out before she could get in properly".

Mrs A's drain was removed at 11.30am, and the wound checked and found to be clean and dry. Mrs A went to have a shower, but had to go back to bed because she was feeling faint. At 3pm, Mrs A walked to the bathroom for a wash. The nursing notes record that Mrs A was complaining of feeling "washed out". She was given Zofran to control her nausea, and was seen by the physiotherapist for postoperative exercises.

Mrs A was seen at 3.45pm by the anaesthetist, who noted that she was suffering "wind pain" and ordered a stronger analgesic, Oxynorm, to replace the tramadol that had been charted, and instructed that she be given antiemetics as required to control her nausea.

At 8pm the nursing staff offered Mrs A ginger ale and green tea to help her nausea, and this appeared to relieve her symptoms. She was given Panadol for pain relief.

Mrs A did not settle and at midnight the night staff suggested she walk to try to pass flatus. She was not nauseated, and settled with Panadol. Her recordings of temperature, pulse and blood pressure were stable overnight.

[4] A fold in the peritoneum, a delicate serous membrane that lines the abdominal and pelvic cavities and also covers the organs contained in them.

Day 2 post surgery — 26 November
At 8.30am, the nursing staff recorded that Mrs A was nauseated and had vomited, and had not passed flatus. She was given Mylanta, which settled her nausea. Her recordings and wound were satisfactory.

Dr B saw Mrs A that morning and found her observations to be normal. She examined Mrs A and found her abdomen soft and non-tender, and advised her not to eat until hungry. Dr B advised HDC that she suspected that Mrs A had developed a paralytic ileus[5] because of the extra handling of her bowel to free the adhesions.

At 2pm, Mrs A was still complaining of a feeling of indigestion and nausea, and was given further Mylanta. At 10pm she was complaining of upper back and abdominal pain, but was mobilising well and had no further nausea or vomiting.

Overnight, Mrs A complained of indigestion and was given Mylanta. The nursing staff noted that she had still not passed flatus, but her recordings and wound were satisfactory.

Day 3 post surgery — 27 November
Dr B examined Mrs A at 3pm on 27 November, noting that she had not passed flatus and was experiencing a sensation of indigestion. Mrs A reported that her abdomen was "gurgling" but she had no pain. Dr B noted that Mrs A had some right upper back and shoulder pain, but did not have a temperature. Her abdomen was distended, but soft and non-tender, with only quiet bowel sounds. Dr B recalls:

> "My impression was that she had an ileus that was not settling. At that stage, I advised she should be nil per mouth until flatus was passed, but she was allowed sips of water to moisten her mouth. Intravenous fluids were charted to keep her well hydrated. I was hopeful that the ileus would settle with conservative management; as well the other observations were normal. There was no indication of bowel perforation."

The nursing notes for 10pm record that Mrs A had passed flatus a number of times, and settled with Panadol.

Usually following laparoscopic hysterectomy a patient steadily recovers and is discharged after two days. Dr B considered arranging an abdominal X-ray and obtaining a surgical opinion but advised HDC that a plain abdominal X-ray would almost certainly show signs of a paralytic ileus or small bowel obstruction without the usual symptoms of a bowel obstruction, so the investigation would not have been particularly useful. She would still have treated Mrs A conservatively in the meantime.

Dr B never considered a renal ultrasound as Mrs A's symptoms were not indicative of renal colic. An ultrasound may or may not have shown ureteric dilatation and would

[5] Paralysis and dilatation of the intestine, characterised by distension of the abdomen and absence of flatus.

not have revealed the leak in her left ureter — an intravenous urogram would have been required for this.

Day 4 post surgery — 28 November
At 5.30am on 28 November the night nurse recorded that Mrs A's abdomen was distended but soft to touch, and she had passed only a very small amount of flatus.

Dr B reviewed Mrs A later that morning, noting the nursing observations. Dr B recalls, "At this stage I was still hopeful that the ileus was settling and left instructions she was to be kept on clear fluids only, until her bowel opened or she passed a lot of flatus."

At 2pm the nurses noted that Mrs A had showered independently, and was up frequently for walks. She was given the glycerol suppository Dr B ordered, but had only a very small bowel motion. Mrs A had no pain or nausea and her recordings were stable.

Later that afternoon Mrs A vomited 200mls, and she declined her evening meal. Her temperature was recorded as slightly elevated at 37.5°C. She had another very small bowel motion that evening.

Day 5 post surgery — 29 November
At 6am, the night nurse recorded that she gave Mrs A two glycerol suppositories with a good result. Mrs A reported feeling "much better". However, her abdomen remained distended, and she was still nauseated. Mrs A did not want any further intravenous fluids, so they were discontinued.

