Dr C /

A Public Hospital

A Report by the

Health and Disability Commissioner

(Case 00HDC00835)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Consumer
Mrs B	Complainant / Consumer's daughter-in-law
Dr C	Provider / General Surgeon
Mr E	Consumer's husband
Mrs F	Consumer's daughter
Dr G	Registrar
Dr H	Medical Director of the public hospital

Mrs A was not interviewed. Mrs A's family advised that she has impaired memory and would not remember the events.

Complaint

On 27 January 2000 the Commissioner received a complaint from Mrs B about the services provided to her mother-in-law, Mrs A, by Dr C. The complaint is that:

- *Mrs A signed a consent form for an above knee amputation of her leg. Dr C removed her leg in a below knee amputation. Mrs A required further surgery for an above knee amputation one week later.*
- *Dr C explained that he performed the below knee amputation so it would be easier for Mrs A to have a prosthesis fitted. Mrs A is permanently in a wheelchair because her other leg was amputated 12 months before.*

An investigation was commenced on 7 April 2000.

Information reviewed

- Mrs A's medical records from her general practitioner and a public hospital.
- Report from independent general surgeon, Dr Robert Robertson.

Information gathered during investigation

The events complained of took place in April 1999. At that time Mrs A was a frail 78-year-old woman who lived in a rest home. Mrs A had a history of diabetes and some degree of cognitive impairment. She also suffered from peripheral vascular disease with impaired blood flow to her lower limbs.

History prior to 1999 – Amputation of left leg
In January 1998 Mrs A developed gangrene in her left foot. In February 1998, she was admitted to the public hospital under the care of Dr C, who amputated her left leg below the knee. The wound from the left below knee amputation did not heal well and, in March 1998, Dr C needed to perform a left above knee amputation. Mr E advised that Mrs A suffered considerable pain and trauma from the two operations.

1998-1999 – Continuing circulation problems
Mrs A continued to have problems with her peripheral vascular disease, and both she and her family were aware that she might eventually require amputation of her right leg.

On 17 August 1998 Mrs A had a vascular bypass operation in an attempt to improve the blood flow to her right foot. The surgery had limited success. On 15 February 1999 Mrs A's general practitioner, Dr D, referred her back to Dr C to have her circulation reassessed. Dr C reported his findings to Dr D:

> "Thank you for referring this elderly lady from [the] Rest Home who is a left mid thigh amputee. She is now getting rest pain in her remaining foot. Clinically there are marked trophic changes [changes to the appearance of the skin caused by poor circulation] and very marked dependent hyperaemia [excess blood vessels]. Doppler measurement [measurement of blood flow] shows that circulation distally [at the foot end] is just ticking over.
>
> We will see her in the future if her rest pain becomes severe enough or she develops any overt signs of gangrene. In the meantime the symptoms are bearable and I have advised her to do as much movement with the limb as possible as this is the only thing that has a long term beneficial effect."

On 6 April 1999 Dr D saw Mrs A at the rest home, and found gangrenous changes on the toes of her right foot. Dr D discussed this with Dr C and arranged for Mrs A to be admitted to hospital the following day.

April 1999 – Amputation of right leg: pre-operative care
Mrs A was admitted to hospital on 7 April 1999. She was accompanied by her husband and her daughter, Mrs F.

Dr C's registrar, Dr G, admitted Mrs A to hospital, and recorded the following in Mrs A's notes:

> "Right foot – no pulses. 3rd toe gangrene. White, ischaemic [inadequate blood supply] looking distal foot … Seen by [Dr C] – told same problem as last time. Will need R AKA [right above knee amputation]."

Dr C saw Mrs A during ward rounds on 8 April and 10 April 1999. Dr C told Mrs A that "she would need to prepare herself mentally to accept amputation above the knee again".

Mrs A's notes record that her operation was scheduled for Monday 12 April 1999. On 10 April 1999 Mrs A was taken to the Intensive Care Unit ("ICU") to establish an epidural for surgical anaesthesia and postoperative pain relief.

Consent

On 11 April 1999 Dr G discussed the operation with Mrs A, Mr E and Mrs F and obtained written consent for a right above knee amputation. Dr G was unable to remember the details of this conversation. Mrs F said she could remember clearly Dr G explaining that Mrs A's leg would be amputated above the knee. Mr E said that to his knowledge a below knee amputation was never discussed as an option, either at the time the consent form was signed, or prior to that. This is consistent with the documentation in the clinical records.

