General Surgeon, Dr B

Tairawhiti District Health Board

A Report by the

Health and Disability Commissioner

(Case 07HDC17438)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Overview

On 11 November 2005, Mrs A, aged 62, was referred to Tairawhiti District Health Board for assessment by a general surgeon, because of bowel changes and blood in her bowel motions. Mrs A had a history of bowel problems and had been diagnosed with ulcerative colitis[1] in the 1970s — information that was included in the referral.

On 24 November, Mrs A was assessed by Dr B, who diagnosed a large pre-cancerous bowel lesion. On 13 December 2005 at Gisborne Hospital, Dr B performed an anterior bowel resection and anastomosis[2] with a protective ileostomy.[3] On examination, the resected bowel was found to have active ulcerative colitis.

Mrs A recovered well and, on 7 March 2006, Dr B reversed the ileostomy. In late March, however, Mrs A's condition deteriorated and she was admitted to Gisborne Hospital. On 4 April, she developed septic shock and a fistula[4] between her bowel and the ileostomy wound.

Mrs A went on to have ongoing difficulties with the fistula and significant ulcerative colitis. On 24 November 2006, the remainder of her large bowel was excised by a specialist colorectal surgeon.

Complaint and investigation

On 2 October 2007, the Health and Disability Commissioner (HDC) received a complaint from Mrs A about the services provided by Dr B. The following issue was identified for investigation:

The appropriateness of care provided by Dr B to Mrs A from 11 November 2005 to 25 May 2006, including his preoperative assessment.

An investigation was commenced on 24 June 2008.

[1] Inflammation of the colon and rectum.
[2] Where a section of bowel is removed and the cut ends are joined (anastomosed).
[3] An external bag to hold faecal matter.
[4] An abnormal passage between two internal organs, or leading from an internal organ to the surface of the body.

Information was obtained from:

Mrs A	Consumer
Dr B	General Surgeon/Provider
Tairawhiti District Health Board	Employer/Provider
Dr C	General Practitioner
Dr D	General Practitioner
Dr E	General surgeon

Additional information was also obtained from the Accident Compensation Corporation, and the Medical Council of New Zealand.

Independent advice was provided by Dr Peter Johnston, general surgeon (**Appendix A**).

Information gathered during investigation

Referral and assessment
On 11 November 2005, Mrs A (aged 62) was referred by her general practitioner, Dr C, to Tairawhiti District Health Board for specialist assessment by a general surgeon. Mrs A had a long history of bowel problems and had recently noticed blood in her bowel motions. Dr C's referral letter advised:

> "Reason for referral: recent change in bowel habit, some frank blood in [bowel motion] ...
>
> [V]ery long [history] of erratic bowels, bleeding, constipation/diarrhoea since childhood — was investigated by [Dr] in 70s, told colitis and just keep fibre high — was apparently a small patch of inflammation in bowel on [barium] enema. For past [six months] has been flared again, some bleeding, very irritable w[ith] any stress, etc. In view of being settled for many years and now aged 61[5] really needs colonoscopy[6] to rule out malignancy."

On 24 November 2005, Mrs A was assessed by a general surgeon, Dr B, at Gisborne Hospital's outpatient department. Dr B performed a sigmoidoscopy[7] and a tumour was noted. Dr B took biopsies of the tumour and arranged for Mrs A to have a CT scan of her abdomen and a barium enema "to rule out other lesions". Dr B did not request a colonoscopy, although Dr C's referral letter directly requested one. Dr B later advised HDC that the waiting time for a colonoscopy in Gisborne was 4–6 months, and "... I

[5] I note that Mrs A was 62 on 11 November 2005, her birthday being 10 November 1943.
[6] Examination of the mucosal lining of the colon using a colonoscope, an elongated endoscope.
[7] Examination of the rectum and lower colon using a lighted tube (sigmoidoscope).

did not think that it was appropriate or ethical to wait this long for colonoscopy before surgery".

On 30 November, an abdominal CT scan of Mrs A's abdomen was performed, but it did not reveal any other lesions. A barium enema, performed on 6 December, showed only the known tumour, and no evidence of ulcerative proctitis[8] or colitis.

