Ex 498

Princess Alexandra Hospital
Health Service District

Queensland Government
Queensland Health

Our Ref: PHW/fl
Date: 20 October 2005

Queensland Public Hospitals Commission of Enquiry
P.O. Box 13147
George Street
BRISBANE QLD 4003

For the Attention of:.....
Mr David Groth.....
Mr Richard Douglas S.C.

Dear Sir

Bile duct injury is a life-threatening event. To survive such an injury the patient must undergo a secondary procedure. If recognised at the time of initial injury, the laparoscopic procedure will be converted to an open procedure. If not recognised at the time of injury then a subsequent procedure will be necessary, often on a desperately ill patient.

The disparity between the report of Patel bile duct injury rate and the results of my initial review prompted me to analyse the Patel bile duct injury rate in detail using the following methodology:

1.
All Patel laparoscopic cholecystectomies were examined to determine if adverse outcomes had occurred. That is how many laparoscopic cholecystectomies proceeded to open operation. Where available the case-notes of those proceeding to open cholecystectomy were reviewed. In the other cases the Crystal coding was relied upon.

2.
Following advice of two senior coders at the PAH *(see attached list of codes)* a list of those patients with coding that could possibly be a variant of "bile duct injury" coding was compiled and the case-notes of these patients were reviewed.

3.
The case-notes of Patel's deaths and inter-hospital transfers were reviewed in my original report to the Commission of Inquiry.

Preliminary Findings:

1.
Approximately 130 laparoscopic cholecystectomies were coded to Patel plus one open cholecystectomy. In 12 cases of laparoscopic cholecystectomy, he proceeded to open cholecystectomy. In 4 cases because of adhesions, on one occasion acute cholecystitis, on another occasion chronic cholecystitis. No reason was given in 3 instances. Of the remaining 3 cases, 2 followed dense adhesions and perforation of the small bowel. The remaining case suffered a bonafide major bile duct injury. This was recognised at the time by Patel who then performed a major primary bile duct repair.

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2.
The process described in methodology (2) did not identify any additional bile duct injury.

3.
There were no deaths or transfers associated with bile duct injury.

This methodology has allowed me to form an interim view that Patel produced one bile duct injury, which he repaired himself at the time of injury. There were two other patients with adverse outcomes secondary to haemorrhage during the performance of laparoscopic cholecystectomy but certainly not bile duct injuries. These results are at variance with the figures in Dr Fitzgerald's audit.

Prior to finalising my figures I must specifically review the case notes of those cases (as yet unidentified but almost certainly captured by the above methodology) included in Dr Fitzgerald's report as having suffered bile duct injury and review how that list of patients was compiled for the purposes of his audit.

This exercise reinforces the requirement for a meaningful clinical audit of patient outcome. The current coding system takes account of events regardless of outcome. For example "bleeding during a procedure" attracts the same code whether the haemorrhage results in no more than a minor bruising of the skin or the patient bleeds to death.

A suggested outline of an effective audit process can be found on page-38 of Exhibit 283.

Yours faithfully

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PLAN FOR AUDIT AND REVIEW

1. All "operations" or the surgeon and anaesthetic reports are logged into a computer data base in the O.T. complex on day of surgery.

2. This computer system is to be a "core system" indispensable & integral to the proper function of the clinical unit, which can gather information from other systems but does not interact with other systems, that is, part of the intrahospital network specifically for the surgical team (*not part of the administrative system*).

3. Weekly meeting - The clinical workload for the week is reviewed by the Unit. In particular all "operations" performed are considered. All adverse outcomes and deaths are registered.

4. M&M meeting - Input for this monthly meeting is from the events registered on the computer system, as well as input from the administrative system via the DMS (*list of deaths*). Director of Unit & DMS sign off on this meeting.

5. Morbid cases - Where deemed, have their case-notes scanned into the "core system" on d/c or death of the patient.

6. Defined "flags" - Reported electronically to a "Central Audit and Review Committee". For this to be enthusiastically embraced by surgeons it must have the confidentiality and structure of the aviation counterpart—composed of senior practitioners.

   For example:
   - A. massive transfusion
   - B. unscheduled return to OT
   - C. perioperative deaths

7. "Audit and Review Committee" - charged with the responsibility of identifying "out-lies", has access to the scanned database and other inputs.
   - Statistical data from DRG analysis
   - " " " ICDM-10 codes
   - Complaints or reports

8. "Audit and Review Committee"
   - has the power to start or initiate its own investigation.
   - Site visit by senior clinician would be particularly valuable at this juncture.

   Outcome:
   - A. remedial action
   - B. nothing required
   - C. medical board referral

9. "Audit and Review Committee" - Reports directly to the Health Regulation and Standards Commission (HRSC).

For cases where there is an injury to the bile duct (i.e. laceration), we would code it to:

T81.2 - *Accidental puncture and laceration during a procedure, not elsewhere classified.*

Since 4th edition, we would also use S36.18 - *injury of bile duct* as an additional code for greater specificity.

This is a broad spectrum code and can include other injuries within its boundaries.

Where there is a bile leak without a puncture or laceration,
we would code it here as:
T81.8 - *Other complications of procedures, not elsewhere classified.*

Again, this could be used for other situations, such as gallbladder rupture.

Where there is a problem with a device, such as a loose clip, we would code it here to:
T85.5 - *Mechanical complication of gastrointestinal prosthetic devices, implants and grafts.*

This code can be utilised for other situations, such as when a patient pulls out their gastrostomy tube.

You may also be looking for these codes:
K65.0 - *Acute peritonitis*
K65.8 - *Other (bile) peritonitis*
K65.9 - *Peritonitis (unspecified)*

Multiples of these codes could be incorporated in a single coding string for an episode.

For the repair of a bile duct we would use:

1)
30472-01 [971] - *Repair of common bile duct*
Note: This code can also be used for fistula repair
Excludes: Repair by dilation (either endoscopic *{30452-00 [971]}* or percutaneous *{90374-00 [971]}*)
Repair of stricture (either endoscopic *{30452-00 [971]}* or percutaneous *{90374-00 [971]}*)

and/or

2)
30460-08 [970]: *Roux-en-Y intestino-biliary bypass*

and/or

3)
30460-03 [969]: *Choledochoduodenostomy*

and/or

4)
30460-04 [969]: *Choledochojejunostomy*

and/or

5)
30460-05 [969]: *Choledochoenterostomy (excludes that with pancreaticoduodenectomy: 30584-00[978])*

and/or

6)
30460-06 [969]: *Choledochopancreatostomy*

and/or

7)
30460-07 [969]: *Hepaticoenterostomy*

You may also see:

30454-00 [963] - *Choledochotomy* as this includes exploration of common bile duct.

and/or

90321-00 [971] - *Other Repair of Biliary Tract*

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