Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Deputy Health and Disability Commissioner

(Case 21HDC00152)

Introduction

1. This report is the opinion of Deborah James, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

2. The report discusses the care provided to Mrs A by a gynaecologist, Dr B. Dr B worked both publicly and privately. Mrs A saw Dr B privately.

3. Mrs A was under the care of Dr B from mid-2019 until late 2020 for treatment of endometriosis.[1] Mrs A felt that her best chance at reprieve from her symptoms was a hysterectomy.[2] She raised concerns that Dr B denied her a hysterectomy due to her age (in her twenties at the time) and lacked medical reasoning for the refusal. Further, Mrs A feels that she was verbally coerced into having a Mirena[3] inserted in August 2020, and raised concerns about Dr B's communication with her generally. Mrs A also advised HDC that she suffered permanent nerve damage in her thigh secondary to being in the lithotomy position[4] during a laparoscopic excision of endometriosis[5] performed by Dr B in November 2020. Mrs A was unaware that she would be positioned in this way and was surprised to learn that this

[1] The presence and growth of endometrial tissue in places other than the uterus, which often results in severe pain and infertility.
[2] Surgical removal of the uterus.
[3] A small T-shaped hormonal contraceptive device that is inserted into the womb.
[4] The patient lies on their back with legs flexed 90 degrees at the hips and knees bent at 70 to 90 degrees. Footrests attached to the table support the legs.
[5] Keyhole surgery to remove endometrial tissue.

was done so that instruments could be used vaginally to manipulate the uterus, which she had also been unaware of. Mrs A feels that her consent should have been requested for this, or she should have at least been informed that this would occur.

4. The following issue was identified for investigation:

- *Whether Dr B provided Mrs A with an appropriate standard of care between June 2019 and December 2020.*

Events leading up to complaint

Background

5. Mrs A was referred to Dr B in 2019 with pelvic pain. On 19 August 2019 Dr B performed a laparoscopy[6] and confirmed and removed a moderate amount of endometriosis. By 4 May 2020 Mrs A was experiencing pelvic pain again and saw Dr B. Dr B recommended trialling a different oral contraceptive pill (Cerazette[7]) and discussed the possibility of introducing pain modulators like amitriptyline[8] in the future. Dr B also explained that 'there [would] be a role for a second laparoscopic procedure', but he wanted to avoid this procedure for as long as possible and first try to 'exhaust all other medical options'.

21 July 2020 appointment

6. Mrs A had a follow-up appointment with Dr B on 21 July 2020. Dr B documented that they had trialled Cerazette and amitriptyline, and that Cerazette was working well but the amitriptyline made Mrs A very sleepy, so he suggested replacing it with pregabalin.[9] Dr B again documented that the plan was to try to exhaust all the medical options before considering further laparoscopic surgery.

17 August 2020 appointment

7. Mrs A had been experiencing bleeding and pain and booked an early follow-up appointment for 17 August 2020. She had tried switching from Cerazette to Ginet,[10] which she had been on previously, but this did not stop the bleeding or pain. Dr B documented:

> '[Mrs A] was very emotional today and she and her husband are very determined that she wants a hysterectomy. They are quite sure that they have completed their family — they have [two children] who are both healthy. They have obviously thought about this option for a while and are very clear about what they want.
>
> I have spent a long time with the couple today in my room, trying to convince them to re-think that option as it is obviously irreversible.'

[6] Keyhole surgery.
[7] A progestogen-only oral contraceptive pill.
[8] A type of antidepressant that is used to treat certain types of nerve pain.
[9] A pain medication used to treat some kinds of nerve pain.
[10] An oral contraceptive for women being treated for acne, hair loss or increased growth of facial and body hair if these conditions are the result of over-production of male-type hormones called androgens.

8. At this appointment, Dr B also explained that although 'hysterectomy [would] definitely sort out the bleeding … there [would still be] a small chance that the pain could persist'. Dr B documented: '[Mrs A] does understand that well and she told me today that this is her best shot to improve her quality of life.'

9. Dr B and Mrs A also discussed Mirena insertion as a possible treatment. Dr B documented:

> 'I have re-explored the Mirena option again. Initially [Mrs A] was not agreeable to the Mirena option; however I explained that offering a hysterectomy at [her age] is a case that will need to be discussed in the Endometriosis MDM[11] and will need to have some consensus from different consultants to agree to offer this kind of treatment at this age. Obviously, having not tried the Mirena will make agreeing to this more difficult.'

10. Mrs A told HDC that she had declined a Mirena on multiple occasions previously and she felt that Dr B 'verbally coerced' her into agreeing to the Mirena insertion. Her understanding from their conversation was that Dr B would present her case to the MDM if she tried the Mirena. She felt that if she did not agree to try the Mirena, Dr B would not entertain the idea of a hysterectomy. She stated:

> 'He promised me that if I tried the Mirena for a period of three months he would present my case to a Board of gynaecologists in [the area] to talk about my hysterectomy. I was essentially being blackmailed into agreeing to a form of medication I did not want, for if I refused he wouldn't even entertain the idea of a hysterectomy. I begrudgingly accepted.'

11. Dr B told HDC:

> '[Mrs A] was keen to proceed with the mirena insertion on that day after our discussion, and I didn't receive any impression of uncertainty, hence I attempted insertion.'

12. Dr B documented that Mrs A 'did not tolerate the procedure', so he booked her for a Mirena insertion under general anaesthetic the following day at the private hospital, which went ahead as planned.

13. Mrs A told HDC:

> '[The attempted insertion by Dr B was] the single most painful thing I have experienced. I was screaming and writhing in pain clinging to the hand of my husband begging for it to be over.'

14. Mrs A said that she felt 'a complete loss of bodily autonomy'. She told HDC that she thought that if she wanted a hysterectomy then she had to 'grin and bear it'.

15. In response to Mrs A's account of the attempted Mirena insertion, Dr B stated:

[11] Multi-disciplinary meeting.

> 'I am so sorry that [Mrs A] experienced significant pain and distress when I attempted to insert the Mirena in clinic. I always ask my patients to tell me to stop if the procedure is not tolerable. I abandoned the procedure when [Mrs A] asked me to stop.'

16. Dr B documented that he would refer Mrs A's request for a hysterectomy to the endometriosis MDM at the public hospital by the end of the month. Dr B also prescribed Provera[12] and codeine[13] for pain management at this appointment.

17. Mrs A told HDC that following this appointment, she ensured that she had a family member with her for every future appointment, as she felt that Dr B 'has the tendency to railroad your thinking if you are alone'.

Multidisciplinary meeting — 2 September 2020

18. Dr B presented Mrs A's case at the endometriosis MDM at the public hospital on 2 September 2020. The case presented was: 'Patient requesting hysterectomy for ongoing pain and [abnormal uterine bleeding]', and the question asked was: 'If patient not satisfied with the mirena and still demanding hysterectomy in light of her young age? Endometriosis confirmed histologically, and family complete.' The MDM's recommendations were:

> 'Next option would be zoladex[14] and add-back HRT.[15] Would need a clinical psychology review and a second opinion from another gynaecologist before proceeding with a hysterectomy.'

28 September 2020 appointment

19. The Mirena was removed at this follow-up appointment as Mrs A had experienced side effects that affected her daily life. Dr B documented that Mrs A wanted the Mirena to be removed because it made her bloated, affected her mood and skin, and did not help with the pain. Mrs A stated that she wanted it to be removed because she had bled for the six weeks since the Mirena insertion.

20. Mrs A asked Dr B about the outcome of the MDM. Dr B stated that he discussed the MDM recommendations with her and that she seemed to accept them. His documentation of this discussion states:

> '[A]s expected, the consensus from the MDM was not to proceed with a hysterectomy at this age. I have discussed these recommendations with [Mrs A] today and she was accepting of this.'

21. Conversely, Mrs A does not recall any discussion of the recommendations made by the MDM and stated that when she asked Dr B about the outcome of the MDM, 'he casually replied

[12] A medication used to treat or prevent irregular, painful or heavy periods and endometriosis.
[13] A medication used to relieve pain.
[14] A treatment to suppress ovulation and induce temporary menopause.
[15] Hormone replacement therapy.

that he had asked them and they said no'. She was skeptical that Dr B had taken her case to the MDM given that she received nothing in writing and no further information.