Dr B saw Mrs A at 1.15pm, noting the nursing observations. She checked Mrs A's wound and saw that there was an amount of serous ooze from the umbilical wound, but it was not inflamed or offensive. Dr B found that Mrs A's abdomen was still distended, with quiet bowel sounds, and she was tolerating small amounts of food and fluid. Dr B recalls:

> "[Mrs A] was quite keen to be discharged at this stage. … Although she had improved, I wanted further improvement before discharging her. So I persuaded her to stay. … If she had further bowel motions and was not nauseated or vomiting, I was hopeful she would be discharged the following day. If she had deteriorated further, I planned to seek an opinion from a General Surgeon or transfer her to [a public] Hospital."

The nursing note at 9pm records that Mrs A tried a small amount of mashed potato at dinner, but an hour later had a coughing fit and vomited. She was not nauseated and refused further intravenous fluids. Mrs A did not vomit any bile, but her abdomen was still distended. She was given a heat pack for the pain in her shoulder.

Mrs A was reassured by the staff that abdominal distension and nausea are common following an LAVH.

Discharge — 30 November
Dr B was on her way to the private hospital to see Mrs A when she was telephoned by the nurse assigned to Mrs A. The nurse reported that Mrs A was comfortable, had no vomiting or nausea, had had two large bowel motions, was feeling comfortable and wanted to go home. Dr B knew that the nurse was experienced and felt that her opinion about a patient could be trusted. Dr B decided that she did not need to see Mrs A and advised that she could go home.

Mrs A recalls being given no instructions on discharge, apart from being told to start a normal diet and take Panadol for pain relief. She decided not to travel home, but to stay in the city with her mother. Mrs A expected that when she was in a familiar environment her bowels would start working, she would start to mobilise and eat, and the pain in her back would improve.

The private hospital manager Ms D advised HDC that Mrs A was discharged with a prescription for Panadol and the anti-inflammatory Arcoxia. She was given two Patient Advice Sheets, which provided details for a patient being discharged on "Managing a fever at home following surgery" and "Managing your pain and discomfort at home".

1–3 December
On 1 December, Dr B's nurse, Mrs C, telephoned Mrs A at home,[6] recording that she was experiencing some pain in her upper back on inspiration, and feeling that she needed to pass "wind". Mrs A still had some indigestion. Mrs C reported this to Dr B, who prescribed Losec capsules to settle Mrs A's stomach.

Two days later, Mrs C again telephoned Mrs A, who reported that her pain had improved, and she was eating a light diet.

By 3 December Mrs A was still taking Panadol every four hours and Losec every morning. That evening she tried to eat a small portion of fish in white sauce, but immediately vomited.

4 December
On the morning of 4 December, Mrs A telephoned Dr B's rooms and told Mrs C that she was concerned about her condition and wished to see Dr B. Mrs C told Mrs A to come to the rooms without delay.

When Mrs A arrived, Dr B took a history and examined her. Mrs A's temperature, pulse and blood pressure were normal. She reported that she had been having three to four loose bowel motions per day, and tolerating small amounts of food until the previous night. Dr B noted that Mrs A did not look well and her abdomen was soft and non-tender, but more distended than it had been in hospital. However, her wounds did not look infected. Dr B ordered a chest X-ray and a series of abdominal X-rays, and some blood tests.

[6] Dr B advised HDC that it is her practice to have her nurse contact patients following discharge to check that they are generally well and their pain is controlled.

The chest X-ray showed that Mrs A had a pleural effusion and some collapse of the right lung. The bowel had the appearance of a small bowel obstruction, but there were no signs that the bowel had perforated. However, Mrs A's blood and liver tests showed an infection. Dr B arranged for Mrs A to be admitted to the gynaecology department of the public hospital.

The public hospital — 4–5 December
Mrs A was admitted to the public hospital at 7.42pm on 4 December with a provisional diagnosis of pneumonia, pleural effusion,[7] and bowel obstruction. She was started on intravenous fluids, antibiotics, anticoagulants and pain relief, and oxygen, and booked for a CT scan for the following day.

The CT scan on 5 December showed a collection of fluid and gas in the abdomen and a section of dilated small bowel, indicating a bowel obstruction. The radiologist recommended a further CT scan with oral contrast and spoke to the gynaecology and surgical registrars, but it was decided to take Mrs A to theatre for a laparotomy.[8]

Laparotomy — 5 December
The surgery was initially performed by a surgical registrar assisted by Dr B. When the registrar was attempting to free some adhesions, she perforated the small bowel, and called for assistance from a consultant surgeon. The report of the operation stated that a perforation was found high in the sigmoid colon, the small bowel was very dilated with multiple adhesions, and there was a collection of offensive-smelling pus in the left side of the pelvis around the sigmoid colon. It was presumed that Dr B had perforated the sigmoid colon during the laparoscopic hysterectomy. This section of the bowel was removed and a de-functioning colostomy formed. Two large drains were inserted and Mrs A was transferred to the Intensive Care Unit (ICU) from theatre for overnight observation and monitoring.

Postoperative care — 6–13 December
On 6 December, Dr B visited Mrs A in ICU and spoke to her and her husband, who was visiting. Dr B advised HDC: "I explained the operation and findings to her, and I was very apologetic, and felt terrible that she had ended up in this situation."

