Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the
Deputy Health and Disability Commissioner
(Case 20HDC01320)

Introduction

This is the opinion of Deputy Commissioner Deborah James, and is made in accordance with the power delegated to her by the Commissioner.

This report discusses the care provided to Ms A by Dr B at a district health board (DHB) (now Te Whatu Ora).[1]

Ms A had a history of pelvic pain, heavy or prolonged menstrual bleeding that was difficult to manage, and uterine fibroids.[2] The size of the fibroids was increasing significantly over time. Multiple avenues of conservative management had been trialled previously, but were unsuccessful. Because of the severe nature of Ms A's symptoms, a decision was made to proceed with a hysterectomy.[3]

On 17 July 2019, Ms A underwent a laparoscopic hysterectomy[4] and bilateral salpingectomy,[5] performed by Dr B. Prior to this, Dr B had performed a hysteroscopy[6] on Ms A on 30 September 2013. Ms A has a unique ureter condition, in that she has two ureters[7] draining from the left kidney into the bladder, rather than the usual one. Regrettably, on the day of the surgery, Dr B did not remember that Ms A had two ureters, and did not follow his usual practice of reading the clinical notes prior to commencing surgery, and he omitted to identify both of the left ureters during the surgery. As a result, the second left ureter was injured inadvertently. The injury was an unlikely consequence of the surgery. Dr B accepted that he had caused Ms A's injury during the surgery on 17 July 2019. Dr B told HDC:

> "Unfortunately, I was not cognisant of the second left sided ureter during the procedure and hence did not actively seek to protect it. Had I been aware of it at the

[1] On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all 20 District Health Boards. Their functions and liabilities were merged into Te Whatu Ora — Health New Zealand. All references in this report to the DHB now refer to Te Whatu Ora.
[2] Uterine fibroids are noncancerous growths of the uterus.
[3] Hysterectomy is the surgical removal of the uterus, with or without the cervix. Hysterectomy is used to treat a number of conditions, including heavy or painful menstrual bleeding and fibroids.
[4] A laparoscopic hysterectomy is a minimally invasive surgical procedure to remove the uterus.
[5] A bilateral salpingectomy is a procedure in which both fallopian tubes are removed.
[6] A hysteroscopy is an examination of the inside of the cervix and uterus using a thin, lighted, flexible tube called a hysteroscope.
[7] The ureter is a tube that carries urine from the kidney to the urinary bladder.

> time, I have no doubt that an injury would not have occurred because I would have taken steps to identify the second ureter and dissect it out to the extent that I was sure it was clear from the hysterectomy dissection. This type of dissection is done routinely when performing a hysterectomy for an enlarged fibroid uterus and indeed was undertaken with the other left sided ureter and the right ureter."

Ms A raised concerns about errors made by Dr B, and whether the correct procedure was performed (whether she should have had a laparotomy[8] (an "open" hysterectomy) rather than a laparoscopic hysterectomy). Ms A also raised concerns that she was not informed that it would be necessary for the ureter to be dissected during surgery, and that the risk of ureteric injury was not discussed with her.

The following issues were identified for investigation:

- *Whether Dr B provided Ms A with an appropriate standard of care in 2018 and 2019.*
- *Whether the DHB provided Ms A with an appropriate standard of care in 2018 and 2019.*

Responses to provisional opinion

Ms A was given the opportunity to respond to the facts gathered during the investigation, excluding the provisional opinions. Her response has been incorporated into this report where relevant.

Ms A told HDC that these events have affected her loved ones, her friendships, her job, and mostly, her mental wellbeing. She said that it has severely impacted every part of her life. She told HDC that she was diagnosed with post-traumatic stress, being a treatment injury following the surgery, which has now been covered by ACC.

Ms A told HDC that she feels that she has not been treated with respect and courtesy by Dr B, in particular in relation to seeking her informed consent prior to surgery. Ms A said that Dr B "failed to check and ask about the ureter prior to conducting the surgery".

Ms A also told HDC that she feels that the surgery and follow-up care were not provided in a manner that respected her dignity and independence. She said that after the surgery, she suffered severe pain for two months, thinking it was normal postoperative pain, when in fact it was due to a treatment injury that was not an ordinary consequence of the procedure. Ms A told HDC that Dr B was "well aware" that she was in pain. She said that she asked to "go private" as she felt that she was not being taken seriously by Dr B following the surgery. She said that the injury was found "months after the botched hysterectomy putting

[8] A laparotomy is an operation to open the abdomen to facilitate a procedure (sometimes referred to as "open" surgery). This is opposed to a laparoscopy, which is a minimally invasive surgical procedure (sometimes referred to as "keyhole" surgery).

