Surgeon - Mr Ian Breeze

Norfolk Hospital

A Report by the

Health and Disability Commissioner

(Case 03HDC19128)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Consumer
Mr A	Complainant, Consumer's husband
Mr Ian Breeze	Provider, general surgeon
Norfolk Hospital	Provider, private hospital
Dr B	General practitioner
Dr C	Anaesthetist
Dr D	General surgeon
Tauranga Hospital	Public hospital
Bay of Plenty District Health Board	Public hospital

Complaint

On 16 December 2003 the Commissioner received a complaint from Mr A about the care and treatment that his wife, Roselyn, received from Mr Ian Breeze. An investigation was commenced on 18 December 2003, as part of a Commissioner initiated inquiry into the quality of care provided by Mr Ian Breeze to a number of patients on whom he performed surgery. The issue the Commissioner investigated was:

- *Whether Mr Breeze provided services of an appropriate standard to Mrs A, on whom he performed a laparoscopic cholecystectomy at Norfolk Hospital in April 2002, and who developed post-operative complications.*

Information reviewed

- Letter of complaint from Mr A, received 16 December 2003
- Transcript of interview with Mrs A on 22 March 2004
- Response to the complaint from Mr Ian Breeze, dated 9 February 2004
- Mrs A's medical records from Norfolk Hospital
- Mrs A's medical records from Tauranga Hospital
- Information from Bay of Plenty District Health Board, dated 5 May 2004
- Mrs A's general practitioner records
- Information from Dr D, general surgeon
- Information from Dr C, anaesthetist
- Information from five nurses from Norfolk Hospital

Independent expert advice was obtained from Mr Mischel Neill, general surgeon.

Names (other than Mr Breeze, the Commissioner's expert advisor and the hospitals) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Information gathered during investigation

Background
Mr Ian Breeze is a general surgeon (practising in Tauranga) and Fellow of the Royal Australasian College of Surgeons. Prior to November 2000, Mr Breeze performed surgery at Tauranga Hospital and two private hospitals, Southern Cross and Norfolk Hospital.

Because of concerns about Mr Breeze's clinical competence following the death of one of his patients on whom he performed colorectal surgery, Mr Breeze's operating privileges at Southern Cross Hospital were terminated on 6 November 2000.

On 17 November 2000 the Chief Executive Officer of Pacific Health (now Bay of Plenty District Health Board) requested the Medical Council of New Zealand to undertake a review of Mr Breeze's competence, because of escalating concerns about his competence in the management of colorectal surgery. The Council resolved to undertake a review of Mr Breeze's competence, and the review took place in June 2001. The reviewers were concerned about the limited scope of their review. On the basis of the cases reviewed, they found that Mr Breeze's management of biliary tract disease was appropriate, but his colorectal work deficient. The reviewers recommended a more detailed and extensive audit. The Council agreed, and a more comprehensive audit was arranged.

On 14 September 2001 Mr Breeze's public practice was restricted by Bay of Plenty District Health Board to day case surgery only, with no acute call or inpatient work, because of general concerns about his competence, including concerns about his competence at abdominal surgery. The restriction applied pending the outcome of the more detailed audit of his competence by the Medical Council.

Southern Cross and Norfolk Hospital merged in December 2001. The agent company acting on behalf of the Southern Cross and Norfolk Hospital partnership is Norfolk Southern Cross Ltd. Following the merger, Mr Breeze was able to operate at Norfolk Hospital, but was still unable to perform surgery at Southern Cross. Mr Breeze's clinical privileges in respect of intra-abdominal surgery at Norfolk Hospital were suspended in June 2002.

On 17 July 2002, following the completion of the more detailed audit of his colorectal work, the Medical Council resolved that Mr Breeze was deficient in the area of colorectal surgery, and that he needed to fulfil the requirements of an educational programme before recommencing colorectal surgery.

Accordingly, in April 2002, the month in which Mr Breeze performed cholecystectomy surgery on Mrs A, Norfolk Hospital was the only hospital where Mr Breeze was able to perform cholecystecomy surgery – his operating privileges at Southern Cross having been terminated in November 2000 and his public practice restricted to day case surgery only in September 2001.

Names (other than Mr Breeze, the Commissioner's expert advisor and the hospitals) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Mrs A

Mrs A woke at 3am on Friday 5 April 2002 in considerable discomfort, with pain in her side. At 4am her husband took her to a Medical Centre, where she was seen by a general practitioner. The general practitioner diagnosed Mrs A with gallstones. He gave her Voltaren, and advised her to see her own general practitioner later that day. At 11.30am Mrs A visited her own general practitioner, Dr B, who confirmed it was likely she had gallstones. Dr B gave Mrs A pethidine for pain relief, and arranged an ultrasound. He prescribed Voltaren for her over the weekend, and noted that she was to be reviewed the following Monday.

An ultrasound was taken at 4.30pm at a private radiology company. The radiologist identified a large gallstone lodged in the neck of the gallbladder. Following the scan, Mrs A phoned Dr B; however, he had left for the day. As it was a Friday, Mrs A was not able to make an appointment with Dr B until the following Monday (8 April).

On 8 April Mrs A saw Dr B, who recommended a referral to a private surgeon. Dr B referred Mrs A to Mr Breeze.

Consultation with Mr Breeze

Mrs A consulted Mr Breeze at 3.30pm on 8 April 2002. Mr Breeze noted that the ultrasound report indicated that Mrs A had a 3cm stone impacted in the neck of her gallbladder, and he recommended an urgent laparoscopic cholecystectomy. Mrs A recalled that Mr Breeze advised her he had a cancellation and could operate at Norfolk Hospital on 10 April. Mr Breeze phoned Norfolk Hospital during the consultation to request surgery on 10 April. Mrs A recalled that during Mr Breeze's conversation with Norfolk Hospital, he advised the hospital that there was a possibility her gallbladder could perforate.

Mr Breeze advised me that although he "strongly advocated" surgery on 10 April, Norfolk Hospital could not accommodate Mrs A until 17 April. Mr Breeze did not consider that Mrs A's condition was severe enough to admit her acutely to the public hospital, and surgery was therefore booked for 17 April at Norfolk Hospital.

Mr Breeze did not inform Mrs A of his operating restrictions at Southern Cross and Tauranga Hospital, or that he was then subject to a competence review by the Medical Council of New Zealand. Mr Breeze did not discuss with Mrs A the option of having her surgery performed at Southern Cross by a different surgeon, or an urgent referral to the public hospital. Mr A advised in his letter of complaint:

> "If we had known that Mr Breeze had limitations with respect to laparoscopic surgery and restricted to operating at Norfolk Hospital only, we would have chosen a general surgeon who could have operated more promptly and was competent at laparoscopic surgery."

Mr Breeze advised that he was competent to perform laparoscopic cholecystectomy surgery on Mrs A,[1] and Mrs A's surgery would not have been undertaken more promptly at either the public hospital or by another surgeon in a private hospital. Mr Breeze did not advise Mrs A of the restrictions on his practice because he did not believe that the information accurately conveyed his ability to competently perform the surgery – he considered that Bay of Plenty District Health Board's restriction on his practice was inappropriate, indiscriminate, and not evidence-based.