On 8 December, Dr B met with Mrs A. He noted her CT and enema results and that the biopsy results were reported as polyps with pre-cancerous cell changes (tubulovillous adenoma with dysplasia). Dr B planned to perform an anterior resection and anastomosis with a protective ileostomy on 13 December. Dr B and Mrs A signed a consent form for a low anterior resection, and he reported the results and plan for surgery to Dr C, in a letter dated 8 December.

Surgery and ileostomy closure

On 13 December, Dr B performed the surgery, and also removed Mrs A's appendix. Mrs A initially recovered in the Intensive Care Unit, and was moved to the general surgical ward on 16 December. Mrs A recovered well and was discharged home on 20 December.

Dr B saw Mrs A on 16 January 2006 and he considered that she was doing well. He noted that the histopathology of the resected sections of Mrs A's rectum and bowel showed that the polyps were, in fact, cancerous. Ulcerative colitis was also found in the lower half of the specimen. This was reported to Dr C in a letter dated 16 January.

Mrs A continued to recover well and, after a contrast study to confirm that her anastomosis was intact, Dr B performed surgery on 7 March to close Mrs A's ileostomy. He wrote to Mrs A's new GP, Dr D, to update her on the surgery and outcome. Mrs A recovered well initially, and was discharged home on 10 March.

On 23 March, Dr B reviewed Mrs A and reported that she was recovering well. Although she had suffered some constipation, this was relieved by lactulose prescribed by Dr D. Dr B reported his findings to Dr D in a letter dated 23 March.

Complications

On 30 March, Mrs A developed severe lower abdominal pain at the site of the ileostomy scar, and a large tender swelling under the site. She attended Dr D's practice and was seen by a colleague, who immediately referred her to Gisborne Hospital's Accident and Emergency Department. Following assessment, an abdominal X-ray was performed and Mrs A was admitted under the care of Dr B.

The X-ray demonstrated faecal loading and, on 31 March, a laxative (Movicol) was administered with Dr B's approval. The weekend plan noted "[Abdominal X-ray] shows faeces +++. Pain probably [due] to constipation. [Plan:] Lactulose, Microlax

[8] Inflammation of the rectum.

enemas & Movicol. — Can be discharged home ?Sat or Sun when has passed a [large] amount of faeces …"

Mrs A failed to pass any significant amount of faeces, and developed a fever, and the swelling underneath her scar continued to increase. An ultrasound on 2 April demonstrated soft tissue inflammation only. On 4 April, Mrs A consented to Dr B performing surgery to investigate and diagnose the cause of her deteriorating condition. Dr B re-opened the ileostomy wound and found a "moderate sized deep haematoma"; he evacuated the clot and packed the wound.

In the early hours of 4 April, Mrs A developed septic shock and required resuscitation (which was provided by Dr E). She was admitted to the Intensive Care Unit, placed on a ventilator, and started on high doses of antibiotic (gentamicin). Dr E found that Mrs A had developed a fistula between her bowel and the re-opened ileostomy wound.

Mrs A improved slowly and Dr B performed a sigmoidoscopy on 6 April to check that Mrs A's anastomosis was intact. In her letter of complaint, Mrs A recalled:

> "[Dr B] ... performed a very painful and rough sigmoidoscopy causing me to howl in pain, he gave me no real reason but told me that I was grossly constipated."

Dr B responded to Mrs A's complaint:

> "[I]t was imperative to exclude anastomotic dehiscence.[9] Unfortunately the patient was constipated and manual removal was performed — this caused her discomfort. It was necessary to view the anastomosis."

Mrs A's anastomosis was intact, and she recovered with antibiotics and fluid replacement. Mrs A was moved to the general ward on 7 April, and continued to recover slowly. Although the fistula was still open, it had become less active, and Mrs A was discharged home on 28 April.

Transfer of care

Mrs A was admitted on three further occasions on 30 April, 10 May and 24 May 2006, with a reopening of the fistula and difficulties with the fistula site. On 25 May, she requested a second opinion on management of her fistula and, on 26 May, chose to transfer her care to Dr E.

Dr E ordered an immediate colonoscopy for Mrs A and this was performed the next day. The colonoscopy demonstrated extensive active ulcerative colitis, and four polyps close to the anastomotic margin, which were removed. On 1 June, Dr E closed the fistula and repaired Mrs A's bowel.

