Te Whatu Ora
Obstetrician & Gynaecologist, Dr B

A Report by the
Health and Disability Commissioner

(Case 20HDC00546)

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Executive summary

1. This report discusses the care provided to a woman by an obstetrician & gynaecologist and Te Whatu Ora. On 6 June 2019, the woman underwent surgery for what she thought was the removal of a right-sided cyst. It was subsequently discovered (during the procedure) that the cyst originated on the left-hand side. An additional left-sided cyst was also discovered and removed. The woman was later diagnosed with a bowel perforation causing sepsis.

2. The report considers the adequacy of the informed consent process and highlights the need for consumers to be provided with all relevant information about their care so that they can make an informed decision.

Findings

3. The Commissioner found the obstetrician & gynaecologist in breach of Right 6(1) of the Code for failing to advise the woman of the increased risk of injury due to her previous surgery, and that the origin of the cyst was in question. The Commissioner considered that by failing to discuss the risks specific to the woman's circumstances, the woman was not in a position to make an informed choice about proceeding with the cystectomy. Accordingly, the Commissioner found the obstetrician & gynaecologist in breach of Right 7(1) of the Code.

4. Te Whatu Ora was found not to have breached the Code.

Recommendations

5. The obstetrician & gynaecologist provided a written apology to the woman in response to the provisional decision. The Commissioner recommended that should he return to practice, he undergo further training in communication and informed consent.

6. The Commissioner recommended that Te Whatu Ora use an anonymised version of this report for training purposes.

Complaint and investigation

7. The Health and Disability Commissioner (HDC) received a complaint from Ms A about the services provided to her by obstetrician & gynaecologist Dr B at Te Whatu Ora (formerly a district health board (DHB).[1] The following issues were identified for investigation:

   - *Whether the DHB provided Ms A with an appropriate standard of care between 14 May 2019 and 6 June 2019 (inclusive).*

[1] On 1 July 2022, the Pae Ora (Health Futures) Act 2022 came into force, which disestablished all district health boards. Their functions and liabilities were merged into Te Whatu Ora|Health New Zealand. All references in this report to the DHB now refer to Te Whatu Ora.

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- *Whether Dr B provided Ms A with an appropriate standard of care between 14 May 2019 and 6 June 2019 (inclusive).*

8. The parties directly involved in the investigation were:

Ms A	Consumer/complainant
Dr B	Provider/consultant obstetrician & gynaecologist
Group provider/district health board	

9. Further information was received from:

Dr C	Consultant obstetrician & gynaecologist
Dr D	Senior gynaecological oncology surgeon
Accident Compensation Corporation (ACC)	

10. Registrar Dr E is also mentioned in this report.

11. Independent advice was obtained from obstetrician & gynaecologist Dr Ian Page (Appendix A).

Information gathered during investigation

Background

12. On 8 March 2019, Ms A (aged in her twenties at the time of events) was referred by her general practitioner (GP) to the DHB's Gynaecology Service when a probable large right-sided ovarian cyst was reported on an ultrasound undertaken on 1 March 2019.[2] The referral letter advised that Ms A had a background of Hirschsprung's disease,[3] and had undergone surgery in infancy[4] and had a dense scar on her left flank. The referral also noted that Ms A had no family history of ovarian cancer.

13. Ms A attended a pre-surgery appointment on 14 May 2019 and a pre-anaesthetic appointment on 20 May 2019. On 6 June 2019, she underwent surgery for what she thought was the removal of the right-sided cyst. However, subsequently it was discovered that the cyst had originated from the left side, and an additional cyst was discovered on the left side. Both cysts were removed, and the surgery concluded without any apparent issue at the time. However, on 8 June 2019, Ms A became unwell and was diagnosed with a bowel

[2] The ultrasound was undertaken to investigate a sudden onset of chest and upper abdominal pain.
[3] Hirschsprung's disease is a birth defect in which some nerve cells are missing in the large intestine, meaning that the intestine cannot move stool effectively and becomes blocked.
[4] Soave procedure.

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perforation causing sepsis. Ms A underwent an emergency Hartmann's[5] procedure and now has a permanent colostomy.[6]

14. Ms A complained to HDC that she had consented to have a cyst removed only from her right ovary and had not consented to left-sided surgery or to the removal of any additional cyst discovered during the surgery.

Ultrasound report — 1 March 2019

15. After an abdominal and pelvic ultrasound on 1 March 2019, the following was reported:

> "Large 250 m[m] cystic lesion arising from the pelvis, probably right ovary which appears heterogeneous.[7] Appearances suggest ovarian cystadenoma[8] or similar. Gynaecology discussion recommended."

Pre-surgery appointment — 14 May 2019

16. On 14 May 2019, Ms A attended a pre-surgery appointment with consultant obstetrician & gynaecologist Dr C. Dr C told HDC that the pre-surgery appointment included taking a gynaecology history with respect to the patient's presenting complaint and undertaking a physical examination. Dr C told HDC: "If surgery is opted for, informed consent is sought, and the electronic surgical booking form and national prioritisation forms are completed." Dr C said that he was aware of Ms A's history of Hirschsprung's disease.

17. As noted above, the referral letter from Ms A's GP stated that she had had previous surgery. Dr C told HDC that during the pre-surgery appointment, he asked Ms A if she had undergone any previous surgery, and she replied that she had not. Dr C said that he also reviewed Ms A's "operation notes" folder in the DHB's electronic database, and there was no mention of any previous surgery. Dr C stated that he did review the referral letter from Ms A's GP, and "it was an oversight that [he] did not detect the discrepancy between the referral letter and the discussion with [Ms A]".

18. In a letter to Ms A's GP on 20 May 2019, Dr C wrote: "[Ms A] has not had surgery before as far as she can remember." The Gynaecology Elective Surgery Booking form (generated by Dr C) does not mention that Ms A had undergone surgery in the past.

19. Contrary to Dr C's recollection, Ms A told HDC that she recalls advising Dr C of her past surgery.

20. Dr C documented in the clinical notes that during the physical examination, he was unable to palpate the cyst. He wrote to Ms A's GP: "On today's examination the BMI was

[5] Usually, a Hartmann's procedure is performed in an acute (emergency) situation for diseases of the sigmoid colon or rectum. The diseased area of the bowel is removed, and the bowel is not re-joined. A temporary or permanent bag (colostomy) is required. If the bag is temporary, one or two further operations may be required to return the bowel function to normal.

[6] A colostomy is an operation that creates an opening for the colon, or large intestine, through the abdomen. Stool drains from the opening (the stoma) into a bag or pouch attached to the abdomen.

[7] A structure with different components or elements, appearing irregular or variegated.

[8] A benign (non-cancerous) tumour.

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significantly increased and because of that the mass could not be identified." Dr C also told HDC that he did not identify any surgical scars.

21. Dr C said that his usual practice is to discuss the rationale and benefits of an operation, as well as the risks associated with the surgery, such as the risk of injury to organs, bleeding, infection, and venous thromboembolism (blood clots). Dr C documented the risks of surgery on the consent form as being infection, bleeding, requirement for a blood transfusion, and a midline incision. The risk of injury to organs is not documented on the consent form.

22. The consent form[9] was signed by both Ms A and Dr C. The description of the treatment/procedure(s) states: "Laparoscopy[10]/Laparotomy [11]/[Right] Ovary Cystectomy[12]."

