General Surgeon, Dr B

A Report by the
Health and Disability Commissioner

(Case 02HDC14836)

Parties involved

Mrs A	Consumer
Dr B	Provider, General Surgeon
Mrs C	Consumer's sister
Ms D	Consumer's daughter
Ms E	Surgical Secretary, public hospital
Mr F	Administration Manager, public hospital
Ms G	Scrub Nurse, public hospital
Ms H	Circulating Nurse, public hospital
Dr I	Anaesthetist, public hospital
Dr J	General Surgeon, public hospital
Ms K	Advocate, a Health and Disability Consumer Advocacy Service
Dr L	Consumer's General Practitioner
Dr M	Pathologist, public hospital

Complaint

On 15 October 2002 the Commissioner received a complaint from Mrs A about Dr B. The complaint was summarised as follows:

Dr B did not provide services with reasonable care and skill to Mrs A. In particular:

Dr B did not perform Mrs A's bowel cancer operation on 18 September 2001 with an appropriate standard of care in that:

- *As a result of the operation Mrs A's belly button was poorly positioned; and*
- *When clamps were removed in the postoperative period, the wound opened and the bowel protruded.*

Dr B did not perform Mrs A's bowel operation on 4 June 2002 with an appropriate standard of care in that:

- *The operation was complicated by excessive bleeding and an arrest in the immediate postoperative period;*
- *The postoperative period was complicated by a twisted bowel and infection; and*
- *As a result of the operation, Mrs A suffered from vaginal discharge including discharge of faecal matter.*

Dr B failed to fully inform Mrs A about her condition in that:

- *He provided inconsistent information as to whether he removed all the polyps; and*
- *He failed to provide Mrs A with a reasonable explanation for her vaginal discharge.*

An investigation was commenced on 16 December 2002.

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On 17 July 2003, following expert advice, the investigation was extended to include the following issue:

Dr B did not provide services with reasonable care and skill to Mrs A. In particular, Dr B did not perform an appropriate preoperative assessment of Mrs A's colon.

Information reviewed

- Letter of complaint from Mrs A, dated 1 October 2002
- Action notes of telephone conversations between Mrs A and Investigation Officer clarifying her complaint, dated 28 November 2002 and 4 April 2003
- Letter received from the public hospital and accompanying documents relating to Mrs A's request for transfer of care, dated 18 December 2002
- Letter of response to first notification from Dr B and accompanying documentation, dated 20 March 2003
- Letter of response to second notification from Dr B and accompanying documentation, dated 25 August 2003
- Medical records from the public hospital for first, second and third admissions
- Information received from Ms K, advocate, a Health and Disability Consumer Advocacy Service, dated 19 September 2003
- Transcripts of interviews with Mrs A, Dr I, and Ms G
- Clinical records received 12 August 2003 from Dr L, general practitioner
- Letters received from Dr M, pathologist, dated 26 August and 1 October 2003, explaining the results of the specimens obtained following the June 2002 operation
- Independent expert advice obtained from Dr Ian Stewart, general surgeon.

Information gathered during investigation

Mrs A, aged 61 years at the time, was referred to the public hospital by Dr L, general practitioner, with a history of changing bowel habit, mild haemorrhoids and bleeding. Dr B, the surgeon who saw Mrs A, considered her symptoms serious and arranged for Mrs A to have an urgent colonoscopy.

Preoperative assessment
On 11 September 2001 Dr B met Mrs A prior to the colonoscopy. Dr B advised me that Mrs A's medical history included having spurious diarrhoea (alternating diarrhoea and constipation) for a year, piles for many years, and mild abdominal pains. He performed a digital rectal examination and identified a mobile tumour in the lower rectum. Dr B proceeded with a colonoscopy and diagnosed a tumour of the lower rectum and polyps in the sigmoid colon. According to the colonoscopy report, multiple pedunculated polyps were

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present in the distal sigmoid colon. Dr B said he informed Mrs A of the results, ordered a chest X-ray and CT scan of her abdomen and pelvis, and arranged to see her in a week's time.

On 13 September Mrs A took her sister, Mrs C, as her support person and returned to see Dr B. Dr B said that he advised Mrs A that the X-ray and CT scan did not show any spread of the cancer, and that the most appropriate treatment would be an anterior resection operation (colon and upper rectum removed and the ends joined up) which was most likely to preserve normal bowel function – an important consideration for someone of relatively young age such as Mrs A. Dr B further proposed to do a defunctioning loop ileostomy (surgically created opening of the small bowel onto the abdominal wall to divert bowel contents) which would allow the joined ends of the bowel to heal and be closed at a later date.

Anterior resection and formation of colostomy operation
On 18 September 2001 Mrs A underwent surgery. However, instead of an anterior resection Dr B performed a Hartmann's procedure (formation of a colostomy). Dr B said the change in planned procedure was necessary as he experienced problems with the surgical stapler and was unable to ensure the integrity of the rectal stump. Dr B felt that the best course was to leave the rectal stump to fully close over and bring out the proximal end of the bowel as a colostomy. Dr B said that he intended to rejoin the rectal stump to the proximal end some months later. This operation is known as a reversal of the Hartmann's procedure. According to the operation record, Dr B noted that "there were a lot of small polyps in the lining of the bowel".

Dr B used skin clips to close the skin wound. Mrs A complained that following the operation Dr B had repositioned her umbilicus approximately four inches to the right of where it should have been. Mrs A said Dr B told her the position of her belly button was not important. However, Dr B said that he did not shift the umbilicus and cannot remember Mrs A complaining about this. There is no record in the medical notes of any problems or abnormalities with Mrs A's umbilicus. Mrs A said that after the operation her daughter, Ms D, asked Dr B if he had removed all the polyps. Mrs A said that Dr B told her daughter after the operation that there were a lot of polyps, too many to remove, and a further operation would be required.

Wound dehiscence and resuturing
On 21 September the drain inserted into Mrs A's wound at the time of the operation was removed. On 24 September Dr B saw Mrs A and, according to the medical record, requested removal of five abdominal wound clips at the end of the wound. Following removal the wound gaped open and steri-strips were used, with little effect, to hold the wound together. Dr B went on annual leave from 24 September 2001 and Dr J took over Mrs A's care.

Mrs A complained that on 27 September, following removal of the remaining abdominal wound clips, she suffered a complete dehiscence (full thickness rupture) of the abdominal wall and thought the "clamps and drain" had been removed too soon. Mrs A said that the nurses could not keep up with the discharge from the wound and had to apply a bag to contain it. Dr J resutured the wound and, according to Mrs A, repositioned her umbilicus to where it was prior to the operation on 18 September.

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Dr B said that Mrs A's abdominal wound dehiscence was due in part to frequent chest physiotherapy, which was necessary as Mrs A was a smoker of long standing. Epidural analgesia made the physiotherapy easier. Dr B said he did not believe that the clamps and drains were removed too soon. Mrs A was discharged on 6 October 2001.

Mrs A was unhappy with the care Dr B had provided and wanted to have her care transferred to Dr J. On 8 January 2002 she contacted Ms K, local advocate for a Health and Disability Consumer Advocacy Service. After discussion, it was decided that Mrs A would address her request directly with the hospital. She wrote to the public hospital by letter dated 15 January, requesting a second opinion and that her care be transferred to Dr J. On 16 January Dr L, Mrs A's general practitioner, also wrote a letter to Dr J at the public hospital requesting that he take over the care of Mrs A. Dr L stated that Mrs A "has communication difficulties and for various other reasons has lost trust and faith in [Dr B] … I trust this is in order and would be grateful if you could fit her into one of your clinics for the beginning of February and cancel her appointment with [Dr B]."