Mr Breeze ordered a blood test for Mrs A, which showed moderate leucocytosis (an increase in the number of white blood cells in the body, indicative of infection), and accordingly prescribed Augmentin for her. Mr Breeze was aware that Mrs A had co-morbidity of borderline elevated blood glucose and unexplained breathlessness.

Mrs A experienced severe discomfort over the following nine days. She recalled that Mr Breeze telephoned her on 8 April to inform her that her blood tests indicated she had an infection, and he prescribed antibiotics for her. Mrs A recalled that she did not have a good sleep that night – she was hot and cold. In the morning her fever had gone, but she was still very uncomfortable. On 10 April Mrs A experienced a severe spasm, and she was concerned that her gallbladder had perforated.

Laparoscopic cholecystectomy
Mrs A was admitted to Norfolk Hospital on 17 April 2002.

Mr Breeze advised that during his pre-operative visit on 17 April, Mrs A described a severe attack of sharp pain the previous evening, which was suggestive to him of gallbladder perforation.

The surgery commenced at 8.35am and was completed at 10.25am. The surgeon was Mr Breeze, and the anaesthetist, Dr C. Mr Breeze advised that laparoscopic cholecystectomy was undertaken using antibiotic prophylaxis of gentamicin 320mg intravenously in addition to oral Augmentin, along with standard thrombo-prophylaxis (clot prevention) of Fragmin (a blood-thinning injection) and intermittent calf compression. Mrs A received a general anaesthetic.

On Mr Breeze's operation note, it is stated that the finding at operation was a gallbladder mass secondary to acute cholecystitis. He noted that it was a difficult laparoscopic cholecystectomy, and dissection of the gallbladder was technically difficult because of the severe degree of inflammation and scarring. The typed operation note recorded:

[1] Mr Breeze advised that his competence was confirmed by: the Medical Council of New Zealand review of his biliary surgery in June 2001, which concluded that his management of biliary tract disease was appropriate; his own self-audit of cases; and a subsequent independent review of his laparoscopic surgery commissioned by Norfolk Community Hospital in late 2002.

"Indications: Developed severe classical biliary colic on 5.4.02 and ultrasound revealed this was secondary to a 3cm stone impacted in the gallbladder neck with no other abnormality. Urgent cholecystectomy was recommended.

Procedure: … inspection revealed a gallbladder mass had developed in the right upper quadrant involving the freater omentum and adjacent anterior abdominal wall. The omentum was dissected off the anterior abdominal wall and then off the underlying swollen subacutely inflamed gallbladder, in the process uncovering a sealed perforation. Once the gallbladder was completely denuded of its overlying omental adhesion a difficult dissection was undertaken, dissecting out the cystic duct and artery and separately trebly clipping these and dividing them between the distal two clips. The gallbladder was then dissected from the liver bed again with some difficulty because of the density of the inflammatory fibrosis. This was accomplished uneventfully, albeit with steady inflammatory capillary ooze. The abdomen was repeatedly lavaged with saline and suctioned and the gallbladder was then delivered intact through the epigastric port site and the presence of a 3cm diameter stone was confirmed. A Redivac drain was then inserted to the right upper quadrant and the 10mm port wounds were closed with Dexon to the fascia and all post-wounds closed with monocryl to skin.

Post-op: As [Mrs A] is at risk of developing a subphrenic abscess I plan to give her further intravenous Gentamicin every 24 hours while hospitalised and discharge her on oral antibiotics."

Mr Breeze considered that Mrs A was at risk of developing a post-operative subphrenic abscess because her gallbladder had perforated and sealed prior to surgery. Dr C confirmed that the procedure was difficult due to the inflamed, tense and adherent gallbladder, which perforated during dissection.

Mr A advised that after the operation Mr Breeze told Mrs A that her gallbladder had perforated but had resealed itself. Mrs A recalled that the anaesthetist, Dr C, told her that her gallbladder had perforated.

Dr C could not recall any undue blood loss intra-operatively.

Post-operative care and treatment

Mrs A was admitted to the recovery room at 10.30am. The recovery room condition and progress notes record that Mrs A was feeling uncomfortable, but settled with morphine. She was returned to the ward at 11.20am. She was pale in appearance, but her observations were stable and she was afebrile. It was recorded that there was no ooze and moderate drainage from the drains. Dr C advised me that Mrs A's condition in the recovery room and the evening after her surgery was unremarkable.

Mrs A remained comfortable. She was reviewed by a doctor at 3.30pm and given post-operative orders for daily Fragmin and a dose of gentamicin (a strong antibiotic) at 7am the following morning. At 4pm Mr Breeze phoned the ward. He requested a blood test to check her haemoglobin level because of her "oozy tendency". The results were reported, with Mrs

A's haemoglobin as 113 g/L. Mr Breeze was informed of the haemoglobin result. The notes record that Mrs A remained comfortable for the rest of the afternoon duty.

At 9.30pm Mrs A's temperature was 38 degrees, but had dropped to 37 degrees at 10pm. Her other recordings were noted to be stable, and she was tolerating fluids. It was noted during the evening shift on 17 April that Mrs A was uncomfortable, however she was afebrile and her observations were stable. Her Redivac drain had drained 150mls.

Mrs A was seen by Mr Breeze on the morning of 18 April. He noted that she was quite well, although sore on movement with shoulder pain. Her observations were stable (pulse was 84 beats per minute), and she was afebrile and well hydrated. Her Redivac drain had drained 260mls. Mr Breeze noted that bowel sounds were present, and he had no concerns about her progress. Mrs A was given Panadol. Mr Breeze arranged further blood tests. The test results indicated that her haemoglobin had decreased to 105 and her white blood cell count was 18 (a moderate leucocytosis). Mr Breeze was informed of these results, and advised me that the leucocytosis finding mandated the post-operative antibiotics he had prescribed. Mrs A recalled asking Mr Breeze on 18 April if he would still have operated on her if he knew she was "so infected", and Mr Breeze confirmed he would have.

On the morning of 18 April Mrs A was also reviewed by Dr C, who charted IV fluids. Dr C noted that Mrs A had not required any morphine during the previous evening, and that she was comfortable.

At 10pm it was noted that Mrs A had not been feeling well during the afternoon duty, and that she was quite lethargic. Mr A's diary recorded that his wife was "feeling very poorly" on 18 April. Dr C reviewed Mrs A that evening. Dr C noted that Mrs A looked tired, but was not concerned given her previous painful cholecystitis and her surgery. Dr C advised that Mrs A's blood tests were satisfactory apart from a low sodium level, so Dr C changed Mrs A's IV fluids. Dr C advised that Mrs A had still not required morphine or antiemetics, and assumed Mrs A would be discharged the following day. By that evening, Mrs A's Redivac drain had drained 350mls.