[her] in grave risk". Ms A told HDC that Dr B went on holiday for a month following her surgery, during which time she had no gynaecology contact.

Ms A maintains that she was not informed of the risks of the procedure, and that they were not explained to her clearly. She maintains that the risk of ureteric injury was never discussed with her.

Dr B and the DHB were given the opportunity to respond to the provisional opinion, and their responses have been incorporated into this report where relevant.

Dr B told HDC that Ms A suffered "a very unfortunate" surgical complication of ureteric injury from her hysterectomy surgery in July 2019, which he deeply regrets. Dr B took the opportunity to provide an apology to Ms A for the injury sustained and the impact this has had on her quality of life.

The DHB told HDC that it will support Dr B to develop a structured format for reviewing patient clinical notes and preoperative consultation notes prior to surgery.

The DHB told HDC that there was additional documentation around informed consent, and provided HDC with a copy of a letter dated 18 December 2018 that was sent to Ms A's GP. The DHB stated that it believes that this letter supports the provision of documentation and informed consent.

Opinion: Dr B

First, I acknowledge the distress the uretic injury has caused Ms A, and the impact this has had on her quality of life.

I have undertaken a thorough assessment of the information gathered in light of Ms A's concerns, and I have found Dr B in breach of Right 4(1) the Code of Health and Disability Services Consumers' Rights (the Code). The reasons for my decision are set out below.

Preoperative work-up and surgery on 17 July 2019 — breach
In my view, the key issue in this complaint is the preoperative work-up that Dr B carried out prior to the surgery on 17 July 2019.

To determine whether the care provided by Dr B was reasonable, I have considered Ms A's complaint, statements made by Dr B, and the expert advice of a gynaecologist, Dr Richard Dover (**enclosed**).

Dr B provided an explanation of the events leading up to the surgery. He explained that the preoperative consultation had taken place on 12 December 2018, but the surgery was then delayed until July 2019 due to external events that occurred at that time. Having performed Ms A's previous surgery in 2013 and undertaken the preoperative consultation in December

2018, Dr B had been aware that Ms A has two ureters. However, he said that from the time when he obtained consent to the time when the surgery was performed, that fact had faded from his memory.

Dr B told HDC that on the day prior to the surgery, the hospital had a "red" status, which meant that there was a severe shortage of hospital beds. Dr B said that he felt "very anxious" that the surgery would be cancelled again. Ms A's psychiatrist had also written to the DHB on 9 April 2019 to advise of her severe anxiety disorder, and that the delay in obtaining a set date for her surgery had led to a resurgence in symptoms. Dr B then had discussions with the theatre manager to ensure that the surgery could proceed on 17 July 2019, as planned.

Dr B told HDC that his usual practice would be to review the consent form on the morning of surgery, and to have a discussion with the patient about the surgery. He said that usually this would be an opportunity for him to obtain an update on the patient's medical condition.

However, Dr B accepts that in this case he did not follow his usual practice, and he did not read the preoperative consultation note. He said that he reviewed the ultrasound images on the morning of the surgery, but he did not read the radiology report. He stated that this was because he had had frequent contact with Ms A and felt fully updated on her condition at that time. He said that there had been a "plethora of ongoing correspondence", and he had already answered many of her questions by email. Dr B stated that for these reasons, he did not consider it necessary to refer to the preoperative consultation note of 12 December 2018. He acknowledged, however, that if he had read either the preoperative consultation note or the radiology report, he would have been reminded that Ms A has two ureters. Dr B told HDC:

> "I deeply regret that I caused an injury to [Ms A's] ureter. It is very disappointing that I did not follow my usual routine on the morning of surgery and review the pre-op consultation note. This had specific information about the double ureters and I believe, if I had read this, it is possible the injury could have been prevented."

Dr B told HDC that ultimately, the main reason for him not having reviewed the preoperative consultation note was the familiarity he had with Ms A's clinical details relating to her enlarged fibroid uterus. He stated that under usual circumstances, he would have little or no contact with patients between the time they were seen for a consent appointment and the time of surgery several months later. He stated that clinical details can rarely be retained for this period of time, and preoperative review of the clinic letter would be an essential prerequisite for surgery.

Dr B told HDC that he would not commence surgery for any patient if he was not fully satisfied with his knowledge of the clinical details. However, Dr B stated that Ms A was not a

"usual patient", and that there had been ongoing communication with Ms A (both by email and text messages) over the seven months between her consent appointment in December 2018 and her surgery in July 2019. On 16 April 2019, Dr B also wrote a letter of support for charitable funding for surgery, which contained a full clinical summary of Ms A's gynaecology history, examination and scan findings.