The following day Mrs A was transferred to the High Dependency Unit. Dr B again visited and apologised for the situation Mrs A found herself in.

On 8 December, Mrs A was progressing well and was transferred to a surgical ward. From 8 to 12 December Mrs A continued to improve. Dr B visited her most days and, when she was unable to do so, telephoned the ward to check on Mrs A's condition.

[7] Introduction of fluid or gas which separates the two coverings of the lungs, the visceral and parietal layers, and increases the volume of the pleural space.
[8] A surgical incision into the peritoneal cavity.

Diagnosis and repair of ureter perforation —13–14 December
On 13 December, Mrs A told the pain service team assessing her that she had back pain and she thought she might have a urinary tract infection. Her abdomen had been distended for two days and she had stopped passing flatus. Mrs A told Dr B that she had the same symptoms of fullness, indigestion and the unpleasant taste in her mouth she had had at the private hospital. Dr B had not previously been aware of the taste symptom.

During the course of the day, Mrs A's back pain increased. The clinicians considered that she might have sustained a ureteric injury, and she was taken for a CT scan. The scan showed that Mrs A had a dilated left ureter, and a further CT urogram was organised. This showed not only a dilated left ureter but that urine was leaking from the ureter near its junction with the bladder, and a pool of urine had collected in her pelvis. The general surgeons at the public hospital told Mrs A that the ureteric injury had occurred during the LAVH performed by Dr B.

On 14 December, the consultant surgeon arranged for Mrs A to be transferred to another public hospital to be reviewed by a urologist. The urologist operated that day and inserted a nephrostomy tube, which gave Mrs A instant relief from her back pain.

Mrs A was discharged back to the first public hospital on 15 December under the care of the general surgical team to await insertion of a ureteric stent.[9] She was finally discharged on 22 December 2008, and made a steady recovery. Dr B telephoned Mrs A intermittently to check on her progress.

Aftermath

Complaint to HDC
In her complaint to HDC (dated 27 January 2009), Mrs A stated that general surgeons had advised her that the only way her surgery could have been successfully completed was by a vertical abdominal incision. Mrs A stated that Dr B never discussed this option with her. However, if she had, she would have refused, as in all her previous surgery the surgeons had "exhibited great care — as much as with the operation itself as well as the end result, the evidence/scarring". As a result of her laparotomy, Mrs A has been left with a visible abdominal scar.

Mrs A is "disappointed and angry" that Dr B "didn't even bother to make sure" that she was fit for discharge, or come into the private hospital to provide her with after-care advice. Mrs A stated:

> "All the way through this experience, I have remained focussed — focussed on full recovery and to date this has enabled me to get on with life. However, the need to do something just brings the anger and frustration back — sleepless nights, inability to lie down comfortably, the constant need to change bags, the inability to wear my 'normal' clothes, the difficulty of being 'intimate' with my

[9] A tube placed inside a duct (in this case the ureter) to reopen it, or keep it open, or to aid healing if the duct has been repaired.

> husband etc — none of this needed to happen and will I be compensated for that? …
>
> I am angry that when I went into hospital for what should have been a straightforward procedure, I was fit and healthy. Today I am still recovering and will be for some time. I have to endure frequent kidney infections (two to date) as a result of the number of 'foreign objects' (tube into my kidney and the stent) and this is likely to continue until these are removed. ACC covers some of the resulting cost of visits to the doctor but there is no other compensation. Soon, hopefully, the line into my kidney will be removed, in a month or two the stent will be removed and eventually the large bowel will also be reinstated. All taking time, time in hospital, more recovery, more discomfort and worry. …
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> This act of 'medical misadventure' has turned my life, and that of my husband, upside down and it would seem that the person that caused the problem is fully isolated from the consequences of her action."

Dr B's response

Dr B advised HDC that she has spent considerable time considering Mrs A's case and how she might have done things better. She now doubts whether she perforated the bowel, as "later it was found that [Mrs A] had a ureteric injury … I think it is correct I caused an ureteric injury during the 24 November surgery." Dr B advised that the ureteric injury went undiagnosed because of the atypical presentation of symptoms, which suggested an ileus rather than ureteric injury.