Ms E, Surgical Secretary, said that she contacted Mr F, Administration Manager at the public hospital, following receipt of the letters and asked his advice. Mr F said he informed Ms E that a general practitioner could not transfer care but that a request could be made to the surgeon (Dr B) for a second opinion. Mr F said that he also told Mrs A that she did not have to go privately to change surgeons and that a second opinion could be sought internally and the secretary would make Dr B aware of her request. Ms E said that she rang Mrs A to advise her of an appointment time with Dr B and informed her that "this would be the opportunity for her to discuss any concerns". Ms E said that she sensed Mrs A was not happy about keeping the appointment and rang back and left a message suggesting that Mrs A take a support person with her to the meeting.

Mrs A said she was contacted by someone from the hospital and told she could not seek to have her care transferred within the public system. On that basis, Mrs A attended her appointment with Dr B.

On 14 February 2002 Mrs A attended her outpatient appointment with Dr B, and the transfer of her care to Dr J was discussed. Dr B said:

> "I offered to assist her with this and discussed ways to expedite her appointment, for example we talked about her seeing [Dr J] privately so she could see him earlier than in the public hospital system. I hope I conveyed my respect for her choice and willingness to help her in whatever way she chose. This reassurance seemed to give [Mrs A] the confidence to talk to me about misunderstandings she had about her recent admission under my care … She was happy to see me again in April 2002."

In response to my provisional opinion Mrs A said she was not "happy" with the arrangement but rather felt she had no choice following Dr B's phone call. Following the meeting Dr B wrote to Mrs A's GP explaining that while there had been some misunderstanding with Mrs A about her admission under Dr B's care, this had been resolved and Mrs A was "now happy to see me for further management". Mrs A did not think she was able to pursue her wish to

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transfer her care to another surgeon within the public system and thought she had no choice but to have Dr B.

Mrs A said that she asked about the removal of the polyps during the operation and Dr B told her that he must have removed them all as he had had to remove so much bowel. Dr B said that he did not remember telling Ms D, Mrs A's daughter, that Mrs A would require a further operation to remove the many polyps present. Dr B recalled:

> "I advised [Mrs A] that I had endeavoured to remove all her polyps but I could not say all had been removed. I explained this was because I could not see inside the remnant sigmoid colon to check during the operation. I also informed her that this would be checked later by colonoscopy."

In response to my provisional opinion Mrs A said that she still has 35 polyps.

Reversal of Hartmann's procedure and creation of a lower ileostomy operation
Mrs A was subsequently readmitted under Dr B on 4 June 2002 for a reversal Hartmann's procedure and creation of a lower ileostomy operation. Dr B's operation record (Appendix 1) describes in detail his approach and procedure. Dr B said that he had expected the operation to be difficult and that adhesions prolonged the operation. He recalled that a size 31mm CEEA (end to end anastomosis) stapler was used to anastomose the proximal bowel to the rectal stump. However, the anterior aspect of the anastomosis was not complete and silk sutures were used to achieve closure. Ms G, scrub nurse for the operation, explained that the CEEA staple gun (Appendix 2) is a disposable instrument inserted through the rectum. The rectum is joined to the colon at the end of the staple gun and firing the staples from the gun seals the rectum and colon together. The two ends are anastomosed and a small amount of surplus tissue (donut shaped) is ejected from the gun following the procedure. Ms G further advised that while the surgeon "lines everything up", one of the circulating nurses can turn the end of the stapler. Ms G informed me that she had "a vivid recollection" of the use of the stapler during Mrs A's operation, as the circulating nurse, when asked to fire the stapler, told Dr B that it did not feel right and refused to continue. According to Ms G, Dr B fired the gun after being told that it did not feel right and that it was very tight. Ms H was one of two circulating nurses in the theatre during Mrs A's operation. Ms H informed me that she could remember the operation vividly because Dr B wanted her (or the other circulating nurse) to work the EEA staple gun, but neither of them was "particularly happy about doing the gun just because we knew in the past he had had difficulty with the guns".

Ms H said that a simple slow rotation (against slight resistance only) of a knob on the end of the gun reveals a window that changes from blank to green. If the window shows red then the knob has been turned too far. Ms H said that as soon as she started to turn the knob it was very tight and she repeatedly said to Dr B that she was not happy. Ms H said Dr B told her to keep turning and she said, "I'm sorry but I'm not happy doing it, it is far too tight and I think you need to come down and feel this." Ms H said that Dr B turned the knob and she could hear it "click", which Ms H explained meant that far too much force had been applied. Ms H had received training in operating the staple guns from the manufacturing company, had operated them before and definitely knew that, on this occasion, it did not feel right.

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The Tyco Healthcare Group Premium Plus CEEA disposable stapler instruction leaflet states that the Premium Plus CEEA stapler should not be used on:

> "any tissue which cannot comfortably compress to 2mm in thickness. The instrument should not be used if unusual effort is required to turn the wing nut in order to visualise part of the green dot in the tissue approximation window."

According to the operation record (Appendix 1) Dr B noted:

> "Unfortunately the rectal stump was too thick making it difficult for the stapler to cut through. The stapler, when fired, may have also caused an opening into the vagina. The anterior part of the anastomosis was clearly disrupted and was closed with 3 interrupted stitches of silk 0."

Dr B stated that the length of colon that he had to work with was limited by a tight middle colic artery. The tension on the artery had the potential to cause an obstruction, but as Dr B was concerned to ensure that the blood supply to the area of joined bowel was restored, he elected to deal with the obstruction if it became a problem at a later stage.

Dr I, anaesthetist, said that while she expected the operation to be long, it became:

> "very very prolonged to the point where we cancelled the second patient on the list and the procedure which started at 1.40pm when she was first brought down into the anaesthetic room didn't finish, I didn't actually leave her in the care of the recovery nurses until 7.45 that evening so it was a very long procedure."

Dr B said that the blood loss was adequately replaced during the operation. According to the medical record Mrs A's intraoperative blood loss was greater than 3000mls. She was given four units of blood, 500mls of fresh frozen plasma, 500mls of Hartmann's solution and five litres of normal saline. A central venous line was inserted in anticipation of postoperative parenteral nutrition.

Dr I explained that there was considerable blood loss because of the prolonged procedure and vaginal bleeding both on the operating table and postoperatively. Dr I was concerned about ongoing problems with bleeding and haemodynamic stability postoperatively. She inserted a central line, partly to monitor blood loss, and arranged for Mrs A to go to the intensive care unit overnight.

Postoperative "arrest"
Mrs A complained that she "arrested" in recovery following the operation.

According to the medical record, Mrs A experienced an episode of breathing difficulty at 8.15pm and collapsed. Another anaesthetist in the area attended and resuscitated Mrs A, who was intubated (tube inserted into the trachea), ventilated and given a further 500mls of fresh frozen plasma. Dr I said she arrived back on the scene, after being called, within 10 or 15 minutes after she left. Dr I suspected Mrs A had had "a brisk bleed" as the drain inserted during the operation was empty when she left to go home, and when she returned it contained

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500mls of blood. There was also “an ongoing steady trickle vaginally”. Dr I said that in light of the prolonged operation with a lot of blood loss, Mrs A may have been a little under-transfused. Mrs A responded immediately to the further 500mls of fresh frozen plasma and awoke a short time later and was able to be extubated. According to the medical record, the differential diagnoses included moderate brisk bleed, pulmonary embolism (blood clot in the lung) and anaphylaxis (sudden systemic allergic reaction).

Dr B recalled that he was informed that Mrs A had gone “flat” in recovery. When he called to see her she had recovered. Dr B said a subsequent chest X-ray did not indicate any reason for the collapse and he did not think she was hypovolaemic. Dr B said that he told Mrs A he could not explain the episode.