23. Dr C assigned Ms A's surgery a CPAC (Clinical Priority Assessment Criteria[13]) booking score of 90 (out of 100) with an "Urgent" priority. However, he also recorded that there was "NOT" a high suspicion of cancer. The DHB told HDC that at the time of these events, it did not have a formal risk analysis tool in place in the Gynaecology Service to determine the risk of malignancy.

24. Dr C told HDC that due to the size of Ms A's ovarian cyst, he considered it unlikely to be cancerous. However, he said that the malignant nature of such cysts can be ascertained only by histological assessment (examination of the tissue under a microscope) during or after removal. Dr C advised that at the time of his assessment, there appeared to be only one risk factor for malignancy. He stated:

> "There were none of the other recognised risk factors like solid areas, ascites[14] or other masses and the lesion was unilateral.[15] In this setting it was clinically a low risk of malignancy."

25. However, Dr C also told HDC:

> "Despite my view on risk, I was alert to the limitations of the prioritisation tool with its limited sensitivity and specificity … I considered the risk of torsion[16] and the implication for [Ms A's] fertility if a cancer diagnosis was not actively excluded. Further, I was mindful that ovarian cancer has a poor prognosis when presenting late … I regarded surgical intervention was prudent in the circumstances because of risk of ovarian torsion, the size of the cyst and that it will only continue to grow and increase the risks

[9] The form is titled "Request for Treatment/Procedure(s)".
[10] A surgical procedure to examine the organs inside the abdomen and pelvis without having to make large incisions in the skin (minimally invasive surgery).
[11] A surgical procedure involving an incision through the abdominal wall to gain access to the abdominal cavity.
[12] Removal of a cyst.
[13] A CPAC score is used to determine the urgency of the surgery.
[14] Excess abdominal fluid.
[15] On one side.
[16] Twisting of the ovary or fallopian tubes on the tissues that support them.

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involved with surgery and even with a low risk of cancer, the exclusion of malignancy is done histologically. I directed [Ms A] be seen within 4 weeks."

26. There is no evidence that the above information was communicated to Ms A prior to the surgery.

Pre-anaesthetic assessment — 20 May 2019

27. On 20 May 2019, Ms A was seen for a pre-anaesthetic assessment.

28. The anaesthetist documented on the "Pre-Anaesthetic Assessment" form that Ms A had undergone surgery as a child,[17] that she had a history of Hirschsprung's disease, and that previously she had undergone colonoscopies[18] under sedation.

29. Under the heading "Anaesthesia and Procedure Plan", the anaesthetist documented: "General Anaesthesia, Risks and conduct discussed, Anaesthetic sheet given." However, there is no documentation of what risks were discussed with Ms A.

Day of surgery — 6 June 2019

Pre-surgery discussion

30. Consultant obstetrician & gynaecologist Dr B first met with Ms A prior to her surgery on 6 June 2019. Dr B told HDC that he was aware of Ms A's previous surgery and her history of Hirschsprung's disease, and he discussed this with her prior to the surgery. Dr B said that prior to a cystectomy he would advise of prospective risks such as bleeding, infection, and injury to adjacent structures. However, he said that due to the passage of time he cannot recall the specifics of the entire discussion with Ms A.

31. Dr B told HDC that having regard to Ms A's previous surgery, he expects that he also would have discussed with Ms A that there was a risk of injury to the bowel. Dr B said that he had expected that he might encounter adhesions[19] intraoperatively, and that adhesions can make the operation more complex. However, other than referencing his normal practice, there is no other evidence that he discussed the risk of injury or the likelihood of adhesions making the surgery more complex.

32. Dr B told HDC that he countersigned the consent form previously signed by Dr C and Ms A, which documented some of the risks associated with the surgery. As discussed, the risks documented on the consent form were infection, bleeding, and the requirement for a blood transfusion or a midline incision. However, the risk of injury to the bowel or adjacent structures is not documented.

33. Dr B accepted that he did not document the risk of injury to the bowel or adjacent structures. He told HDC:

[17] Documented as being the Soave procedure, which involves resecting parts of the rectum and pulling through the bowel. It is often used for Hirschsprung's disease.
[18] Examination of the large intestine (colon) and rectum to detect changes or abnormalities.
[19] Bands of scar tissue.

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"Normally, I am quite meticulous with documentation. It was an oversight not to have documented the risk of injury to adjacent structures, in this case, the bowel. But as above, my expectation would be that I would have discussed this as a risk in this case."

34. Conversely, Ms A told HDC:

"I can recall the risks were outlined but there was no specific risk of injury to the bowel or other organs mentioned, despite me raising my history of procedures including [Hirschsprung's] disease with [Dr B]. However, he was very reassuring in our discussion prior to the 6th June[20] and day of procedure that it was a standard procedure, so it gave me the perception [that] the risks did not apply to me. I distinctly remember hearing 'standard procedure' and 'simple procedure' repeatedly."

35. Ms A stated: "I would not have agreed to a [l]eft sided surgery unless it was life threatening or the risks [were] fully explained before I went into surgery."

Surgical procedure

36. The operating surgeon was registrar Dr E, under the direct supervision of Dr B. Dr E made a Joel-Cohen (J-C) incision.[21] Dr B told HDC that a J-C incision was used rather than a midline incision (as documented in the consent form) because he had palpated the cyst below the level of the umbilicus, and therefore he considered a J-C incision to be more appropriate as it enabled more direct entry.

37. The ACC report noted that during the procedure, significant adhesions involving the bowel and ovaries were discovered, which required dissection (known as adhesiolysis). It was considered likely that the adhesions on the left-hand side of Ms A's abdomen had developed after the Soave surgical procedure that Ms A had undergone when she was an infant.

38. Dr B advised that on encountering the adhesions, and because of difficulty determining the cyst's origin, he took over the operation from Dr E.

39. Dr B told HDC:

"On entering her abdomen, there was about a 30 cm ovarian cyst. It was difficult at that point to ascertain whether it arose from the left or right ovary as it occupied the lower abdomen and there were adhesions distorting the anatomy of the pelvic organs. I drained about 1.2 litres of fluid from the cyst in an attempt to shrink the tumor; this did not improve my ability to tell if it arose from the left or right ovary."

40. Dr B stated that he removed part of the cyst, and that as its origin was still in doubt and because of the adhesions, he called Dr D (a senior gynaecologist with an interest in gynaecological oncology) to assist. Dr B said that, to the best of his recollection, he made Dr D aware of Ms A's previous surgery. However, it is not clear whether Dr D was aware of the procedures for which Ms A had provided her consent.

[20] I note that Dr B did not meet with Ms A prior to her procedure of 6 June 2019.

[21] A straight skin incision often used for Caesarean section.

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41. Dr B told HDC that Dr D removed the remaining part of the cyst. An additional left ovarian cyst was discovered adherent to the left pelvic side wall, and this cyst was also removed. The operation record notes that although the right ovary was not able to be visualised, it "[felt] normal", and the uterus was also recorded as appearing normal. Dr B told HDC that he then realised that the first cyst that had been removed had originated from the left ovary and not the right.

42. The operation was completed with the closure of the abdominal wall, and standard postoperative instructions were recorded. Dr B told HDC that no damage to adjacent structures was evident (intraoperatively).

43. The operation record documented:

> "Operation title:
> LAPAROTOMY + PREOP WASHINGS + LEFT OVARIAN CYSTECTOMIES X 2
>
> Procedure: Joel Cohen incision after prepping abdomen and abdomen opened in layers. … About 30cm left ovarian cyst aspirated and 1.8L fluid sent for cytology. Left ovarian cystectomy performed. [Dr D] called in as additional left ovarian cyst adherent to pelvic side wall and Pouch of Douglas.[22] Ovarian cystectomy performed. The fluid sent to cytology subsequently returned a benign (non-cancerous) result."