Although the fistula remained closed, Mrs A became increasingly troubled by ulcerative colitis, which required inpatient treatment. Dr E referred her to a colorectal

[9] A surgical complication involving bursting open or splitting along the suture line.

surgeon and expert in management of ulcerative colitis, for specialist care and excision of the remainder of her large bowel. This was performed on 24 November 2006. Unfortunately, Mrs A went on to develop a fistula between her rectum and vaginal wall, which was repaired, only for another to develop.

Mrs A has undergone further surgery, and continues to make a slow recovery.

Responses to provisional opinion

Dr B

Dr B responded through his lawyer. He did not accept the finding that he breached the Code of Health and Disability Services Consumers' Rights (the Code), and argued that surgical management of Mrs A's colorectal tumour was within his area of expertise, and that his choice of operative procedure was appropriate for Mrs A's presentation.

Dr B noted that he had "worked as a Consultant in a Colorectal unit at [an English] Hospital for one year and am familiar in dealing with colorectal tumours".

He believes that Dr Johnston's comments that "tumours of the mid or lower rectum are ... really in the area of the sub-specialist colorectal surgeon" are not relevant, because Mrs A's tumour was at the rectosigmoid junction.

Contrary to his previous statement that he was "operating for tubulo villous adenoma and not carcinoma", Dr B now says that his "... intention is ALWAYS to perform a cancer operation in these cases". Dr B does not believe that his choice of procedure exposed Mrs A to unnecessary risk.

Tairawhiti DHB

Tairawhiti DHB submits that it should not be held vicariously liable for Dr B's breaches of the Code.

The DHB commented that Dr Johnston's advice that Mrs A's surgery should have been referred to a colorectal surgeon "reflects a metropolitan view where colorectal surgery is considered a subspecialty" and that this is not "the reality of provincial general surgeons".

Tairawhiti DHB argued that the development and maintenance of subspecialty services "would neither be sustainable nor efficient" and that "a shift to subspecialty service provision would also be detrimental to patients and the community as it will force the transfer of patients out of the district". It submitted that "patients in provincial centres are still able to receive safe and effective care provided by general surgeons for subspecialty problems.

The DHB acknowledges that general surgeons are not specifically credentialled for colorectal surgery, "colorectal surgery [is] considered within the realm of general surgery at [Tairawhiti DHB]" and, at the time, the DHB considered Dr B competent to perform surgery for colorectal cancer.

The DHB accepts that its credentialling process can always be improved, but believes that the credentialling process in place at the time of Mrs A's surgery was appropriate to guide clinical practice and protect the public.

Tairawhiti DHB undertook to review its referral guidelines, but noted that "such guidelines support rather than replace surgeon's clinical decision making", and submitted that "absolute guidelines" would remove appropriate clinical autonomy and "overburden secondary and tertiary centres [and] lead to deskilling and a loss of trained staff from the provinces".

Opinion: Breach — Dr B

Mrs A was diagnosed with a large rectal tumour and underwent an anterior resection with ileostomy. She had the right to surgical services provided with reasonable care and skill. Surgical services include the preoperative assessment and consultation with other specialists where necessary. One of the key issues in this case is whether it was appropriate for Dr B to carry out the type of operation he performed on Mrs A.

Assessment and diagnosis
The initial referral form sent to Dr B by Mrs A's GP outlined a history of colitis in the 1970s, but no symptoms since then except for the six months prior to her presentation in late 2005.

Although Mrs A's GP requested that a colonoscopy be performed, Dr B did not order one as he considered that the 4–6 month wait was too long. Dr B did perform a sigmoidoscopy as part of his investigations and took biopsies of the tumour. He did not note any evidence of ulcerative proctitis,[10] and the barium enema did not demonstrate any evidence of colitis. Dr B concluded that Mrs A did not have ulcerative colitis or proctitis, and proceeded with a low anterior resection of her bowel.

My surgical expert, Dr Johnston, advised:

> "Any resection of the rectum in the presence of proctitis is best to be done in the form of excision of the whole large bowel.
>
> ...

[10] A form of ulcerative colitis that is localised in the lower rectum.