Vaginal discharge
Immediately following the operation on 4 June Dr I recorded her postoperative instructions, which included monitoring blood loss, including vaginal blood loss. At interview Dr I stated that she was concerned about the vaginal blood loss and had assumed that there had been some vaginal trauma, as Mrs A had no apparent clotting problems that might account for the problem. Dr I said that the theatre nurses were also aware that vaginal blood loss was not a normal outcome for this type of surgery and commented on the vaginal loss as they transferred Mrs A from the theatre table to the recovery trolley.

The day following the operation, on 5 June, Mrs A had fresh bleeding from her vagina. She was concerned about this and asked for an explanation. According to the medical record, nursing staff noted that Dr B should be asked to explain to Mrs A the reason for the vaginal bleeding. There is no record of any explanation from Dr B.

Continuing vaginal discharge is reported in the medical record, and the description of the discharge changed from fresh blood to scant watery brown. Mrs A said that Dr B never mentioned that he might have caused trauma to the vaginal wall during the operation, and she was not aware that there was a breach of the vaginal wall until she experienced the vaginal discharge of faecal matter.

Dr B said he had noted that Mrs A had vaginal bleeding that required her to wear a pad. He informed me that he intended to do “a comprehensive examination of this when she became more settled after her operation”. If the discharge continued he planned to perform an examination under anaesthetic at three weeks to inspect the bowel anastomosis.

Bowel obstruction
Mrs A complained that she became “violently ill” five days after the operation and an X-ray revealed that she had a “twisted” bowel. According to the medical records Mrs A began vomiting bile-stained fluid on 9 June. On 11 June Dr B ordered a gastrogram and ordered that a nasogastric tube be inserted and low suction applied. Dr B said that the gastrogram showed that she had an obstruction at the duodenojejunal flexure, as he had predicted would happen. According to the nursing records, Dr B met with Mrs A on 12 June and advised her that she had a “blockage”, which might resolve, given time to settle. Mrs A said that Dr B told her that he might have to operate again because there was an artery in the way, which he

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would have to cut. Mrs A remained on total parenteral nutrition, intravenous fluids and nasogastric suction, and the blockage resolved.

Histology

The histology report on specimens taken during the operation was reported on 7 June, eight days postoperatively. Dr B was still Mrs A's surgeon at this time. The anastomosis of the proximal end of the rectum to the distal end of the colon results in the excision of rings or donut-shaped pieces of tissue. The microscopic histology of the distal donut tissue showed squamous epithelium. Dr M, the pathologist who reported the microscopic histology of the anastomosis donuts, said that squamous epithelium is vaginal tissue and is not found in the colon. Further, Dr M informed me that his intention in including the description of the squamous epithelium was to draw attention to the fact that it was present and should not have been. According to the nursing notes, Dr B visited Mrs A on 12 June and discussed the operation and options for future procedures and, on 13 June, discussed her "feeling of heartburn". Mrs A said Dr B did not discuss the possibility of a colovaginal fistula (a fistula between the colon and vagina).

On 17 June Dr B met with Mrs A and her family to discuss further surgery related to the bowel obstruction. At this time Mrs A and her family communicated their concerns to Dr B and their desire for a second opinion on her condition.

Infection

On 25 June Mrs A had an elevated temperature, and blood cultures and urine specimens were taken. On 26 June Dr B ordered the central venous line to be replaced. The tip of the removed CVP catheter was sent to the laboratory for culture, and Mrs A was commenced on antibiotics. According to the medical records, the probable site of infection was the central venous line. Dr B last saw Mrs A on 26 June, when he went on leave. Dr J took over Mrs A's care until she was discharged from hospital on 5 July 2002.

On 28 June Advocate Ms K saw Mrs A in the ward. Mrs A discussed her concerns about Dr B and her desire for a change of surgeon. The Advocate raised her concerns with the Clinical Leader, who then met with Mrs A. On 8 July the Service Leader wrote to the advocate following the meeting with Mrs A, as follows:

> "I have spoken to [Dr J] who is caring for [Mrs A] at present whilst [Dr B] is on leave. On [Dr B's] return from leave I will speak with him and outline [Mrs A's] concerns and her wishes for ongoing treatment by another consultant."

Mrs A was reported to be happy with this process.

Discharge from hospital

Mrs A said that from her discharge on 5 July until 26 September 2002 she had continuing vaginal discharge and had to wear a sanitary pad. On 26 September she had an excessive amount of "very peculiar looking discharge" which increased over the day and became a brown colour. Mrs A felt something "explode" and discovered "pure faeces" coming out of her vagina. She went to see Dr L, her general practitioner, who advised her that Dr B had accidentally cut her small bowel and vagina during the last operation. Dr L had been sent a

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copy of the operation record, which noted that trauma to the vaginal wall may have occurred. Mrs A said that she did not know this complication might have occurred and was concerned that no remedial action had been taken.

Examination under anaesthetic

On 21 November 2002 Mrs A had an examination under anaesthetic, which confirmed the presence of a colovaginal fistula. Dr J, the surgeon who performed the examination, found a palpable staple and a hole through to the rectal mucosa.

Further surgery

On 20 May 2003 Mrs A underwent further surgery. At interview Mrs A described the operation as follows:

> "I think it was a six-hour operation because everything in there was like concrete. He [Dr J] said it took two hours just to get through … I had an ileostomy then and he put it back to colostomy but instead of having it on the colostomy side, he couldn't get in with the scar tissue … so he brought the large bowel right across to the ileostomy side and he had to undo all what was done last June, the join up, because of all the scar tissue and everything else, so there's no join up any more … So I just keep the bag now, and there's a bit of trouble with it, because he had to bring the large bowel over, there wasn't a lot of length with the stoma and I've been having a lot of stoma trouble."

Mrs A feels that Dr B has "ruined" her life.

The public hospital advised that subsequent to this complaint it requested a full review of Dr B's competence by the Medical Council (the outcome of which is pending). Dr B has withdrawn from practice and his credentialling has been withheld.

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Independent advice to Commissioner

Initial advice
The following expert advice was received from Dr Ian Stewart, general surgeon, on 23 June 2003:

"I will answer this using numerical notation, the numbers relate to the questions you have asked under Your Decision Required.

1. *[Mrs A] complained that [Dr B] repositioned her belly button 4 inches to the right of where it was prior to the operation.*
    - *Is this an acceptable result following the operation [Mrs A] had? Please comment*
    - *Was the removal of polyps part of the low anterior resection with Hartmann's reconstruction operation?*

1. (a) [Mrs A's] original surgery (18/09/2001) was done through a left paramedian incision. This is a vertical incision to the left of the midline. It is very unlikely with that wound, that the umbilicus (belly button) would be significantly removed from its original position.

[Mrs A's] complaint about her belly button obviously involves the 10 day post-operative period from her first operation (18/09/2001). It was 10 days after that operation that she returned to theatre for the repair of the wound dehiscence. The wound and her abdominal shape and contour would be distorted to a degree during that 10 day period because of the normal immediate post-operative changes. These changes are largely due to post-operative ileus (a normal phenomena), but would be exaggerated in her case because of the minor distortion her colostomy would cause in the abdominal wall shape and more particularly because her wound was complicated, with the ultimate development of a wound dehiscence. Following repair of the wound dehiscence [Mrs A] states that she was happy '……… puts my belly button back where it should be'.

I don't think her complaint about the 'belly button' position is a legitimate complaint, but more likely reflects her interpretation of the immediate post-operative abdomen, particularly one that was later to develop a complication.

(b) Management of synchronous colonic polyps during surgery for colorectal cancer is based on the following principles :-

(i) If possible **full** colonoscopic assessment of the bowel from rectum through to caecum. Due to an acute presentation, and possibly obstruction, it may not always be possible to achieve a complete pre-operative colonoscopic assessment.

(ii) Most polyps should be dealt with pre-operatively by colonoscopic polypectomy or at the least biopsy.