Dr B stated:

> "There is no doubt that [Mrs A] had a terrible outcome from her hysterectomy. To have a laparotomy, with bowel resection and defunctioning colostomy is an awful outcome and then to be found to have a ureteric injury, eight days after the laparotomy, and required nephrostomy tube and ureteric stenting, is terrible. I have felt very distressed about this, and continue to be distressed about this. But I realise, however distressing is this to me, it is infinitely more distressing for [Mrs A]. I fully understand [Mrs A's] anger at the outcome. …
>
> Tragically, if I did cause a ureteric injury, it went undiagnosed, due to the atypical presentation of symptoms. A bowel injury would normally cause abdominal pain, with fever and peritonitis. … It is clear with the benefit of hindsight, that I was overly optimistic regarding [Mrs A's] recovery in the days following her hysterectomy. However, she did not progressively deteriorate, but had a variable course, appearing to get better. … I discharged [Mrs A] from [the private hospital] on 30th November in the belief that the ileus had settled. …
>
> [Mrs A] also has made a comment in her complaint that she did not know how she was supposed to feel after hysterectomy. I found when I examined closely the information sheet given to patients upon their discharge from the private hospital that [Mrs A's] symptoms were not listed as symptoms to be concerned about, and to notify the surgeon. I have therefore created a new information

> sheet for my patients upon discharge from hospital … I am supplying an electronic version of this to the private hospital, so they can use this information if they wish to."

The private hospital's response
The private hospital manager, Ms D, stated that when the private hospital was advised about Mrs A's complaint in February 2009, her case was classified as an Eventful Case and an internal investigation was commenced. Mrs A's case was reviewed by the Clinical Medical Committee in March 2009.

Dr B is, and was in November 2008, credentialled with the private hospital to perform general gynaecology, laparoscopy, incontinence and prolapse surgery. She is an independent specialist who can admit and treat patients at the hospital. Dr B is not an employee of the private hospital.

Opinion: Breach — Dr B

Postoperative care
Mrs A's first day after surgery proceeded normally. She had some nausea and pain, which is normal after surgery, and was given medication to relieve these symptoms.

Over the next two days, Mrs A continued to report "wind" pain and some distension of her abdomen. Dr B examined her each day, and on day 2, 27 November, suspected that Mrs A had a paralytic ileus. Dr B was aware that Mrs A had adhesions round her abdominal organs which needed to be dissected so that the surgery could proceed, and that this extra handling of the bowel might have caused a paralytic ileus.

On day 3, Dr B reviewed Mrs A, noting that her observations were normal, and that she had passed only a small amount of flatus and faeces. Her abdomen, although distended, was soft to touch. Dr B stated that she was "hopeful that the ileus was settling".

On day 4, Dr B again reviewed Mrs A, noting that she still had some distension and nausea, but was keen to be discharged. Dr B wanted Mrs A to improve further, for her nausea and vomiting to settle, and for her to have further bowel motions, before she was discharged. She persuaded Mrs A to remain in hospital for another day.

On day 5, Dr B was telephoned by one of the senior nurses at the private hospital to ask if Mrs A could be discharged. The nurse advised that Mrs A was comfortable, had had two large bowel motions, and no further vomiting and nausea, and wanted to go home. Dr B trusted the nurse's opinion, and decided not to proceed to the hospital to review Mrs A before her discharge. Mrs A was given a prescription for Panadol and the anti-inflammatory Arcoxia for pain, and two patient advice sheets relating to managing fever and pain and discomfort after discharge.

Mrs A decided to stay in the area for the immediate postoperative period rather than travel home. Dr B's nurse telephoned Mrs A on 1 and 3 December to check on her welfare. This is a routine service Dr B provides to all her post-surgery patients.

On 1 December, Mrs A reported some upper back pain on inspiration and a feeling that she needed to pass "wind". On 3 December, Mrs A reported to the nurse that her pain had improved and she was taking a light diet. However, when Mrs A vomited after her meal that evening, she decided she needed to speak to Dr B.

Mrs A telephoned Dr B's rooms on the morning of 4 December. Dr B was informed and asked to see Mrs A without delay. Dr B conducted a series of tests including chest and abdominal X-rays. The X-ray of Mrs A's bowel had the appearance of a small bowel obstruction. Dr B admitted Mrs A urgently to the public hospital.

A CT scan indicated a bowel obstruction and Mrs A underwent emergency surgery by a surgical registrar assisted by Dr B. A consultant surgeon was asked to advise and, on the presumption that the bowel had been perforated, recommended that a section of the sigmoid bowel be excised and a colostomy formed. Initially, Mrs A progressed well, but on 13 December she was complaining of back pain. An abdominal CT scan and CT urogram were performed and showed that Mrs A had sustained a ureteric injury. She was transferred to another public hospital for specialist surgery and treatment.

Independent expert gynaecologist Dr Michael East advised that most patients undergoing a laparoscopically assisted vaginal hysterectomy (LAVH) will be discharged home within two to three days. Abdominal distension is not an unusual complaint, nor is shoulder tip pain, but it is usually easily controlled with simple analgesia. Resumption of a light diet usually starts with breakfast on day one gradually increasing to a normal diet depending on the patient's appetite returning.

Dr East advised that the normal postoperative course is one of continual improvement up to the point of discharge. Anything other than this clinical course should alert the surgeon to the possibility of postoperative complications, and should lead the surgeon to start to search for a cause for the delay in recovery. A high index of suspicion is required to diagnose postoperative complications such as bleeding and injury to the bowel, bladder or ureter. Dr East advised that had Dr B ordered a plain abdominal X-ray to look for abnormal abdominal distension when she was considering the possibility of a paralytic ileus, it could have alerted her to a bowel obstruction. Dr East stated:

> "The surgeon must avoid falling into the trap of 'wishing the patient to be well', and thus in one's mind 'explaining away' the anomalies of a slow recovery."

