Surgical error during hysterectomy
(13HDC01557, 21 June 2016)

Obstetrician and gynaecologist ~ Gynaecology ~ Menometrorrhagia ~ Hysterectomy ~ Surgical error ~ Colostomy ~ Record keeping ~ Open disclosure ~ Rights 4(1), 4(2)

A 46-year-old woman consented to undergoing a total vaginal hysterectomy performed by an obstetrician and gynaecologist (OB/GYN) at a public hospital. During the procedure, initial attempts by the OB/GYN to open the Pouch of Douglas (the extension of the peritoneal cavity between the rectum and the posterior wall of the uterus) failed. The OB/GYN then mistakenly identified the woman's bowel wall as the Pouch of Douglas and attempted to open it, causing a perforation to the woman's bowel.

The OB/GYN then stopped the procedure and sought assistance from another OB/GYN. The other OB/GYN found that the woman had extensive adhesions of the "uterus, tubes [and] ovaries, to the side walls and posterior wall of [the] pelvis". Due to the difficulties with the vaginal hysterectomy, they converted to an abdominal hysterectomy.

The OB/GYN contacted a general surgeon and requested his assistance with repairing the perforation to the woman's bowel. The general surgeon was unsure about being able to close the perforation entirely, so decided to perform a loop colostomy. The abdominal hysterectomy was then completed.

The OB/GYN and the woman have different recollections of what was discussed after the surgery. There are no records of any conversations during which the OB/GYN told the woman that she had made an error during the surgery, which resulted in her having perforated the woman's bowel.

The OB/GYN had been involved in prior adverse events at the public hospital.

It was held that the OB/GYN's failure to seek advice or assistance from a more senior colleague and convert to an abdominal procedure earlier, plus her mistake in incising incorrectly identified tissue amounted to a serious departure from expected standards. Accordingly, the OB/GYN failed to provide services to the woman with reasonable care and skill and breached Right 4(1). Her poor standard of record-keeping amounted to a breach of professional standards and, accordingly, she breached Right 4(2). Criticism was also made of the OB/GYN's failure to openly disclose the surgical error in a way that was adequately understood by the woman.

Adverse comment was made about the DHB's systems for identifying and reporting serious surgical events.

The Commissioner recommended that the OB/GYN apologise to the woman for her breaches of the Code and that the Medical Council of New Zealand undertake a review of the OB/GYN's competence should she return to practise medicine in New Zealand.

The Commissioner also made recommendations to the DHB regarding extra credentialing for advanced surgical procedure and reviewing its process for identifying serious surgical morbidity.