Subsequent events

44. Ms A remained in hospital and appeared well until 8 June 2019, when she became acutely unwell and was diagnosed with a bowel perforation causing sepsis. Subsequently, Ms A underwent an emergency Hartmann's procedure and now has a permanent colostomy.

Further information

Ms A

45. Following these events, Ms A raised her concerns with the DHB directly. She wrote a letter outlining her experience and the profound impact that the events have had on her, including on her relationships, mental health, and inability to return to work.

46. Ms A told HDC:

> "I felt what happened to me was unfair. I went in with right sided pain and the intentions of having a large cyst removed on my right ovary, but I had left sided surgery that I didn't consent to. Now I am left with a permanent left sided [c]olostomy. I did not receive any emotional support to help me cope with everything while I was in hospital. I'm still trying to deal with the trauma."

47. Ms A raised concerns that she found it difficult to navigate applying for assistance from various services (such as ACC and social work advice), and that the hospital did not assist her with this.

[22] A small area between the uterus and rectum.

48. In relation to the second cyst found incidentally during her surgery and removed by Dr D, Ms A asked the DHB to ensure that no "opportunistic surgery" is carried out on a patient who has not agreed to that surgery. She stated: "My surgeon found an additional Left Ovarian Cyst and took it upon himself to remove the cyst. I did not consent to that procedure."

Dr B

49. Dr B clarified that from the outset, the origin of the cyst was in question. He said that this was highlighted in the terminology used in the ultrasound report, such as "appears to extend from the right ovary" and "probably" arising from the right ovary.

50. Dr B told HDC:

> "I was alert to the risk of injury to the bowel evident by the fact that through the procedure we were careful to observe any intraoperative injury. We detected none at that time and noted the same in the notes of the operation.[23]"

51. Dr B has since retired from practice.

Dr C

52. Dr C told HDC that even if he had been aware of Ms A's previous surgery, he would still have advised her to have the ovarian cyst removed for the following reasons:

- There is a risk of pre-malignancy, borderline or early malignancy in large tumors. The malignant nature of any ovarian cyst (however low the likelihood) can be confirmed or excluded only by histological assessment during or after removal.
- There is a risk of ovarian torsion with cysts of that size. As Ms A was premenopausal, ovarian torsion would decrease her ovarian reserve significantly, which in turn could precipitate the onset of early menopause and decrease her fertility potential.

DHB

<u>Informed consent</u>

53. The DHB provided HDC with its Informed Consent policy, which outlines the following:

- "The health professional who is to provide the service must ensure the patient has given informed consent before proceeding. This responsibility continues in the situation where another practitioner is delegated responsibility for obtaining consent."
- "It is recognised that other members of the team may be involved in imparting information or may be delegated the responsibility of seeking consent to services. Where another practitioner obtains the patient's consent, while the treating practitioner retains overall legal responsibility and accountability for the consent process, the practitioner with delegated responsibility will be responsible for their own actions in obtaining the consent."

[23] This was not documented in the copy of the operation record provided to HDC.

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Internal review

54. The DHB undertook an investigation into Ms A's care and met with her to discuss her concerns. The DHB's investigation identified areas for service improvement, and these changes are discussed at paragraph 126.

55. In addition to a discussion of Ms A's clinical concerns, the DHB apologised for the lack of support, and information on how to access support, provided to Ms A. The DHB said:

> "We have committed to working with allied health and our nursing staff to put support systems in place and remove the burden you experienced as much as possible from other patients."

56. The DHB also organised three funded counselling sessions for Ms A.

57. The DHB stated:

> "Calling a surgeon (rather than a second gynaecologist) would have been more effective when extensive adhesions were found at the time of the surgery in a patient with a history of Hirschsprung's disease."

58. The DHB said that there is an expectation for its obstetricians and gynaecologists to obtain general surgery input when difficulties are encountered in theatre, and that a general surgery team is on call at the DHB throughout the week.

ACC

59. ACC provided HDC with the results of its assessment of Ms A's treatment injury claim, which included the following:

> "On reviewing the information, we have concluded that the sigmoid colon perforation was caused by the laparotomy and left ovarian cystectomies on 06/06/2019. Research shows us that the risk of inadvertent bowel defects (inclusive of perforations) can be as high as 19% for adhesiolysis related abdominal surgery. In one particular study, when adhesiolysis took longer than 1 hour, 40% of the procedures resulted in bowel defects."

Responses to provisional opinion

60. Ms A, Dr B, Dr C and Te Whatu Ora were provided with the opportunity to comment on relevant sections of the provisional report.

61. Dr B and Te Whatu Ora had no further comments to make.

62. Ms A confirmed that the "information gathered" section of the provisional report was accurate.

Dr C

63. HDC made several attempts to contact Dr C for comment on the provisional opinion. However, currently he is living abroad, and HDC has had no response to the attempts.

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Opinion: Dr B — breach

Introduction

64. The issue for me to determine is whether Dr B provided care of a reasonable standard to Ms A, and whether he had obtained appropriate consent for the surgery.

65. As part of my assessment of this complaint, I obtained independent advice from obstetrician & gynaecologist Dr Ian Page.

Provision of information and informed consent — breach

Introduction

66. Right 6(1) of the Code of Health and Disability Services Consumers' Rights (the Code) stipulates that every consumer has the right to the information that a reasonable consumer in that consumer's circumstances would expect to receive, including an assessment of the expected risks, side effects, benefits, and costs of the options available.

67. Right 7(1) of the Code states: "Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent."

68. On 6 June 2019, Dr B met with Ms A for the first time preoperatively. Dr B told HDC that he was aware of Ms A's previous surgery and her history of Hirschsprung's disease, and that he discussed this with Ms A prior to the surgery.

69. The DHB's Informed Consent policy outlines that the health professional who is to provide the service must ensure that the patient has given informed consent before proceeding. This is consistent with the right to informed consent under the Code. This responsibility continues in the situation where another practitioner is delegated responsibility for obtaining consent. Although Dr C went through a consenting process with Ms A during the pre-surgery appointment on 14 May 2019, Dr B also had a responsibility (as the health professional providing the service) to discuss the risks of surgery and obtain informed consent from Ms A prior to proceeding on 6 June 2019.

Discussion of risks

70. According to ACC, the risk of inadvertent bowel defects (inclusive of perforations) is between 19% and 40% for adhesiolysis-related abdominal surgery. This is a significant risk.

71. Dr B told HDC that preoperatively it was his usual practice to discuss the risks of treatment with the patient while he worked through the consent form, and that he would summarise the discussion in bullet points. Dr B said that prior to a cystectomy, generally he would advise of prospective risks of bleeding, infection, the need for a blood transfusion, the incision, and accidental injury to adjacent structures.

72. Dr B told HDC that although he cannot recall the specifics of the discussion with Ms A, he expects that he would have discussed the risk of injury to the bowel.

73. Dr B countersigned the consent form that documented some of the risks associated with the surgery, including the risk of infection, bleeding, or a blood transfusion, and the

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possibility of a midline incision. However, the risk of injury to the bowel or adjacent structures was not documented. Dr B told HDC that usually he is meticulous with documentation, and that it was an oversight that he did not document this specific risk.

74. Dr B also said that because of Ms A's surgical history, he had expected that he might encounter adhesions intraoperatively, and adhesions can make the surgery more complex. However, there is no evidence that Dr B informed Ms A of the possibility of finding adhesions, and the surgical complexity that could arise from this.

