General Practitioner / Medical Trust

Report on Opinion - Case 98HDC11934

Complaint

The Commissioner received a complaint from the consumer about the care he received from the general practitioner at the medical centre. The complaint is that:

- *Between mid-September and early November 1997, the general practitioner failed to provide the consumer with vasectomy services of an appropriate standard.*
- *In particular, the complaint is that the general practitioner attempted on a date in early October and on a date in early November 1997 to perform a vasectomy on the consumer. Both attempts failed, resulting in tissue damage and pain to the consumer.*

Investigation

The Commissioner received the complaint on 13 February 1998, and an investigation was undertaken. Information was obtained from the following people:

The Consumer
The Provider/General Practitioner
The Chairman of the Medical Trust that owned the Medical Centre

The consumer's medical notes were obtained and reviewed by the Commissioner. The Commissioner sought advice from an independent general practitioner.

Information Gathered During Investigation

Between July 1997 and mid November 1997 the general practitioner was working as a locum at the medical centre in a town. At the time, he was the consumer's general practitioner.

In early September 1997 the consumer telephoned the medical centre to request a referral to a doctor who performed vasectomy operations. He was informed that the general practitioner was able to carry out this procedure, and that he should come into the surgery for a consultation.

On a date in mid-September 1997 the consumer visited the general practitioner and recalled the general practitioner assuring him that:

> *"He had performed many vasectomies, including himself. After the check he was satisfied that all was in order and to return when convenient."*

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Information Gathered During Investigation, *continued*

With respect to this, the general practitioner advised the Commissioner:

> *"I did not advertise to perform vasectomies but rather* [the consumer] *asked if I had performed vasectomies before, as this would save him from travelling to* [the city] *and paying higher Consultant prices, and I replied that I had, and then he asked if I would perform a vasectomy on him. I agreed to this, having experienced no major problems with vasectomies carried out in the past in* [another rural area and in another country while working for a voluntary organisation]. *I explained to him that nothing was ever absolutely guaranteed and that I would be sending any specimen I took for microscopic analysis, to double-check the results. He was satisfied by this".*

Further, the general practitioner advised he had done about twenty vasectomies prior to undertaking the consumer's vasectomy. The general practitioner also advised the consumer of the proximity of both urological and general surgeons for him to consult with for a vasectomy.

The First Procedure

In early October 1997 the general practitioner performed the vasectomy on the consumer with the assistance of his nurse. It appears from the clinical notes that a bilateral vasectomy was attempted, entering the scrotum on each side. The general practitioner stated the following about the procedure:

> *"The operation was carried out under local anaesthesia with* [the consumer's] *consent, and at operation both vas deferens were found to be very difficult to mobilise and very tortuous. I found it difficult to identify either vas in the vascular bundles. At the conclusion of the operation, because of the difficulty I was more determined to send the specimens to the laboratory".*

The consumer informed the Commissioner the operation took one hour and fifteen minutes and was extremely painful. The consumer stated that the general practitioner then asked him to return the next day so that he could inspect the wound. During the course of the operation the general practitioner unintentionally made a small extra cut on the left side of the scrotum.

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Information Gathered During Investigation, *continued*

The consumer returned the following day. The general practitioner inspected the site and according to the consumer *"had to place another stitch in the accidental cut"*.

Three days after the procedure had been performed the general practitioner telephoned the consumer to inform him that the microscopic analysis had established that the procedure had not been successful, and that the consumer should return the following week to have it performed again. With respect to this, the general practitioner stated:

> *"After the first failure I offered to send* [the consumer] *to a specialist surgeon in* [a city] *but because of the distance and my lesser charge, he chose for me to revisit the operation, which I did"*.

The consumer advised he was "*cagey*" about going back to the general practitioner a second time. He stated he could have gone elsewhere, but he had already paid for the vasectomy prior to the general practitioner starting the operation. Further, the general practitioner had not given him any indication that what had happened was anything out of the ordinary. The consumer added he was sure the general practitioner had not advised him he would be better to go to someone else.

The general practitioner informed the consumer that:

> *"*[A] *failed vasectomy was unexpected and distressful to me, and that he had a choice of referral to a specialist surgeon or that I could redo the operation myself. He chose the latter course of action"*.

In mid-October 1997 the consumer returned to the general practitioner. However, the general practitioner concluded there was too much swelling to operate, and the vasectomy was delayed for a further two weeks.

