# Standards of care not met in bowel surgery (02HDC14836, 24 March 2004)

*General surgeon ~ Bowel surgery ~ Standard of care ~ Preoperative assessment ~ Complication following surgery ~ Rights 4(1), 5, 6(1)(a), 6(1)(e), 7(8)*

A 61-year-old woman was referred to hospital with a history of changing bowel habit, mild haemorrhoids and bleeding. An urgent colonoscopy revealed a tumour of the lower rectum, and polyps in the sigmoid colon. The surgeon performed an anterior bowel resection, but had problems with the surgical stapler and was unable to ensure the integrity of the rectal stump. Consequently, he changed his plan and performed a Hartmann's procedure (formation of a colostomy).

The woman complained that the surgeon did not inform her about her bowel cancer, or of the outcome of the operation, and gave her inconsistent information about whether all of the polyps had been removed. She also complained that in the course of the operation he had shifted her belly button. However, expert advice indicated that this was a temporary and not unexpected consequence of complicated abdominal surgery.

The following year, in spite of the patient's wish to be placed under another surgeon's care, the same surgeon operated to reverse the Hartmann's procedure. Difficulties arose when the tissue being stapled was too thick for the stapler. The surgeon ignored the advice of colleagues and used force to effect the stapling, and created a colovaginal fistula. The site and nature of the operation made perforation a risk, and this was exacerbated by the surgeon's insistence on forcing the stapler. The second operation was long and complicated, and the patient suffered significant blood loss. She stated that she also suffered a postoperative "arrest" and an infection, and was not informed about the complications.

It was held that the surgeon breached Right 4(1) in not conducting an appropriate assessment of the patient prior to the first operation; in failing to use the stapler with reasonable care and skill; and failing to examine and repair the colovaginal fistula at the time of the operation. The surgeon also breached Right 6(1)(a) and (e) in not informing the patient about the possible complications of her surgery; and Right 5 in failing to communicate effectively.

The Commissioner accepted expert advice that the postoperative "arrest" and later infection were more likely to be related to the nature of the operation than to a lack of skill and care on the surgeon's part.

Issues were also raised regarding a patient's right to obtain a second opinion and to express a preference for the health provider. Although there is no absolute right to have such a preference accommodated, under Right 7(8) patients have the right to have their preferences met where practicable. The District Health Board advised that in light of this case it was developing a process for staff to follow when patients request transfer of care.

The matter was referred to the Director of Proceedings, who issued a charge of professional misconduct before the Health Practitioners Disciplinary Tribunal. The charge was upheld and the Tribunal censured the surgeon and ordered that he practise under supervision for a period of two years.