Identification of risks to thyroidectomy patient (09HDC01422, 29 March 2011)

General surgeon ~ Anaesthetist ~ Public hospital ~ District health board ~ Thyroidectomy ~ Complications ~ Vicarious liability ~ Rights 4(1), 4(4)

The family of a 36-year-old woman complained about the care she received when she underwent thyroidectomy surgery. Following surgery the woman was noted to have high blood pressure which the anaesthetist decided not to treat. The woman was later transferred to the ward. Later in the day she developed breathing difficulties and stopped breathing. Due to a failure in the DHB's paging system there was a delay in the emergency response team arriving and attempts to resuscitate the patient were unsuccessful.

It was held that that the surgeon breached Rights 4(1) and 4(4) by failing to carry out an adequate preoperative assessment and placing the patient at an unnecessary risk by deciding to perform surgery at a facility which had limited ability to cope with major complications.

It was also held that the DHB breached Right 4(4) for failing to have an adequately functioning paging system and for failing to have in place adequate support and guidance for staff in the management of complex cases, and was held vicariously liable for the surgeon's breach.

The anaesthetist's decision to proceed with surgery was held to be appropriate. When the woman's blood pressure rose postoperatively, his decision not to treat her at that time was reasonable. On that basis, he did not breach the Code. However, he was reminded of the importance of documenting all patient findings and observations, particularly when they directly influence clinical decision-making.