Mrs A was seen by Mr Breeze at 8am on 19 April. He was pleased with her progress, and believed that she was improving – earlier shoulder tip pain, referred from the diaphragm and commonly experienced by patients for several days after laparoscopic cholecystectomy, was easing. Mrs A's pulse was 90 beats per minute, her temperature 37.8 degrees, and her abdomen was noted to be soft. He asked that she be given a repeat dose of Gentamicin, and that her Redivac drain be removed. He also wrote her a prescription for antibiotics. Bloods were sent off, and it was noted that Mr Breeze would phone that afternoon/evening regarding her discharge.

The morning nurse noted that Mrs A had a settled time over her duty and was mobilising well, although she did appear pale. The blood results were returned, and it was noted that her haemoglobin had dropped to 91 (haemoglobin less than 100 is low), and her white blood cell count was 19.7. Mr Breeze was informed. Mr Breeze advised:

> "Full blood count revealed a fall in haemoglobin to 91g/L and a slight further rise in white blood count to 19.7. Because of the drop in haemoglobin, I considered withholding fragmin. On balance, I decided not to, as this would have exposed [Mrs A], who was quite immobile, to a significant risk of potentially fatally pulmonary embolus. I was concerned she may be at enhanced risk of this because of her past history of unexplained breathlessness, which I considered might have been due to occult pulmonary emboli. Low grade bleeding is not a contra-indication to fragmin."

Mrs A's observations were noted as satisfactory. Her temperature was 37.5 at 11am, and she appeared comfortable, was passing a good volume of urine, and tolerating a light diet and fluids well. She was given Panadol and gentamicin, as ordered by Mr Breeze. Mrs A's Redivac drain was removed during the morning shift. The puncture sites from the operation were steri-stripped and left open, as they were noted to be dry and intact.

At 1pm Mr Breeze phoned the ward. It was noted that Mrs A was comfortable and mobilising well, although she had an unsettled stomach. She was afebrile, drinking well, and had no ooze from her Redivac site.

Dr C did not review Mrs A on 19 April.

Mr A's diary records that Mrs A was feeling worse on 19 April.

Mr Breeze phoned the ward at 6.30am on 20 April. Mr Breeze advised that Mrs A seemed satisfactory, and he ascertained that it would be fine for him to visit her after midday. It was recorded in the progress notes that he would see Mrs A at 12pm, for possible discharge, and that he recommended she have a further dose of gentamicin that morning. The night nurse for 19-20 April noted that Mrs A's observations were satisfactory and stable. Mrs A's temperature was 37.8. She also noted that Mrs A was comfortable, declining analgesia, and had no nausea.

At 9am Mr Breeze was unable to be contacted regarding the need for gentamicin levels to be tested. Dr C was contacted instead, and recommended checking the gentamicin levels. Bloods were taken at 9am, and Mrs A was seen by Dr C. Dr C recalled that Mrs A was febrile, but other vital signs were normal. Dr C charted extra fluids, and reviewed Mrs A's notes. Dr C said that the notes indicated that Mr Breeze had been monitoring Mrs A closely, and was aware of her dropping blood count and increasing white cell count. Dr C was aware that Mr Breeze was due to contact the hospital later that morning, and did not feel that Mrs A's condition was bad enough for her to immediately contact him.

At 11.15am Mr Breeze was phoned and made aware of the recent blood results, which showed a drop in Mrs A's haemoglobin to 88 and a rise in her white blood cell count to 21.6.

At 12.15pm Mrs A was seen by Mr Breeze. Mr Breeze advised me that he considered, on the basis of Mrs A's progressive blood test changes, that she may have developed a

subhepatic collection. He arranged transfer to Tauranga Hospital for an urgent abdominal scan. Mr Breeze phoned the on-call surgeon, Dr D, and discussed Mrs A's case with her.

Mrs A was transferred to Tauranga Public Hospital by ambulance at 12.45pm. The transfer information sheet stated under 'diagnosis' that Mrs A had a laparoscopic cholecystectomy, with suspected right upper quadrant collection. It was noted that her haemoglobin was 88, and her temperature 37.3. Mr Breeze wrote:

> "Thank you for arranging CT or US for suspected fluid collection post difficult lap chole 17/4/02 for gb mass [secondary] to pert. emphyemia.
>
> Normally well except sl. Hyperylyc.
>
> WBC
>
> 14 → 18 → 18 → 21.6
>
> pre-op PO1 PO2 PO3
>
> HB 98 → 88"

He also noted that she had received gentamicin and Fragmin post-operatively. Mr Breeze's summary for Tauranga Hospital of Mrs A's haemoglobin and white blood cell count is inconsistent with the recordings of her haemoglobin and white blood cell count in her progress notes. On day two post-operatively the notes record her haemoglobin as 91 and her white blood cell count as 19.7.

The Clinical Observation Chart indicates that Mrs A's temperature was 37.5 at 3.30am on 19 April, remained at around 37–37.3 on 19 April, but increased to 38.3 at 9.15am on 20 April. Her temperature was back down to 37.3 at 12.30pm on 20 April. During this time, Mrs A's pulse was also variable, peaking at 115 at 3.30am on 19 April, and settling at approximately 95 on 20 April.

Tauranga Public Hospital

Mrs A arrived at Tauranga Hospital at 12.55pm on 20 April 2002. It was noted that she was in no pain, but was lethargic and pale (haemoglobin 88), with signs of uneasiness. She was otherwise alert and orientated. Her condition was noted to be stable. Her temperature was 37.5. Her puncture site was noted to be clean and dry, as was her drain site.

At 1.15pm Mrs A was reviewed by Dr another doctor who recorded that Mrs A had had a difficult laparoscopic cholecystectomy, and her postop drains had drained serous fluid for two days. The drains were removed on 19 April. He queried whether she had a right upper quadrant collection. He noted that three days post-op she was experiencing fevers, sweats, had some right upper quadrant abdominal pain, and a decreased appetite, secondary to nausea. On observation she was sweaty, but comfortable. Her temperature was 37.5, her blood pressure 150/100, and her pulse 100. His plan was to discuss the case with Dr C.

At 2pm Mrs A was reviewed by Dr C, and she was referred for a CT scan (taken at 2.30pm). The scan was reported by a radiologist, who noted:

> "There is extensive fluid extending from the subphrenic space on the right lateral aspect of the liver where it measures up to 3cm in depth, around the inferior margin of the right lobe of the liver and extending into the right paracolic gutter. This has no definable margin or enhancement and does not contain any gas to suggest infection, but does appear to contain linear substance most in keeping with clot, and I note the intra-operative haemoglobin drop …
>
> There is no significant fluid collection in the pelvis or in the left side of the abdomen. There is some infiltration of the subcutaneous fat in the right flank."

At 3pm it is recorded that Mrs A was feeling cold with shakes. Her blood pressure was 130/65, and her heart rate 112. At 3.30pm Mrs A was seen by Dr D, who advised me that Mrs A was febrile with tachycardia and localised abdominal pain in the right upper quadrant. Dr D recalled that clinically the picture was of a collection in the right upper quadrant following gallbladder surgery, most likely to be infected haematoma given the drop in haemoglobin and signs of infection. She arranged for drainage of the collection by aspiration at radiology. The continuation of the CT report by the radiologist noted:

> "Following the scan, under sterile conditions, an 18 gauge needle was placed intercostally into the fluid adjacent to the right lobe of the liver, and 10mls aspirated. This appeared to be almost completely serosanguinous blood with some small clots, which did not allow further aspiration and I assume that this is due to clot maturation."