Dr B stated that Ms A's communication with him had been unusual both in its frequency and detail and, as such, he was fully aware of her clinical history. He stated that he was "far more aware" of Ms A's clinical history than any other patient, but despite his familiarity with her symptoms and clinical details, he had not been reminded of the incidental finding of a duplex kidney.

Dr Dover reviewed the email communications between Ms A and Dr B prior to the surgery, and said that the frequency of these communications attested to the high level of care that was provided by Dr B. Dr Dover considers that the general preoperative work was "above what would be expected from a standard specialist". However, Dr Dover was critical that Dr B did not review the preoperative consultation documentation and radiology report prior to performing the surgery. Dr Dover advised:

> "I think most surgeons, irrespective of specialty, would feel that reviewing the patient's notes, history and imaging investigations prior to surgery would be a basic prerequisite."

Dr Dover said that in Ms A's case, the requirement to review the preoperative consultation documentation and radiology report was even more crucial because of the delay between the preoperative consultation and the surgery, and the knowledge that it would be a complicated procedure. Dr Dover considers that the failure to do so fell short of the accepted standard of care, and that it would be viewed "at the upper end" of a moderate departure from the accepted standard of care.

I accept Dr Dover's advice and agree that Dr B should have reviewed the relevant documentation prior to performing the surgery. While there was a delay between the preoperative consultation and surgery, I acknowledge that during that time, Dr B had ongoing and frequent communication with Ms A, and that he was well aware of her clinical history. However, while Dr B may have felt reassured and confident about the surgery because of the significant contact he had had with Ms A prior to the surgery, it was not reasonable for him to perform the surgery without having reviewed the relevant documentation which would have revealed Ms A's duplicate kidney. Dr B's lack of review of the clinical notes and radiology findings resulted in a lack of awareness of Ms A's two ureters.

HDC has stated previously that a surgeon needs to read the notes to the extent necessary to be satisfied that, as the operating surgeon, he or she has all of the information that he or she needs to know.[9] Further, as stated in another opinion:[10]

> "The onus is on the clinician to ask the relevant questions, examine the patient, and keep proper records. Only then is the clinician in a position to properly consider all the risks, review all available information, and then and only then, proceed to perform surgery."

I consider it more likely than not that the injury to Ms A's ureter was a result of Dr B's failure to review the documentation to ensure that he had all the relevant information about Ms A prior to performing the surgery. Dr B also acknowledged that it is possible that the injury could have been prevented, if he had reviewed the documentation.

I acknowledge Dr B's excellent communication with Ms A up until the time of surgery. However, his failure to familiarise himself with Ms A's notes immediately prior to the surgery resulted in a lack of awareness of Ms A's two ureters, and constitutes a moderate departure from the accepted standard of care. Therefore, I find that Dr B failed to provide services to Ms A with reasonable care and skill and breached Right 4(1) of the Code.

Decision for laparoscopic hysterectomy — no breach
Ms A raised concern about whether the correct procedure was performed.

Regarding the decision to proceed with a laparoscopic hysterectomy, Dr Dover advised that whilst the decision appeared contentious (due to Ms A's significantly enlarged uterus), it was justified and did not depart from accepted practice. He stated:

> "When faced with a potentially difficult operation like this most clinicians would feel that it would be reasonable to insert the laparoscope, assess the pelvis and make a decision at that point. Sometimes it is not certain whether the procedure would be able to be completed that way but nonetheless it is reasonable that the procedure begins and as long as steady and safe progress is made then it is entirely reasonable to continue with a laparoscopic attempt."

Dr Dover also advised that the surgery performed appeared challenging (again due to the significantly enlarged uterus), but that steady progress was made during the procedure.

I accept Dr Dover's advice that it was reasonable for Dr B to proceed with a laparoscopic hysterectomy in these circumstances.

[9] See case number 18HDC00131.
[10] Case number 09HDC01501, page 23.

Dr B stated that there was no suspicion of a ureteric injury during the course of surgery. There were also no complications noted or documented at the time of surgery. The anaesthetist also stated:

> "I have no recollection of anything unexpected occurring, and there were no intraoperative complications to my memory. Usually if there was a significant intraoperative complication I would have recorded it on the anaesthetic record. [On] reviewing the anaesthetic record, there is nothing out of the ordinary that I recorded."

I am therefore not critical that the injury was not detected at the time of the procedure.

Informed consent — other comment

Ms A and Dr B presented differing accounts of what was discussed with Ms A prior to surgery.