75. Ms A told HDC that she recalls some risks being outlined, but there was no mention of risk of injury to the bowel. She said that although she had concerns prior to the surgery, she was reassured from pre-surgical discussions that the procedure was straightforward and "standard", and that it was to be performed on her right-hand side.

76. With the evidence before me, including Ms A's recollection of her discussion with Dr B, particularly that the surgery would be "simple" and "standard", and the lack of written documentation about a discussion of the risk of injury to the bowel, I am not satisfied that Ms A was informed by Dr B of the risk of injury to the bowel or adjacent structures. In addition, I am concerned that while Dr B has asserted that he was cognisant of the risk of adhesions (and their ability to make surgery more complex), Ms A does not appear to have been informed of this possible risk and complexity.

77. In his initial advice, Dr Page considered that the failure to mention the risk of damage to the bowel, particularly given Ms A's surgical history, would be a significant departure from accepted standards, which would be viewed with mild to moderate disapproval by his peers. However, in his later advice, Dr Page advised that it was a mild departure, because he considers it likely that Ms A would have proceeded with the surgery despite this risk.

78. It is not my role to speculate about the decision Ms A may have made had relevant information about the risk of injury been provided to her. That is for her to determine. Consumers are entitled to information that a reasonable consumer in their circumstances would expect to receive. Providers cannot withhold relevant information based on their presumption of the choice the consumer will make.

79. In my view, given Ms A's surgical history, the risk of injury to the bowel was pertinent information that Ms A should have understood before providing her consent for the procedure. This was especially so noting Dr B's expectation that the surgery would be more complex owing to her earlier surgery, and that the known risk of complication in this context is significant (at least 19%). Dr B was responsible for communicating this information to Ms A, and I am critical that she was not advised of these matters.

Origin of cyst

80. Dr B told HDC that from the outset, the origin of the cyst was in question, and that this was highlighted in the terminology used in the ultrasound report, such as "appears to extend from the right ovary", and "probably" arising from the right ovary. However, it appears that this possibility was not discussed with Ms A. The consent form noted Ms A's consent only

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for a right ovarian cystectomy, with no contingency plan in place for how to proceed should the location of the cyst continue to be uncertain during the surgery, or if it was on the left-hand side.

81. The significance of the cyst's location, and Ms A's knowledge about that, is indicated in her complaint to this Office and to the DHB. Ms A understood the surgery to be a simple removal of a cyst from her right ovary. She said that she would have proceeded with surgery on her left side only if at least one of the following two conditions had been met:

1. The cyst was life-threatening; or
2. She had been fully informed of the risks, including the risk of bowel injury and of having a permanent colostomy.

82. I note that Ms A has told HDC that she was more hesitant about having surgery on her left side than her right, due to her previous left-sided surgery.

83. I am concerned that although Dr B was aware of the uncertain nature of the cyst's origin, this was not explained to Ms A prior to the surgery. If Dr B was not entirely certain of the cyst's origin, I would have expected him to communicate that uncertainty to Ms A alongside an explanation that intraoperative findings could necessitate a deviation from the original plan. In light of Ms A's hesitations about left-sided surgery due to her surgical history, I consider this to be information that a reasonable consumer in Ms A's circumstances would expect to receive.

Conclusion

84. In conclusion, noting Ms A's increased risk of injury to adjacent structures because of her previous surgery, I consider that she was entitled to receive information about this risk in order to make an informed choice and give informed consent. I also consider that a reasonable consumer in Ms A's circumstances would expect to be informed that the origin of the cyst was uncertain from the outset, especially noting Ms A's hesitations about left-sided surgery due to her surgical history, and the impact that could have if the intraoperative findings necessitated a change to the intended plan. I am concerned that Ms A was not informed of these matters, and I consider that Dr B was responsible for this omission as the operating surgeon.

85. Right 6(1) of the Code states that "[e]very consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive", including an assessment of the expected risks and side effects of each option. In my view, Dr B did not provide information that a reasonable consumer in Ms A's circumstances would expect to receive before the treatment was provided, namely, information about the risk of injury to adjacent structures, and information about the origin of the cyst being uncertain from the outset. Accordingly, I find that Dr B breached Right 6(1) of the Code.

86. It follows that by not providing such information, Dr B also breached Right 7(1), which states that "services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent". By failing to discuss with Ms A the risks specific to her

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circumstances, Ms A was not in a position to make an informed choice about proceeding with the cystectomy procedure.

Surgical technique — adverse comment

87. Once the operation had commenced, Dr E (under direct supervision from Dr B) performed a J-C incision, which Dr B said was used because of the location of the cyst when palpated. Dr Page advised that usual practice for an ovarian cystectomy would be a midline incision,[24] and that a midline incision would have been more appropriate as usually it would give better access to the whole abdominal cavity. Dr Page considers that the decision to use a J-C incision rather than a midline incision was a mild departure from accepted standards. I accept Dr Page's advice in this regard and am concerned that Dr B advised that a J-C incision be used, rather than a midline incision. I encourage Dr B to reflect on my expert's comments in this regard, should he return to practice in the future.

Clinical decision to remove additional left cyst — no breach

88. With regard to the removal of the additional left ovarian cyst, Dr Page advised: "[T]he management of the incidental finding of an ovarian cyst is a subject of endless debate amongst gynaecologists." He explained that usually asymptomatic cysts are best left alone, but that was not the case with the cyst found on Ms A's left ovary, as her presenting complaint was abdominal pain. Dr Page advised that there is no way of telling preoperatively which cyst is the cause of the pain.

89. Dr Page told HDC:

> "If [Ms A] had not had significant adhesions and difficult access due to her abdomen then leaving the smaller cyst would have been reasonable (as would removing it). However I think most gynaecologists would have considered removing the second cyst, as if it subsequently enlarged and caused symptoms then removing it later would be even more difficult. This is because every abdominal operation carries a risk of causing further adhesions."

90. I accept Dr Page's advice in this regard.

91. However, I would encourage Dr B (should he return to practice) to reflect on my comments at paragraph 83 regarding discussing such possibilities with patients prior to surgery as part of informed consent discussions. In my view, the fact that the management of incidental findings of ovarian cysts is the subject of such debate amongst gynaecologists supports the need to discuss such a possible eventuality with the patient prior to their surgery, as part of the informed consent process, so that the patient may have a say in the decision that is made intraoperatively should an incidental finding eventuate.

[24] Dr Page advised that a midline incision would be favoured for diagnostic purposes as it allows wide access to all areas of the abdomen and organs and gives better access to the whole abdominal cavity.

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Clinical decision to remove left cyst — no breach

92. Dr Page advised that the clinical decision to remove the left ovarian cyst (originally thought to be a right ovarian cyst) was reasonable in the circumstances. He stated:

> "It is often difficult to ascertain from which side large cysts arise before surgery is performed … It was therefore appropriate, having opened [Ms A's] abdomen, to continue with the surgery and remove the cyst. This is particularly the case when adhesions are found within the abdomen, and the possibility of malignancy was being considered."

93. I accept Dr Page's advice above about the risks associated with not removing the cyst, and I also acknowledge Dr B's comments that the origin of the cyst remained unclear until the procedure had commenced. On this basis, I consider that the clinical decision to remove the left ovarian cyst was reasonable in the circumstances. However, I would again encourage Dr B to reflect on my comments at paragraph 83 regarding the need to explain any uncertainty to patients, and that intraoperative findings may necessitate a deviation from the original plan. I have already concluded that the uncertain origin of the cyst was information that Ms A should have received.