> I believe the situation here was not at all obvious but there were some clues which many experienced surgeons would have picked up on and required colonoscopy with biopsies of the non-tumour bowel before surgery ... the diagnosis [of] dormant proctitis or colitis in [Mrs A] was sufficiently unclear that it would not be appropriate to censure [Dr B] ..."

I am satisfied that Dr B's failure to diagnose active ulcerative colitis did not necessarily indicate a deficiency in care, but I draw his attention to Dr Johnston's comments.

Subspecialist input

Dr Johnston advised that "rectal cancer is one cancer where treatment results depend on a surgeon with specific skills. This treatment may well not be available in the average provincial hospital." Colorectal cancer outcomes, and especially rectal cancer outcomes, are improved in the hands of surgeons with high caseloads. Better results are underpinned by appropriate training and subspecialisation.[11]

At the time, Dr B was credentialled for general surgery, minor urological procedures, and endoscopy. Dr B was not credentialled specifically for colorectal surgery, but it was considered within the realm of general surgery at Tairawhiti District Health Board. Dr B had previously worked as a consultant in a colorectal unit. However, I agree with Dr Johnston that this "... does not necessarily mean that he was adequately trained or supported to do rectal cancer surgery in New Zealand in 2005".

Dr Johnston commented that, while the choice of procedure "reflects a lack of knowledge on [Dr B's] part ... the issue is wider that this". Dr Johnston advised:

> "Tumours of the mid or lower rectum are (and were in 2005) really in the area of the sub-specialised colorectal surgeon, and no longer for the generalist general surgeon ... the outcome for [Mrs A] was certainly compromised by the initial management of the problem, including [Dr B's] first operation."

At best, the management of Mrs A's rectal tumour was at the limit of Dr B's expertise. Dr B should have considered referring Mrs A to a sub-specialised colorectal surgeon or at least sought input from a colleague in planning her treatment.

[11] O'Grady, G and Secker, A. "Colorectal cancer management in the provincial New Zealand setting of Nelson" *ANZ J Surg* 2007: 1004–1008.

Adequacy of surgery
Dr B performed an anterior resection with ileostomy, and obtained a very limited margin (7mm) distal to the tumour. He explained his choice of procedure: "I was operating for tubulovillous adenoma not for rectal [cancer]." Subsequently, Dr B advised that he *did* intend to perform a cancer operation.

Dr Johnston advised that Dr B's anterior resection operation was not satisfactory in terms of contemporary standards. The type of tumour present in Mrs A's rectum follows a specific life history, which includes transformation to a cancer with a stage in which some parts of the tumour are benign and some are malignant. Although the biopsies Dr B obtained through sigmoidoscopy showed pre-cancerous changes only, complete excision of the tumour was necessary, and thorough pathologic examination needed to determine the presence of cancer. Dr Johnston advised:

> "This operation should have been regarded as a cancer operation, and conducted with the aim of securing an adequate margin of bowel distal to the tumour with excision of the meso-rectum, which removes the appropriate group of lymph nodes adjacent to the bowel."

Dr Johnston advised that the surgery was inadequate as a cancer operation. He noted that Mrs A's mesorectum and lymph nodes were not excised, which would be standard for a cancer operation, and advised that he does "not support [Dr B's] belief that a lesser course of action was adequate".

Conclusion
In my opinion, the deficiencies in Dr B's management of Mrs A amount to a failure to provide services with reasonable care and skill. Accordingly, Dr B breached Right 4(1) of the Code.[12]

Opinion: Breach — Tairawhiti District Health Board

Vicarious liability
Tairawhiti District Health Board has a duty to select competent staff and monitor their continued competence. It should have a robust credentialling process. The Ministry of Health has provided specific and clear guidance on credentialling, which is currently under review. The need for effective credentialling was highlighted in my Tauranga Hospital inquiry report[13] and more recently in my Wanganui Hospital inquiry report.[14] The specific need to consider what support services should be place before surgical

[12] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."
[13] See http://www.hdc.org.nz/files/hdc/opinions/04hdc07920surgeon.pdf (February 2005).
[14] http://www.hdc.org.nz/files/hdc/publications/whanganui-dhb-feb08.pdf (February 2009).

services can safely be undertaken in smaller centres, and the importance of regional collaboration, were highlighted in a case from the West Coast.[15]

There has been a move towards the regionalisation of colorectal services in New Zealand as a strategy to improve quality. However, a recent study shows that an appropriately trained surgeon practising in provincial New Zealand can maintain high standards of care.[16]

Dr Johnston commented that rectal cancer surgery could be done in Gisborne if an adequately trained and supported surgeon practised there. I accept that an appropriately trained general surgeon practising in provincial New Zealand can maintain high standards of care if adequately supported. Provincial centres must have strong relationships with larger centres as they inevitably face limitations in terms of support. As noted by Dr Johnston, support includes "pathology, anaesthesia, nursing staff, access to regular discussion of cases with oncologists and other colorectal surgeons".