22. There is no documentation outlining what specific MDM recommendations were discussed and whether those recommendations were progressed. Mrs A also asked Dr B about a second laparoscopy and possible excision of any further endometriosis, which Dr B agreed was appropriate, and he booked this for 23 November 2020. Dr B also suggested that Mrs A take gabapentin[16] and restart Cerazette since the Mirena had been removed. He also referred Mrs A to a pelvic floor physiotherapist and a psychotherapist who deals with chronic pelvic pain.

Surgery and postoperative care — 23–24 November 2020

23. On 23 November 2020 Dr B performed a second laparoscopic excision.[17] Dr B's operation notes do not document any complications, and record that the procedure was 'all performed safely'.

24. Within a few hours of waking from the surgery, Mrs A noticed that her right thigh was 'completely numb'. She mentioned this to Dr B when he came to see her the following morning. Mrs A recalls that he was 'very surprised', then left and came back 15 minutes later with a printout about positional nerve damage. Mrs A stated: 'He didn't explain much more other than the feeling should return soon.'

25. Dr B stated that when Mrs A told him about the numbness, he explained the possibility of meralgia paresthetica.[18] He said that he apologised to her, gave her written information on this complication, and explained that most cases resolve spontaneously.

26. Dr B said that this was the second time in his career that he had encountered nerve damage secondary to lithotomy positioning. The previous instance had been about eight months earlier in March 2020. Dr B stated that he teaches his registrars and fellows that the patient's positioning is primarily the surgeon's responsibility, and his usual practice is to review the position of the patient before scrubbing for surgery.

30 November 2020 appointment

27. At this postoperative follow-up appointment, Dr B documented that he explained the nature of the surgical complication and how it occurred, which he believed was 'likely due to compression of the nerve, secondary to lithotomy position[19]'. In a letter to Mrs A's physiotherapist on 30 November 2020, Dr B noted that this was unfortunate as Mrs A's surgery was not long, and he was 'pretty sure she was correctly positioned'.

[16] A pain medication used to treat some types of nerve pain.
[17] Operative laparoscopy, adhesiolysis, and excision of endometriosis.
[18] Compression of one of the large sensory nerves in the leg resulting in numbness, tingling, pain, or a burning sensation felt in the outer thigh.
[19] Lying on the back with the legs flexed 90 degrees at the hips, knees bent at 70 to 90 degrees.

28. Mrs A told HDC that she was unaware that she would be in the lithotomy position during surgery. Dr B told HDC:

> '[Mrs A] was unaware that laparoscopic Gynaecological procedures are normally performed while patients are positioned in the lithotomy position. This position allows the operating surgeon to access the deep pelvis and facilitates mobilizing the uterus.'

29. Mrs A stated that while she understands the reason for the positioning and mobilisation of the uterus, she was not informed that anything would be done vaginally and felt that her consent should have been requested for this, or she should at least have been informed that this would occur.

30. The 'agreement to treatment form' signed by Mrs A states that the risks discussed were infection, bleeding, and damage to organs (bowels, bladder, uterus). There was no mention of positioning, a potential risk of nerve damage from being in the lithotomy position, or that instruments would be used vaginally.

31. Dr B apologised for not having discussed positioning with Mrs A preoperatively and said that in future he will explain to his patients that this is how they are likely to be positioned during surgery.

32. Dr B told HDC that he explained the role of gabapentin in managing the complication and referred Mrs A to physiotherapy for management of her chronic pelvic pain, and to expedite gaining sensation in her thigh.

21 December 2020 appointment

33. At this follow-up appointment, Dr B recorded that Mrs A's pelvic pain had improved significantly apart from one spot that was painful intermittently, and she was continuing with Cerazette and taking tramadol[20] for pain. Dr B documented that he told Mrs A: '[A] hysterectomy still remains the last card that we can play; however I would like to leave that as far as possible.'

34. Dr B booked Mrs A a follow-up appointment in April 2021. However, following the appointment on 21 December 2020, Mrs A informed Dr B that she did not want any further follow-up with him as she was seeing another gynaecologist.

Further information from Mrs A

35. Mrs A understood that Dr B's reason for declining her a hysterectomy was due to her age and an assumption that she might want more children in the future.

36. Mrs A told HDC that she understands the reservations about a hysterectomy for someone her age but feels that Dr B failed to take into account the individual circumstances of her case as a whole. She said that she understood that a hysterectomy would 'change [her] life', and that it was not a decision made lightly. She said that she understood that a hysterectomy would fix the bleeding but might not fix the pain. She stated that she would still have been

[20] A medication used to relieve pain.

happy to proceed with the procedure on that basis. Mrs A feels that the second laparoscopic surgery would not have been needed if she had been allowed to have a hysterectomy, and that therefore she would not have suffered the nerve damage in her thigh, which she stated has not resolved spontaneously and is permanent.

Further information from Dr B

37. Dr B acknowledged that he was 'not entirely agreeable' to offer the option of a hysterectomy 'based on Mrs A's young age, and the possibility of failure of that approach of relieving pelvic pain symptoms'. Regarding his clinical rationale for declining a hysterectomy, Dr B stated:

> 'Offering a radical irreversible treatment like hysterectomy is not an easy option to offer to a relatively young patient with chronic pelvic pain.
>
> In my experience some patients have regretted that decision in the past especially when performed at [a] relatively young age. Also, there is no guarantee that removing the uterus will cure the pelvic pain. Consequently, as a routine practice in [this region], we tend to discuss these requests in a monthly endometriosis MDM and consensus was to offer alternative options at that stage. [Mrs A] appeared to be content to adopt that course when I explained it to her. Had those options that were agreed with [Mrs A] been unsuccessful then the hysterectomy option would have been revisited with the MDM.'

38. Dr B stated: 'I would like to finish with a sincere apology to [Mrs A] for the distress that she has experienced.'

Responses to provisional opinion

Mrs A

39. Mrs A was given an opportunity to comment on the information gathered during the investigation, as set out in this report. Mrs A stated:

> 'After leaving the care of [Dr B] I have since had a hysterectomy. The very surgery I fought so hard to receive from [Dr B] was given to me without the need to exhaust other medical options and without the need for further discussion around my competency to make this decision about my own body … Interestingly further biopsy testing on my removed uterus revealed the presence of Adenomyosis — a condition only treated by a hysterectomy.'

40. Mrs A told HDC that the hysterectomy has been life changing. She said:

> 'I can now be the active, healthy, present mother I had always hoped to be for my two children. My pain has significantly reduced and I am no longer bound by my dysfunctioning body. It is so disappointing that this level of freedom was not afforded to me sooner.'

41. Mrs A advised that her nerve damage from the 2020 surgery is permanent and has not improved since then.

Dr B

42. Dr B was given an opportunity to comment on the provisional opinion. Where appropriate, his responses have been incorporated into the report. Dr B stated: '[Mrs A's] case illustrates the challenges doctors face in the care of patients with endometriosis and chronic pain.' He noted that HDC's independent advisor 'felt comfortable with the care [Dr B] provided to Mrs A's (discussed further below).

Opinion: Dr B — breach

43. To assist my assessment of this case I sought independent advice from obstetrician and gynaecologist Dr Richard Dover. His advice is included as Appendix A. Although Dr Dover did not identify any departures from the standard of clinical care, I am concerned that Dr B did not:

a) Provide Mrs A with information that a reasonable person in her circumstances would expect to receive regarding the options to treat her bleeding and pain; and

b) Provide Mrs A with honest and accurate answers to her questions about the MDM.

44. I discuss my concerns below and explain why I consider that Dr B breached Rights 6(1)(b),[21] 6(3),[22] and 7(1)[23] of the Code of Health and Disability Services Consumers' Rights (the Code).

45. I am also critical of the information provided to Mrs A in relation to her laparoscopic surgery on 23 November 2020, and comment on the standard of care in relation to positioning during this surgery and the attempted Mirena insertion.

46. As a general introductory comment, it appears to me that Dr B was unduly influenced by his own views about what he perceived to be the best course of action for Mrs A, without giving due consideration to Mrs A's wishes. In response to the provisional opinion, Dr B's legal representative stated that when a patient has requested a permanent, life-altering procedure it is reasonable for a medical practitioner to recommend a patient consider alternative options, and likely they would be critiqued if they did not. Dr B's legal representative stated: '[T]he fact that [Dr B] presented alternative options to [Mrs A] does not demonstrate that he did not have due consideration of [Mrs A's] wishes.'