Mrs A was transferred back to ED in a stable condition at 4.40pm. At 5pm she was given IV antibiotics, and transferred to Ward 4. At 5.30pm her temperature was 38, and her haemoglobin remained 88. Mrs A recalled that Dr D advised her she would require surgery, and warned her that following surgery she would be "a very sick lady".

Mrs A was taken to the operating theatre that evening, where Dr D, general surgeon, performed a laparotomy and drainage of infected haematoma. The typed operation note recorded:

> "Indications: This lady had had a laparoscopic cholecystectomy for an acutely inflamed gallbladder three days previously. She had had pain following this associated with fevers and drop in her Hb with elevated white count. A CT scan had shown a large collection surrounding the liver and in the gallbladder fossa and extending down the right paracolic gutter. A needle was inserted to aspirate this but only small volumes of haemoserious fluid could be obtained and it wasn't felt that this could be drained radiologically.
>
> Findings: There was large amounts of haematoma and fibrinous exudates surrounding the liver and within the gallbladder fossa and extending down the right paracolic gutter. There was no obvious bile. The transverse colon was looped up adjacent to the

gallbladder fossa but the colon itself looked intact. Again the pyloric region and duodenum were thickened but appeared intact.

Procedure: … Using copious amounts of irrigation the haematoma was removed and the area thoroughly lavaged. There was no obvious bleeding point or any active bleeding although there was some small bleeders from raw surfaces. One drain was placed into the gallbladder fossa and a second up the right paracolic gutter. These were sutured in place."

A handwritten note of the operation records that 400mls of blood, and a 200-300ml clot, semi-infected, were found at operation. Mr Breeze advised me that microbiology analysed the fluid removed at operation and found no evidence of infection on microscopy, or on culture. However, this is contrary to recorded findings of these clinicians who were present at the operation.

Following surgery, Mrs A was transferred to HDU (the High Dependency Unit) for observation. When she arrived in the unit, she was stable, awake, alert, oriented, with no pain and no wound ooze. Her temperature was 36 and her blood pressure stable. There was minimal fluid in the wound drains.

On 21 April it was noted by the nurse that Mrs A was stable, her wounds intact, and that bloods had been sent for analysis. Mrs A was seen by Dr D that morning. Dr D noted that Mrs A was alert, her temperature was 37, and her blood pressure was 142/64. Her bloods were stable, with her haemoglobin recorded as 106. It was noted that she was improving, but would remain in HDU over the weekend.

At 10.40am on 21 April it was noted in the progress notes that Mrs A was very sore, experiencing spasms at times, but was alert. Her temperature was between 36.7 and 37, and her heart rate between 100 and 80. Brown vomitous smelling fluid had drained from her naso-gastric tube, and haemoserous fluid had drained from her two drains.

At 8pm on 21 April Mrs A was noted as being stable and comfortable, and afebrile.

Mr Breeze advised me that he visited Mrs A on 21 April in the HDU and talked to her. He advised that he explained to her that she had suffered from a persistent low grade post-operative bleed, but that the blood had been evacuated by Dr D. Mr Breeze said that Mrs A told him she had bled heavily following previous gynaecological surgery, and he recommended investigations for a possible underlying bleeding disorder. Mrs A could not recall Mr Breeze visiting her while she was in HDU, and there was no record of his visit in her progress notes. When asked, during the course of the investigation, Mrs A recalled that she suffered from septicaemia following her hysterectomy operation, but she had not previously experienced post-operative bleeds.

On 22 April Dr D reviewed Mrs A and noted that she was haemodynamically stable and could be referred to the ward the following day. Mr A recorded in his diary that Mr Breeze

phoned him at 2pm on 22 April, and told him that Mrs A was improving. Mrs A was moved to the ward at 10pm on 22 April.

Mrs A's condition continued to improve. Her bloods were monitored, and she was regularly reviewed. At 2.30pm on 24 April her abdominal drain was removed. On the evening of 24-25 April, Mrs A's temperature rose to 38.5 degrees, however in the morning she was recorded as being afebrile and stable. Mrs A remained afebrile.

On 26 April Mrs A was seen by Mr Breeze. A nurse recorded the visit in the progress notes, and recorded that Mr Breeze said that Mrs A could be discharged over the weekend, if she was comfortable.

On 27 April Mrs A's temperature rose to 37.4 (at 4.30pm) and 37.5 (at 8.30pm), and she reported slight pain in the lumbar area at times. On 28 April Mrs A's temperature had dropped back to 36.9 degrees. Her temperature was discussed with the house surgeon, and it was recorded that Mrs A was still for discharge. At 11.30am she was discharged home.

Mrs A's discharge summary noted that she was for follow-up with Mr Breeze in private, as required, and with her general practitioner. She was told to see her general practitioner in a week. She was also referred to the District Nursing service.

Mrs A's subsequent condition and concerns

Mr A advised me that his wife's recovery was slow and gradual, and it was approximately two and a half months before she could return to work. Mrs A still experiences some discomfort, due to scar tissue. Mrs A expressed concern that Mr Breeze proceeded with a laparoscopic operation on her, and queried whether Mr Breeze should have performed open surgery. Mrs A felt that there was very little discussion with her about her progress and condition while she was at Norfolk Hospital.

Mrs A's general practitioner records note that she visited her general practitioner on 6 May 2002, and discussed her concerns about the surgery, the delay in being operated on at the private hospital, and the subsequent outcome. During an appointment on 13 May 2002, Mrs A's general practitioner encouraged her to discuss her concerns with Mr Breeze. I understand that Mrs A did not approach Mr Breeze directly with her concerns.

Timing of laparoscopic cholecystectomy operation

Mr Breeze advised that the operation findings confirmed that Mrs A had "acute on chronic cholecystitis". He advised:

> "With respect to gall bladder inflammation, it is axiomatic that with increasing acuity, the risk of complications from gall bladder disease increases. To minimise the risks, I sought to remove [Mrs A's] gall bladder at the earliest time possible, but this was delayed by seven days by unavailability of beds at Norfolk Hospital. I assumed [Mrs and Mr A] would have understood that my perceived need that the surgery be performed as soon as possible, was because delay would impart an increased risk, and that because delay occurred, [Mrs A's] recovery may be prejudiced …

> During the time, acute admission to the Public Hospital was an option, but to the best of my knowledge, [Mrs A] didn't require this. She did not report to me her episode of severe sharp pain occurring the night preceding surgery, until the next morning."

Mr Breeze also advised me that he believed that Mrs A's outcome was prejudiced by her surgery being delayed by seven days because of the unavailability of beds at Norfolk Hospital. However, he advised, "I stand by my decision to operate on 17 April 2002."