Mr E and Mrs F advised that Mrs A's desire was to have an above knee amputation. She did not want to have to endure the pain and suffering that she experienced at the time her left leg was amputated, when she required two operations because her below knee amputation did not heal. Mr E and Mrs F said that they and Mrs A stated this clearly during the five days when Mrs A was in hospital prior to her surgery.

Operation

Mrs A's operation took place on 12 April 1999. Dr C had expected that an above knee amputation would be necessary, but a trial incision revealed a "surprisingly good blood supply", and he decided to perform a below knee amputation instead. Dr C explained that:

> "[i]n keeping with a basic professional reflex to attempt to look after the best interests of my patient, it is my usual practice to make a trial cut at the lowest level reasonable at the time. The bleeding proved to be brisk and closer inspection revealed a surprisingly good blood supply. So much so, that it seemed at the time that a below knee amputation stood a very good chance of success."

Dr C explained the benefits of a below knee amputation as follows:

> "[e]ven in a patient who has lost one leg above the knee, a below knee amputation allows a patient to wear a prosthesis and have some independence moving about in the bed, not much of an advantage, you might think, but when so limited as a bilateral amputee, this can be a very important advantage. This was the thought that made me consciously discount the risk of not operating in accord with the consent. Unfortunately, in retrospect, this proved to be the wrong decision because of the treacherous nature of the diabetic peripheral circulation. Diabetics exhibit a

> tendency to 'die back'. As well as having an increased tendency to obstructive disease of the large arteries, diabetics have microvascular disease [disease of the small blood vessels], and if this is not enough their white cells, particularly macrophages (the large white cells that ingest bacteria) are incompetent.
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> So, what was apparently healthy bleeding tissue at the time of the amputation, subsequently died and became necrotic [dead tissue], necessitating as you have been told, amputation at a higher level. So I am at fault if my conduct is judged purely by the letter of the law – but it seems that the spirit of the law has been complied with.
>
> I very much regret that my last minute change in the level of amputation, ultimately resulted in a further procedure and unnecessary, distress, discomfort and suffering to my patient at the time – [Mrs A]."

After surgery

After surgery Mrs A was taken to ICU. When Mr E visited her, he was surprised to see the impression of the bedclothes, and what looked to be a below knee amputation. Not long after, Dr C came in to see Mrs A. Mr E said that Dr C did not explain why he had not performed an above knee amputation.

In the initial post-operative period Mrs A made good progress and her wound seemed to be healing well. However, by 20 April 1999 Mrs A's wound was no longer healing well and Dr C decided that further surgery was required. On 22 April 1999 Mrs A's amputation was extended to above the knee.

Mrs F and Mrs B complained to Dr C that he had not followed the request for an above knee amputation. Dr C rang Mrs B some months after Mrs A's second operation to explain why he had initially removed Mrs A's leg below the knee. Dr C told Mrs B that he had performed the operation because it would be easier to fit an artificial limb to a below knee amputation. Mrs A's family did not accept this explanation because Mrs A had been confined to a wheelchair from the time she had her right leg amputated.

Independent advice to Commissioner

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

> "In [Dr C's] report and in the operation note dated 12 April 1999 it was made clear that 'a trial incision was conducted showing surprisingly good blood supply to the tissues below the knee'. Because of this instead of proceeding to an above knee amputation, the operation was continued as a below knee amputation in an endeavour to give [Mrs A] a better outcome for potential mobility in transferring from wheelchair to bed, bath facilities and toilet facilities etc. While the consent for

the operation was for an above knee amputation, the object of [Dr C's] procedure was to maximise the benefits to [Mrs A] that a below knee amputation would give her compared to becoming a bilateral above knee amputee. Unfortunately, 10 days following this surgery she did require an above knee amputation because of the inability of the wound to heal which probably is a reflection of her diabetic status and the fact that patients with diabetic vascular disease suffer from both microvascular and large vessel disease.

I believe that [Dr C's] decision to remove [Mrs A's] leg below the knee was reasonable in the circumstances he was faced with and, while there is information to show that [Mrs A] had signed consent for an above knee amputation, to give her the best possible physical outcome that could be achieved was an objective that if it had been successful she would have certainly benefited from.