Surgical consultation — no breach

94. Ms A raised concerns that a general surgeon was not consulted when difficulties were encountered intraoperatively.

95. Dr Page advised that gynaecologists are trained to perform abdominal surgery, which may involve "dissecting gynaecological structures" away from other structures (such as the bowel). Dr Page said that both Dr B and Dr D were clearly aware of the possibility of damage to the bowel occurring, and that they documented that there was no damage to adjacent structures during surgery. Dr Page advised that given that the surgeons considered there was no damage to the bowel, it was reasonable to conclude the operation without general surgery input. Dr Page stated:

> "Had there been a full appreciation of [Ms A's] previous surgery … then a general surgical opinion might have been sought once the difficulties were encountered. However this is very much a matter of opinion and would vary with the skills and experience of the gynaecologists concerned. From a process point of view they were aware of the risk of harm, assessed the situation and concluded none had occurred."

96. I note that the Operation Record provided to HDC did not document that there was no injury to adjacent structures noted intraoperatively. However, Dr B told HDC that he was alert to the risk of injury to the bowel, was careful to observe any intraoperative injury, and did not detect any at the time. I accept that Dr B was cognisant of the risk of damage to the bowel and considered this during the operation. He noted significant adhesions on Ms A's bowel during the surgery and was aware that adhesions could make surgery more complex. His awareness of the difficulty of adhesiolysis-related surgery was evidenced by his decision to take over the operation from Dr E, and his subsequent decision to rely on input from a senior

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gynaecologist (Dr D). On this basis, I accept Dr Page's advice that it was reasonable for Dr B to conclude the operation without general surgery input.

Damage to bowel during surgery — no breach

97. ACC concluded that the sigmoid colon perforation that Ms A suffered was caused by the laparotomy and left ovarian cystectomies on 6 June 2019, meaning that Ms A suffered the bowel perforation as a result of the surgical procedure. Dr B told HDC that there was no damage to adjacent structures evident (intraoperatively) at the conclusion of the surgery.

98. In regard to the standard of the clinical procedure, and whether or not it was performed with appropriate care and skill, Dr Page advised:

> "Whilst it would not be accepted practice to deliberately perforate the bowel in this situation, that it occurs is a recognised complication no matter how well the surgery was performed. As I noted in my original advice both [Dr B] and [Dr D] were aware of the possibility of perforation occurring as a complication of the surgery, considered the question and concluded that it hadn't. That hindsight has shown their assessment was incorrect does not make it a departure from accepted practice — that can happen to any and everyone. Had they not considered the possibility then that would have been a departure from accepted practice."

99. As I have noted above at paragraph 96, I accept Dr B's evidence that he was cognisant of the risk of perforation of Ms A's bowel and considered whether it had occurred during the operation.

100. On that basis, I accept Dr Page's advice and am satisfied that Dr B took reasonable steps to perform the procedure with appropriate care and skill, despite the subsequent events. In my view, as discussed above, the primary issues involve the information provided to Ms A about the risks the surgery entailed.

Opinion: Dr C — adverse comment

Introduction

101. Consultant gynaecologist & obstetrician Dr C saw Ms A for her pre-surgery appointment on 14 May 2019.

Knowledge of surgical history

102. Dr C told HDC that as part of his usual process, he asked Ms A if she had undergone surgery previously, and Ms A told him that she had not. Dr C also advised that he checked the operation notes folder on the DHB's database and did not note any mention of prior surgery. His evidence in this respect is, in part, corroborated by the letter he later sent to Ms A's GP, which records that she had not had previous surgery. However, contrary to this, Ms A told

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HDC that she told Dr C that she had undergone surgery as a child. The referral form from Ms A's GP to the Gynaecology Service also contained this information.

103. With the conflicting information available to me, I am unable to determine whether Ms A did advise Dr C of her prior surgery.

104. In any event, Dr C told HDC that he reviewed the referral letter from Ms A's GP prior to the appointment on 14 May 2019. He accepts that "[i]t was an oversight that [he] did not detect the discrepancy between the referral letter and the discussion with [Ms A] in which she indicated she had had no prior surgery".

105. Notwithstanding the details of any discussion that took place between Dr C and Ms A about her surgical history, I am concerned that Dr C did not identify the discrepancy between his understanding of Ms A's surgical history and the information on the referral form (which stated that Ms A had undergone surgery). This is information that he should have utilised to support a more thorough and adequate informed consent discussion with Ms A.

106. Dr Page also advised that Ms A would have had a scar on her abdomen from her previous surgery, and that Dr C does not appear to have noticed that when he examined Ms A. However, Dr C told HDC that due to Ms A's increased BMI and the fact that he was not anticipating any surgical scars, he did not notice the surgical scar on examination. I can only conclude that given that the referral letter stated that Ms A had a scar on her left side, Dr C should have been aware of it.

Discussion of risks

107. Dr C told HDC that when undertaking a pre-surgery assessment, it is his usual practice to discuss the rationale and benefits of the proposed surgery, as well as the risks associated with the surgery. However, on this occasion there is no documentation of the risk of injury to adjacent structures being discussed with Ms A.

108. Although I accept that ultimately it is the responsibility of the performing surgeon to ensure that informed consent has been obtained, the DHB's Informed Consent policy recognises that other practitioners are responsible for their own actions in obtaining consent. With the information before me, including the lack of documentation, and that Ms A does not recall the risk of injury to the bowel being discussed, I consider it is likely that Dr C did not raise the risk of injury to the bowel with Ms A in the pre-surgery assessment. Dr C had a clear individual responsibility to advise Ms A of the risks associated with the procedure, and to document these clearly. Accordingly, I am mildly concerned about Dr C's practice in this regard.

Decision to advise surgery

109. Dr Page considered that the decision to advise surgery to remove the cyst was appropriate, given that the cyst was thought to be causing symptoms and that its nature (benign or malignant) can be ascertained only once it has been removed. I accept this advice.

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110. However, I note Dr Page's comments that there appeared to be some inconsistences between the CPAC (Clinical Priority Assessment Criteria) booking score of 90 ("Urgent") that Dr C assigned to Ms A's surgery, and the fact that he considered Ms A's risk of malignancy to be low. Dr Page considered that the Risk of Malignancy Index in the NICE guidelines would not assign a high risk of malignancy in Ms A's case.

111. Dr Page also raised concerns that Dr C considered it appropriate to consider and obtain consent for the option of a laparoscopy if malignancy was considered, as it is usual practice to go straight to laparotomy in these circumstances.

112. On the basis that Dr Page considered surgery to be appropriate, I accept that these issues did not impact on the care provided. I also note that Dr C put forward the options of laparotomy or laparoscopy for the responsible surgeon (Dr B) to consider, and it eventuated that Dr B proceeded with a laparotomy.

Conclusion

113. In summary, Dr Page considered that the above issues raise concerns about the assessment process undertaken by Dr C. Dr Page advised:

> "As [Ms A's] subsequent management was determined, in part, by [Dr C's] consultation and note-keeping I think [Dr C] did not meet the standard of care that would have been expected and this would be viewed with at least mild criticism by his peers."