I asked the Bay of Plenty District Health Board whether, given Mrs A's presentation, she would have been admitted acutely if she had been referred by Mr Breeze to Tauranga Hospital for her cholecystectomy operation. The Board advised me that if Mrs A had been referred to Tauranga Hospital it is likely that she could have been managed conservatively with pain relief, dietary restriction and antibiotics, and placed on the waiting list as a semi-urgent case (urgent gallbladder cases wait between three and 18 months, and semi-urgent cases wait 18 months or more). The Bay of Plenty District Health Board advised me that some general surgeons will operate in the acute phase of biliary colic/cholecystitis, usually within the first 24-48 hours of the disease presentation.

However, after that time period surgery becomes difficult, and the rule of thumb is that after 24–48 hours there is a three month 'no-go' period. Most patients who present in an acute phase are managed with conservative treatment and are operated on approximately three months later.

Comment by Mr Breeze on the management of Mrs A's haematoma
Mr Breeze questioned the need for Mrs A's second operation at Tauranga Hospital, to drain the infected haematoma. He advised:

> "Open surgery established that there was no active bleeding, and no infection. With foresight, particularly recognising the stable haemoglobin level from 19 to 20 April 2002 it is debatable whether surgery was indicated. Patients with intra-abdominal haematoma (blood collection) from traumatic rupture of spleen or liver are now managed without operation, provided the bleeding has stopped, in the absence of infection. A trial of this much less invasive strategy of bed-rest, reassurance, pain relief and transfusion may have established that this was the appropriate management for [Mrs A]. If [Mrs A] had been successfully managed conservatively, this complaint may not have arisen."

Mr Breeze also questioned the finding that the clot removed during surgery on 20 April 2002 was infected. Mr Breeze advised that Mrs A was not septic. Although she had an elevated white cell count, a raised temperature, tachycardia and hypoalbuminuria, those findings were consistent with haemorrhage without infection. In Mr Breeze's opinion, Mrs A "would probably have been managed successfully without re-operation" and, "In the unlikely scenario that she did subsequently develop infection, this would optimally have been treated by minimally invasive percutaneous drainage radiologically."

Norfolk Southern Cross Ltd
Following the case of Mrs A and another case, the Board of Norfolk Hospital resolved to commission an independent report on Mr Breeze's laparoscopic surgery, and to restrict Mr Breeze performing intra-abdominal surgery at Norfolk Hospital until that report and the report of the Medical Council's competence review (then being undertaken) were available. At the request of Norfolk Hospital, a review of Mr Breeze's laparoscopic cases over the previous five years was undertaken by a general surgeon in January 2003. He concluded that Mr Breeze's laparoscopic surgery did not pose a heightened risk to patient safety and his overall complication rate compared with published data. However, the general surgeon noted, "Over the last year there were more incidental or small glitches than I would normally expect."

Independent advice to Commissioner

Advice from general surgeon
The following expert advice was obtained from Mr Mischel Neill, general surgeon:

> "I have read all the information sent to me regarding this patient and after careful consideration the following are the answers to the questions raised.
>
> Pre-operative period
>
> Whether it was reasonable for Mr Breeze not to refer [Mrs A] acutely to the public hospital for surgery when he was advised that a bed was not available at the private hospital until the 17th of April.
>
> Opinion
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> [Mrs A] first presented with severe biliary colic on the 5th of April 2002. She was given Voltaren for pain relief, and presented to Mr Breeze on the 8th of April 2002 with low grade pain and a moderate Murphy's sign (tenderness over the gallbladder on deep breathing). Her temperature was normal, her pulse was normal and she had no elevation of her liver function tests. An ultrasound of her abdomen showed a gallstone in the Hartman's pouch. There was no report of the ultrasound, and no mention in the notes of any inflammation seen on ultrasound. She was not clinically jaundiced.
>
> From the clinical signs there was really no indication for urgent surgery. Many surgeons would treat this patient with antibiotics and let the whole thing settle, and she would then be placed on the waiting list for a routine cholecystectomy. Other surgeons would operate on this lady on the next available list. These policies vary from hospital to hospital.

From the available notes I do not believe this patient needed to be admitted acutely to the public hospital, and that it was reasonable for Mr Breeze to place her on his next list in the private hospital.

The relevant ethical and professional standards relating to surgeons [obligations] with respect to public and private referrals

I am unaware of any written material on this subject. Each surgeon would have his own beliefs and the following are mine. This is best answered by the question 'What is best for the patient?' Consideration must be given to the diagnosis and treatment necessary. With the patient's overall health in general and whether the private hospital is equipped to cope with the management of the patient. Some private hospitals are as well equipped as the public sector, while others have a very limited range of supporting facilities for patients. Clearly if a patient is otherwise healthy with a straightforward surgical condition then there is no reason why they should not be operated on in a private hospital. If a patient has a number of underlying conditions, such as a cardiac condition, severe diabetes or a general poor state of health, with perhaps a somewhat complicated diagnosis requiring technically difficult surgery, then the public hospital is a better option for them, where there are more medical staff to cope with the various problems that may arise. But the ultimate decision is that of the surgeon.

In this particular case there is no evidence in the pre-operative examination to suggest that this lady should not be operated on in private. On admission her temperature was recorded as normal. She had a normal pulse, which really did not hint at the findings at operation.

It is my opinion that if a person sees a surgeon in his private rooms and has insurance, then it is reasonable to expect the patient will want to be treated in a private hospital, providing the patient's condition and diagnosis is suitable for private surgery.

What information would you expect a reasonable surgeon to provide on the option of a referral to a public hospital in these circumstances?

I am unaware of the exact circumstances of Tauranga Hospital, and their waiting lists and their treatment of gallbladder disease, but in general terms I would suspect that this patient [would not have been treated] before the 17th April 2002.

She may well have found that she was placed on a waiting list, and would have waited a much longer time.

What information would you expect a reasonable surgeon to provide about the risks involved in delaying the operation so it could be performed in private?

The patient should be informed about any deteriorating condition that may occur prior to the operation such as increasing pain, increasing fever with loss of appetite, the onset of jaundice, the onset of peritonitis or generalized abdominal tenderness and the general feeling of unwellness. Should any of the above occur then the patient's condition should be reassessed by the surgeon involved. This may then be followed by advancement of the operating time, whether it be in public or private.

Whether it was appropriate for Mr Breeze to proceed with [Mrs A's] operation without the back up available at the public hospital, knowing that [Mrs A's] gallbladder had possibly perforated

There are no indications in the notes of any increasing symptoms apart from some pain the previous night. This was suspected to be a perforation, but there was no associated peritonitis or fever suggesting any deterioration in the previous assessment of her condition. These circumstances would be normal to carry out a routine cholecystectomy, even if the patient had a perforation, which had sealed.

It was reasonable to expect that this would be a routine cholecystectomy with no specific backup necessary from the public hospital. It was appropriate for Mr Breeze to proceed with [Mrs A's] operation without the backup available at the public hospital.