Ms A said that Dr B did not inform her that it would be necessary to dissect the ureter during surgery, and he did not discuss with her the risk of ureteric injury. She said that there was no information provided on the risks, consequences, and potential side effects of the surgery. She told HDC:

> "… I was never ever told [that I might get ureter damage] to one of my tubes because it was something I was terrified of. I've always known I had the duplex kidney and [it's] something I would have reconsidered because [I've] always been scared of the safety of surgery around it …"

Dr B told HDC that the risk of ureteric injury was discussed and documented during Ms A's preoperative consultation on 12 December 2018, and ureteric catheters were noted as a possible means to reduce the risk of ureteric injury. He said that Ms A's enlarged uterus was also noted, with the possibility that the uterine fibroids might extend laterally and be in close proximity to the ureters. Dr B stated that he had a specific discussion with Ms A around the increased risk of ureteric injury in relation to distorted anatomy from fibroids, and the expectation that ureteric dissection would be required.

Dr B said that he also discussed with Ms A the possibility of bowel or bladder damage, along with the risk of having to make a large incision to perform a laparotomy if any complications were to occur. He said that he also discussed with Ms A the risk of bleeding and infection, and the loss of fertility.

Dr B told HDC that an in-depth discussion had occurred with Ms A, and that there was a specific and detailed discussion about ureteric injury. He stated that the increased risk of ureteric injury was discussed both in terms of anatomical distortion leading to increased risk of injury, as well as the potential need to use ureteric catheters to help identify the ureters if they were not visible.

A consent form signed by Ms A on 12 December 2018 states that Dr B had explained the reasons for, and expected risks of, the operation or procedure relating to her clinical history and condition. However, the risks are not listed on the consent form.

It is documented that Dr B had discussed the surgical removal of the fibroids with Ms A on several occasions, and that Ms A had been informed about the treatment options (which were a myomectomy[11] or a hysterectomy).

It is also documented that Dr B had discussed with Ms A the possibility of bowel or bladder damage, as well as the risk of bleeding and infection, and the loss of fertility.

Dr Dover advised that given Ms A's significantly enlarged uterus and duplicated ureters, there was increased risk of ureteric injury. He advised that in this case, there were two "obvious areas" that should have been discussed with Ms A in detail, being the risk of conversion to an "open procedure" or laparotomy, and the risk of ureteric injury.

In a letter to Ms A's GP dated 12 December 2018, Dr B specifically stated:

> "She has a 12 week size fibroid uterus and she does have double ureter on either side. I have explained to her that if the lateral extension of the fibroid is significant and in close proximity to her pelvic side wall and ureter then we may need to insert ureteric catheters at the time of her procedure. This would be with the aim of avoiding ureteric injury. I have also briefly discussed the possibility of damage to other pelvic structures such as the bowel and bladder. I have warned her regarding the risk of infection and haemorrhage and also risk of laparotomy."

Based on the above, I find it more likely than not that the risk of ureteric injury and the risk of having to perform an "open procedure" or laparotomy was discussed with Ms A. I appreciate that Ms A remains of the view that Dr B never informed her of the risk of ureteric injury. However, I am unable to reconcile this for Ms A, and must reach my findings based on the best evidence before me, which is the contemporaneous documentation.

I note Dr B's submission that the discussion about the risk of ureteric injury was more in-depth and detailed than usual, as the potential need for ureteric catheters was not something that was discussed routinely with patients who have normal anatomy. Without having been present at the time of the discussion, it is not possible for me to determine to what extent the risk of ureteric injury was discussed. However, the documentation is sufficient for me to be reassured that at least some discussion about these risks occurred.

[11] A myomectomy is the surgical removal of uterine fibroids. In contrast to a hysterectomy, the uterus is preserved.

Opinion: DHB — no breach

As a healthcare provider, the DHB was responsible for providing services in accordance with the Code.

In this case, I consider that the deficiencies in the care provided to Ms A by Dr B related to Dr B individually, and did not indicate broader systems or organisational issues at the DHB. Accordingly, I consider that the DHB did not breach the Code.

Conclusion

To conclude, I have found Dr B in breach of Right 4(1) of the Code, as he failed to ensure that he had all relevant information about Ms A's ureter condition prior to performing surgery. This led to an injury to Ms A's ureter.

I have not found the DHB in breach of the Code.

I acknowledge that since the events of 2019, Dr B has made changes to his practice. Dr B told HDC that he now ensures that he reads the preoperative consultation note one week prior to his operating list, and again on the morning of surgery. Further, he said that if a risk factor (such as duplex ureters) is identified preoperatively, he makes a note of it on the consent form so that it will be raised during the "time out"[12] preoperative procedure.

Recommendations and follow-up actions

Taking into account the changes made by Dr B since the time of events, I make the following recommendations to ensure that improvements are made, and to reduce the likelihood of similar occurrences in future:

1. For Dr B to provide a formal written apology to Ms A. The apology should be sent to HDC, for forwarding to Ms A, within three weeks of the date of this decision.