While there was obviously a 10 day delay and two operations involved in this case after the below knee amputation, in the longer term of things for [Mrs A], if it had been able to be achieved as a below knee amputation, the gain and independence she would have achieved would have been immensely beneficial to her."

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 6
Right to be Fully Informed

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

…

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

2) Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent.

…

RIGHT 7
Right to Make an Informed Choice and Give Informed Consent

1) Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.

Opinion: Breach – Dr C

Rights 6(1)(b) and 6(2)

In my opinion Dr C breached Rights 6(1)(b) and 6(2) of the Code of Health and Disability Services Consumers' Rights by not providing Mrs A with sufficient information about her operation in April 1999.

Mrs A had the right to the information that a reasonable consumer, in her circumstances, would expect to receive.

Relevant circumstances in this case included Mrs A's experience of needing two operations when she had her left leg amputated, and her express desire to avoid suffering from incremental amputations to her right leg. I am satisfied that Dr C knew, or ought to have known, of Mrs A's concern about the possibility of once again having to endure a below knee amputation followed by an above knee amputation.

In my opinion, a reasonable consumer, in Mrs A's circumstances, would have expected to receive information about the possibility of a below knee amputation. Dr C should have clearly informed Mrs A that, while he expected that she would require an above knee amputation, he would save as much healthy leg as possible. Dr C should have discussed the possibility of a below knee amputation with Mrs A, and he should have explained the risks and benefits of both above and below knee amputation. After the operation, it would have been appropriate for Dr C to discuss the operative findings with Mrs A, and to explain his clinical decision to perform a below knee amputation rather than the proposed above knee amputation.

I note that Dr G, Dr C's registrar, discussed above knee amputation with Mrs A and her family, and signed the informed consent form. In doing so, he was acting in accordance with information from Dr C that Mrs A would be having an above knee amputation. I am aware that junior doctors are expected to obtain informed consent for complex surgical procedures in many New Zealand hospitals. However, it remains the responsibility of the person performing the surgery, in this case Dr C, to take all reasonable steps to ensure that patients have been provided with sufficient information, and have given properly informed consent.

In my opinion, Dr C breached Right 6(1)(b) and Right 6(2) of the Code by failing to inform Mrs A about the possibility of below knee amputation.

Opinion: No Breach – Dr C

Right 7(1)

In my opinion Dr C did not breach Right 7 of the Code by performing a below knee amputation instead of an above knee amputation. In all the circumstances of the case, it was appropriate for him to perform a less invasive procedure (below knee amputation) when it became apparent at operation that the more invasive procedure (above knee amputation) was no longer clinically indicated.

Mrs A's family accept that she consented to an above knee amputation. (Although as discussed above, for her consent to have been properly informed, she should have been given more information about the possibility of a below knee amputation.) At operation, Dr C made a trial incision and discovered viable tissue lower down the leg than expected. Dr C advised that it would have gone against his surgical training to amputate what appeared to be very healthy tissue. I accept my expert's advice that a successful below knee amputation would have given Mrs A the best possible physical outcome and that Dr C's decision to remove Mrs A's leg below the knee was reasonable in the circumstances.

In all the circumstances of the case, Dr C's clinical decision to perform a below knee amputation when an above knee amputation was no longer clinically indicated did not amount to a breach of Right 7 of the Code.

Opinion: No liability – The Public Hospital

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

I am satisfied that the public hospital took such steps as were reasonably practicable to ensure that medical staff, including Dr C, provided sufficient information about proposed surgery. In my opinion the public hospital is not vicariously liable for Dr C's breaches of the Code.

Actions

In response to my provisional opinion, Dr C wrote a letter of apology to Mrs A's family for his breaches of the Code. This letter will be forwarded to Mrs A's family, care of Mrs B.

I am advised that Dr C has resigned from the public hospital, is no longer working as a surgeon, and intends to surrender his practising certificate.

In the circumstances, no further action is necessary.

Further actions

- A copy of this opinion will be sent to the Medical Council of New Zealand.
- A copy of this opinion, with all identifying features removed, will be sent to the Royal Australasian College of Surgeons and will be placed on the Commissioner's website, www.hdc.org.nz, for educational purposes.