The Operation

Whether it was appropriate for Mr Breeze to proceed with a laparoscopic cholecystectomy in the light of [Mrs A's] clinical presentation

It was entirely reasonable to start the operation with the laparoscopic examination as there was no clinical indication not to do so. Once an assessment was carried out laparoscopically a decision whether to continue laparoscopically or to open the abdomen in a routine manner is entirely a call at the time and depends on the experience of the surgeon. There was no indication from the operation note that laparoscopic removal of the gallbladder should be abandoned. It appeared to go reasonably well, although it was a clearly difficult procedure and took a long time.

Rupture of a gallbladder during dissection or during retrieval does occur and is a recognised complication. A gallbladder can be ruptured during an open procedure as well, and the standard procedure in such a case is to wash out the upper abdomen and provide an adequate drainage both for an open procedure and laparoscopic procedure. This was indeed carried out.

Post-operative bleeding is also a recognized complication as there can be a lot of dissection from the gallbladder bed in the liver, which can bleed easily. In this case a Redi-vac drain was inserted to cover this complication, it would appear from the notes that this did not drain properly.

Whether the operation was performed in accordance with professional standards

I believe the operation was performed in accordance with professional standards.

Any other matters

In hindsight I wonder about the advisability of using Fragmin (blood thinning medication), which would increase the likelihood of bleeding.

Post-operative care and treatment

Whether [Mrs A's] post-operative management by Mr Breeze was appropriate

The patient was commenced on Gentamicin (an antibiotic) during the operation and then on a daily dose to cover the risk of infection from the spillage that occurred. She was monitored daily by Mr Breeze, and showed a mildly raised temperature over the first two days, but on the 19th April the temperature started to rise to 38.3 and her pulse rose accordingly. Daily blood examination was carried out showing a slowly decreasing haemoglobin level and a slowly increasing white blood count. The patient over this time was drinking and eating. The Redi-vac was not draining large amounts of blood, and the post-operative course up until late on the 19th of April would have been expected from the findings at operation, and I believe that the post-operative management to this point was appropriate. It was not until late on the 19th and early on the 20th of April that it became obvious that the infection was progressing rather than settling down, and so a further antibiotic Rocephin was started. The patient was feeling worse, the white count had risen to 21.6 thousand and the haemoglobin had dropped to 88 g percent, a drop of almost 20 g percent over two days. Her Redi-vac at this point in time measured only 330 ml of blood. It was becoming apparent that there was progressive infection. When this deterioration was realized she was transferred to Tauranga Hospital for investigation and CT scanning. I believe the management over the post-operative period and the timing of the transfer to Tauranga Hospital was appropriate. It was reasonable to accept a raised white count and temperature and pulse in the post-operative period with the operative findings, and one would have expected over a few days for this to settle on antibiotic treatment. When the infective process failed to improve and with the slowly falling haemoglobin one would be anticipating an infective haematoma. The small volume of drainage from the Redi-vac was clearly misleading.

On admission to Tauranga Hospital a CT scan showed a large collection in the right side of the upper abdomen in the subpleural and subhepatic space and extending down the paracolic gutter. With the raised white count and temperature and the low haemoglobin an infective haematoma had to be the provisional diagnosis. This was treated correctly by an open drainage of the area and extensive washouts. Once the haematoma had been washed out the white count dropped to normal quite rapidly over the next two days. The haematoma was cultured in the laboratory and showed

no growth over 48 hours, which is not in keeping with the clinical signs and findings in the patient.

Any other matters

Mr Breeze in his conclusions quotes examples of non-draining haematomas. This is a very different and unrelated situation. He quotes a ruptured spleen or liver without infection, [which he states] is frequently treated by conservative management. In the case of [Mrs A] she was very septic with a white count of 21.6 thousand, a raised temperature and pulse and a low albumin of 20 g. An infected gallbladder had been removed with a resulting haematoma. I do not believe any surgeon would have left this haematoma in place without draining it.

In conclusion I believe Mr Breeze's management of the patient at Norfolk Hospital on 17th–20th of April 2002 was appropriate and in accordance with normal professional standards."

Advice from Royal Australasian College of Surgeons

The following information was obtained from the President of the Royal Australasian College of Surgeons about the College's views on the referral of patients between the private and public systems, and a surgeon's obligations in respect of such referrals:

"The College does not have formal guidelines or policy statements on the difficult and controversial area of the interface between the private and public systems. However we have a Code of Ethics which covers indirectly a number of aspects of this issue and we are developing a Code of Conduct which is also relevant to the matters you raise. I will try to describe what might be regarded as a 'College view' on this subject.

A dilemma that surgeons working in both sectors face regularly is how to handle the personal conflict of interest between the two sectors. A surgeon working in the two sectors clearly has a vested financial interest in the patient choosing to have private surgery. This must not prevent the patient being made aware of the public system option, when this option is applicable. There are surgical procedures e.g. heart transplantation that are only performed in the public sector and others e.g. cosmetic surgery which are only performed in the private sector. It is important for the surgeon to present the options of treatment in the two sectors in a way that is truthful, balanced and not seen to coerce the patient into the private sector.

The key pieces of information that the patient needs in choosing between the private and public sectors are:

1. That he/she has, in many cases, a choice between private and public systems. (As already stated a number of treatments are only available in one or other sector.)

2. The total costs for the private sector (clearly no direct cost for the public system).

3. A best estimate of the waiting times for each sector (this can only be provided with any degree of accuracy for the sector(s) in which the specialist works).

4. An indication of the differences between the systems e.g. will the patient have access to the surgeon and anaesthetist of choice in the public sector, will the patient have freedom to choose the timing of the surgery in the public sector and will trainees be involved in the patient's care, particularly in the public sector?

Your questions relate to:

1. A delay in accessing the private system for urgent surgery rather than a 'direct' referral to the public system. This is an unusual scenario with waiting times, in general, being much shorter in the private sector even for emergency surgery. The College position is that the patient should make the choice having been fully informed and without coercion.

2. This question relates to information that should be provided about referral to a public hospital. This is covered in 1-4 above.

Patients may come to surgery after prior consultation in either private rooms or hospital OPDs [Outpatient Departments]. In theory there is no difference between these two routes in terms of information that should be provided about options. Many surgeons however are reluctant to discuss private surgery with patients seen in hospital OPDs for fear of a perception of coercion into the private sector. This may well be information that should be given to the patient."

Code of Health and Disability Services Consumers' Rights

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

Right 4

Right to Services of an Appropriate Standard

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

Right 6

Right to be Fully Informed

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

(a) An explanation of his or her condition; and

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

(c) Advice of the estimated time within which the services will be provided; …

Opinion: Breach – Mr Ian Breeze

Disclosure of information
Mrs A presented to Mr Breeze on 8 April 2002 with a large (3cm) stone impacted in the neck of her gallbladder. Mr Breeze recommended an urgent laparoscopic cholecystectomy. Because of the restrictions on his practice, Mr Breeze could only perform the proposed surgery at Norfolk Hospital.[2] Mr Breeze wanted to operate on Mrs A urgently; however, a bed was not available at Norfolk Hospital until 17 April. Mr Breeze did not inform Mrs A of the restrictions on his practice or alternative options, and performed the surgery at Norfolk Hospital on 17 April.