47. I agree that it is important to discuss the available options with the consumer. I acknowledge in these circumstances that ensuring the patient was aware of the different options was very important, but it was also important that Dr B gave sufficient weight to Mrs A's wishes and preferred treatment option. Having considered all the facts of this case, I am not

[21] Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including — an explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option.
[22] Every consumer has the right to honest and accurate answers to questions relating to services.
[23] Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.

satisfied that sufficient weighting was given by Dr B to the wishes of Mrs A, who should have been at the centre of the decisions made about her care.

Information about options to treat bleeding and pain — breach

48. At the appointment on 17 August 2021, Mrs A requested a hysterectomy. Dr B then discussed Mrs A's options with her. The information given about these options is discussed below.

Hysterectomy

49. When Mrs A raised with Dr B that she wanted a hysterectomy, Dr B spent much of the appointment trying to get her to re-think this option. Mrs A understood that Dr B did not want to proceed to hysterectomy due to her age and an assumption that she might want more children in the future. Dr B acknowledged that he was 'not entirely agreeable' to offer the option of a hysterectomy based on her age and the possibility that it would not relieve the pelvic pain symptoms.

50. Dr B documented that Mrs A was aware that a hysterectomy is irreversible and understood that there was a possibility it might not fix the pain, but that she still felt that a hysterectomy was the best option for her quality of life. Dr B also documented that Mrs A and her husband 'are quite sure that they have completed their family … they have obviously thought about this option for a while and are very clear about what they want'.

51. Dr Dover advised:

> 'I would feel that most gynaecologists would not rush to offer hysterectomy to a woman of [her] age. Equally, I feel that this option should not be withheld purely on the basis of age and that ongoing discussion about it, particularly after counselling and perhaps a second opinion, would make this a reasonable option to discuss openly.'

52. Dr B stated:

> '… I believe most if not all gynaecologists would be reluctant to offer hysterectomy to [a woman of her age] before trialling some of the conservative options. My reluctance to offer hysterectomy was more based on not yet trialing other known options, and not solely based on [Mrs A's] young age.'

53. Dr Dover advised that the discussion Dr B had with Mrs A and her husband on 17 August 2020 seemed to be based on convincing Mrs A to re-think a hysterectomy, and that there was no documentation of the benefits that Mrs A would have accrued from a hysterectomy, which could have been weighed against the disadvantages. Dr Dover stated:

> 'I think we need to be quite careful that we do not become overly patriarchal and viewed from a different perspective, we are discussing the case of a … woman [in her twenties] who already has two children.'

54. Dr B disagreed that there was no documentation about the benefits that Mrs A would gain from a hysterectomy, as he did mention that a hysterectomy would cure the bleeding.

55. Dr Dover acknowledged that Dr B did mention that a hysterectomy would stop the bleeding.[24]

56. Dr B's notes from this appointment give an impression that Mrs A's case *needed* to be presented to the MDM in order to proceed to hysterectomy. The notes state:

> 'I explained that offering a hysterectomy at [her age] is a case that will need to be discussed in the Endometriosis MDM and will need to have some consensus from different consultants to agree to offer this kind of treatment at this age.'

57. However, there is no evidence to suggest that there was a clinical requirement to present Mrs A's case to the MDM. Dr B referred to it as 'routine practice'. Further, Dr Dover advised that whilst there is an increasing move towards using MDMs, which suggests they may be a useful tool, there is not a set requirement for cases to be presented to an MDM before proceeding to hysterectomy.

58. In response to the provisional opinion, Dr B stated:

> 'I consider my approach to discuss [Mrs A's] request for a hysterectomy at the MDM and revisit the option with her at a later stage was appropriate. This gave me the opportunity to discuss [Mrs A's] individual circumstances with colleagues, to determine what they felt was appropriate. It also provided [Mrs A] with a further opportunity to consider her options. It is important to acknowledge that regret about permanent procedures in gynaecology regarding fertility are well known and need to be discussed with great sensibility.'

59. Overall, Dr Dover believes that the management and options that were offered were reasonable. I acknowledge his advice. However, it is important to note that Dr B did not present hysterectomy as a viable option at that time. Instead, he told Mrs A that her case would require further discussion in an MDM and consensus from different consultants before they could proceed with hysterectomy. However, there is no evidence to support that this was a requirement.

60. I consider that Dr B failed to inform Mrs A that her case did not *require* presentation to an MDM or the need for consensus in order to proceed with a hysterectomy. It appears that hysterectomy was an available option, irrespective of the need for MDM or consensus. In my view, this is the kind of information that a reasonable person in Mrs A's circumstances would expect to receive, particularly as she specifically requested a hysterectomy.

61. Further, I am concerned by Dr B's general approach to the question of a hysterectomy. I consider that Dr B did not approach the discussion around hysterectomy with an open mind, or give sufficient consideration to Mrs A's particular circumstances — those being that Mrs A had completed her family; she understood well that a hysterectomy was irreversible and would cure her bleeding but there would still be a small chance that her pain would persist;

[24] Dr Dover also raised concern that the 'small chance' that pain would persist after a hysterectomy was perhaps not that 'small' given the context of chronic pelvic pain.

and that she had considered this option for some time and was very clear about what she wanted.

Mirena

62. Mrs A told HDC that she had declined a Mirena on multiple occasions, and she felt that at the 17 August 2020 appointment Dr B 'verbally coerced' her into agreeing to a Mirena insertion. Her understanding from the conversation with Dr B was that he would present her case to the MDM only if she tried a Mirena, and that if she did not agree to try a Mirena, Dr B would not consider a hysterectomy. Mrs A stated:

> 'He promised me that if I tried the Mirena for a period of three months he would present my case to a Board of gynaecologists in [the area] to talk about my hysterectomy. I was essentially being blackmailed into agreeing to a form of medication I did not want, for if I refused he wouldn't even entertain the idea of a hysterectomy. I begrudgingly accepted.'

63. Dr B told HDC that Mirena insertion was not a prerequisite for discussing Mrs A's case at the MDM, but he believed that a Mirena would likely have been recommended if it had not already been trialled. In relation to a possible MDM consideration of her case for a hysterectomy, Dr B documented: 'Obviously, having not tried the Mirena will make agreeing to this more difficult.' He also documented that after a long discussion, they agreed to trial a Mirena, with the hope that it would settle the bleeding and improve the pain and Mrs A's quality of life. Dr B told HDC:

> 'When I offered a mirena insertion I was hoping to help [Mrs A] with her pain, and bleeding as potentially ongoing conservative treatment, and not as a temporary measure or to facilitate the hysterectomy request. Mirena is considered one of the successful treatment options for pain, and bleeding and has worked extremely well for many of our patients.'

64. Dr Dover advised:

> '[Mrs A] had already had a laparoscopy with excision of some endometriosis and had been managed medically on the contraceptive pill. I suspect many clinicians would move next to the Mirena coil as an option and would perhaps have considered adding in some adjuvant hormonal therapy to deal both with the pain and with the bleeding. I think that would be a fairly mainstream practice.'

65. Dr Dover agreed that if a Mirena had not already been trialled, this would have been the most likely recommendation from the MDM. He stated, from a personal perspective:

> '[I]t is entirely reasonable to trial the use of a Mirena coil before going down the route of definitive surgery, particularly in someone [of this age]. There is a real chance that there may be a degree of regret in the future.'

66. Dr Dover advised that Dr B's rationale would have been to, in theory, remove one of the perceived barriers to the MDM agreeing to a hysterectomy.

67. However, Dr Dover also advised that most gynaecologists would not feel that it would be mandatory for patients to have trialled a Mirena before proceeding with a hysterectomy, as there may be several 'very valid reasons' why patients would not want a Mirena, and as such it could be reasonable to move directly to a surgical option. He stated that the trialling of a Mirena should not preclude going down the route of a hysterectomy. Dr Dover advised:

> 'I think we also need to be careful that as individual clinicians we are there to advocate for the individual patient whom we are seeing, who may have very valid reasons for not wanting to go down that route.'