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(iii) The pre-operative evaluation of the polyps, particularly their histology (i.e. type of polyp) and their number, is important in devising the surgical strategy for the cancer.

(iv) If synchronous polyps are near the primary tumour, then it is permissible to leave them in situ and assume they will be removed in the surgical specimen.

(v) Barium enema (either with or without colonoscopy) is still probably an accepted investigation to evaluate the bowel pre-operatively. If a barium enema does demonstrate significant synchronous polyps then these should be further evaluated by colonoscopy or some provision made in the operative strategy to deal with them.

Based on these principles, I am critical of [Dr B's] management of [Mrs A's] polyp. This criticism is for the following reasons:-

(i) Pre-operatively the whole colon should have been examined by colonoscopy.

(ii) He states in the colonoscopy report (a limited study) that multiple pedunculated polyps were seen in the sigmoid colon. According to the report these were not biopsied – he presumably made the assumption that these would be removed in the surgical specimen. With multiple polyps in this distal segment, it was even more important to fully examine the whole bowel pre-operatively to rule out the possibility, although rare, of a multiple polyp syndrome or more likely, a possible synchronous cancer.

(iii) According to [Mrs A's] letter, they (she and her daughter) were given the impression further surgery would be required to remove polyps. I believe [Dr B] was not referring to further surgery, but a further colonoscopy. This situation and the management of the polyps would not have been an issue had a full pre-operative colonoscopy with biopsies occurred.

2. *Following [Mrs A's] first operation she developed a full thickness abdominal wall dehiscence.*
   - *How commonly does this occur following surgery?*
   - *Why does it occur?*
   - *Are there any factors that you can identify that may have contributed to the dehiscence?*

2. Full thickness abdominal wall dehiscence is a rare but well described complication following abdominal surgery. Exact incident figures are hard to find, but in most busy general hospitals an incidence of somewhere between 1% - 5% would not be unusual. The reasons for dehiscence are usually technical (poor suture technique, inappropriate suture material), with certain patients being at high risk. Prominent risk factors are obesity, history of smoking, chronic obstructive airways disease,

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wound infection, previous abdominal surgery and certain medications (particularly steroids and immunosuppressives). The main risk factor [Mrs A] had was smoking and clearly as [Dr B] acknowledged, the need for her to have aggressive post-operative physiotherapy for her chest, would have placed considerable strain on the abdominal wound.

I would refute [Mrs A's] contention that removal of "clamps and drains" was either too soon or in any way contributed to the wound dehiscence. I believe wound dehiscence is probably destined to happen once the wound is closed but clearly, much more likely to occur in those at risk. In the context of this case, I do not believe the occurrence of a wound dehiscence itself should be regarded as inferior care, but rather an unfortunate, but well recognised complication.

3. When [Dr B] performed the Reversal Hartmann's procedure and creation of ileostomy on [Mrs A] he noted in the operation note that 'the stapler when fired may have caused an opening into the vagina'.

- *Is this a recognised complication of the type of surgery [Mrs A] underwent?*
- *If [Dr B] thought a staple may have pierced the vagina what corrective action was available to him?*
- *What information should [Dr B] have given [Mrs A]?*

3. The vagina and lower half of the rectum have a very close anatomical relationship (the vagina lies directly in front of the rectum) and care must be taken in females when anastomosing low in the rectum, that the posterior wall of the vagina does not get involved in the anastomosis.

Opening into the vagina or developing a colovaginal fistula when anastomosing low in the rectum is a recognised, but very rare complication. There are surgical techniques well described to minimise the likelihood of this occurring, but failing that if this complication is suspected to have occurred, then there is a responsibility to thoroughly examine the vagina and the anastomosis to ensure there isn't a fistula.

[Dr B] describes in his operation note '…….. the stapler when fired, may also have caused an opening into the vagina'. This suspicion clearly should have been pursued further. A simple examination within the vagina is likely to have shown the problem. It may have been difficult to discern with any clarity the situation from inside the pelvis but with an examination from below, it is conceivable the fistula could have been demonstrated. Having established the presence of a fistula, [Dr B] would have no option but to take down the anastomosis and either re-do it, or if that wasn't technically possible, then consider either leaving the rectal stump closed or resect it. Either of those latter options would have been preferable to leaving a fistula.

I believe [Dr B] underestimated the probable legacy of a potential colovaginal fistula. As mentioned, if he genuinely was concerned at the likelihood of this complication, then the best opportunity to rectify the situation was during that second operation.

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In the immediate post-operative period, the notes testify that a profuse vaginal discharge occurred. That observation taken with [Dr B's] intra-operative suspicion of a fistula, should have alerted him to discuss the possibility of such a complication with [Mrs A]. Unfortunately, the best opportunity to successfully resolve this problem had gone, but at least a discussion with [Mrs A] and her family at that stage may have averted some of her subsequent anxieties. However, with an established enterovaginal fistula in a patient who has already had two operations in this area, particularly low pelvic procedures, the likelihood of further restorative surgery being successful is low. She is more likely (?inevitably) facing completion proctectomy and a permanent stoma.

4. *Can you comment on the excessive bleeding and arrest [Mrs A] suffered following the Reversal Hartmann's procedure? In particular*
   - *How commonly does this occur following surgery?*
   - *Why does it occur?*
   - *Are there any factors that you can identify that may have contributed to the excessive bleeding and arrest?*

4. Repeat pelvic surgery (described in this case as a Hartmann's reversal) is very challenging surgery. Depending on how low the initial surgical dissection had gone, repeat surgery in this area is variably characterised by dense adhesions, obscure (if not absent) tissue planes and a high potential for bleeding problems.

In [Mrs A's] case, the rectal stump was probably difficult to isolate (……… 'extensive adhesions ………… firm and deep in the pelvis ….' – as documented in the operation note), and significant intra-operative blood loss occurred. She required a 4 unit blood transfusion.

A close examination of the clinical notes doesn't support [Mrs A's] post-operative collapse being due to post-operative bleeding, or excessive blood loss. I base this statement on the documented blood pressure recordings showing > 150mmHg systolic and also a Hb level (149) taken at the time of her collapse being well within the normal range.

From the notes it is very difficult to be entirely sure why this collapse occurred. It has been variously referred to as an 'arrest', the implication presumably being a cardiac arrest. There is nothing in the notes to support either hypovolaemia and/or cardiac arrest, and I think in all likelihood, it may have been a desaturation due to respiratory causes, ?poor oxygenation due to post-operative sedation and analgesia.

The fact that she improved with resuscitation very quickly (within 10 minutes) would strongly support a respiratory cause rather than blood loss or fluid depletion.

5. *What were the possible causes of [Mrs A's] bowel obstruction and infection post operatively?*

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5. Post-operative ileus is common and although theories are postulated about etiology, the exact causes are not known. An ileus is perhaps best described, as a functional obstruction. The degree or length of ileus probably reflects her long operation with the protracted and tedious freeing of adhesions.

The notes make reference to a post-operative bowel obstruction presumably indicating a mechanical obstruction. Whilst this is always a possibility in the post-operative period, I think the more likely explanation was an ileus. [Dr B] referred to a '….. taut middle colic artery ……' as likely causing obstruction at the duodenojejunal flexure. The middle colic artery takes a variable origin off the superior mesenteric artery. In rare cases (I am not referring to post-operative bowel cases here) the superior mesenteric artery can compress the third part of the duodenum, so called superior mesenteric artery compression syndrome. I have never heard or read of this vessel or indeed one of its branches (the middle colic artery) causing compression post-operatively after colonic mobilisation for a low rectal anastomosis. I believe this is most unlikely to have occurred and would go as far as to say, it is probably anatomically impossible.

The ileus (which I believe occurred with [Mrs A]) is an almost inevitable consequence of long complicated surgery. I think it was appropriate the ileus was treated conservatively, and in particular intravenous feeding (TPN) was indicated and sensible.