Mr A advised in his letter of complaint:

> "If we had known that Mr Breeze had limitations with respect to laparoscopic surgery and restricted to operating at Norfolk Hospital only, we would have chosen a general surgeon who could have operated more promptly and was competent at laparoscopic surgery."

The Code is based upon the central right of patients to be fully informed in order to make informed choices. Informed consent is a process that is embodied in three essential elements under the Code: effective communication (Right 5), provision of all necessary information (Right 6), and consent freely given by a competent consent (Right 7).

[2] At the time, Mr Breeze's privileges at Southern Cross Hospital had been withdrawn following concerns about his competence. In addition, his practice at Tauranga Hospital was restricted to day case surgery only due, in part, to concerns about his management of abdominal surgery. Mr Breeze was also then subject to a review of his competence by the Medical Council of New Zealand.

Right 6(1) gives every patient the right to information that a reasonable consumer, in that patient's circumstances, would expect to receive. Right 6(1)(a) to (g) of the Code sets out specific types of information that a patient may expect to receive, including the right to information about the options available (Right 6(1)(b)). However, the list is not exhaustive, and Right 6(1) allows for a broad interpretation of the information that a reasonable patient would expect to receive. This recognises that patients are likely to want a wide range of information in making decisions about care, depending on the circumstances.

It is well recognised that patients should be told of all relevant options, including those the provider does not offer[3] and publicly funded services,[4] to enable them to make an informed choice. As noted by the President of the Royal Australasian College of Surgeons, when surgery may be performed in both the public and the private sector, patients should be informed that they have a choice between the two sectors. In providing information about these two options, the surgeon should inform the patient of the estimated waiting times for each sector (where possible) and provide the patient with an indication of the differences between the two systems, for example, whether the patient will have access to the surgeon of choice and the freedom to choose the timing of the surgery, in the public sector.

My expert advisor commented that if a person sees a surgeon in his private rooms and has insurance, then it is reasonable to expect the patient will want to be treated in a private hospital, provided that it is clinically appropriate. While I accept that in these circumstances a patient would usually choose to continue to receive private care, this does not mean that the patient is not entitled to information about the option of having the surgery performed in the public hospital, or about any relevant differences in the service. My view is supported by the statement of the Royal Australasian College of Surgeons.

Other types of information a reasonable patient may expect to receive include the risk of having a procedure performed at a certain location (for example, where fewer back-up services are available) or specific relevant information about having a particular provider perform the proposed procedure (for example, where the provider has limited experience in performing that procedure, or the provider's practice in that area has been restricted).[5]

Providers have a duty to provide balanced and fair information about the options available to a patient and to subordinate any private interests to the interests of the patient in making informed decisions about their treatment. Providers must take care not to present patients with unbalanced explanations of their condition or options to support their treatment preferences.[6]

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[3] Case 01HDC00755 (General, Laproscopic and Endoscopic Surgeon, 9 May 2003), Case 02HDC18414 (Neurosurgeon/Radiation Oncologist, 6 April 2004).
[4] Case 01HDC05619 (Heptabiliary Surgeon, 31 July 2002).
[5] See HDC opinions 00HDC10159 and 00HDC08628.
[6] Manning, J., "Informed Consent to Medical Treatment: The Common Law and New Zealand's Code of Patients' Rights" Medical *Law Review* (2004) 12 (2) 181-216.

The fulfilment of this duty not only respects patient autonomy but also fosters professionalism. One of the fundamental principles of professionalism is the recognition of one's responsibilities as a health practitioner, and of the obligation to place the interests of the patient above those of the doctor.[7] The obligation to provide information – such as information about relevant restrictions on practice – is not intended to place an undue burden on the provider but to support a culture where patients' rights and medical professionalism are protected.

In my view, the obligation to provide information about practice restrictions is neither unreasonable nor unrealistic. I see no practical reasons why the delivery of information about practice restrictions, with a careful explanation of the circumstances and with appropriate support available, would necessarily preclude a patient from choosing to proceed with surgery performed by that provider. A provider should not underestimate the impact that openness and candour can have on the doctor–patient relationship. Studies in relation to open disclosure of adverse medical events support this view. However, the ultimate decision whether to proceed with surgery by that provider is the patient's.[8]

In short, Mrs A was entitled to information about all available options to make an informed choice about her care and treatment. In my view, given the particular circumstances of Mr Breeze's situation, greater disclosure about available options was required. A reasonable patient, in Mrs A's circumstances, would expect to be informed of Mr Breeze's restrictions and of alternative management options, including the option of having the surgery performed by another surgeon (whether in private or public). Mr Breeze's personal view about the reasonableness of the restrictions on his practice did not excuse him from his obligation to inform Mrs A of those restrictions. Mr Breeze could have discussed the basis for his restrictions with Mrs A to enable her to make an informed choice whether to proceed with surgery performed by him.

As noted by my advisor, there were a number of options available to Mrs A. Many surgeons would treat her with antibiotics and place her on a waiting list for routine surgery, while others would operate on the next available list.

I accept that it is unlikely that Mrs A would have received surgery sooner than 17 April even if she had been referred urgently to the public hospital or to another private surgeon, and that her condition probably did not warrant an urgent referral to the public hospital. I also note that if Mrs A had been referred to the public hospital, it is possible that she may have initially been treated conservatively and operated on several months later when the inflammation of her gall bladder had subsided. However, even if an urgent referral to the public hospital was not clinically indicated in this case, Mrs A may have wanted to be treated by a different clinician in light of Mr Breeze's restrictions, and this option should

[7] Charter of medical professionalism: Medical professionalism in the new millennium: a physicians' charter, *Lancet* 2002; 359:520-522.

[8] I note in passing that I do not agree with my expert advisor's view that the "ultimate decision" (whether to have surgery in public or private) is that of the surgeon.

have been discussed with her. I suspect that if Mrs A had been adequately informed about Mr Breeze's restrictions and other management options, it is likely she would have chosen not to proceed with surgery performed by him.

In summary, in the circumstances of this case, Mr Breeze had an obligation to inform Mrs A of the restrictions placed on his practice and the options open to her. Mr Breeze should have facilitated a discussion with Mrs A about the basis for, and implications of, the restrictions on his practice for her care and treatment, and of the feasibility of the other available options for treatment. By failing to inform Mrs A of the restrictions on his practice and to discuss the option of surgery performed by another surgeon (whether in a private or public hospital), Mr Breeze breached Right 6(1) of the Code.

Opinion: No breach – Mr Ian Breeze

In my opinion Mr Breeze did not breach the Code with regards to his clinical treatment of Mrs A, for the reasons set out below.