68. Dr Dover said that even in the case that an MDM recommendation was made for Mirena to be trialled, the presenting clinician should perhaps have some degree of 'push back' towards the MDM. Dr Dover stated:

> 'I think it's very reasonable to present the case for advice and second opinion, and a degree of peer review, and to act as a sounding board for ongoing management. I suspect, however, there must always be the option for each individual clinician to choose not to follow the advice that has been given.'

69. I accept Dr Dover's advice that the MDM would have likely recommended trialling a Mirena if it had not been done already, and that it is entirely reasonable to suggest trialling the use of a Mirena coil before going down the route of definitive surgery. Therefore, I consider that it was reasonable and appropriate for Dr B to recommend a Mirena to Mrs A. However, it is my view that the information Dr B provided to Mrs A about trialling a Mirena made it seem that this was a prerequisite to her case being presented at an MDM, and subsequently to proceed to hysterectomy.

70. Considering that there was no requirement for Mrs A's case to be presented at an MDM before proceeding to hysterectomy (as discussed above), and Dr Dover's advice that most gynaecologists would not feel that trialling a Mirena is a prerequisite to hysterectomy, it is my view that there was no requirement for Mrs A to trial a Mirena before proceeding to hysterectomy, and that Dr B failed to provide this information to Mrs A. I consider that this is the kind of information that a reasonable person in Mrs A's circumstances would expect to receive, particularly given that at the beginning of the appointment, and on multiple previous occasions, Mrs A had clearly expressed that she did not want to trial a Mirena.

Summary

71. It is my view that Mrs A had a right to receive an explanation of the available option of a hysterectomy. Dr B acknowledged that he was not entirely inclined to offer the option of a hysterectomy. He told Mrs A that her case needed to be presented to an MDM and receive a consensus from consultants before progressing to a hysterectomy, and that having not tried a Mirena would make a consensus to a hysterectomy more difficult. In response to the provisional opinion, Dr B's legal representative stated:

> 'While there may be no evidence that bringing a case to an MDM, or considering the option of a Mirena, are pre-requisites to proceeding to a hysterectomy, these options are entirely reasonable to present to a patient in the circumstances. This much is

> reinforced by Dr Dover, and by [Dr B's] colleagues. We do not accept that [Dr B] presented these options as a pre-requisite, but rather as a strong recommendation.'

72. From the evidence available to me, Mrs A did not understand that a hysterectomy was an option available to her, and she left her consultations with Dr B believing that it required discussions at an MDM, and then a trial of a Mirena before this option would be entertained. I therefore do not accept that Dr B presented the options as a strong recommendation rather than pre-requisites. While I accept that these were reasonable steps to consider, my concern is around the information given and how this was communicated to Mrs A. In the circumstances, there was no requirement to go to MDM or to try a Mirena before proceeding with a hysterectomy. In my view, a reasonable consumer in Mrs A's circumstances would have expected to receive an explanation of a hysterectomy as an available option, and I am not satisfied that it was presented as an available option. By failing to discuss this information with Mrs A, Dr B breached Right 6(1)(b) of the Code.

73. In addition, by failing to discuss with Mrs A that there was no requirement to trial a Mirena before proceeding to hysterectomy, Mrs A was unable to make an informed choice and give informed consent to the Mirena insertion, and therefore I consider that Dr B breached Right 7(1) of the Code.

Answers to questions about MDM — breach

74. Dr B presented Mrs A's case at the endometriosis MDM at the public hospital on 2 September 2020. The MDM recommended:

> 'Next option would be zoladex and add-back [hormone replacement therapy]. Would need a clinical psychology review and a second opinion from another gynaecologist before proceeding with a hysterectomy.'

75. In the notes from the appointment following the MDM (28 September 2020), Dr B documented that the consensus from the MDM was 'not to proceed with a hysterectomy at this age', and that he discussed the recommendations with Mrs A, and she was accepting of them.

76. Mrs A stated that she asked Dr B about the outcome of the MDM and 'he casually replied that he had asked them and they said no'. Mrs A told HDC that she was skeptical that Dr B had taken her case to the MDM at all, given that she received nothing in writing and no further information than this. Mrs A has no recollection of the MDM recommendations being discussed. She told HDC that if this option had been presented to her, she would have wanted to pursue a second opinion.

77. In response to the provisional opinion, Dr B's legal representative stated: '[Mrs A] would have been aware, as most consumers are, that she was entitled to obtain a second opinion from another practitioner at any point.' This comment is concerning. Providers should not assume that consumers are aware of all their options, and it does not discharge them of their obligation to inform them of those options.

78. Dr B stated that he agrees that a second opinion would have been beneficial. However, he said that when Mrs A asked about a second laparoscopy at this appointment, he felt that they had reached an agreement on a plan going forward, and that 'a second opinion might just cause a delay, as [he] felt a second clinician would likely agree with [their] plan'.

79. Dr Dover agreed that organising a second opinion would have slowed down the procedure, but said that equally, the pathology and symptoms in question were a quality-of-life issue rather than a life-threatening one, and the offer of a second opinion may or may not have been something that would have been taken up.

80. Dr Dover advised:

> 'I have no reason to doubt that the case was presented [to the MDM]. My comments relate, based on the information and the comments made by [Mrs A], … that the way in which the information was passed on could perhaps be improved. Certainly from [Mrs A's] perspective she seems to have some mistrust, … and stated in her complaint "I struggled to believe that he took my case to the Board at all."
>
> Again, without having been present, it is very difficult for me to decide what has or hasn't happened, but it certainly appears that there is perhaps some potential for the channels of communication to be improved.
>
> A reasonable suggestion would be for the specialist to write to the patient concerned immediately following the meeting with a short note, such as "I discussed your case at the Board today and the recommendation was … I would be very happy to discuss this with you at our next appointment on …".'

81. The MDM recommendations are not specifically documented anywhere in Dr B's notes from this appointment, and there is no mention of them being progressed. Dr B did refer Mrs A to a psychotherapist, although this was for chronic pelvic pain rather than a clinical psychology review with a view toward hysterectomy. In response to the provisional opinion, Dr B said:

> 'I did discuss the recommendations of the MDM with [Mrs A], as noted in my clinical letter. I acknowledge that I could have elaborated further about the details of the conversation in my clinical letter.'

82. Dr B said that when discussing the outcome of the MDM, Mrs A asked if a second laparoscopy would be a possible approach, and he believed it was an appropriate next step, and so he offered her this option.

83. On the balance of probabilities, it remains my view that Dr B did not inform Mrs A of the MDM recommendations accurately, given that Mrs A has no recollection of the MDM recommendations being discussed. She does recall that Dr B advised that the outcome of the MDM discussion was 'they said no' to a hysterectomy. There was no specific mention of the MDM recommendations in Dr B's documentation of this appointment. In addition, the documentation in the clinical record states that the consensus from the MDM was 'not to

proceed with a hysterectomy at this age', when in fact the MDM recommendation was for medication and then a second opinion and clinical psychology review ahead of considering hysterectomy. Further, there is no evidence of the MDM recommendations being progressed. Mrs A stated that if the option of a second opinion had been presented to her, she would have wanted to pursue this.

84. I accept Dr Dover's advice that organising a second opinion would have slowed down progress toward a second laparoscopy, but equally that this was a quality-of-life issue rather than a life-threatening one. Mrs A should have been informed of the MDM recommendation for a second opinion so that she could choose whether to proceed with the second opinion or the laparoscopic surgery. I do not accept that because most consumers are aware of being able to seek a second opinion, this meant that Dr B did not have to tell her about this option recommended by the MDM.

85. I consider that Dr B did not provide Mrs A with honest and accurate answers to her questions about the outcome of the MDM, and, therefore, I find that Dr B breached Right 6(3) of the Code.

Information on positioning and use of instruments vaginally during laparoscopic surgery — other comment

86. Mrs A told HDC that she was not informed before the operation of 23 November 2020 that she would be placed in the lithotomy position or that instruments would be used vaginally to mobilise the uterus. She felt that she should have been informed of this and her consent requested.

87. There is little recorded information on what was discussed with Mrs A preoperatively. The 'agreement to treatment form' signed by Mrs A states that the risks discussed were infection, bleeding, and damage to organs (bowels, bladder, uterus). There was no mention of positioning, a potential risk of nerve damage from being in the lithotomy position, or that instruments would be used vaginally.