[Mrs A] developed fevers during the long post-operative period and blood cultures returned organisms consistent with the infection being due to the central venous line. Again, this is not an uncommon scenario in patients being treated with TPN for long periods. It is an unfortunate complication, but one that is well recognised and relatively easy to treat. I believe the treatment [Mrs A] received for this infection was entirely appropriate.

In summary, I am critical of [Dr B's] management of this case. Specifically there were deficiencies in his pre-operative assessment of the cancer and clearly he had significant problems with surgical technique, which ultimately led to several severe complications. These complications were never clearly explained to [Mrs A] or her family and largely because of that, communication between [Dr B] and [Mrs A] deteriorated.

The management of low rectal cancer in recent years has taken on a specialty interest. The various possible approaches to pre-operative assessment are important to understand and the surgical techniques can be demanding. Whilst I don't necessarily subscribe to the notion that this disease should not be treated in provincial centres, I do believe if these cases are to be treated there, the onus is on the surgeon to upskill, keep in contact with a larger centre, develop a reasonable case load and probably do the surgery with another colleague.

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Based on the evidence of this case, it seems unlikely that [Dr B's] experience fulfils many or any of those criteria and therefore, at this stage he should not treat low rectal cancers."

Further advice

Following the interviews with the public hospital staff and Mrs A, Dr Stewart provided the following comments:

"I have considered the additional information supplied concerning the operations of [Mrs A] on 18 September 2001 and 4 June 2002 obtained from transcripts of interviews between [Mrs A, Dr I, Ms G, Ms H] and investigation officers with the Health and Disability Commissioner.

Operation 4 June

My reading of the initial notes was that the collapse in the recovery ward was relatively short-lived; it only went over a ten minute period. The most accurate opinion on that would come from the intensivist or whoever was looking after [Mrs A] at that time. The anaesthetist ([Dr I]) said that [Mrs A] responded to what is a relatively small transfusion need, 500mls of frozen plasma. [Dr I] argued that she may have had a brisk bleed and responded to that. After a major, long operation such as redo surgery in the abdomen and the pelvis, it is not uncommon to have some fluctuations of blood pressure and vital signs or vital parameters in the immediate post-operative period. To say that this was due to a catastrophic bleed is, I think, over calling it as she responded so quickly to what is a trivial amount of resuscitation. The question is whether this arrest was possibly a respiratory collapse or something like that. I think the evidence for it being purely and simply due to significant huge blood loss is not strong and there is nothing in the additional information sent to support such an assertion.

Redo surgery, particularly in the pelvis, is a procedure that has a high potential for significant blood loss. This is recognised beforehand and adequate amounts of blood are available if needed. Obviously the onus is on the surgeon to have bleeding under control. There is a level of bleeding, minor bleeding, that goes on all through the operation which, when totalled up, can be quite significant. As long as this is recognised both by the surgeon and the anaesthetist, it is never out of control and it can be replaced. This is in contrast to trouble with a major pelvic vein from which you can lose huge amounts of blood very shortly, very quickly, but I don't think that occurred. I think [Mrs A] just had a long, difficult operation which is not uncommon with Hartmann's reversals. I stress the point particularly, that the lower you go into the depth of the pelvis the more tendency there is for the difficult surgery. The main reason for this is because the usual tissue planes and lines of dissection are absent due to fibrosis from previous surgery.

In relation to [Dr B's] theory of a tight colic artery

The idea of a tight colic artery is something entirely new to me and I have never heard of it. As I mentioned in the report, duodenal obstruction by the superior mesenteric artery (which I presume is the artery [Dr B] refers to) is extraordinarily rare. I have never heard of a problem such as this occurring during rectal or even bowel surgery.

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Use of the staple gun
I have read the recent interview with [Ms H], who was involved with the case, and a lot of what she has said is of concern. Firstly, she says that she wasn't entirely happy to fire the [staple] gun in the first place, although she did say she has done it from time to time with other surgeons. There are a couple of things that make me uneasy about what went on. Namely that, she kept saying there was resistance – and then she just said boldly at one point she was not happy to do the gun and she was not happy with the way it felt. She said she thought it was too tight. That is not satisfactory when you are using those guns. Such a statement would be an indication (for the surgeon) to see why it felt stiff or it did not feel right. [Ms H] talks about the green window and I quote:

> 'I remember quite clearly because as soon as I started to turn it, it was very tight and I said I was not happy, it was very, very tight and he kept saying just keep turning it.'

This is an indication that something is not right, particularly from someone who has fired a gun before (as they know what it should feel like). The surgeon needs to take over. [Dr B] was also not happy but he did go and fire the gun. [Ms H] was unhappy that when [Dr B] fired the gun he put too much force on. There is a familiarity with the gun which I believe this nurse had and she was not that happy about using it in this situation. She was also perturbed at the lack of support. A lot of surgeons would fire the gun themselves. There aren't any rules or anything like that, but I often have the registrars firing the gun. At the beginning of an attachment I make sure that they are entirely happy to do it. Senior nurses can also fire the gun.

Colovaginal fistula
The vagina has a close anterior relationship to the low rectum. Potentially part of the posterior vaginal wall could be caught in a low rectal anastomosis. If the rectum and vagina aren't separated sufficiently a colovaginal fistula will result.

Preoperative assessment
Synchronous tumours, although rare, are said to occur between 1–5% of colonic cancers. I do not regard [Dr B's] statement that he had never come across them therefore they must be very rare, as a mitigating factor. Twenty to 30 years ago it was very much encouraged to put your hand around the abdominal cavity when doing a laparotomy and feel in various areas and say everything is fine, but it is highly inaccurate. I do not think you can necessarily rely on just hopefully finding something else at surgery. It goes without saying that a preoperative assessment of the bowel, preferably by colonoscopy or possibly barium enema (most would regard colonoscopy as being the absolute gold standard), is the usual preoperative assessment. In a few situations you might not do that ie: patients who are admitted with an acute problem in their bowel or those who have an obstructing lesion such that you can't get beyond the tumour to look into the more proximal bowel.

I got the impression [Dr B] saw the tumour and then went up into the sigmoid colon. In the rectum a polypoid tumour was found. Then multiple polyps were found in the distal sigmoid colon so he has got beyond the tumour to the distal sigmoid. In the context of the difficulties this lady has had, I would regard this as a lesser criticism. I am sure all

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of us who have done bowel resections for cancer (and I include the whole bowel, not just rectal cancer) have from time to time done the surgery and not done a full examination of the bowel.

Laparotomy and hoping to find other lesions lacks precision and you are certainly not going to feel certain types of polyps. Failure to do a pre-operative colonoscopy is a criticism, that in the context of this lady's difficulties, it is only a minor criticism. Post-operative colonoscopy will pick up further polyps.

Rectal cancer is a condition of which I'm familiar. It is an operation I do relatively frequently. The area I work has a big population and clearly we see a lot more of this condition than would be seen in [this region]. I am very mindful of the fact that surgeons in certain areas in surgery now feel insecure about doing certain things because if they get it wrong there is often a lot of criticism. Those criticisms often will come from people who see a lot more of the disease and the operation than he is seeing. I think a lot of what went on with [Mrs A] reflects unfamiliarity with operating in that area."

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 4
Right to Services of an Appropriate Standard

1) *Every consumer has the right to have services provided with reasonable care and skill.*

RIGHT 5
Right to Effective Communication

1) *Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter.*
2) *Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively.*

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 –*
   a) *An explanation of his or her condition; and*
   …

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e) Any other information required by legal, professional, ethical, and other relevant standards; …

3) Every consumer has the right to honest and accurate answers to questions relating to services, including questions about –

…

c) How to obtain an opinion from another provider; …

RIGHT 7

Right to Make an Informed Choice and Give Informed Consent

8) Every consumer has the right to express a preference as to who will provide services and have that preference met where practicable.