At the time, Dr B was not credentialled specifically for colorectal surgery, but it was considered within the realm of general surgery at Tairawhiti DHB. This is far from ideal in the case of a recognised subspecialty. In my view, general surgeons should be specifically credentialled as competent in colorectal surgery, if they intend to undertake it.

I am also concerned about the adequacy of the support provided to clinicians by Tairawhiti DHB. The DHB did not have any policies or specific written guidelines for staff to follow when considering referring patients for specialist care. It advised:

> "Guidance to clinicians on referrals as well as scope of service is provided during induction. Referral is a professional decision based on clinical presentation of individual patients and the clinical expertise available at the time."

Dr B advised that the internal investigation report noted:

> "In two cases [Mrs A] and [another unrelated case] where consultant assistance might reasonably have been sought [Dr B] explained that the low staffing levels for much of the time in Gisborne makes consultant assistance difficult to arrange."

Dr Johnston advised:

> "[Dr B's] performance of the surgery, and taking it on in the first place, would be viewed with moderate disapproval [by his peers], as would Tairawhiti [DHB] for

[15] See http://www.hdc.org.nz/files/hdc/opinions/06hdc09552orthopaedicsurgeon.pdf (January 2008).
[16] O'Grady, G and Secker, A. "Colorectal cancer management in the provincial New Zealand setting of Nelson" *ANZ J Surg* 2007: 1004–1008.

not having a policy in place which directed cases such as [Mrs A's] to an appropriately trained and supported colorectal surgeon."

Although Dr B's decision to treat Mrs A without specialist input demonstrated poor clinical decision-making on his part, the DHB should have had systems in place to support clinicians to refer appropriate cases or seek appropriate input. By this omission, the DHB failed to take all reasonably practicable steps to prevent Dr B's breach of the Code. Accordingly, Tairawhiti District Health Board is vicariously liable for Dr B's breach.

Recommendations

I recommend that Dr B:

- Apologise to Mrs A for his breach of the Code, and send HDC his letter of apology for forwarding to Mrs A.
- Review his practice in light of this report.

I recommend that Tairawhiti District Health Board:

- Apologise to Mrs A, and send HDC its letter of apology for forwarding to Mrs A.
- Review its credentialling and referral policies and procedures in light of this report, and send HDC copies of its revised policies and procedures by 30 September 2009.

Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand, with a recommendation that the Council consider the implications for Dr B's competence. The report will also be sent to the Royal Australasian College of Surgeons.
- A copy of this report, with details identifying the parties removed except Tairawhiti District Health Board, Gisborne Hospital, and the names of the experts who advised on this case, will be sent to the Minister of Health, the Director-General of Health, the Quality Improvement Committee, and DHBNZ, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Expert advice from surgeon Peter Johnston

Initial advice

"I am asked by the Commissioner to provide expert advice on this complaint, with reference to the following issue: *the appropriateness of care provided by [Dr B] to [Mrs A] from 11 November 2005 to 25 May 2006, including his preoperative assessment.*

Supporting information provided includes the following:

[Mrs A's] letter of complaint to the Commissioner
The Commissioner's notification to [Dr B]
[Dr B's] response to the notification
[Mrs A's] records from Tairawhiti Health.

My background in relation to reviewing this case is of General Surgical practice with specialist registration since 1986, in the last three years exclusively transplant and hepatobiliary surgery, but until 2005, General Surgery including colorectal surgery.

I have read and agreed to follow the HDC's 'Guidelines for Independent Advisors'.

Please advise the Commissioner whether, in your opinion, [Mrs A] received an appropriate standard of surgical care from [Dr B].

1. Please comment generally on the standard of care provided to [Mrs A] by [Dr B], particularly discussing pre-, intra- and post-operative care.