2. For Dr B to continue to adopt the changes made to his practice by ensuring that the clinical notes and preoperative consultation notes are reviewed prior to surgery being performed. Dr B is to provide HDC with evidence of having done so over a six-month period from receipt of this decision.

[12] "Time out" is the procedure that is performed before skin incision. The "time out" checklist review occurs after the patient is prepared for surgery, but before the surgery commences.

I will take the following follow-up actions:

1. A copy of this decision with details identifying the parties removed, except the expert who advised on this case, will be sent to the Medical Council of New Zealand, and it will be advised of Dr B's name.
2. A case summary of this decision[13] with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

I thank Ms A for bringing her concerns to this Office.

[13] Subsequently, the follow-up action was changed so that a copy of the decision (not just a case summary), with details identifying the parties removed, except the expert who advised on the case, will be placed on the Health and Disability Commissioner website for educational purposes.

Appendix A: Independent clinical advice to Commissioner

"16 December 2021

Re: Complaint 20HDC01320

Thank you for your letter of instruction dated 16 November 2021 in which you have requested that I provide my opinion on the care provided by [Dr B] and [the DHB] in relation to the care provided to [Ms A] between December 2018 and July 2019.

My qualifications and experience

1. I can confirm I am registered with the Medical Council of New Zealand in the vocational scope of practice of obstetrics and gynaecology. I am a Fellow of the Royal College of Obstetricians and Gynaecologists and a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG).

2. I am a full time practising private gynaecologist working out of Oxford Women's Health based in the Forte Hospital complex in Christchurch. I am currently the Clinical Director of this unit.

3. I have been based in New Zealand for over 20 years, initially working in private practice and through the CDHB. I have been employed solely on a private basis for the last 14 years.

4. In the past I have served two terms on the RANZCOG New Zealand committee and have been an examiner for the RANZCOG final exam for over 12 years.

5. I have been involved in practice visits for both the Medical Council and the Royal College.

Documentation considered and relied upon

6. I have reviewed the information that has been provided to me by your office.

An overview of the case

7. The time frame of December 2018 relates to the time of consent taken for the operation up to July 2019, the date of the surgery itself.

8. There is obviously a significant degree of correspondence that relates to the management of the complainant prior to the date of the surgery and whilst this falls out of the time line I think it does speak to the relationship that existed between the complainant and the medical specialist [Dr B].

9. A significant amount of the correspondence and information sent through relates to the management of the ureteric injury and as such falls outside of the time line.

10. There are a number of key points that need to be addressed.

11. The first relates to the information that was discussed and documented at the time of the consenting appointment.

12. The next relates to the interval between the consenting appointment and the date for surgery.

13. The next issue relates to the surgical procedure that was undertaken.

14. The last issue relates to the after care and diagnosis of the complication.

Summary of Case

[Ms A] first saw [Dr B] in August of 2013. She had been referred through to the Public clinic but could not wait and opted to see [Dr B] privately.

She had a full and complete assessment including an ultrasound scan that demonstrated multiple fibroids in the uterus. These were also detected clinically.

A discussion was made with regard to [Ms A's] therapeutic options. An MRI scan was organised and performed in September 2013. This confirmed the presence of a number of fibroids. Importantly there was no comment about any hydronephrosis.

[Ms A] underwent a hysteroscopy with resection of a sub mucous fibroid in October 2013.

In August 2014 [Ms A] was seen again in the Gynaecological Clinic with ongoing heavy periods and abdominal pain.

In June 2015 [Ms A] underwent a further procedure with a further resection of two fibroids but also a laparoscopy with removal of some endometriosis.

The surgical procedure was performed by [Dr B] and at the time of laparoscopy comment was made about the size of the uterus and the size and location of the fibroids.

The other positive finding was that there was endometriosis across the left side wall. This was described as 'thick and fibrous with areas of scarring'. These areas were removed but were negative for endometriosis on histology.

Following that procedure [Ms A] had an episode of shortness of breath and a CTPA was organised which excluded pulmonary embolism.

Post-operative follow up was originally organised through [Dr B's] rooms with plans that [Ms A] would come back to the Public clinic in February 2016.

Ongoing follow up continued and a repeat ultrasound was performed which again documented the fibroids, mentioning that one of them had not changed significantly in size.

No comment was made about the change of the others.

Importantly it did show that the left kidney showed mild hydronephrosis. [Dr B] wrote to [Ms A] with the synopsis of this report showing that one of the fibroids was perhaps a little smaller and the other was perhaps slightly bigger, although the size of the uterus had not changed. He did not mention the finding of the hydronephrosis.