Opinion: Breach – Dr B

Preoperative evaluation

On 11 September 2001, Dr B performed a colonoscopy on Mrs A. Dr B informed me that the colonoscopy showed a rectal tumour, which was photographed and biopsied, and polyps, which were photographed. According to the colonoscopy report, the examination was limited by the pathology encountered.

My expert advised that a full colonoscopic assessment from rectum to caecum should have been done and most polyps dealt with preoperatively where possible. While my expert has noted that an acute presentation or obstruction may prevent a complete preoperative colonoscopic assessment, this was not the case with Mrs A. The tumour was situated in the rectum and Dr B was able to proceed with his investigation beyond this to the sigmoid colon. My expert advised that assessment of the bowel by colonoscopy or barium enema is the usual preoperative assessment. I note my expert's comment that in the context of Mrs A's other problems, Dr B's failure to perform an appropriate preoperative evaluation is a minor criticism.

In my opinion Dr B failed to exercise reasonable care and skill by not conducting an appropriate preoperative assessment and therefore breached Right 4(1) of the Code.

Use of surgical stapler

Mrs A was concerned that Dr B did not carry out her operation on 4 June 2002 with reasonable care and skill, with the result that she suffered from vaginal discharge including discharge of faecal matter.

On 4 June 2002, Dr B performed a reversal of Hartmann's procedure and creation of a lower ileostomy operation. A stapler was used to anastomose the proximal bowel to the rectal stump. Dr B lined up everything and asked one of the nurses to turn the end of the stapler. Ms G informed me that she had "a vivid recollection of that part of the operation", as the

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circulating nurse, Ms H, refused to fire the gun and told Dr B that it did not feel right and felt very tight, as if there was too much tissue in it. Ms H could not rotate the staple gun knob without excessive force, and she refused to carry on with the procedure, noting that Dr B had had difficulty with staple guns in previous operations. Dr B noted that the thickness of the rectal stump made it difficult for the stapler to cut through. He used considerable force and eventually turned the end of it. As a result, the stapler caused an opening in the vagina.

In relation to the creation of a colovaginal fistula, my advisor noted:

> "The vagina and lower half of the rectum have a very close anatomical relationship (the vagina lies directly in front of the rectum) and care must be taken in females when anastomosing low in the rectum, that the posterior wall of the vagina does not get involved in the anastomosis."

I accept that causing an opening into the vagina when anastomosing low in the rectum is a rare, recognised complication that can arise despite the exercise of reasonable care and skill. However, I am not satisfied that Dr B exercised reasonable care and skill to minimise the likelihood of the complication occurring in this case. Dr B was on notice that there was a concern with the stapler. The stapler gun should not have been used in these circumstances, as the tissue was too thick, and unusual effort was required to turn the end of it. Despite this, Dr B fired it and an injury resulted. Dr B failed to use the stapler with reasonable care and skill during Mrs A's operation and therefore breached Right 4(1) of the Code.

Examination for colovaginal fistula
Dr B recorded in his operation note that he suspected he might have caused an opening in the vagina at the time of the operation. Dr B did not examine the vagina and anastomosis to ensure there was not a fistula. Dr B advised that he intended to undertake a comprehensive examination at three weeks if the discharge continued.

My expert advisor noted:

> "Opening into the vagina or developing a colovaginal fistula when anastomosing low in the rectum is a recognised, but very rare complication. There are surgical techniques well described to minimise the likelihood of this occurring, but failing that if this complication is suspected to have occurred, then there is a responsibility to thoroughly examine the vagina and the anastomosis to ensure there isn't a fistula … having established the presence of a fistula, [Dr B] would have no option but to take down the anastomosis and either re-do it, or if that wasn't technically possible, then consider either leaving the rectal stump closed or resect it. Either of those latter options would have been preferable to leaving a fistula."

I accept the advice of my independent expert that if Dr B suspected such a complication he should have undertaken an examination at the time of the operation and endeavoured to rectify the problem. Dr B breached Right 4(1) of the Code by failing to examine and repair the colovaginal fistula at the time of the operation.

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Information about vaginal trauma
Dr B suspected he had created a colovaginal fistula. He recorded his suspicion in the operation note. In the immediate postoperative period Dr I was concerned about the vaginal blood loss. The theatre nurses also commented on the vaginal blood loss, which was not usual for such an operation. Postoperatively, on the ward, Mrs A expressed concern about her vaginal blood loss, for which she had to wear a sanitary pad. Dr B was aware that Mrs A had vaginal bleeding. The histology report of tissue obtained during surgery showed evidence of vaginal tissue in the donut. My expert advised that the vaginal discharge, combined with Dr B's suspicion that he had breached the vaginal wall, should have prompted him to discuss with Mrs A the possibility of the complication of a fistula.

In relation to Dr B's lack of action over the colovaginal fistula, my expert advisor noted:

> "Unfortunately, the best opportunity to successfully resolve this problem had gone, but at least a discussion with [Mrs A] and her family at that stage may have averted some of her subsequent anxieties."

Three months after the operation Mrs A experienced faecal matter coming from her vagina. Mrs A's general practitioner referred her to Dr J, noting that Dr B had mentioned that he might have made a hole in Mrs A's vagina during the operation in June 2002. Dr J found a palpable staple and a hole through to the rectal mucosa when he performed an examination under anaesthetic in November 2002. My expert further advised that Dr B "underestimated the probable legacy of a potential colovaginal fistula".

The Code of Health and Disability Services Consumers' Rights is based on the fundamental right of patients to be fully informed in order to make informed choices. The test in Right 6 is whether the patient has received the information that a reasonable patient, in that patient's circumstances, would expect to receive. Such information not only enables patients to make informed choices about their health care but also provides them with information about their condition. Doctors have a duty of candour and patients have a right to full disclosure when something goes wrong. Such action is underpinned by a respect for autonomy and promotes trust in the medical profession. Disclosure of adverse events also serves to minimise the potential harm of unknown conditions going untreated.

Despite numerous opportunities, Dr B failed to inform Mrs A of the adverse event that may have occurred during her surgery. This is information that Mrs A would have wanted to know and was entitled to receive under Right 6(1)(a) and (e) of the Code. Mrs A was instead subjected to the experience of a totally unexpected and distressing evacuation of faeces from her vagina before being informed by her GP of the complication.

Dr B's omission was a serious breach of his professional and ethical duties. In failing to inform Mrs A of the possible complication of her surgery, Dr B breached Right 6(1)(a) and (e) of the Code.

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Communication about the removal of polyps
Following Mrs A's operation on 18 September 2001, Ms D, Mrs A's daughter, asked Dr B if he had removed all the polyps. Dr B said that there were too many polyps to do at the time of the operation and that a further operation would be required. My expert commented that Dr B was most likely referring to a further colonoscopy rather than further surgery to remove the remaining polyps. Mrs A said that at their meeting in February 2002 she asked Dr B about the additional surgery to remove the polyps and he told her that as he had removed so much bowel he must have removed them all. Dr B said he told Mrs A postoperatively that he had tried to remove all the polyps but was not sure if he had, and so would check if there were remaining polyps at a later date by colonoscopy.

There is conflicting information about the removal of Mrs A's polyps. In accordance with Right 5 of the Code, Dr B was required to communicate in a manner that enabled Mrs A to understand her situation. On balance I am satisfied that Dr B's communication on this matter was far from effective. Dr B breached Right 5 of the Code in failing to convey information about her situation clearly to Mrs A.