The Commissioner's subsequent questions focus on the appropriateness of the operation (anterior resection with ileostomy) carried out on [Mrs A]; the time period referred to includes the ileostomy closure and the subsequent complication of that procedure, which is also referred to in the patient's complaint.

[Dr B], in his response to the Commissioner, refers several times to a report on his work, including this case, by […], either at the instigation of the Medical Council or Tairawhiti Health; it should be noted that I have not had access to this report.

As suggested by the subsequent questions, the most important issue is that of whether [Dr B] did know or should have known that [Mrs A] had a history of ulcerative colitis, which would have implied that his choice of initial investigation and surgery was incorrect.

The details of the referral are as follows: the referral letter from [Dr C] reads: 'very long Hx [history] of erratic bowels, bleeding, constipation/diarrhoea since childhood — was investigated by [doctor] in 70s, told colitis and just keep fibre high — apparently a small patch of inflammation in bowel on Ba enema'. [Dr B's] clinic notes (transcribed by himself from the hand-written clinic sheet in his response to the Commissioner) state: 'long history of bowel problems — investigated 1970 — Shiach

Rx — predsol enemas'. [Dr B] states, also in his response, that 'the colitis referred to here is in fact proctitis which was treated with local steroids and the patient was symptom free for a long period until 6 months ago'. He considered the recommendation of a high fibre diet to be inconsistent with ulcerative colitis, and concluded that he did not know that [Mrs A] had ulcerative colitis.

[Dr B] organised a Barium enema and CT scan, to exclude other bowel lesions and metastatic disease, respectively. The Barium enema was deemed to be normal other than the known rectal lesion, and the CT was unremarkable. A colonoscopy was not requested, although the GP's referral included a direct request for colonoscopy. [Dr B's] subsequent comment on this, in his response to the Commissioner, was that the waiting time for colonoscopy in Gisborne was 4–6 months.

The biopsies of the rectal lesion obtained at rigid sigmoidoscopy were reported as tubulovillous adenoma with dysplasia. No macroscopic evidence of proctitis was noted at this time. [Dr B] proceeded with surgery, in the form of anterior resection with ileostomy. It was certainly appropriate for surgery to be undertaken for this lesion, as an endoscopic biopsy does not rule out malignancy: these lesions can progress to a cancer, passing through a stage in which some parts of the lesion are benign and some are malignant.

Evidently [Mrs A] recovered well from this surgery; the ileostomy was closed after about three months, after a contrast study to confirm the integrity of the anastomosis. The histopathology of the resected rectum in fact showed a carcinoma arising in a villous adenoma; ulcerative colitis of mild severity was present in the distal (lower) 5cm of the 11 cm specimen. No lymph nodes were identified for sampling, although the report records that 'up to 100mm of sigmoid mesentery is present'.

Initially there was no problem after the ileostomy closure, but some four weeks later [Mrs A] presented with a serious septic illness due to leakage from the ileostomy closure, which resulted in a fistula (a communication between the breakdown of the ileostomy closure and the skin). This fistula did not close spontaneously, as would sometimes happen, and required operative closure. [Mrs A] had transferred to the care of [Dr E] at this time, and he together with [a colleague] closed this fistula on 1.6.2006, after a colonoscopy on 27.5.2006, which showed active colitis in the rectum and some small polyps above the anastomosis. After this procedure, [Mrs A] did not do well in the sense that she became increasingly troubled by colitis, which required inpatient treatment. [Dr E] referred her to [a colorectal surgeon] for excision of the remainder of the large bowel (with ileo-anal pouch anastomosis) because it was considered the surgical margin of the rectal excision was too narrow, and complete excision of the large bowel is the only satisfactory operation in the presence of ulcerative colitis. A fistula developed between the ileal pouch and the vagina, and this has been very troublesome but is not the subject of this report.