In June 2018 [Ms A] had a further outpatient appointment where her symptoms and history were thoroughly reviewed. Appropriate follow up was organised in the form of a repeat scan and clinical review in 12 months.

On 17 September 2018 an ultrasound of the pelvis was undertaken to review the size of the fibroids but also to exclude any ovarian pathology.

The scan mentions that there is a mild right hydronephrosis which was more prominent than that seen on a CT from August 2017. It also mentions a duplex left sided collecting system with slight prominence of the upper pole.

At some point there was a consenting appointment with [Dr B]. He alludes to this in his written statement but there was no information relating to this in the information that was sent through.

In December 2018 there is an entry in the printed notes (page 29) documenting a pre-assessment visit with [Dr B]. [Ms A] was listed for a laparoscopic hysterectomy. It was made clear that [Dr B] was to undertake the surgery.

The next entry is in April 2019 where comment was made about the multiple avenues of conservative management that [Ms A] had trialled and that a decision had been made to proceed to hysterectomy. Comment is made about the delay between [Ms A] being listed and the surgery being completed. There were certainly issues with regard to staff illness, lack of locum cover and industrial action of a number of hospital specialities.

It is very clear that [Dr B] was aware of the issue that this was having upon [Ms A] and initiated an application for charitable funding for the surgery.

The surgery itself was performed on 17 July 2019 in the form of a total laparoscopic hysterectomy and bilateral salpingectomy.

Histology of the uterus confirmed that it was significantly increased at 700g but there were no histological abnormalities.

A follow up appointment was undertaken on 16 August 2019 suggesting that [Ms A] was recovering well. The wounds were healing well and vaginal examination was unremarkable.

The last line of the notes mentions that [Ms A] had noticed some intermittent pains in the left loin area and the recognition that the pre operative ultrasound did show mild hydronephrosis. It was thought that this would resolve but a follow up ultrasound was organised.

A further assessment was performed on 12 September 2019 where no apparent problems were noted. There was the possibility of some emotional lability and hot flushes but the expectation that these would settle.

On 26 September 2019 an ultrasound was performed. The clinical details mention '*previous left sided hydronephrosis, had large* fibroid *uterus, post hysterectomy loin pain, ?evidence of renal tract injury.'*

The ultrasound noted that the right kidney appeared normal but that the left kidney was duplex with a dilated lower moiety hydronephrosis. The upper collecting system appeared normal. Following this ultrasound scan [Dr B] wrote through to the Urology Department at [the DHB] detailing the dilatation and given the clinical history. He also comments that there was no intraoperative suspicion of a ureteric injury. He clearly states that he has 'arranged for [Ms A] to have a CT of the urinary tract and would be grateful for a urological review and advice regarding ongoing management.'

Following on from this on 2 October 2019 a kidney CT was organised which diagnosed an obstruction of the lower pelvic system on the left hand side.

Following this [a] Urologist was involved and took over the care.

The Surgical Procedure

There are two notes relating to the operative procedure; the hand written ones and the dictated ones. Both of these are very full and comprehensive.

A standard laparoscopy was performed and it is clear that a large 16 week sized uterus was present within the pelvis. Documentation shows a large left fundal fibroid bulging anteriorly which was approximately 8 x 8cm. There was also a 7 x 6cm lateral fibroid on the right hand side. There was no evidence of endometriosis.

A Harmonic scalpel was used to perform the surgical procedure. It mentioned that the Harmonic scalpel was used to 'partially dissect the bladder inferiorly, however access to the left side of the bladder was difficult because of the fibroid bulging anteriorly'.

There were some bowel adhesions on the left hand side that were divided and the left ureter was identified and partially dissected out. The pedicles and tissues on the left hand side were then dealt with in a standard manner. The surgical procedure continued and again comment is made about care being taken to check the position of the left ureter.

There were similar issues with access on the right hand side but with some manoeuvring. It was possible to access this and the procedure was continued. Some dissection was also required to visualise the ureter on the right hand side.

Once this had been completed access to the deeper areas appeared to be more straightforward and the procedure was continued.

The post operative recovery went smoothly and [Ms A] was discharged and followed up as discussed earlier.

1. What risks would you have expected to have been discussed with [Ms A] at the time of consent being obtained.

At the time of her consenting appointment I think there would be an expectation that the surgeon would discuss the general risks of surgery. These would include the development of deep vein thrombosis, infection and bleeding perhaps necessitating a return to theatre. It would be reasonable to explain the measures that were taken to reduce, but not eliminate these risks, including the use of antiembolic stockings, the use of thromboprophylaxis and the antibiotic regime that would be used.

The process should then go on to discuss the specific risks of that type of surgery.