In an earlier case in similar circumstances I noted that "it is an axiom of minimally invasive gynaecological surgery (such as laparoscopic surgery) that patients should make a rapid recovery"[10] and stated that when a previously well woman became

[10] Opinion 06HDC17645, p 32 (19 March 2008).

unwell postoperatively with nausea and vomiting and abdominal symptoms, this should have triggered a higher degree of suspicion and investigation.

Dr East advised that Mrs A's clinical signs were "soft", and it was more a matter of her not recovering at the right speed than being obviously unwell. Ultrasound assessment of the renal tracts may have been helpful in detecting a ureteric leak, but may not have detected the ureteric injury or altered the postoperative course. Dr East noted that the cause of Mrs A's ureteric injury is unclear, and that it may have developed some days after the operation. There were no signs of peritonitis or an acute abdomen.[11] Despite these factors, Dr B should have organised an abdominal X-ray and a renal tract ultrasound while Mrs A was in the private hospital. Dr East advised that had such investigations been performed, and found to be within normal limits, the standard of Dr B's postoperative management would have been without reproach.

Conclusion
Guided by Dr East's advice, I conclude that Dr B should have recognised that Mrs A's recovery was not following the expected pattern. Because she did not adequately investigate the delay in Mrs A's recovery, in my opinion, Dr B breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights.[12]

Opinion: No Breach — Dr B

Preoperative information
Mrs A first saw Dr B on 7 April 2007 to discuss treatment options for heavy menstrual bleeding. Dr B outlined the possible treatment options of a Mirena intrauterine device, endometrial ablation and hysterectomy, and took a cervical smear and arranged for Mrs A to have an ultrasound scan. Mrs A returned to see Dr B 10 days later to get the results of her scan and smear. Dr B advised Mrs A that she was not a suitable candidate for ablation because she had two precluding conditions. They had further discussion about treatment options, with Dr B recommending a Mirena IUD. However, Mrs A was due to leave for a month's travel overseas, so Dr B suggested that she have a prescription for a progesterone medication, norethisterone, to control the bleeding in the meantime. The plan was that Dr B review Mrs A on her return from holiday.

Dr B next saw Mrs A on 6 August. Treatment options were again discussed, and as the progesterone had not been effective in controlling the bleeding, Dr B recommended an LAVH. Dr B had given Mrs A a hysterectomy information leaflet. Dr B advised Mrs A that an abdominal hysterectomy was not advised in her case, because of the incisional hernia repair. Dr B also told Mrs A that the three Caesarean

[11] An abnormal condition characterised by the acute onset of severe pain within the abdominal cavity.
[12] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."

sections she had had would have caused scarring around the bladder and could be a risk during surgery.

Mrs A agreed to the LAVH and was booked into the private hospital for surgery on 13 August. The surgery was twice postponed, and Dr B saw Mrs A again on 15 October, discussed the effects of the norethisterone, and further discussed LAVH. Mrs A signed a new consent form for LAVH and was booked for surgery on 24 November.

Dr East advised that Dr B gave Mrs A adequate information about the options for managing her symptoms. The advantages and shortcomings were each explained. It was suggested that because of her bicornuate uterus, a Mirena device might be less likely to be effective, but it was appropriately recommended to Mrs A as being reasonably low risk, with the option of proceeding to hysterectomy if the treatment proved ineffective. Dr East noted that there was a total of four preoperative consultations prior to the surgery. At the final consultation on 15 October 2008, Dr B provided Mrs A with the details of LAVH surgery.

Dr B anticipated that Mrs A's surgery could be complicated by adhesions caused by her previous surgery and told Mrs A that there was a risk that there could be scar tissue round her bladder. On the day of surgery, Dr B told Mrs A that if any difficulties arose during the surgery, she might have to proceed to an open procedure. However, there is no evidence that Dr B specifically told Mrs A that, in the event of an open operation (ie, the laparotomy that eventually proved necessary) she would be left with a visible scar. Dr East considered that this fact "would be obvious" and did not need to be explicitly stated.

I accept Dr East's advice that Dr B provided Mrs A with adequate discussion regarding management options, both surgical and non-surgical, and appropriately discussed the possible complications of surgery. However, in my view a prospective surgical patient in Mrs A's circumstances (ie, a fit woman who enjoyed outdoor activities, including swimming, and took care about her physical appearance) should be told explicitly by her surgeon about the likelihood and nature of a scar.[13] It is information that a reasonable woman in her situation would expect to be told. Mrs A was not given this information. Nevertheless, I consider that overall Dr B provided adequate preoperative information to Mrs A, apart from the information about a possible scar.