114. I accept Dr Page's advice. Dr C's assessment on 14 May 2019 had the potential to influence subsequent decision-making by Dr B and did not facilitate a good informed consent discussion — noting the relevance of Ms A's prior surgery to the expected risks of surgery. That is, Dr C's alleged unawareness of Ms A's surgical history meant that he was not in a position to discuss with her the possibility of adhesions being discovered intraoperatively, which could make the surgery more complex. There is also no evidence that Dr C discussed the risk of injury to adjacent structures with Ms A. In my view, these matters call into question the thoroughness of Dr C's consultation. I encourage Dr C to reflect on my comments and those of my advisor.

Opinion: District health board — no breach

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

116. In this case, I have found deficiencies in the care provided by both Dr B and Dr C. I consider that as Dr B and Dr C were both experienced senior clinicians, it was reasonable for the DHB to expect that they would obtain informed consent from their patients appropriately, in line with the DHB policies. Accordingly, I consider that the deficiencies in the care provided by

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both Dr B and Dr C to Ms A do not indicate broader systems or organisational issues at the DHB.

117. I note that Ms A also raised concerns about the lack of support that she received from the DHB during her time in hospital, particularly in relation to accessing appropriate services (such as ACC and social work). The DHB met with Ms A to discuss these concerns and apologised for the lack of support that she received. In addition, the DHB said that it has committed to working with allied health and nursing staff to put support systems in place to avoid this happening again in the future. Accordingly, I am satisfied that the DHB has taken appropriate learnings and has addressed this issue adequately.

Surgical lists — other comment

118. Following Dr C's pre-surgery assessment of Ms A, Ms A was placed on Dr B's surgical list. I have considered the appropriateness of having different clinicians involved in different stages of the surgical process, particularly the operating surgeon meeting the patient for the first time on the day of surgery, and how this could impact on the quality of patient care.

119. Dr Page advised that it is common practice for surgical services to have patients operated on by anyone in the department who is competent to do so. Dr Page stated:

> "There are risks in this process, as it is very dependent on good written communication between doctors. In addition the long waiting lists in many DHBs, which have led to this process, put the surgeons under pressure to do what is presented to them. In most cases it isn't a problem, but without adequate time to review patients admitted only a few hours before their surgery it is a definite risk."

120. Dr Page was also cognisant of the difficulties facing DHBs, owing to various external constraints such as funding and targets. Dr Page advised that he is not overly critical of the DHB, as similar cases occur every day throughout New Zealand.

121. On the basis of Dr Page's advice, and the resourcing constraints he has referred to, I am not critical of Ms A's placement on Dr B's surgical list. However, it is my view that in order to ensure continuity of care, the systems in place must be robust enough to support clinicians who are expected to operate on patients whom they have not met previously, and to obtain informed consent safely and in a manner that allows consumers to make an adequately informed choice about their care. Ideally, this would involve meeting patients prior to the day of surgery to allow further discussions and confirm their consent.

122. I also acknowledge Dr Page's comment about the importance of good written communication between doctors, and note the deficiencies identified in this opinion in regard to the thoroughness of the clinicians' assessments and documentation. As I have already concluded, I do not consider that these deficiencies indicated broader systems or organisational issues at the DHB. However, I encourage Te Whatu Ora to ask staff to reflect on the importance of good written communication.

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Changes made

Dr B

123. Dr B retired from clinical practice as a gynaecologist & obstetrician in August 2019, and told HDC that he does not plan to return to practice.

124. Dr B said that had he remained in practice, he would have considered amending his practice as a result of these events, including the following:

- In a circumstance such as Ms A's, where she was placed on his surgical list but he had not been responsible for her prior care, he would attempt to retrieve prior notes, "to enable an understanding of the exact nature of the prior surgery".
- He would make a careful effort to document all details of the preoperative discussion, including all of the risks discussed during the conversation.
- He would consider whether it was appropriate in the circumstances to call in a general or colorectal surgeon for assistance.

Dr C

125. Dr C told HDC that he is involved in evaluating the Ovarian-Adnexal Reporting and Data System (O-RADS) at a national level. He advised that O-RADS is a risk-stratification and management system designed to provide consistent interpretations, to decrease or eliminate ambiguity in ultrasound reports, resulting in a higher probability of accuracy in assigning risk of malignancy to ovarian masses and to provide a management recommendation for each risk category. Dr C said that O-RADS is thought to be better than the "Risk of Malignancy Index", as it promotes consistency in interpreting and reporting lesions, "but still has shortcomings in accuracy in predicting cancer".

DHB

126. The DHB told HDC that as a result of these events, the following is now undertaken for any women who have a previous history of surgery for Hirschsprung's disease (or have had extensive pelvic surgery as a child) and who are to receive pelvic or abdominal gynaecology surgery:

a) The gynaecologist will endeavour to perform the proposed surgery in conjunction with a general surgeon; and

b) If a conjoint operation (with a surgical colleague) is not possible and additional support is required by a gynaecologist in theatre, the surgical team will be asked to respond.

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Recommendations

Dr B

127. In the provisional report I recommended that Dr B provide a written apology to Ms A for the failings identified in the report. This apology has been provided to HDC and forwarded to Ms A.

128. I recommend that should Dr B return to practice, he undergo further training in communication and informed consent.

Te Whatu Ora

129. I recommend that Te Whatu Ora use an anonymised version of this case for educational purposes, and advise HDC that this has been completed within four months of the date of this report.

Follow-up actions

130. A copy of this report with details identifying the parties removed, except the advisor on this case, will be sent to the Medical Council of New Zealand and Te Whatu Ora|Health New Zealand, and they will be advised of Dr B's name.

131. A copy of this report with details identifying the parties removed, except the advisor on this case, will be sent to the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to Commissioner

The following expert advice was obtained from obstetrician & gynaecologist Dr Ian Page on 10 December 2020:

> "Thank you for your letter of 2 November 2020 and the enclosed documents, requesting expert advice to the Commissioner on the care provided by [Dr C], [Dr B], [Dr D] and [the DHB] to [Ms A] between 14 May 2019 and 6 June 2019. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.
>
> I am a practising Obstetrician & Gynaecologist and have been a consultant for over 30 years. I obtained my MRCOG in 1985, my FRCOG in 1998 and my FRANZCOG in 2002. I have been employed for the past 20 years by Northland DHB. I have been a member of the RANZCOG Expert Witness register since 2012.
>
> *Background*
>
> An ultrasound scan on 1 March 2019 identified that [Ms A] had an ovarian cyst, which appeared to extend from the right ovary. On 14 May 2019 [Ms A] was seen at [the DHB's] gynaecology clinic by [Dr C], her history of Hirschsprung's disease was discussed and she was scheduled for a laparotomy and right ovarian cystectomy. [Ms A] was scheduled onto [Dr B's] surgical list, and he met with her on the morning of her surgery. Consent was obtained for the removal of the right ovarian cyst. [Dr B] was aware of her history of Hirschsprung's disease. During surgery it was noted that there were numerous adhesions and it was difficult to determine the cyst's origin. The cyst was approximately 30cm and it was unclear whether it arose from the left or right ovary. 1.2L of fluid was drained from the cyst but this did not improve visibility to tell if it arose from the left or right ovary. As the origin of the cyst was in doubt, and there were significant adhesions, [Dr B] asked [Dr D] to attend. [Dr D] removed the cyst, and it was identified that it arose from the left ovary. An additional cyst from the left ovary, which was adherent to the left pelvic side-wall, was removed. No iatrogenic injuries were noted at this point. Two days after the procedure [Ms A] started to experience abdominal pain, fevers and tachycardia. A CT scan identified that her bowel was perforated and she underwent emergency surgery, resulting in a permanent colostomy.
>
> *Advice Requested*
>
> You asked me to review the documents and advise whether the care provided to [Ms A] by [Dr C], [Dr B], [Dr D] and [the DHB] was reasonable in the circumstances and why. You also asked me to comment specifically on:
>
> 1. Whether input from general surgery was warranted following [Ms A's] clinic appointment with [Dr C] on 14 May 2019, given her history of Hirschsprung's disease.
> 2. Whether input from a general surgeon was warranted at any time prior to, or during, [Ms A's] operation on 6 June 2019.