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Information Gathered During Investigation, *continued*

The Second Procedure

On a date in early November 1997 the consumer returned to the general practitioner for the second vasectomy operation. Again, there were difficulties, and the consumer left the surgery *"with two small sutured cuts in his scrotum"*. The consumer returned to the general practitioner for a check up the following day. Seven days after the procedure the stitches were removed and there was a lot of bruising and swelling. The consumer advised the Commissioner that the general practitioner informed him at this visit that:

> *"He thought he had again missed the left side but to wait until the sperm sample was tested"*.

The general practitioner advised the Commissioner:

> *"*[T]*he time taken for the procedure is a reflection of the unexpected difficulties encountered at the time of operation rather than a reflection on the competency of the operator"*.

Shortly after, the general practitioner left the area.

In early January 1998 a sperm sample was taken from the consumer for microscopic analysis. Later that day the replacement general practitioner at the medical centre telephoned the consumer to inform him there were still sperm present in the sample. The consumer made the following comment to the Commissioner about the services he received:

> *"...* [A]*s you may understand I am not at all keen to repeat this whole performance again. It has made me very angry to think something that was described as a simple procedure could have ended like this. It took quite considerable organising of farm work to juggle around what was supposed to be 2 or 3 days of inconvenience. I have written to* [the general practitioner] *to request the $200.00 be refunded but have had no reply as of yet ... this has caused more than just inconvenience for my wife and myself"*.

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Information Gathered During Investigation, *continued*

In reply, the general practitioner stated:

> *"Unfortunately this incident was near the end of my time at* [the town]*, but when I found out about the result not being entirely successful, I apologised and advised him to await the result of a post operative sperm analysis. On hearing that this demonstrated an unsuccessful procedure I apologised again and refunded his money paid in full".*

The general practitioner advised the Commissioner that this is his only vasectomy failure. Additionally, *"this procedure has a recognised failure rate in the hands of both Specialists and Generalists".*

Advice to the Commissioner

The advisor stated they would expect a vasectomy to take at the most thirty minutes, but usually twenty minutes for the entire operation – five minutes to isolate each side and ten minutes at the start of the operation for the anaesthetic to work. Further, this type of surgery is considered to be "*minor*" and does not require any further qualifications to undertake it.

With regard to the first procedure that was performed on the consumer, my advisor stated:

> *"It is apparent, however, from the length of time taken to do the operation (1 hour, 15 minutes), the histology of tissues removed (sections of skin and no vas deferens present on the left and fibrovascular tissue, no vas deferens on the right) and from the statement made in* [the general practitioner's] *letter addressed to you, (I found it difficult to identify either vas in the vascular bundles), that this was a particularly difficult operation. ... One might be excused for failing to identify the vas deferens at the first operation".*

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Advice to the Commissioner, *continued*

However, with regard to the second procedure, the Commissioner's adviser noted:

> *"Given the difficulties encountered with this patient it was, in my opinion, unwise to proceed to a second operation.* [The general practitioner] *should have referred* [the consumer]*, not necessarily to a specialist, but another doctor more competent in carrying out these procedures …*
>
> *In summary, having encountered problems during the first operation and having failed to carry out bilateral vasectomy, I believe* [the general practitioner] *should not have proceeded with the revision".*

Code of Health and Disability Services Consumers' Rights

The following Right is applicable to the complaint:

RIGHT 4
Right to Services of an Appropriate Standard

…

2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

…

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Opinion: Breach The General Practitioner

Right 4(2)

In my opinion, the general practitioner breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights.

I am satisfied on the basis of the evidence presented to me that it was reasonable for the general practitioner to fail to identify the vas deferens at the first operation. However, given the difficulties that were encountered with the consumer, the general practitioner should not have proceeded to a second operation. The actions of a reasonable doctor in this situation would have been to refer the patient to another doctor, more competent in carrying out these procedures, or to have another doctor, conversant with vasectomies, assist with the second operation.

In my opinion the general practitioner failed to provide the consumer with the appropriate standard of care expected from a practitioner in these circumstances.

Opinion: No Breach The Trust

In my opinion, the trust did not breach the Code of Rights. Any actions taken by the general practitioner were on his own initiative and as such he must take full responsibility.

Actions

I recommend the general practitioner takes the following actions:

- Apologises in writing to the consumer for breaching Right 4(2) of the Code. This letter is to be sent to the Commissioner who will forward it to the consumer.
- Confirms he will undertake appropriate surgical continuing education prior to undertaking similar surgery in future.

As the general practitioner has refunded the consumer's fee, no further action will be required.

Other Actions

A copy of this opinion will be sent to the Medical Council of New Zealand.