Standard of surgery

Dr East advised that the time Dr B took to perform the LAVH on Mrs A, approximately 90 minutes, was well within the timeframe for a skilled, experienced surgeon, especially considering the adhesions that had to be divided at the start of the surgery. Dr East stated:

> "I can determine nothing from the hospital notes to suggest that the surgery was not conducted in a professional and competent manner, thus complying with appropriate professional standards."

[13] Right 6(1) of the Code states: "Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive …"

Dr East advised that injury to the bowel during surgery can occur during a number of procedures during surgery: when gas is being introduced into the peritoneal cavity, or during the insertion of the laparoscopic trochar, dissection, or the thermal sealing of vessels. The risk of injury is directly proportional to the experience of the operator, but it is generally accepted that the overall risk of bowel injury during laparoscopic procedures is around 0.1%. Dr East stated that, despite histological examination of the excised portion of Mrs A's bowel, there is no evidence that a direct bowel injury occurred. The decision of the surgical team on 4 December to remove the bowel is not irrefutable evidence of a bowel perforation. Dr East advised that the subacute peritonitis that Mrs A had would have made it very difficult to be certain of a perforation.

Dr East also advised that the incidence of ureteric injury is as high as 1% during the first 100 LAVH procedures undertaken by a surgeon, with a reduction down to 0.5% or less. In this case, the exact cause of the ureteric injury is not clear. Some injuries, such as lateral thermal spread caused by electrocautery, can cause injury to the wall of the ureter which may remain intact for several days postoperatively. The burn injury will eventually break down and perforate due to gradual necrosis and disintegration of the ureteric wall. In such cases both an ultrasound assessment of the genital tract and intravenous contrast radiological studies of the urogenital tract may pass as completely normal until such time as the tissue breaks down, which might be four or five days postoperatively.

I conclude that Dr B provided an appropriate standard of surgical care to Mrs A on 24 November 2008.

Postoperative information

Dr B saw Mrs A in Recovery after her LAVH on 24 November, and visited her daily for five days following surgery. Mrs A had a distended abdomen and a number of unanswered questions, including, "How was I meant to be feeling?"; "Was it normal that my stomach was so large?"; and "How long would it be before I could eat without feeling or being sick?"

Mrs A was reassured by the staff that abdominal distension and nausea are common following an LAVH, so it was difficult for her to assess the point at which these symptoms were abnormal.

Dr B accepts that Mrs A appears to have had little understanding about how she should feel after the hysterectomy. The patient information sheets given to Mrs A preoperatively did not list the symptoms that Mrs A experienced, nor advise that they needed to be reported to the surgeon. Since these events, Dr B has created a new information sheet and provided it to the private hospital for distribution to hysterectomy patients.

When things took a turn for the worse, Dr B was very attentive to Mrs A. Dr B visited Mrs A in ICU at the public hospital on 6 December (following the laparotomy the previous day) and explained the operation findings (including the bowel perforation) and said that she was "very apologetic, and felt terrible that [Mrs A] had ended up in this situation". Dr B visited Mrs A in HDU on 7 December, and apologised again.

Dr B continued to visit Mrs A regularly at the public hospital until her condition worsened on 13 December, leading to the diagnosis of ureteric injury and the repair surgery and insertion of a nephrostomy tube at the second public hospital on 14 December. Dr B learnt that the general surgeons at the first public hospital had told Mrs A (on 13 December following the CT scan and CT urogram) that the ureteric injury had occurred during the LAVH performed by Dr B.

Dr B continued to check on Mrs A's progress following her return to the first public hospital on 15 December and her discharge on 22 December.

I am satisfied that once the surgical complication became evident, Dr B took reasonable steps to explain to Mrs A the nature of the adverse events that had occurred, accepting responsibility for the bowel perforation (which in fact probably did not occur during the LAVH) and offering repeated apologies. I consider it reasonable for Dr B not to have seen Mrs A in the aftermath of the ureteric repair surgery and nephrostomy insertion, since she knew that the general surgeons had explained that the injury occurred during the LAVH.

Overall, I consider that Dr B complied with her professional duty of open disclosure following an adverse event, and provided appropriate information to Mrs A postoperatively. The one exception relates to Mrs A's symptoms in the days following the LAVH. I am satisfied that Dr B has taken steps to improve the quality of information given to hysterectomy patients about what to expect following surgery.

Opinion: No Breach — the private hospital

I am satisfied that the private hospital provided appropriate services and information to Mrs A. I note that the private hospital provides LAVH patients with an information sheet providing advice about expected postoperative symptoms and their management.

Dr East advised that the standard of care provided to Mrs A by the private hospital was "reasonable and without deficiency". I conclude that the private hospital provided appropriate care and information to Mrs A in November 2008, and did not breach the Code.

Actions taken

Dr B
Dr B has apologised to Mrs A for her breach of the Code. Dr B advised HDC that she is now much more sensitive to presentations such as Mrs A's and to the possibility of bowel and ureteric injury. She also has a low threshold for arranging X-rays, ultrasounds and urograms.

Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand.

- A copy of this report with details identifying the parties removed, except the name of my expert, Dr East, will be sent to the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, the Royal Australasian College of Surgeons, and the New Zealand Private Surgical Hospitals Association, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Expert advice from gynaecologist Dr Michael East

I have been asked to give an opinion regarding the standard of care given by [Dr B] to [Mrs A] pertaining to events leading up to and post surgery dated 24 November 2008 at [a private hospital]. The surgery consisted of a laparoscopically assisted vaginal hysterectomy (LAVH).

I have been asked to give an opinion regarding —

1. What is the risk of bowel perforation during laparoscopic hysterectomy?
2. What is the risk of ureteric injury during laparoscopic hysterectomy?
3. Was the information [Dr B] provided to [Mrs A] about the surgical procedure adequate? Please comment.
4. Did [Dr B's] surgical approach comply with professional standards? If not, please explain.
5. Was [Dr B's] postoperative management of [Mrs A] appropriate?
6. [Whether the private hospital provided [Mrs A] with adequate treatment and care between 24 and 30 November 2008.]

1. What is the risk of bowel perforation during laparoscopic hysterectomy?

This question can be answered under the collective question with regard to the risk of bowel perforation during any laparoscopic procedure. An injury to bowel can occur in several different ways

(a) during the establishment of pneumonoperitoneum (placing gas into the peritoneal cavity)
(b) during trocar insertion
(c) direct trauma due to dissection, i.e. surgical instruments may cut or pierce the bowel
(d) thermal injury due to electrocoagulation which can be
    (i) direct thermal injury from electrocoagulation
    (ii) collateral spread of heat energy from nearby electrocoagulation energy
    (iii) remote electrothermal injury due to wayward current looping and 'capacitance' (confined to monopolar electrodiathermy).

The risk of injury is directly proportional to the experience of the operator with regard to advanced laparoscopic procedures or any particular procedure in question. It is generally accepted that the overall risk of bowel injury at laparoscopic procedures is of the order of 0.1% (1:1000.) It must be said at this point however that I agree with [Dr B's] statement that a direct bowel injury in this case is unlikely to have occurred as there was no evidence of such histologically when the excised portion of the large bowel was examined in the Pathology Department. The opinion of the surgical team at the time of laparotomy to remove the bowel cannot be taken as irrefutable evidence of a bowel perforation as subacute peritonitis would have made it very difficult to be certain.

2. What is the risk of ureteric injury during laparoscopic hysterectomy?

Similarly the risk of ureteric injury is directly proportional to the experience of the operator. Specifically relating to a laparoscopic hysterectomy, there is a more clearly pronounced learning curve with regard to ureteric injury during laparoscopic hysterectomy. It has been reported that the incidence of ureteric injury is as high as 1% during the first one hundred cases with reduction down to 0.5% or less. (A useful reference would be The Australian and New Zealand Journal of Obstetrics and Gynaecology 2009; 49:198–201 Evolution of the complications of laparoscopic hysterectomy after a decade: A follow up of the Monash experience. Jason J. Tan, Jim Tsaltas et al.) In this particular case it is difficult to know the exact mechanism of the ureteric injury. This point will be relevant to a later discussion.

3. Was the information [Dr B] provided to [Mrs A] about the surgical procedure adequate? Please comment.

I believe that there was adequate information given by [Dr B] to [Mrs A] about the surgical procedure and the risk prior to undertaking the surgery. Other methods of management were discussed and the advantages and shortcomings of each defined. It was suggested that, although given the bicornuate nature of the uterus, a Mirena intrauterine device may have been less likely to work than when used within a uterus of normal shape, it was still suggested that this was a reasonable low risk course of action to take and then perhaps proceed to a hysterectomy if the treatment proved ineffective. From the result of the discussion however it seems that [Mrs A] preferred the option of hysterectomy which is a reasonable option to take. There were a total of four pre-operative consultations prior to the surgery with significant time between the first and last, namely 7 April through to 15 October 2008. Conservative therapy in the form of high dose progesterone medication (Norethisterone) was used between 17 April and 6 August but proved to be ineffective and eventually was responsible for tipping the balance away from a Mirena insertion towards a laparoscopic hysterectomy as the preferred course of action thereafter. It is my conclusion then that adequate information and time for reflection was provided by [Dr B] to be available for [Mrs A] pre-operatively.

4. Did [Dr B's] surgical approach comply with professional standards? If not, please explain.

The surgical time was noted to take approximately 90 minutes which is well within the timeframe that a skilled experienced surgeon would take to perform an LAVH, especially when it is considered that adhesions required division at the start of the procedure. No particular difficulty was encountered with bleeding etc and I can determine nothing from the hospital notes to suggest that the surgery was not conducted in a professional and competent manner, thus complying with appropriate professional standards.