With regard to laparoscopy comment is usually made about the risk of perforation of the bowel with a risk quoted. Comment should be made about risk of injury to the bladder and the ureter, again with some quantum attached to this.

It is always worth pointing out that whilst the aim is to complete the hysterectomy laparoscopically there is always the risk of unexpected complications developing during the procedure that would necessitate the conversion to an open procedure/laparotomy.

I think it would also be prudent to explain to patients that removal of the uterus would mean that she would be unable to have children in the future, although as the ovaries were being conserved there would be the opportunity to act as an egg donor if she so desired. Most clinicians would also point out that whilst the uterus was being removed it would remove the bleeding with the expectation that it would improve some of the pelvic pain.

Comment should also be made that the cyclical hormonal symptoms would not be altered by removal of the uterus as these are ovarian in origin and would be retained.

There are clearly a number of other issues that could be addressed as well but I think these would be the main ones.

With specific reference to this case there are two obvious areas that should have been discussed in detail.

It was well recognised that this was a significantly enlarged uterus and was going to be a technically challenging operation. This does mean that the risk of conversion to an open procedure was always going to be much higher in this case and that is certainly something that should have been formally documented.

The increased size of the uterus meant that this would be a more challenging operation and I think it would probably be reasonable to suggest that there may be a generalised increase in the risk of all complications due to the complexity of the surgery.

The other relates to the risk of ureteric injury. At the time of the consenting appointment it was known that there was a duplex system on the left hand side and that this would have the potential to increase her risk of ureteric injury. Having laparoscoped [Ms A] before it was obvious that the uterus was occupying a large area of the pelvis and that access whilst adequate was certainly less than one would get at the time of a hysterectomy with a normal sized uterus. I certainly feel a little deeper discussion about that may have been worthwhile.

Having looked through the notes several times I have been unable to find any documentation relating to that appointment and indeed the only information that I was able to glean was that from [Dr B's] statement. In this he states 'the risk of ureteric injury was discussed and documented at that time'. Whilst I cannot find any written documentation relating to that point I have no reason to doubt that this was the case.

Without the formal documentation relating to that visit it is difficult to comment whether there has been departure from the standard of care and how this would be viewed by peers and indeed to come up with any recommendations for improvement. Having said that, with regard to the specifics of this case I am not sure that it is particularly important.

2. The care provided to [Ms A] by [Dr B] and whether you consider there to be any departures from accepted practice from an individual clinician level.
Having reviewed the notes, there is substantial documentation to reveal a very thorough and comprehensive level of care that was performed by [Dr B]. There were good levels of clinical documentation in the patient notes and an attempt to treat the claimant as conservatively as possible in order to retain her fertility as she had not had any children.

There are a number of email correspondences and queries backwards and forwards between the patient and [Dr B] that were always answered promptly and politely.

The frequency and number of these claims and queries are, I think, quite unusual even for private practice and I think do attest to the level of anxiety that the patient may have been experiencing. All were, however, answered promptly and professionally and I think demonstrate and attest to the very high level of care that was being provided by [Dr B].

At the time of surgery a total laparoscopic hysterectomy was performed. The uterus was significantly enlarged and it will be very clear to all concerned that this was potentially going to be a challenging and taxing procedure.

It should, however, be noted that [Dr B] had already performed a previous laparoscopy and had been aware that there was some scarring and thickening of the peritoneum on the left hand side and had also visualised the uterus and the pelvis at that time. Clearly though there had been a passage of time between the original laparoscopy and the subsequent hysterectomy.

The operation notes detail what was clearly a challenging procedure but from reading them it appears that there was steady progress throughout the operation and an acute awareness of the anatomy and the location of the ureters.

Following the procedure the post operative course was unremarkable with follow up arranged one month afterwards and subsequent to that.

At the mention of some loin pain an appropriate investigation was organised.

With regard to the specific questions, I think with regard to the general pre operative work up the level of care, as mentioned, was above what would be expected from a standard specialist.

The decision to proceed to a laparoscopic hysterectomy, whilst it may appear contentious, I think is justified.

When faced with a potentially difficult operation like this most clinicians would feel that it would be reasonable to insert the laparoscope, assess the pelvis and make a decision at that point. Sometimes it is not certain whether the procedure would be able to be completed that way but nonetheless it is reasonable that the procedure begins and as long as steady and safe progress is made then it is entirely reasonable to continue with a laparoscopic attempt. I am very comfortable from reading the operation notes that this was the situation here. It is certainly documented that the relevant anatomical land marks were observed and that as certain areas of the procedure were completed it had a knock on effect to make other areas easier to proceed with. As such I am comfortable that the level of care offered here was certainly at, if not above, that that would be standard or accepted and I think would be viewed as such by our peers.