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3. The decision made to proceed with the removal of the identified cyst from [Ms A's] left ovary.
4. The decision made to remove an additional cyst on [Ms A's] left ovary.
5. The adequacy/appropriateness of the information conveyed by [Dr C] and [Dr B] to [Ms A] prior to surgery. In particular to advise whether I consider [Ms A] was provided with a reasonable explanation of her condition and the options available, including an adequate assessment of the expected risks, side-effects and benefits of surgery.
6. The reasonableness of the care provided to [Ms A] by [the DHB], including comment on her placement on [Dr B's] surgical list.
7. Whether I had any further matters in this case that warrant comment or amount to a departure from the standard of care or accepted practice.

Sources of Information

In assessing this case I have read:

- Letter of complaint dated 19 March 2020
- [DHB's] responses received 20 August 2020
- Clinical records from [the DHB] covering the period January 2019 onwards
- [DHB's] 'Informed Consent Policy'

Summary of the Case

[Ms A] was referred to [the DHB's] Gynaecology service on 8 March 2019 by her GP. The referral letter noted that a large (25cm) right ovarian cyst had been found on ultrasound, performed to investigate right chest/upper abdominal pain. The referral letter noted that [Ms A] also had an asymptomatic cervical polyp, and that she had a history of Hirschsprung's disease for which she had surgery in infancy. The examination findings from the GP noted a dense scar in her left flank, and increased BMI. The ultrasound scan report was included in the referral. It noted a large cyst arising from the pelvis, and probably from the right ovary.

She was seen in the gynaecology clinic at [the] Hospital on 14 May 2019 by [Dr C], consultant gynaecologist. His notes record the incidental finding of the 25x18x9cm ovarian cyst, that her Ca125 was 26 (normal) and that she had a cervical polyp. He noted she had had Hirschsprung's, had a BMI of 40, and Penicillin allergy. He noted her increased BMI and that he could not feel the mass. His letter to the GP noted the finding of the cyst, which could not be felt due to her increased BMI when he examined her. He noted that she had not had surgery before, as far as she could remember, and that she was known to have Hirschsprung's disease. He booked her for laparoscopy/laparotomy + peritoneal washings + ovarian cystectomy +/- omentectomy + cervical polypectomy, and obtained her consent. She was scheduled to have her surgery within 4 weeks due to the high probability of malignancy or pre-malignancy (National Prioritisation Web Service).

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[Ms A] was seen for her pre-anaesthetic assessment by [the anaesthetist] on 20 May 2019. His notes record that she had undergone a SOAVE procedure for Hirschsprung's as a child, and possibly had anal stenosis. She had been admitted in 2008 with possible large bowel obstruction which had been relieved by the insertion of a rectal tube.

[Ms A] was seen by [Dr B] on the morning of surgery. [Dr B's] response to the complaint states that he discussed the previous surgery for Hirschsprung's disease with [Ms A] when he saw her on the morning of surgery. He counter-signed the consent form, and it records the risks of infection, bleeding, blood transfusion and the possibility of a midline incision.

The operation note of 6 June 2019 was dictated by [Dr B]. It records the principal surgeon was the registrar, [Dr E], assisted by [Dr B] and [Dr D]. A transverse Joel-Cohen incision was made, noting fibrosis of the rectus sheath from her previous surgery. Peritoneal washings were obtained. A left ovarian cyst, about 30cm diameter, was noted. This was aspirated and 1.8L of fluid sent for cytology, after which the cyst was removed. At some point [Dr B] took over the surgery when it was apparent that the adhesions made it too difficult for [Dr E] to continue safely. A further left ovarian cyst was noted, adherent to the pelvic sidewall and Pouch of Douglas, at which point [Dr D] was asked to come and assist. [Dr D] removed the remaining part of the main cyst and then the smaller cyst. He noted that no damage to adjacent structures was evident. The right ovary was palpated as being normal, the tubes were not clearly seen due to pelvic adhesions, and the uterus was recorded as appearing normal. The operation was then completed with closure of the abdominal wall. Standard post-op instructions were recorded.

The notes record that she was reviewed by [Dr B] later that day and the operation explained. She was seen the next day by [Dr B] and all appeared to be well. The following day (8 June 2019) the nursing notes record that [Ms A] was up, had showered independently and hoped to be going home later that day. She was seen at 4.05pm by [a house surgeon and a consultant] when she was complaining of feeling sore and cold. Her abdomen was tender on the right, and there were no bowel sounds. A differential diagnosis of post-op pain, bleeding, perforation or ileus was recorded and chest and abdominal x-rays were ordered. It was reported as showing significant faecal loading of the large bowel and a significant pneumoperitoneum.

At 6.20pm her respiratory rate was markedly elevated at 36, she had a pyrexia of 38.6°C, and she was reviewed by the Medical Emergency Team (MET). A diagnosis of sepsis was made and antibiotics commenced. She was reviewed by [the gynaecology registrar] at 8.40pm who confirmed the likely diagnosis of sepsis, possibly from an intra-abdominal cause. Her care was discussed with the duty consultant gynaecologist and a CT of the abdomen and pelvis ordered to rule out bowel perforation.

While waiting for the CT scan [Ms A] again became unwell, with a high respiratory rate and pyrexia. The CT was performed at 10.14pm and showed a 35mm defect in the wall

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of the sigmoid colon in the left lower quadrant of the abdomen, with faeces extending into the peritoneal cavity.

[Ms A] was then taken to the operating theatre for a laparotomy. This confirmed the CT appearances of a perforation of the sigmoid colon, with gross faecal contamination of the peritoneal cavity. A piece of bowel needed to be resected and a stoma was formed, after which the peritoneal cavity was thoroughly cleansed and closed.

[Ms A] was reviewed by [a] consultant general surgeon, at about 9am on 9 June when the operation was explained. She was subsequently seen by [the] consultant gynaecologist at about 10am. [Dr B] met with [Ms A] and her whānau around noon, explained the initial operation and then the findings at the laparotomy. [Ms A] was discharged from ICU to the general surgical ward on 10 June.

The histology report on the two ovarian cysts stated the large one was a serous cystadenoma, and the smaller one a haemorrhagic corpus luteum cyst, with no evidence of malignancy in either. The peritoneal washings and the cyst fluid sent for cytology did not show any evidence of atypia or malignancy.