88. Dr B stated:

> '[Mrs A] was unaware that laparoscopic Gynaecological procedures are normally performed while patients are positioned in the lithotomy position. This position allows the operating surgeon to access the deep pelvis and facilitates mobilizing the uterus.'

89. Regarding the lithotomy position and the risk of nerve injury, Dr Dover advised that it is an uncommon but clearly recognised complication of surgery. However, Dr Dover also advised that it is not in his own, nor any of his professional partners' practice, to warn patients about this specifically. Dr Dover does not think that failing to mention the specific possibility of a nerve injury would be considered a deviation from standard practice.

90. Dr B has apologised for not discussing with Mrs A preoperatively that laparoscopic gynaecological procedures are normally performed while patients are positioned in the lithotomy position, and he said that in future he will explain this to his patients.

91. Dr Dover advised that although it would be reasonable to expect a preoperative general discussion about how the laparoscopy would be performed, he is 'not convinced' that it is routine practice to inform patients that instruments are inserted vaginally to help manipulate the uterus during surgery. Dr Dover also noted that the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) information sheet on laparoscopy does not mention this.

92. I am critical that Dr B did not inform Mrs A about the use of instruments vaginally during laparoscopy. The fact that instruments would be used vaginally was important for Mrs A to know preoperatively, noting that her expectation was to undergo a procedure involving incisions in the abdomen. Mrs A should have been informed about what was going to happen during the laparoscopy, especially when instrument insertion and sensitive areas are involved. However, I acknowledge Dr Dover's advice that it is not routine practice to inform patients of the use of instruments vaginally during laparoscopy. I also acknowledge that this information is not included in the RANZCOG information sheet on laparoscopy. These factors mitigate my criticism of Dr B in this matter.

93. However, I am critical that the RANZCOG information sheet does not include information that instruments are routinely used vaginally to manipulate the uterus during laparoscopic surgery, and the lack of guidance from RANZCOG regarding the need to inform patients of this. As stated above, patients should be informed about what is going to happen during laparoscopic surgery, especially when instrument insertion and sensitive areas are involved. I consider that the use of instruments vaginally is information that a reasonable consumer in these circumstances would expect to receive, and therefore, as set out in Right 6(1) of the Code, it is information that needs to be provided to patients.

94. As such, I have made a recommendation for RANZCOG to review its guidance to practitioners (including information sheets), to ensure that there a clear expectation for patients to be informed whenever instruments will be used vaginally.

Standard of care regarding positioning during laparoscopic surgery — other comment

95. Dr B stated that this was the second time in his career that he had encountered nerve damage secondary to lithotomy positioning. The previous instance was about eight months previously in March 2020. Dr B stated that he teaches his registrars and fellows that the patient's positioning is primarily the surgeon's responsibility, and his usual practice is to review the position of the patient before scrubbing for surgery. Dr B documented in a letter to Mrs A's physiotherapist that he was 'pretty sure' she was positioned correctly during the surgery on 23 November 2020.

96. Dr B told HDC that since these incidents he has been 'more vigilant about positioning [his] patients'. He understands that it is unlikely to be possible to eliminate the risk of this complication completely but said that correct positioning and shorter operating times reduce the risk.

97. Dr Dover advised that this complication is an uncommon but known risk. He raised no concern with the standard of care in this case in relation to this complication. In response

to the provisional opinion, Dr B stated: '[C]onsidering the variations in normal anatomy, nerve entrapment is a complication that will not be preventable in every patient, despite standardised positioning.'

98. I acknowledge Dr Dover's advice, and unfortunately I am not in a position to make a finding as to whether or not Dr B positioned Mrs A correctly. I recognise that nerve damage from positioning is a risk of laparoscopic surgery, and it is very unfortunate that it is a complication Mrs A suffered. However, the fact that Mrs A experienced this complication is not sufficient evidence for me to conclude that she received inappropriate care.

Standard of care regarding Mirena insertion — other comment

99. Mrs A told HDC that she had declined a Mirena on multiple occasions, but following a lengthy discussion with Dr B on 17 August 2020, she agreed to the procedure. At the same appointment, Dr B attempted to insert the Mirena. Mrs A described the attempted insertion as 'the single most painful thing [she had] experienced'. She stated: 'I was screaming and writhing in pain clinging to the hand of my husband begging for it to be over.' Dr B documented that Mrs A 'did not tolerate the procedure', and he booked her for an insertion under general anaesthetic the following day at a local hospital. Dr B told HDC that he is sorry that Mrs A experienced significant pain and distress during the attempt and stated that he always asks his patients to tell him to stop if the procedure is not tolerable, and he abandoned the procedure when Mrs A asked him to stop.

100. Dr Dover advised that with the benefit of hindsight, it may have been better to delay the Mirena insertion. He said that in patients with a history of two Caesarean sections, such as Mrs A, cervical dilation could be more difficult and, in those cases, medication can be given an hour or two before the procedure to soften the cervix and facilitate the implantation. Dr Dover advised that taking that approach also would have allowed more time for Mrs A to reflect on her decision and be certain that she was comfortable to go ahead.

101. I recommend that Dr B take this advice into consideration for the future.

Changes made since events

102. Dr B apologised that preoperatively he did not specifically discuss with Mrs A the positioning that would be used during surgery. He stated that this was a good learning experience and that he will explain positioning to patients in future.

103. Dr B told HDC that since these events he has been more vigilant about positioning his patients. He said that during his weekly operating lists he has taught his fellows and other training registrars at the public hospital the correct positioning of patients for laparoscopic procedures, and he includes this in the annual workshops he facilitates with other advanced laparoscopic surgeons in the department.

Recommendations

104. I recommend that Dr B:

a) Provide a written apology to Mrs A. This should be sent to HDC, for forwarding to Mrs A, within three weeks of the date of this report.

b) Re-familiarise himself with the Medical Council of New Zealand's Good Medical Practice publication and statements on communication and consent, particularly on the expectations of adequately documenting treatment discussions and working in partnership with patients (and colleagues). A written reflection on the learnings and how these will be applied in practice are to be provided to HDC within three months of the date of this report.

105. In the provisional decision, I recommended that Dr B consider Dr Dover's suggestion to write to the patient concerned immediately following an MDM with a short note stating what was discussed and what was recommended, and to advise that this could be discussed at the next appointment. In his response to the provisional decision, Dr B accepted that providing Mrs A with a written letter of the recommendations immediately after the MDM may have been a more appropriate way of communicating. He stated: 'I will definitely adopt this practice in future.' I therefore consider this recommendation to have been met.

106. In the provisional decision, I recommended that RANZCOG consider a review of:

a) The information sheet for laparoscopic surgery, to include information that patients may be placed in the lithotomy position and instruments may be used vaginally; and

b) Its guidance to practitioners, to ensure that there is a clear expectation for patients to be informed whenever instruments will be used vaginally.

107. In response to this recommendation, RANZCOG advised that its Women's Health Committee agree that it should be standard practice for medical practitioners to inform women of the likely position (eg, supine, lithotomy) as part of the consent process for their procedure. Further, it agreed that it should be standard practice to inform women that they may have some type of vaginal instrumentation placed during the procedure. RANZCOG advised HDC that it will update its patient information pamphlet on laparoscopy to include:

a) Potential use of vaginal instrumentation during laparoscopy;

b) Potential to be placed in a lithotomy position;

c) Risk of nerve injury as a common complication of laparoscopic surgery, in particular, injury to nerves of the entry abdominal wall; and

d) Standard RANZCOG advice on informed consent.

108. RANZCOG advised that it will share this update with its members, draw their attention to the above guidance of the Women's Health Committee, and report back to HDC within six months of the release of this report.

Follow-up actions

109. 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. It will be advised of Dr B's name in covering correspondence.

110. A copy of this report with details identifying the parties removed, except the advisor on this case, will be sent to Health New Zealand|Te Whatu Ora and RANZCOG, and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to Commissioner

The following advice was obtained from obstetrician and gynaecologist Dr Richard Dover:

'Thank you for your letter of instruction dated 6 May 2022 in which you have requested that I provide my opinion on the care provided by [Dr B] to [Mrs A] from June 2019 to January 2021.