Opinion: No breach – Dr B

Operation on 18 September 2001
Mrs A said that Dr B had repositioned her belly button following the anterior resection operation. She was concerned both by the different position of her belly button and by Dr B's lack of concern. Dr B informed me that he did not shift Mrs A's belly button. There is no record of the reposition of Mrs A's belly button in the medical notes. My expert advised:

> "[Mrs A's] complaint about her belly button obviously involves the 10 day post-operative period from her first operation (18/09/2001). It was 10 days after that operation that she returned to theatre for the repair of the wound dehiscence. The wound and her abdominal shape and contour would be distorted to a degree during that 10 day period because of the normal immediate post-operative changes. These changes are largely due to post-operative ileus (a normal phenomena), but would be exaggerated in her case because of the minor distortion her colostomy would cause in the abdominal wall shape and more particularly because her wound was complicated, with the ultimate development of a wound dehiscence."

I accept my expert advice that Mrs A's abdominal shape was affected by her wound and the colostomy. Accordingly, in my provisional opinion, Dr B did not breach the Code in relation to this matter.

Dehiscence
On 24 September, six days after her operation, Dr B ordered five of Mrs A's abdominal wound clips to be removed, and on 27 September, nine days after her operation, the remainder of Mrs A's abdominal wound clips were removed. Following the removal of the remaining clips the wound completely dehisced and Dr J had to resuture the wound. Mrs A

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thought the "clamps and drain" were removed too soon. Dr B thought it more likely that frequent chest physiotherapy facilitated by epidural analgesia contributed to the wound opening. Dr B does not believe that the clamps and drains were removed too soon.

My expert advised that "full thickness abdominal wall dehiscence is a rare but well described complication following abdominal surgery". Smoking and the consequent aggressive postoperative physiotherapy required put Mrs A at greater risk of wound dehiscence. My expert advised that in this case the occurrence of a wound dehiscence was an unfortunate but well recognised complication rather than an indication of inferior care. I accept the advice of my expert. Mrs A suffered a well-described complication of surgery that was not attributable to a lack of care and skill on the part of Dr B.

Excessive bleeding and an arrest in the immediate postoperative period
Mrs A complained that her operation on 4 June 2002 was complicated by excessive bleeding and an arrest in the immediate postoperative period. Dr B said that he expected the operation to be difficult, and adhesions prolonged the operation. The blood loss during the operation was greater than 3000mls and Mrs A received four units of blood, fresh frozen plasma and other intravenous fluid. Dr I explained that the prolonged nature of the operation, the considerable intraoperative blood loss and the continuing vaginal blood loss caused her to have concerns about the maintenance of Mrs A's haemodynamic state postoperatively. For this reason Dr I arranged for Mrs A to go to the intensive care unit overnight. However, before Dr I had left the hospital Mrs A suffered a "collapse" during which time her blood pressure was unrecordable and she required assistance with her breathing. Dr B informed me that he could not explain the episode as he did not think Mrs A was hypovolaemic. When Dr I was called to attend Mrs A following the collapse, she found 500mls of blood in the previously empty wound drain. Dr I said the 500mls of blood in the drain supported a brisk bleed as precipitating the collapse. Dr I was aware that Mrs A may have been under-transfused and cautioned the nurses to be aware. Dr I noted that Mrs A had an epidural anaesthetic and this can make people more vulnerable to sudden bleeds. Dr I further noted that Mrs A responded quickly to frozen plasma.

I note the advice of my expert that there is a high potential for bleeding problems with repeat pelvic surgery. My expert commented:

> "A close examination of the clinical notes doesn't support [Mrs A's] post-operative collapse being due to post-operative bleeding, or excessive blood loss. I base this statement on the documented blood pressure recordings showing >150mmHg systolic and also a Hb level (149) taken at the time of her collapse being well within the normal range."

My expert concluded that Mrs A's rapid recovery with resuscitation strongly supported "a respiratory cause rather than blood loss or fluid depletion".

I accept my expert advice that Mrs A's collapse was not attributable to excessive blood loss. Accordingly, Dr B did not breach the Code in relation to this matter.

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Postoperative bowel obstruction and infection
My expert advised that the obstruction was more probably functional than mechanical:

> "An ileus is perhaps best described, as a functional obstruction. The degree or length of ileus probably reflects her long operation with the protracted and tedious freeing of adhesions."

I note my expert's comment that Dr B's explanation of "a taut middle colic artery" as the cause of the obstruction was "most unlikely to have occurred and would go as far as to say, it is probably anatomically impossible".

My expert also commented:

> "[Mrs A] developed fevers during the long post-operative period and blood cultures returned organisms consistent with the infection being due to the central venous line. Again, this is not an uncommon scenario in patients being treated with TPN [total parenteral nutrition] for long periods. It is an unfortunate complication, but one that is well recognised and relatively easy to treat. I believe the treatment [Mrs A] received for this infection was entirely appropriate."

I accept the advice of my independent expert that Mrs A's bowel obstruction was a result of her lengthy operation and that Dr B provided appropriate treatment for Mrs A's postoperative infection. Accordingly, Dr B did not breach the Code in relation to this matter.

Opinion: No vicarious liability – the public hospital

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. However, under section 72(5) an employing authority has a defence if it shows that it took such steps as were reasonably practicable to prevent an employee from breaching the Code.

Dr B breached Rights 4(1), 5 and 6 of the Code. In my view, the failure of Dr B to provide services with reasonable care and skill and fully inform Mrs A cannot fairly be attributed to any failure by the public hospital. The public hospital had credentialling processes in place for senior medical staff, in an attempt to ensure their continuing competence. When notified in writing of problems concerning Dr B, the public hospital requested the New Zealand Medical Council, on 23 December 2002, to conduct a review of Dr B's competence and Dr B withdrew from practice. In these circumstances, the public hospital is not vicariously liable for Dr B's breaches of the Code.

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Comments

Request for another provider

It is clear that Mrs A was unhappy with the first operation performed by Dr B in September 2001 and wanted to have her care transferred to Dr J. On 15 and 16 January 2002 Mrs A and her GP respectively made formal requests in writing to have her care transferred. It appears that Mrs A may also have asked for a second opinion on her condition. While it is not entirely clear what Dr B and other staff at the public hospital advised Mrs A in response to her request, it is clear that she was required to discuss it with Dr B at her next appointment. Mrs A considered she had no choice of provider under the public system.

Patients have a right to honest, accurate answers to questions about how to obtain a second opinion (Right 6(3)(c) of the Code). The information provided in response to such a request must not be misleading or inaccurate. Such information enables patients to make informed choices about their health care.

Patients also have a right to express a preference as to who will provide services and have that preference met where practicable (Right 7(8) of the Code). The right to receive services from a provider of one's choice is not an absolute right under the Code. Patients have a right to have their preference met "where practicable". In some situations it may not be possible or appropriate to meet a patient's preference, for example if a preferred provider is not available at a particular time or it is an emergency. In addition to the qualification contained in Right 7(8) itself – that the right is to be met "*where practicable*" – clause 3 of the Code also places reasonable limitations on the rights in the Code.

The general obligation on providers under clause 3 is to take reasonable actions in the circumstances to give effect to the rights and comply with the duties in the Code. The onus is on the provider to show that he took reasonable steps to accommodate a patient's preference and that it was reasonable in the circumstances to refuse the request.

It was natural for Mrs A to feel uneasy about having to discuss her request with Dr B and that she felt that she had no choice but to continue under his care. In such a sensitive situation it was especially important for staff at the public hospital to take time to ensure that Mrs A understood her options and the process for dealing with such requests. It was only a further request, following surgery by Dr B on 4 June 2002, that prompted transfer of Mrs A's care to Dr J within the public system.

In response to my provisional opinion, the public hospital advised me that it is developing "a clear process" for staff to follow when patients request transfer of care.