I will preface my opinion on [Dr B's] care by setting out several facts:[17]

a) ulcerative proctitis is a localised form (in the lower rectum only) of ulcerative colitis, not a separate disease. About 5–15% of persons with proctitis will eventually progress to have more extensive colonic disease.

b) brief episodes of proctitis without recurrence or long term consequence are not uncommon.

c) any resection of the rectum in the presence of proctitis is best to be in the form of excision of the whole large bowel, as extension of the process into the more proximal colon is common after excision or other surgery on the rectum alone.

d) colonoscopy should ideally be done before any excision of bowel for benign or malignant tumours, as multiple lesions will occur in about 10%, but is not imperative. If colonoscopy cannot be done before surgery for practical or logistic reasons, then it should be done within the first year after surgery.

e) large benign tumours (of the size present in [Mrs A] at presentation) have a life history which includes transformation to a cancer, with a stage in which some parts of the lesion are benign and some are malignant. Multiple biopsies can help to exclude cancer but only complete excision of the lesion and thorough pathologic examination can determine the presence of cancer. It follows that an operation for such a lesion should be done as a cancer operation in the first instance, unless the patient is unfit for such surgery.

I will now attempt to interpret events in relation to these facts. The issue on which the following questions focus is one of identification of proctitis/colitis before the initial rectal surgery. This is not a simple question to answer. The GP's letter mentions 'colitis' and [Dr B] elicited a history of use of Predsol enemas, which would only be used for proctitis/colitis. On the other hand, those events were 35 years previously, there had evidently been no symptoms beyond that episode until the 6 month before presentation, the advice to have a high fibre diet is as [Dr B] notes not the usual advice given with colitis, and this took place in 1970 when medical understanding would have been different to what is the case today, and there was no documentation available to [Dr B] on this history. [Dr B] did not see visible proctitis when he sigmoidoscoped [Mrs A]. A colonoscopy if done before the surgery may well not have recognised proctitis/colitis unless random biopsies of the bowel were done, and suspicion would need to have been raised for this to occur: colonoscopy as a pre-operative test before colorectal surgery for tumour is focussed on excluding multiple tumours.

[17] These would be regarded as common knowledge among General Surgeons; I have checked that these are in accord with an appropriate edition of a commonly used textbook, 'Surgery of the Rectum and Colon' by M Keighly and N Williams, 2nd ed. 1999.

I believe the situation here was not at all obvious but there were some clues which many experienced surgeons would have picked up on and required a colonoscopy with biopsies of the non-tumour bowel before surgery. It is disappointing, particularly in view of the very difficult illness [Mrs A] has suffered, that these clues were not followed; if the waiting time for colonoscopy was indeed 4–6 months then the surgeon's judgement could not fail to be coloured by this, although there must have been some ability to prioritise within this waiting time. I conclude on this issue with the view that the diagnosis in dormant proctitis or colitis in [Mrs A] was sufficiently unclear that it would not be appropriate to censure [Dr B] in this matter alone.

Of greater concern, in terms of practical management and decision-making, was the operation itself. As I have outlined above, this operation should have been regarded as a cancer operation, and conducted with the aim of securing an adequate margin of bowel distal to the tumour with excision of the meso-rectum, which removes the appropriate group of lymph nodes adjacent to the bowel. It appears the operation was not done with these goals in mind. [Dr B's] comment to the effect that he obtained a very limited margin distal to (i.e. below) the tumour was adequate because he was 'operating for tubulovillous adenoma not for rectal Ca' implies some lack of understanding of the well-known natural history of these lesions. This reflects a lack of knowledge on [Dr B's] part, but the issue is wider than this.

Tumours in the mid or lower rectum are (and were in 2005) really in the area of the sub-specialised colorectal surgeon, and no longer for the generalist General Surgeon, which is what I assume [Dr B] to have been. I do not know what expectation the General Surgical service at Tairawhiti Health had of such cases, and what [Dr B's] understanding was of what work was to be done locally and what was to be referred elsewhere, but whatever the balance was among these various factors ([Dr B's] knowledge/performance, local expectations, geographic isolation) the outcome for [Mrs A] was certainly compromised by the initial management of the problem, including [Dr B's] first operation. This is not to say that such surgery should not be done in Gisborne if appropriate personnel are available, but referral elsewhere is necessary otherwise.

With regard to the fistula which developed from the ileostomy closure and the serious septic illness suffered at that time, this is a complication which occasionally follows ileostomy closure, and is not an indication of a surgical performance problem unless the complication occurred more frequently than expected.