The operation
Mrs A was admitted to Norfolk Hospital for surgery on 17 April 2002. Before surgery she advised Mr Breeze that she had experienced a severe attack of sharp pain, which suggested to him that her gallbladder had perforated. Mrs A's operation, a laparoscopic cholecystectomy, went ahead as planned. The operation was technically difficult, because of the severe degree of inflammation and scarring. The operation finding was of a gallbladder mass secondary to acute cholecystitis. It was noted that the gallbladder had perforated, but had resealed itself. There was also a suggestion that the gallbladder perforated during dissection. Following removal of the gallbladder, Mrs A's abdomen was lavaged with saline, and a Redivac drain was inserted. Mr Breeze considered that Mrs A was at risk of developing a post-operative subphrenic abscess (due to the perforation of her gallbladder), and accordingly he commenced her on intravenous gentamicin (a strong antibiotic).

My advisor noted that it was reasonable for Mr Breeze to proceed with a laparoscopic cholecystectomy in Mrs A's case. There were no clinical reasons why surgery was inappropriate or should have been abandoned. My advisor commented that, in his opinion, the operation was performed in accordance with professional standards. Although there was a suggestion that the gallbladder perforated (or ruptured) during dissection, rupture of a gallbladder during dissection is a recognised complication of both open cholecystectomy and laparoscopic cholecystectomy. When a gallbladder ruptures during dissection, standard procedure is to wash out the upper abdomen and provide adequate drainage. Following removal of Mrs A's gallbladder, Mr Breeze washed out (lavaged) her abdomen with saline, and inserted a Redivac drain. In all the circumstances, based on my expert's advice, Mr Breeze's actions in performing Mrs A's operation appear to have been appropriate and reasonable. Accordingly, Mr Breeze did not breach Right 4(1) of the Code in relation to his operation on Mrs A.

My advisor did comment that in hindsight it may not have been advisable for Mr Breeze to administer Fragmin to Mrs A, since it is a blood thinning medication that can increase the likelihood of bleeding. My inquiry is whether, at the time, and in the circumstances at the time, Mr Breeze acted with reasonable care and skill. Mr Breeze advised me that the administration of Fragmin pre-operatively is part of his standard thrombo-prophylaxis. Although Mr Breeze did consider discontinuing Fragmin post-operatively, he was concerned about Mrs A's history of unexplained breathlessness and her post-operative immobility and believed there was a risk of her developing a pulmonary embolus if Fragmin was discontinued. Mr Breeze's explanation is reasonable given the circumstances he faced at the time, and it would not be appropriate for me to criticise his actions with the benefit of hindsight.

Post-operative care and treatment
Post-operatively Mrs A had a mildly raised temperature, and daily blood tests indicated that her haemoglobin was dropping and her white blood cell count rising. Initially neither Mr Breeze nor Dr C had concerns about Mrs A's progress, in light of her previous painful cholecystitis and surgery. Mr Breeze visited Mrs A daily, and also kept in regular contact with the ward by telephone to order and receive blood test results and information about her condition. In particular, Mr Breeze either reviewed Mrs A or received information from the ward about her condition on the following occasions between 17 and 20 April:

- 4pm on 17 April – Mr Breeze phoned the ward to request a blood test to check Mrs A's haemoglobin levels.

- At some time later on 17 April Mr Breeze was informed of the blood test results. Mrs A's haemoglobin was 113, and her white blood cell count 14.

- Morning of 18 April – Mr Breeze reviewed Mrs A. He had no concerns about her progress, but ordered further blood tests.

- At some time later on 18 April Mr Breeze was informed of the blood test results. Mrs A's haemoglobin was 105, and her white blood cell count 18.

- 8am on 19 April – Mr Breeze reviewed Mrs A. He was pleased with her progress. Further blood tests were taken.

- Some time later on 19 April Mr Breeze was informed of the blood test results, possibly at 1pm when he phoned the ward. Mrs A's haemoglobin was 91 and her white blood cell count 19.7.

- Mr Breeze phoned the ward at 6.30am on 20 April to enquire about Mrs A's condition. From the information received he ascertained that she was satisfactory.

- At 11.15am Mr Breeze was phoned and made aware of blood test results taken that morning, which indicated a further drop in Mrs A's haemoglobin (to 88) and a rise in her white blood cell count (to 21.6).

- At 12.15pm Mr Breeze reviewed Mrs A.

Following Mr Breeze's review of Mrs A on 20 April, he considered that her progressive blood test changes indicated that she may have developed a subhepatic collection, and he arranged for her to be transferred to Tauranga Hospital for an urgent abdominal scan.

Over the three post-operative days at Norfolk Hospital, Mrs A was receiving intravenous gentamicin.

I asked my expert advisor whether Mr Breeze's post-operative management of Mrs A was appropriate. My advisor considered that Mr Breeze's management of Mrs A over the post-operative period, and the timing of the transfer to Tauranga Hospital, was appropriate. It was reasonable to accept a raised white count, temperature and pulse in the post-operative period given the operative findings (a gallbladder mass secondary to acute cholecystitis in the presence of a severe degree of inflammation and scarring). A reasonable surgeon would expect the raised white blood cell count, temperature and pulse to settle with antibiotic treatment over a few days post-operatively. Mrs A received a strong antibiotic post-operatively. When her condition failed to improve despite antibiotic treatment and her haemoglobin continued to drop, it was appropriate to suspect that she may have a collection. My advisor noted that in these circumstances, the small volume of drainage from the Redivac was "clearly misleading".

I accept my expert's advice that Mr Breeze's post-operative management of Mrs A was appropriate. When her condition failed to improve with antibiotic treatment, Mr Breeze appropriately suspected a collection and referred her to Tauranga Hospital for further investigation and treatment in a timely manner. There is no evidence to suggest that Mr Breeze failed to provide services with reasonable care and skill in his post-operative management of Mrs A, and he therefore did not breach Right 4(1) of the Code.

Other comment

In his response to the complaint, Mr Breeze questioned Dr D's decision to operatively drain Mrs A's haematoma. Drawing a comparison to intra-abdominal haematoma from traumatic rupture of the spleen or liver, Mr Breeze commented that such patients can be managed conservatively, without surgery, and that such an approach may have been more appropriate in Mrs A's case.

My advisor considered that the examples quoted by Mr Breeze were unrelated and very different from the situation in Mrs A's case:

> "In the case of Mrs A, she was very septic with a white count of 21.6 thousand, a raised temperature and pulse and a low albumin of 20 g. An infected gallbladder had

been removed with a resulting haematoma. I do not believe any surgeon would have left this haematoma in place without draining it."

Although Mr Breeze disagrees that Mrs A was septic and her haematoma infected, I bring this advice to his attention.

Recommendation

I recommend that Mr Breeze take the following action:

- Apologise in writing to Mrs A for his breach of Right 6(1) of the Code. Mr Breeze's apology should be sent to my Office, and will be forwarded to Mrs A.
- Review his practice in light of my report.

Follow-up actions

- A copy of my report will be sent to the Medical Council of New Zealand and the Royal Australasian College of Surgeons.
- In light of the significant public interest in my inquiry into Mr Breeze's practice, a copy of my report, with details removed identifying all parties other than Mr Breeze, my expert advisor, and the hospitals, will be released to the media and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes, upon completion of my inquiry.

Names (other than Mr Breeze, the Commissioner's expert advisor and the hospitals) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.