5. Was [Dr B's] postoperative management of [Mrs A] appropriate? Please comment.

The immediate postoperative course experienced by [Mrs A] was abnormal and I believe that [Dr B's] postoperative management was suboptimal. This statement however requires further elaboration.

Most patients following LAVH will be discharged home within two or three days of the surgery and in some cases the day after the surgery. Abdominal distension is not an unusual complaint nor is shoulder tip pain and wound pain but usually at a level that is easily controlled with simple analgesia and resumption of a light diet usually starts with breakfast on day-1 postoperatively, gradually increasing to more substantial feeding, depending upon the return of appetite. Occasionally nausea can be a troublesome occurrence usually due to pharmacological reasons, for example nausea due to analgesics used or residual nausea secondary to general anaesthetic agents used. Nonetheless the postoperative clinical course is usually one of continual improvement up to the point of being able to be discharged within two or three days of the surgery. Anything other than the above clinical course should alert the surgeon to the possibility of postoperative complications existing and it is generally accepted that a high index of suspicion is required to diagnose complications such as bleeding or a viscus injury to either ureter, bowel or bladder. It is reasonable to state that if the recovery does not fall within normal parameters then investigations should follow to search for a cause of the recovery delay. Such would include a plain abdominal x-ray to look for abnormal bowel distension that could alert to a bowel obstruction, an ultrasound assessment of the renal tracts may be helpful as may a contrast urogram to search for a ureteric leak. The surgeon must avoid falling into the trap of 'wishing the patient to be well' and thus in one's mind, 'explaining away' the anomalies of a slow recovery. It is not possible to say that such investigations would have altered the course of clinical events with regard to [Mrs A]. As I mentioned earlier, the exact cause of the ureteric injury is not clear. Some injuries such as lateral thermal spread due to the use of electrocautery can cause injury to the wall of the ureter which may remain intact for several days postoperatively, eventually to 'break down' and perforate due to gradual necrosis and dissolution of the ureteric wall and in such cases both an ultrasound assessment of the genital tract and intravenous contrast radiological studies of the urogenital tract may pass as appearing completely normal until such time as a delayed ureteric contracture and/or perforation presents perhaps four or five days postoperatively. Had such investigations been performed, and found to have been within normal limits, then although the post operative course would not have been altered, the standard of the postoperative management given to [Mrs A] by [Dr B] would have been beyond reproach. Given the fact that bowel sounds were eventually present and given that a light diet was able to be tolerated prior to discharge and that the vital signs as recorded were within normal limits, then it would have been inappropriate to perform the only other investigation that could have been done, that is of exploratory laparoscopy/laparotomy.

My opinion is that if the above investigations had been carried out and found to be abnormal then such information would have altered the post operative course of events. Had they been normal they would not have altered the post operative course of

events as there was insufficient other reason to change the management from anything other than expectant management and observation. However such investigations were appropriate and in my opinion should have been performed.

6. Was care provided to [Mrs A] by [the private hospital] considered reasonable treatment and care between 24 and 30 November 2008?

I believe that the standard of care provided by [the private hospital] to [Mrs A] was reasonable and without deficiency and I base this opinion upon having thoroughly read through the detailed clinical and nursing notes provided by [the private hospital].

CLOSING STATEMENT

By way of summary I will make the following statements —

As far as I can determine without having been present at the consultations, I believe that [Dr B] provided [Mrs A] with adequate discussion regarding the management options, both surgical and non-surgical, and also adequate discussion regarding possible complications that could take place during the surgery.

I also believe that [Dr B] conducted the surgery on 24 November 2008 in compliance with established professional standards.

I believe that the post operative course of [Mrs A] was abnormal and that [Dr B's] post operative management was suboptimal. Whether, what in my view amounts to suboptimal management altered the clinical course thereafter is open to debate, but the possibility certainly exists.

This has been a difficult opinion to give as clearly [Mrs A] has suffered greatly from the complications of an LAVH. In addition [Dr B] has obviously been over and over the case in her mind, trying to think of how she may have managed things differently and is clearly horrified by the outcome and admits in her own words that she was "overly optimistic regarding [Mrs A's] recovery in the days following her hysterectomy".

Additional advice

Dr East subsequently advised that [Mrs A's] postoperative clinical signs were "soft", but she was not recovering at the right speed. There were no signs of peritonitis or an acute abdomen. He said that [Dr B's] follow-up would be viewed by peers as a minor to moderate departure from expected standards.

Dr East was asked to clarify the following:

1. In her letter of complaint, [Mrs A] said that while she was in [the public hospital] a couple of surgeons told her that the only way her hysterectomy surgery could have been successfully completed was by a vertical incision. Is this correct?

   Definitely NO — a laparoscopic approach was very reasonable to do.

2. I note that [Dr B] did tell [Mrs A] (on the ward before surgery on 24 November) that she might have to perform an open procedure. Should [Dr B] specifically have told [Mrs A] that in the event of an open procedure she would be left with a visible scar?

   No — I would state that such would be obvious.