To summarise my opinion, the diagnosis of proctitis/ulcerative colitis was a difficult issue and not necessarily a deficiency in care, but the conduct of the anterior resection operation was not satisfactory in terms of contemporary standards. The Commissioner suggests that negative opinion be rated on a scale of disapproval by surgical peers; as I see it, [Dr B's] performance of the surgery, and taking it on in the first place, would be viewed with moderate disapproval, as would Tairawhiti Health for not having a policy in place which directed cases such as [Mrs A's] to an appropriately trained and supported colorectal surgeon.

If not discussed already, please provide advice on the following, giving reasons for your opinion.

2. Did [Dr B] undertake an appropriate pre-operative assessment, and order appropriate pre-operative tests, for [Mrs A]?

[Discussed above]

3. If [Dr B] knew preoperatively that [Mrs A] had a history of ulcerative colitis was anterior resection and ileostomy the appropriate surgery for [Mrs A]? If not please explain.

No — discussed above

4. If [Dr B] did not know preoperatively that [Mrs A] had a history of ulcerative colitis was anterior resection and ileostomy the appropriate surgery for [Mrs A]? If not please explain.

Yes, discussed above, but anterior resection in the form of a cancer operation.

5. Are there any aspects of the care provided by [Dr B] that you consider warrant additional comment?

No."

Further advice
Dr Johnston reviewed Dr B's and Tairawhiti DHB's responses to the provisional opinion, and provided the following additional advice:

"Regarding expertise in colorectal surgery, [Dr B's] having practised as a consultant in a colorectal unit in Great Britain at an unspecified date does not necessarily mean that he was adequately trained or supported to do rectal cancer surgery in New Zealand in 2005. There is conflict between [Dr B's] previous and current statements regarding the intent of the rectal surgery being for cancer or not for cancer. Adequate surgery for rectal cancer includes removing a section of the mesentery to remove adjacent lymph nodes. No lymph nodes were found in the operative specimen from [Mrs A]; this could certainly be due to inadequacy of the pathology examination, but it does not appear that the mesorectum (mesentery of the rectum) was excised, as would be standard in surgery for possible rectal cancer.

Regarding surgery on rectal cancer in the presence of ulcerative colitis or with a history of ulcerative colitis, I can only reiterate the views given in my report, and do not support [Dr B's] belief that a lesser course of action was adequate.

I have re-examined the Commissioner's file of clinical information on this case; it is stated here by [Dr B] in his clinic notes that the lower edge of the tumour was seen at 12cm from the anus on rigid sigmoidoscopy. This is the mid-rectum, hence my

statement that this was a mid-rectal tumour. After mobilisation of the rectum, the tumour can certainly be found to be higher in the rectum but I believe [Dr B] should have treated this as a mid-rectal cancer and that a more adequate rectal cancer operation should have been done.

The complications that [Dr B] states that [Mrs A] subsequently experienced after her proctocolectomy in [another region] are not relevant to this discussion.

[Dr B] refers to an investigation by […] into cases including [Mrs A]. I respect [the writer's] expertise and standing but I have no knowledge of why he undertook the investigation referred to, nor the terms of reference of this; I can only comment on what is put before me. I did not consider it appropriate to ask to see [the] report when writing mine.

I am not persuaded to alter my opinion, with a proviso to be noted below.

Response from [the] Chief Executive, Tairawhiti DHB.

I had already taken onto account the geographic isolation of Gisborne and the difficulties faced in staffing provincial hospitals when writing my report. It should be noted that I did comment to the effect that rectal cancer surgery could be done in Gisborne if an adequately trained and supported surgeon practised there. 'Support' in this context means pathology, anaesthesia, nursing staff, access to regular discussion of cases with oncologists and other colorectal surgeons. [The CEO] makes the rather bold statement that 'subspecialisation is a luxury that metropolitan hospitals are able to support'. I think this misses the point; the issue at hand is the adequate provision of cancer treatment. Rectal cancer is one cancer where treatment results depend on a surgeon with specific skills. This treatment may well not be available in the average provincial hospital. …

Regarding waiting time for colonoscopy, [Mrs A] had a semi-urgent indication for colonoscopy (up to 2 weeks). [Dr B] evidently judged that this would not have occurred at the time he was treating her.

I am not persuaded to question the Commissioner's provisional opinion in relation to Tairawhiti DHB."