My qualifications and experience
I can confirm I am registered with the Medical Council of New Zealand in the vocational scope of practice of obstetrics and gynaecology. I am a Fellow of the Royal College of Obstetricians and Gynaecologists and a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG).

I am a full time practising private gynaecologist working out of Oxford Women's Health based in the Forte Hospital complex in Christchurch. I am currently the Clinical Director of this unit.

I have been based in New Zealand for over 20 years, initially working in private practice and through the CDHB. I have been employed solely on a private basis for the last 14 years.

In the past I have served two terms on the RANZCOG New Zealand committee and have been an examiner for the RANZCOG final exam for over 12 years.

I have been involved in practice visits for both the Medical Council and the Royal College.

Documentation considered and relied upon
In formulating my response I have read the documents provided and indices as 1 through to 5 on your letter of introduction.

I am aware, however, that the terms of reference for the expert advice are directed to two separate occasions, firstly the consultation in August 2020 and secondly the repeat laparoscopy in November 2020.

Even though specific comment is directed to two areas of the ongoing care I think some form of summary is beneficial.

CLINICAL LETTERS FROM DR B
[Dr B] first saw [Mrs A] on 17 June 2019. The documentation states that she was referred with some problems with her periods *"mostly heavy and painful"*. She had been started on a contraceptive pill which had worked well until she'd had a significant degree of break through bleeding.

Based on the history [Dr B] organised a diagnostic laparoscopy as part of an investigation of endometriosis.

There was no real consideration for any alternative options with regard to the management of her heavy bleeding. Although the pill had worked [Mrs A] had recently had, what was described as, "*massive, heavy, break through bleeding that lasted for more than one week".*

It was, however, explained to [Mrs A] that treatment for the endometriosis would be targeting the pain but may not help with the heaviness of the period. It seemed that [Mrs A] was happy to continue with the pill if that was the case.

The laparoscopy was performed on 19 August 2019 when endometriosis was identified and surgically removed from the pelvis. From reading follow up correspondence it does seem that the presence of the disease was confirmed histologically.

[Mrs A] came through for a follow up consultation in May 2020, approximately 9 months following the surgical procedure. It seemed that she had become pain free four months after the operation, had a couple of months of respite and at that point had noticed ongoing pelvic pain.

A recommendation was made to switch to a different contraception pill and the possibility of a second surgical procedure was raised, as were the options of the use of pain modulators.

There was a further follow up consultation on 21 July 2020. It appeared that the symptoms seemed to be reasonably well controlled, however the amitriptyline made her sleepy and it was switched to an alternative preparation. Further discussion was had about the pathophysiology of chronic pain.

There was a third follow up appointment on 17 August 2020. The main problem at that point was that [Mrs A] seemed to have been bleeding continually with the Cerazette and was also undergoing a significant amount of pain, which was occurring daily. The letter states "*she was very emotional today and she and her husband are very determined that she wants a hysterectomy".* Discussion was had with regard to this, although the points that were discussed, other than the fact that it was irreversible, are not documented. There was a further discussion with regard to the Mirena and a comment that the option of hysterectomy would need to be referred up to an MDM meeting.

After some discussion, [Mrs A] agreed to have a Mirena inserted but this was unsuccessful and it was performed the following day under general anaesthetic.

[Dr B] documents that he will refer the case through to the MDM and also states very clearly that the hysterectomy will "*definitely sort out the bleeding: however, there is a small chance that the pain could persist".* It seems that [Mrs A] understood this but thought this was the best option to improve her ongoing symptoms.

On 28 September a further follow up was arranged and [Mrs A]'s husband was also present. It seemed that the Mirena had not helped and had caused a number of side

effects, particularly bloating, mood and skin issues and had not really helped with the pain. The Mirena was removed and discussion undertaken with regard to introducing a different form of pain relief and using a mini pill for contraception.

There also appeared to be discussion about the decision from the MDM, where the consensus was that hysterectomy was not appropriate. According to documentation [Mrs A] raised the role of a second laparoscopy and was told that was still an option.

The other issue discussed was a referral through to a pelvic floor physiotherapist and a psychotherapist to deal with chronic pelvic pain.

A repeat laparoscopy was performed on 23 November and evidence of recurrent endometriosis was documented and excised. Five areas had a surgical excision, two of which were positive and three of which were negative.

On 30 November at the time of the first follow up visit (histology was not yet back at this time) the issue of the numbness on the upper lateral part of the right thigh was raised. The documentation suggests that this was explained to [Mrs A] and she was told that there was a 90% chance that this would resolve spontaneously.

The final appointment appears to be on 21 December, where the correspondence suggests she was feeling better and her pelvic pain had improved significantly apart from one small area. A prescription for a significant amount of tramadol was given and an appointment made for four months to organise further follow up. No comment or documentation was made at that time with regard to the numbness on the leg.

NOTES FROM MULTIDISCIPLINARY TEAM MEETING

I've reviewed the documentation regarding the gynaecology multidisciplinary team meeting. This documents the people who were present and four out of 20 gynaecologists were present, one of these being [Dr B]. Some adjuvant staff were also present.

On the form it states that the question for the MDM was "*patient requesting hysterectomy for ongoing pain and AUB".* When the history was documented it again touches on the fact that the patient was "*very distressed, requesting hysterectomy for ongoing AUB".* The recommendation from the committee was that the next option would be ovulation suppression with add back hormone and that a clinical psychology review and a second opinion from a gynaecologist would be needed before proceeding to a hysterectomy.

ANSWERS TO SPECIFIC QUERIES (EXPERT ADVICE REQUESTED)

1. ***The care provided by [Dr B] in August 2020 in response to pelvic pain and menorrhagia management:***

a) With regard to this there are two areas that should be looked at, one is the management of the pain and one of the management of the heavy bleeding.

At the time of this consultation [Mrs A] had previously been on Ginet and had switched through to the Cerazette which had led to some continuous bleeding and a recurrence of pain. She therefore switched back to the Ginet which she appeared to be taking at the time of the consultation. At that point she was still bleeding and in constant pain. The documentation suggests that there was a significant discussion about the pros and cons of the Mirena. It is clear from the letter that [Mrs A] had not been agreeable to this in the past but it does seem that her position changed and she agreed to have it inserted.

The documentation discusses hysterectomy and referral through to the MDM but there is a suggestion that having tried a Mirena, would potentially make the decision of the MDM group a little more straightforward and there is the potential interpretation that [Mrs A] felt that undergoing a Mirena insertion would facilitate either a hysterectomy or favourable decision from the MDM meeting.

b) Discussions with the patient about a hysterectomy procedure;
I think it is difficult to comment on the discussion that was undertaken as the documentation in the letter through to the GP is scant.

It is very clear that [Mrs A] and her husband were keen for a hysterectomy on the basis that she thought that this would deal with her pain and with her bleeding. It is certainly very clear that it would deal with her bleeding conclusively but the impact on the pain would be much less clear cut.

The discussion seemed to be based on convincing [Mrs A] to "convince them to re-think that option as it is obviously irreversible". There certainly is no documentation about the benefits that she would have accrued from the hysterectomy and then these could have been weighed against the disadvantages that, at [Mrs A's] age … may well be significant.

It is clearly stated that [Dr B] would feel uncomfortable proceeding directly to a hysterectomy without exploring the options with colleagues and he suggested that the case was referred through to the multidisciplinary meeting.

With regard to the specific features I think that it is difficult to come up with a definitive outcome.

I would feel that most gynaecologists would not rush to offer hysterectomy to a woman of [Mrs A's] age. Equally, I feel that this option should not be withheld purely on the basis of age and that ongoing discussion about it, particularly after counselling and perhaps a second opinion, would make this a reasonable option to discuss openly.

It is a little unclear at the time as to the dominant symptom and clearly there did seem to be an element of both pain and bleeding.

[Mrs A] had already had a laparoscopy with excision of some endometriosis and had been managed medically on the contraceptive pill. I suspect many clinicians would

move next to the Mirena coil as an option and would perhaps have considered adding in some adjuvant hormonal therapy to deal both with the pain and with the bleeding. I think that would be a fairly mainstream practice.

The difficulty here is that [Mrs A] was reluctant to go down that route but following discussion acquiesced and felt that the use of a Mirena was an appropriate intervention.