Competence review

During the course of my investigation I asked the Medical Council of New Zealand about the outcome of Dr B's competence review. The Medical Council requested that I seek the information from Dr B. My request to Dr B (via his legal counsel) for the results of the review was declined. The Medical Council has since advised that there is a condition on Dr B's practice which states that he will undertake his competence programme in a position

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approved by the Council's Medical Advisor. The public hospital has informed me that Dr B is no longer working there.

Contemporaneous investigation
I note that a contemporaneous investigation of Dr B's surgery on another patient at the public hospital also resulted in breach findings: HDC Case 02/17107, 24 March 2004.

Follow-up actions

- I have referred this matter to the Director of Proceedings in accordance with section 45(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any further action should be taken in relation to Dr B.
- A copy of this report will be sent to the Medical Council of New Zealand; the Royal Australasian College of Surgeons; the Director-General of Health; and Ms K, Advocate, Health and Disability Consumer Advocacy Service.
- A copy of this report, with identifying features removed, will be sent to the Royal Australasian College of Surgeons and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes, upon completion of the Director of Proceedings' processes.

Addendum

At a hearing before the Health Practitioners Disciplinary Tribunal on 19 September 2005, Dr B admitted a charge of professional misconduct, which was upheld by the Tribunal. Dr B was censured and ordered to practise under conditions, that is, that he is supervised for a period for two years from the date of the hearing. A contribution of 25% costs or $20,000 (whichever was the lesser) was also ordered. The Tribunal lifted the interim name suppression order, but Dr B appealed on the question of final name suppression and has been granted further interim name suppression pending the hearing of that appeal.

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Appendix 1

Operating Theatre

FILE COPY

Name: No:
Date: Age: Ward:
Surgeon:
Anaesthetist:

Operation: REVERSAL HARTMANS PROCEDURE AND CREATION OF LOWER OF ILEOSTOMY

SUMMARY

This 61-year-old woman had a very low anterior resection for carcinoma of the rectum 8 months ago for carcinoma of the rectum.
Because of difficulty with anastomosis at the time, a Hartman's procedure was carried out.
It was noted at that time that the left colon was extremely short and extensive mobilisation of the left colon, splenic flexure, and transverse colon was required to obtain enough length for colostomy.

OPERATIVE FINDINGS AND PROCEDURE

Rocephin 1 gm.
Flagyl 500mg for prophylaxis.
TED and Fragmin.
Urinary catheter.
Routine prep and drape in the Lloyd Davis position.
The colostomy was taken down and the old wound was reopened very carefully.
As expected there was extensive adhesions, mainly involving small bowel to the anterior abdominal wall to each other and also firmly and deep in the pelvis.
After tedious, careful dissection I was able to mobilise the small bowel.
I had to mobilise the colon a lot more, right down to the hepatic flexure.
The length was however, limited by the pedicle of the pedicle of the middle colic artery.
The pedicle came across OJ flexure with some tension, but was enough to cause an obstruction.
Further mobilization would compromise the blood supply to the distal colon.
There was enough length to try to facilitate an anastomosis using the size 31mm EEA Stapler.
Unfortunately the rectal stump was too thick making it difficult for the Stapler to cut through.
The Stapler, when fired, may have also caused an opening into the vagina.
The anterior part of the anastomosis was clearly disrupted and was closed with 3 interrupted stitches of silk 0.
The peritoneal cavity was lavaged with warm saline.
A Jackson Pratt drain was placed in the pelvis.
The wound was closed in mass closure fashion with continuous Nylon 1 reinforced with figure of "8" Nylon 1 stitches.

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…2

[…]
[Mrs A]

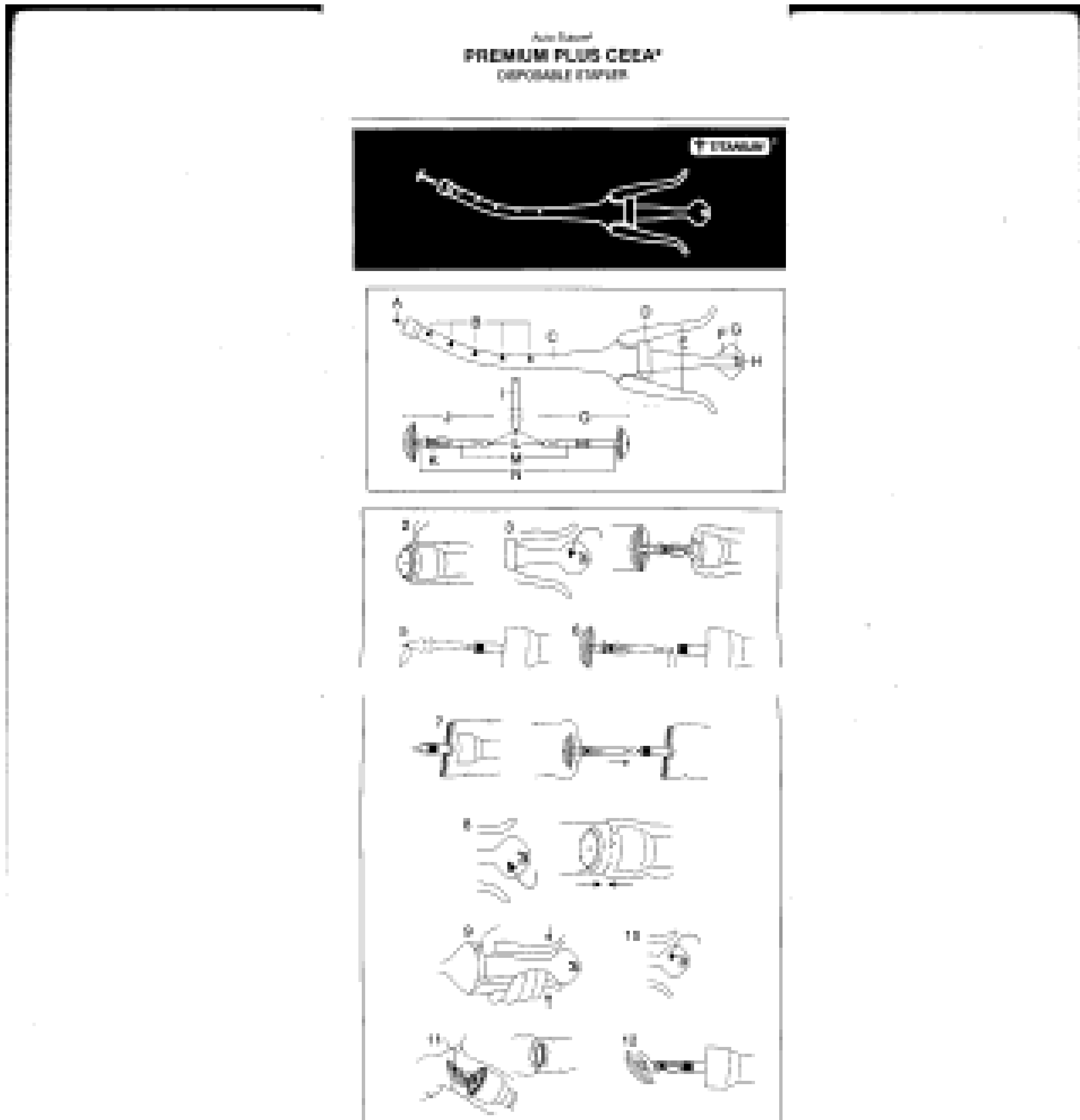
OPERATIVE FINDINGS AND PROCEDURE cont'd
Clips to skin.
Ileostomy was brought out at the right iliac fossa and was opened and stitched onto the skin using the Brookes technique.
A CV line was placed by [Dr I] at the end of the procedure in anticipation of possible TVN because there is a possibility of a prolonged ileus from extensive mobilization of adherent small.

[Dr B]
[…]

COPY TO – [DR L]

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix 2



Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.