3. The care provided to [Ms A] by [the DHB]

I think this is a difficult point to raise as it alludes to institutional and organisational issues rather than those of any individuals.

It is very clear that the claimant was put on the operating list with the expectation that surgery would take place in a timely manner but that it was 7 months before that came to fruition.

I think it is clear from reading the documentation that it is very difficult to hold the organisation liable for scheduled staff leave. The rolling levels of industrial action that were undertaken by a variety of health practitioners would have made the provision of any level of service incredibly difficult. These were clearly issues that were beyond the control of [the DHB].

It should also be remembered that this was surgery for a benign condition, albeit one that was having a significant impact on the claimant's quality of life. Under conditions where access to theatre time is restricted then it is appropriate that the operating spaces are given to those that would be dealing with the serious nature that would often be leading to the threat of life or limb and often means that they are restricted to cases requiring cancer surgery.

The impact of this on the gynaecological service is I think surmised by [Dr B], who points out that in the period concerned he did four to five cases whereas normally he would be expected to be doing four or five a month.

Whilst the delay is disappointing I think it is very difficult to hold either the DHB or an individual responsible. As such I think that whilst a delay of 8 months for scheduled surgery is clearly disappointing and would I think fall below what we would hope to offer our patients, it is difficult to hold the service liable for this. I think it is difficult to see how this could be altered or improved in the future.

The caveat to this I think is that with a delay of this length that there could perhaps have been a repeat assessment of the patient, review of symptoms and perhaps a recap of the consenting process. I could not find any evidence of this in the paperwork that was sent through to me.

4. Recommendation for improvement that may help prevent a similar occurrence in future:

The crux of this case relates to the ureteric injury. There was very clear evidence pre operatively of an anatomical variant on the patient's left side with radiology demonstrating this and indeed written notes from [Dr B] confirming his awareness.

It is also apparent that there was a significant and unavoidable delay in the surgery being performed once the patient had been put on the list. There were a number of events that

were beyond everybody's control and I think it would be very unfair to lay blame at any one individual for that delay.

At the time of surgery it seems that there was a lack of a review process where [Ms A's] notes, imaging and paperwork would have been re-read. I think if this had taken place the presence of the ureteric abnormality would have been noted and as a result I have no doubt that [Dr B] would have been even more conscientious in his surgical technique than he appears to have been.

Conclusion:
In my opinion, and for the reasons above I do think that [Ms A] received a good degree of clinical care and post operative follow up from [Dr B].

The pre operative assessment, investigations and management was of high quality.

There was an awareness that there was an anatomical variant with the ureter on the left hand side and this was recognised prior to the surgery and this point is acknowledged by [Dr B] in his own statement.

There was then a significant delay in the surgery being performed. There was no evidence to suggest that the surgery was of anything other than the highest quality.

As soon as there was a suspicion of an injury appropriate investigations were organised and the correct management rapidly instituted.

I have not been able to find written evidence for some points and this is mentioned in the body of the report. I am not sure, however, that this alters the above findings in any way. It does seem that at the time of the operation there was a lack of a review of the clinical notes and radiology findings and the fact that there was a lack of awareness of the anatomical variant with regard to the left ureter.

If this had happened then it is possible that even more care and attention would have been performed and the injury may have been avoided.

Richard Dover
Obstetrician & Gynaecologist
BM, MRCPI, FRCOG, FRANZCOG
RD/dc"

"**Re: Complaint C20HDC 01320**
Thank you for your recent note and the clarification that is required.

In December 2018 there was some documentation relating to a pre operative assessment visit between [Dr B] and [Ms A]. She had obviously been listed for surgery slightly prior to that and due to a number of unavoidable delays the procedure itself was not performed until 17 July 2019. This is a gap of 7 months.

I think most surgeons, irrespective of specialty, would feel that reviewing the patient's notes, history and imaging investigations prior to surgery would be a basic prerequisite.

I think in this case, where there was a lengthy interval of 7 months, combined with a complicated past history and scans detailing in advance what would be a challenging and difficult operation that the requirement and necessity to review the notes and to get back up to speed would be even more crucial.

As such, I think failure to do so does fall short of what most people would describe as an accepted standard of care. The severity I think is more difficult to assess and clearly should not be influenced in light of the adverse outcome that eventuated. Having said that, I think that this is not a minor departure and would have to be viewed as either moderate or severe, with my preference being at the upper end of a moderate deviation.

Kind regards and best wishes

Yours sincerely

Richard Dover
Obstetrician & Gynaecologist
BM, MRCPI, FRCOG, FRANZCOG
RD/dc"