There is, however, a lingering impression that this was perhaps not a freely made decision and from reading the letters it could be interpreted that there was some linkage between having the Mirena inserted and the outcome of referral through to the MDM. I think it is also fair to say that [Dr B] was aiming to undertake all forms of conservative management before embarking on definitive surgery that could lead to some form of post operative regret. He had also clearly thought of issues with regard to pelvic pain and had actually touched on this in his previous consultation. I note, even though it relates to the following consultation in September, that this aspect is looked at more thoroughly and an assessment with a pelvic floor physiotherapist and a psychotherapist are recommended.

Overall I think the management and the options that were offered were very reasonable and I think would be generally supported by our peers.

My one concern relates to the function and role of the MDM, which did not seem to be used with any degree of openness and transparency and indeed from reading [Mrs A's] notes she was uncertain as to whether her case had ever been referred. Clearly there is a disconnect between what happened and what was communicated and this can clearly be improved in the future.

The multidisciplinary meeting seemed fairly well organised with a good proforma. I note, however, that of the gynaecologists listed only four were present and [Dr B] was one of these. There was no documentation about what would be a required quorum of the group before the meeting nor is there any documentation about the information that was given to the group and indeed whether the recommendation that was decided upon was a consensus opinion or whether there were dissenting views. It also seems that very little of this was fed back to [Mrs A].

I think that moving forward the transparency relating to the MDM could be improved and I also think there would be some benefit in offering patients the option of a second opinion with an independent colleague. This would certainly give the patient the option of meeting someone face to face, telling their story and describing the impact that their symptoms are having on their lives and knowing that the information has been presented passionately to an independent observer. I certainly think that would be viewed as a far more open and transparent system than the more closed door MDM meeting.

c) The decision to treat using the Mirena following this consultation, taking into account [Mrs A]'s request not to have internal birth control treatments;

The documentation in the notes does suggest a degree of discussion about Mirena and that [Mrs A] changed her mind and was agreeable to this.

In the clinical context inserting a Mirena would be a good option to deal with both her pain and bleeding.

With hindsight, it may have been an error to try to insert it at the time. I note [Mrs A] had had two caesarean sections in the past and this can sometimes make dilatation of the cervix more difficult. Often in these cases misoprostol can be taken an hour or two before surgery to soften the cervix and facilitate the introduction. This may well have meant that the attempted insertion under local anaesthetic may have had a higher chance of success and the need for insertion under general anaesthetic may have been avoided.

Again, and perhaps with the benefit of hindsight, rescheduling that for another day to allow the medication to be given would also have separated out the discussion with regard to the Mirena and the insertion itself and could perhaps have been interpreted as giving some time for reflection perhaps by [Mrs A], to be certain that she was comfortable to go ahead with the procedure.

d) Whether in your experience, evidence of contraception use (such as a Mirena) would be needed or beneficial for a patient under 40 prior to considering them for a hysterectomy;

I think this is a difficult point to answer as the answer to this question may not relate directly to [Mrs A]'s case.

I am sure most gynaecologists would not feel that it would be mandatory for patients to have trialled and been unsuccessful with a Mirena before moving through to a hysterectomy. There may be a number of reasons why patients would not want to use a Mirena and as such it would be very reasonable to move directly to a surgical option rather than moving through what may have seemed like an interval procedure such as a Mirena insertion.

The corollary to this of course is that the Mirena is a very good option and that any discussion with these patients should include the Mirena as a viable option. There will clearly be a number of patients, however, who do not wish to go down this route and wish to aim for a definitive surgical option as this is the only one that will guarantee they will never bleed again. At the age of 40 patients would need at least two Mirenas and they may feel that is not an option they wish to exercise.

e) Any other comments I wish to make regarding this consultation;

No comments.

2. The care provided by [Dr B] surrounding the second laparoscopy in November 2020:

a) Completing a second laparoscopy;

[Mrs A] had surgery in August of 2019 and had what sounds like a reasonably extensive excision. At that point endometriosis was removed from a significant area of the posterior compartment.

Following this there were issues with ongoing pain that failed to settle and a number of conservative options were trialled.

In view of the extensive resection at the time of the first procedure it would be very reasonable to have considered some scarring as a result of that as a potential causative pathology. Adhesions/scarring would not show up on ultrasound scanning or with any imaging and I think in view of the failure of [Mrs A] to respond a repeat laparoscopy was a very reasonable option.

b) What discussions should have taken place;
Prior to surgery it would be reasonable to expect that a general discussion about how laparoscopy would be performed should have been undertaken. This should certainly have described the use of a number of laparoscopic ports in the abdomen. This discussion would be verbal.

It would be reasonable to expect that the patient would have been given the RANZCOG handout on laparoscopy.

I am not convinced that it is routine practice for everyone to describe the fact that instruments are inserted into the uterus to help manipulate this and to facilitate vision at the time of surgery. I accept that some specialists may discuss this with their patients but I am confident that a significant number, including myself, do not. Any discussion about this I expect would be verbal rather than written.

Review of the RANZCOG information sheet does not make any mention of instruments being placed inside the vagina to facilitate its movement and to improve visualisation within the pelvis.

I would have expected routine discussions about return to work, analgesia etc.

c) Potential risks of surgery;
I would have expected that the general and the specific risks of surgery would be discussed. The generalised risks clearly include bleeding, thrombosis and infection and the specific ones include the risk of damage to bowel, bladder and ureter. These are fairly standard complications and it would be expected that everybody would discuss these and I think it is important that these should be documented. They are also discussed and listed on the RANZCOG handout.

The issue of nerve injury is far less clear. It is an uncommon, although clearly recognised complication of surgery and indeed is listed as one of the possible complications of surgery on the RANZCOG information sheet. It is, however, very uncommon and it is certainly not my practice, nor indeed any of my professional partners' practice, to specifically warn patients about this.

There are other possible complications of laparoscopy that are listed on the back of the RANZCOG information sheet and I would certainly be very surprised if many gynaecologists worked their way through this list exhaustively. As such I do not think that failing to specifically mention the possibility of a nerve injury counts as any form of deviation from standard practice.

d) The post operative care provided;
[Dr B]'s letters show that he saw [Mrs A] a week after the surgery and the documentation seems like a fairly standard follow up consultation. Unfortunately the histology was not back and this is often the case seeing patients a week afterwards.

The third paragraph of the letter clearly describes the complication of the nerve damage and the fact that this would be expected to settle spontaneously. Indeed, most cases will respond within six weeks or so.

[Dr B] wrote through to … a physiotherapist updating her about what was happening and the fact that she would be seeing [Mrs A] to work on the chronic pain but also to ask her to look at any specific techniques that could be used to improve the sensation. At that point he organised a follow up appointment with himself and also asks specifically to be updated about the progress of [Mrs A]'s care. As such I think the standard of care exhibited in this regard was consistent with accepted practice and there was certainly no deviation or departure from this.

e) Any other comments;
I am not convinced that there are any additional comments that need to be made.

I think the rationale for a repeat procedure was very reasonable in view of the extent of the previous surgery. The operation notes describe what would be just a fairly standard, straightforward procedure and I think the issue relating to the nerve damage should be viewed as an uncommon complication that despite all of our best intentions will affect one of our patients at some point or another.

I am comfortable with the level of consenting that was done beforehand and certainly feel that most colleagues would not routinely describe or explain the use of uterine manipulators during the procedure.

3. Any comments you wish to make on any other aspects of [Dr B]'s care:

Having reviewed the notes and the patient journey I feel comfortable with the quality of care that [Dr B] provided.

I think based on the information I have been given it would be reasonable to suggest that at times there may have been a lack of clarity in the correspondence to the GP as to the extent and nature of the symptoms and I think, moving forward, separating out the symptoms and detailing them in perhaps more depth and the specific plans for each of them would be more useful.

It was certainly a little unclear at times as to whether the dominant symptom was pain or bleeding and a more distinct narrative about each of these may have made it slightly clearer as to what was hoped to be achieved. I think this is certainly important in the context of [Mrs A] and her desire for a hysterectomy as clearly there does seem to be ongoing problems with regard to heavy and prolonged bleeding and hysterectomy would clearly have dealt with this definitively.