My Assessment

You asked me to review the documents and advise whether the care provided to [Ms A] by [Dr C], [Dr B], [Dr D] and [the DHB] was reasonable in the circumstances and why. You also asked me to comment specifically on:

1. *Whether input from general surgery was warranted following [Ms A's] clinic appointment with [Dr C] on 14 May 2019, given her history of Hirschsprung's disease.*

I do not think there was any strong indication for general surgical input into [Ms A's] care at this point. Consultant Gynaecologists are trained to perform surgery in situations such as this, so a general surgical consultation would not have added anything. However there are some aspects of her care that warrant comment. Clearly [Ms A] had a scar on her abdomen from her previous surgery, and yet [Dr C] does not appear to have seen it when he examined her. In addition when [Ms A] was seen for her pre-anaesthetic assessment the anaesthetist seems to have found details of her previous surgery and admission with possible large bowel obstruction. I presume this was either in her paper or electronic records, and so should have been available to [Dr C] when he saw her in the clinic. According to the prioritisation process [Dr C] seems to have thought there was a high probability of the cyst being malignant or pre-malignant. That being the case I am concerned that he thought it appropriate to consider (and obtain consent for) a laparoscopy or laparotomy. Usual practice would be to go straight to laparotomy. However it is not clear what risk analysis tool [Dr C] used when he completed the surgical priority score. The Risk of Malignancy Index[1] in the NICE guidelines would not give a high risk of malignancy in [Ms A's] case. Whilst none of these points would necessarily have altered the events that followed they do raise concerns about the assessment process by [Dr C] in the gynaecology outpatients. As her subsequent management was determined, in part, by his consultation and note-

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keeping I think he did not meet the standard of care that would have been expected and this would be viewed with at least mild criticism by his peers.

2. *Whether input from a general surgeon was warranted at any time prior to, or during, [Ms A's] operation on 6 June 2019.*

As I noted above gynaecologists are trained to perform abdominal surgery which may involve dissecting the uterus, tubes or ovaries away from other structures — such as bowel, bladder or ureters. Both [Dr B] and [Dr D] were clearly aware of the possibility of damage occurring, as the operation note states that no damage to adjacent structures was evident. Given that they felt there was no damage to the bowel it was reasonable for them to finish the operation without any general surgical input. Had there been full appreciation of her previous surgery (I cannot tell from the notes just how aware [Dr B] and [Dr D] were of what the Soave procedure entailed) then a general surgical opinion might have been sought once the difficulties were encountered. However this is very much a matter of opinion and would vary with the skills and experience of the gynaecologists concerned. From a process point of view they were aware of the risk of harm, assessed the situation and concluded none had occurred.

3. *The decision made to proceed with the removal of the identified cyst from [Ms A's] left ovary.*

It is often difficult to ascertain from which side large cysts arise before surgery is performed. In this case prior knowledge is unlikely to have made any difference to the risks put before [Ms A] when her consent was obtained, as I expect she would have accepted the advice to have the cyst removed regardless of its origin. It was therefore appropriate, having opened her abdomen, to continue with the surgery and remove the cyst. This is particularly the case when adhesions are found within the abdomen, and the possibility of malignancy was being considered.

4. *The decision made to remove an additional cyst on [Ms A's] left ovary.*

The management of the incidental finding of an ovarian cyst is a subject of endless debate amongst gynaecologists. Asymptomatic small cysts are usually best left alone, but that was not the situation here. [Ms A's] presenting complaint was abdominal pain which could have been caused by the large cyst or the smaller one. There is no way of telling pre-operatively. If [Ms A] had not had significant adhesions and difficult access due to her abdomen then leaving the smaller cyst would have been reasonable (as would removing it). However I think most gynaecologists would have considered removing the second cyst, as if it subsequently enlarged and caused symptoms then removing it later would be even more difficult. This is because every abdominal operation carries a risk of causing further adhesions.

5. *The adequacy/appropriateness of the information conveyed by [Dr C] and [Dr B] to [Ms A] prior to surgery. In particular to advise whether I consider [Ms A] was provided with a reasonable explanation of her condition and the options available, including an adequate assessment of the expected risks, side-effects and benefits of surgery.*

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I think advising surgery to remove the cyst was appropriate, given that the cyst was thought to be causing symptoms and that its nature (benign or malignant) can only be ascertained once it has been removed. I do think that the failure to mention the risk of damage to the bowel, given her history of the Soave procedure as a child, was a significant departure from accepted standards which would be viewed with mild to moderate disapproval by their peers.

6. *The reasonableness of the care provided to [Ms A] by [the DHB], including comment on her placement on [Dr B's] surgical list.*

I have noted some concerns over the overall pre- and intra-operative care provided to [Ms A] by [the DHB]. I was also surprised to see the incision used for the ovarian cystectomy was Joel-Cohen, rather than a midline. The possibility of a midline incision had been considered by [Dr C], as noted in the consent form, and I could not determine why [Dr E] (under direct supervision from [Dr B]) made the J-C one. In my opinion the decision falls somewhat short of the accepted standard of care, and it would be viewed with mild disapproval by [Dr B's] peers. It is common practice for many DHB surgical services to have patients operated on by anyone in the department who is competent to do so. There are risks in this process, as it is very dependent on good written communication between doctors. In addition the long waiting lists in many DHBs, which have led to this process, put the surgeons under pressure to do what is presented to them. In most cases it isn't a problem, but without adequate time to review patients admitted only a few hours before their surgery it is a definite risk. This is a consequence of targets being set by the Ministry of Health, on behalf of Parliament, which DHBs are expected to meet without the necessary funding to ensure safety. I would not be overly critical of [the DHB] in this case, as similar cases occur every day throughout New Zealand. Nor would I be overly critical of [Dr B], as had he decided to postpone the case he would have left an operating theatre empty and denied its availability to other people awaiting surgery. Without becoming too political in my opinion, I would ask the Commissioner to note the dilemma in which many doctors are placed by these external constraints. Finally although I am not strictly qualified to review the care provided by the surgical teams to [Ms A] it does seem that they worked very well to provide her with the best possible outcome.

7. *Whether I had any further matters in this case that warrant comment or amount to a departure from the standard of care or accepted practice.*

I have not found any further matters to note.

I do not have any personal or professional conflict of interest to declare with regard to this case.

If you require any further comment or clarification please let me know.

Dr Ian Page MB BS, FRCOG, FRANZCOG
Consultant Obstetrician & Gynaecologist
Whangarei Hospital

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

References https://www.nice.org.uk/guidance/cg122/chapter/Update-information"

Dr Page provided the following further advice on 14 September 2021:

"[Dr Page was asked to clarify the level of departure attributable to [Dr B's] failure to discuss the risk of injury to the bowel.]

I think this is a mild departure from accepted standards. Even if the risk had been mentioned I think it probable that [Ms A] would have elected to proceed with the surgery.

[Dr Page was asked to comment on whether, having considered [Dr B's] explanation for using a J-C incision, he remained of the view that the use of a J-C incision was a mild departure from accepted standards.]

I still think this was a mild departure from accepted standards. The reason I would suggest a midline incision would have been more appropriate is that it would (usually) give better access to the whole abdominal cavity. It is only when the abdomen has been entered that one can determine whether or not it was (with hindsight) actually necessary. Adding a midline incision to a J-C incision is possible, but in general is used reluctantly."

Dr Page provided the following further advice on 28 August 2022:

"[Dr Page was asked to advise on whether he considered the surgical procedure was carried out with appropriate care and skill.]

I think that if [Ms A] had not had her surgery on 6 June 2019 then the perforation of her bowel would not have occurred. I would agree with ACC that this was a treatment injury.

Your question then relates to the standard of surgery that led to the perforation. Whilst it would not be accepted practice to deliberately perforate the bowel in this situation, that it occurs is a recognised complication no matter how well the surgery was performed. As I noted in my original advice both [Dr B] and [Dr D] were aware of the possibility of perforation occurring as a complication of the surgery, considered the question and concluded that it hadn't. That hindsight has shown their assessment was incorrect does not make it a departure from accepted practice — that can happen to any and everyone.

Had they not considered the possibility then that would have been a departure from accepted practice, but it does not apply in this case."

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