I think there was a very clear recognition of the potential for a chronic pain syndrome and enlistment of adjuvant therapists in the form of pelvic floor physiotherapists, clinical psychologists and even the use of specific pain medication. This is clearly in line with some of the working groups and the guidelines they are putting out, particularly with regard to the development and fostering of a multidisciplinary environment.

As mentioned before, my obvious concern relates to the perhaps slight perception from the correspondence (I accept this may not have been absolute but certainly could be construed to being applied) that the insertion of a Mirena was necessary before consideration of hysterectomy or going through to the MDM. I have already put down my thoughts about the MDM and certainly think that process could be improved, or perhaps replaced with a consultation with a different gynaecologist in the form of a second opinion.

This certainly is a challenging area and I think all practising gynaecologists will have been faced with young women who wish to go down the route of definitive surgery and will be having to walk a tight rope of providing good clinical care, without going down a path that may lead to regret in the future. Clearly there is no right or wrong answer here and I do wonder whether [Mrs A]'s perception of this process would have been different had she had a chance to speak openly, frankly and possibly forcefully with a separate specialist.

With kind regards and best wishes,

Yours sincerely

Richard Dover
Obstetrician & Gynaecologist
BM, MRCPI, FRCOG, FRANZCOG
RD/dc'

The following further advice was provided by Dr Dover on 24 February 2023:

'Thank you for supplying me with [Dr B]'s feedback.

I have read through his comments and I have decided to respond to them all individually.

1. a) My difficulty, in this case, has been looking at the documented correspondence rather than listening into the conversations as they may have taken place. As such I have based my report on the written information that has been provided to me.

With regard to the insertion of the Mirena, I have on one hand, some information from [Mrs A]: "He verbally coerced me into having a Mirena inserted, even though I have stated on multiple occasions, that I don't want a form of birth control inserted into my body. He promised me that if I tried the Mirena for a period of three months he would present my case to a Board of gynaecologists in the … area to talk about my hysterectomy. I was essentially being blackmailed into agreeing to a form of medication I did not want, for if I refused he wouldn't even entertain the idea of a hysterectomy. I begrudgingly accepted."

On the other hand, I have correspondence from [Dr B]: "I have spent a long time with the couple today in my rooms, trying to convince them to re-think that option, as it is obviously irreversible. I have re-explored the Mirena option again. Initially [Mrs A] was not agreeable to the Mirena option; however, I explained that offering a hysterectomy at [her] age … is a case that will need to be discussed in the Endometriosis MDM and will need to have some consensus from different consultants to agree to offer this kind of treatment at this age. Obviously, having not tried the Mirena will make agreeing to this treatment more difficult. After a long discussion, we have agreed to give the Mirena a go, hoping it will settle the bleeding and improve the pain, as well as the quality of life; however, she wanted me still to discuss her case in the Endometriosis MDM at [the public hospital] to get some consensus that if the Mirena did not help, we can offer a hysterectomy for [Mrs A]. I have agreed to this and have tried to insert a Mirena today in my rooms; however [Mrs A] was very sensitive and did not tolerate the procedure so I had to abandon this today. We have decided to have a Mirena insertion under a general anaesthetic tomorrow at [the private hospital]."

It is obviously very difficult, from my perspective, to work out which one of these statements is most accurate.

From a personal perspective I would like to add that I think it is entirely reasonable to trial the use of a Mirena coil before going down the route of definitive surgery, particularly in someone [of Mrs A's age]. There is a real chance that there may be a degree of regret in the future. I am also comfortable that it should not preclude going down the route of a hysterectomy.

I have personally been involved with MDM meetings and I fully agree with [Dr B] that the most likely decision from the Multidisciplinary Meeting would be a recommendation that a Mirena should be trialled, before proceeding to hysterectomy. [Dr B's] rationale here is that by going down this route it eliminates one of the potential options that the MDM meeting could come up with and, in theory, should remove one of the perceived barriers to them agreeing to the option of a hysterectomy.

Again, from having been involved in MDM meetings I understand this is how things will work, but I think we also need to be careful that as individual clinicians we are there to advocate for the individual patient whom we are seeing, who may have very valid reasons for not wanting to go down that route. As such, the presenting clinician should perhaps have some degree of "push back" towards the MDM meeting. I think we also need to look at what level of commitment there is to the MDM outcomes and whether or not any individual clinician is bound to follow them. I think it's very reasonable to present the case for advice and second opinion, and a degree of peer review, and to act as a sounding board for ongoing management. I suspect, however, there must always be the option for each individual clinician to choose not to follow the advice that has been given.

1. b) I am again basing my comments on the letter from 17 August 2020. This does mention that the hysterectomy will sort out her bleeding, but it describes "a small chance that the pain could persist".

b2) I think in the context of chronic pelvic pain the risk of ongoing pain is probably going to be higher than "small". I am also aware that this was not a formal counselling or consenting appointment, where issues such as the inability to have further children, other than via surrogacy would perhaps have been used.

With regard to the second point in 1b2, I think both [Dr B] and myself are broadly in agreement on this point. Answering specifically, I think that in an ideal world the use of alternative medical options such as Mirena hormonal therapy et cetera, should be used before going to definitive surgery. I think it's clear that [Dr B] and I agree on this. Personally, I would not view those as an absolute contraindication but under those circumstances, would feel comfortable with a second opinion from one of my colleagues, and an assessment by a psychologist.

Again, from a personal experience, I think we need to be quite careful that we do not become overly patriarchal and viewed from a different perspective, we are discussing the case of a [young] woman who already has two children.

1. b3) With regard to clarification of the symptoms, this suggests that the role of hysterectomy would deal with one of her symptoms but clearly the issue is about what degree of pain she may have afterwards.

1. b4) I think there is an increasing move towards MDM meetings and I think they have some value. There is the potential risk that they will lead to everybody practising in a similar way (this may not be a bad thing), but there does perhaps need to be a degree of clinical override and I think perhaps a degree of transparency with the patient.

In this case, the team members present numbered four specialists, one of whom was [Dr B]. There are, however, 20 potential people put down on the list, which gives an attendance rate of the specialists of 20%. I note that their comments relate to the quorum being two specialists.

I am not looking to belittle the work that is done through these groups and I have no reason to doubt the claims regarding … the efficacy of this Board.

My comments relate to the passage of information from the patient via the gynaecologist, up to the Board.

Again, based on the complainant's notes, "at my next consultation I once again asked [Dr B] about the hysterectomy and presenting my case to this 'board of gynaecologists' he casually replied that he had 'asked them and they said no'." In contrast the letter from [Dr B] on 28/09/2020 states "as you are aware from my previous letter, [Mrs A] was requesting a hysterectomy for her pain and I promised to discuss that request at our Gynaecology MDM at the hospital; however, as expected, the consensus from the MDM was not to proceed with a hysterectomy at this age. I have discussed these recommendations with [Mrs A] today and she was accepting of this."

I have no reason to doubt that the case was presented. My comments relate, based on the information and the comments made by [Mrs A], which may be inaccurate, that the way in which the information was passed on could perhaps be improved. Certainly from [Mrs A]'s perspective she seems to have some mistrust, whether this was justified or not, and stated in her complaint "I struggled to believe that he took my case to the Board at all".

Again, without having been present, it is very difficult for me to decide what has or hasn't happened, but it certainly appears that there is perhaps some potential for the channels of communication to be improved.

A reasonable suggestion would be for the specialist to write to the patient concerned immediately following the meeting with a short note, such as "I discussed your case at the Board today and the recommendation was I would be very happy to discuss this with you at our next appointment on …"

With regard to comment 1c, I think I've touched on this in my earlier response to 1a.

2. Any comments you wish to make on other aspects of [Dr B]'s care:

Again, I suspect that our opinions are very close together.

We would also need to recognise that we are making these comments in retrospect.

I think my words were chosen carefully, "and I do wonder whether [Mrs A]'s perception of this process would have been different". This obviously means her perception and her feelings about the process, it does not necessarily mean that the clinical outcome would have altered. I also agree that organising a second opinion would undoubtedly have slowed down the procedure, but equally the pathology and symptoms in question were clearly of a quality of life issue rather than a life threatening one and the offer of a second opinion may or may not have been something that would have been taken up.

With kind regards and best wishes,

Yours sincerely

Richard Dover
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BM, MRCPI, FRCOG, FRANZCOG
RD/dc'