Urologist

A Report by the

Health and Disability Commissioner

(Case 02HDC15043)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mr A	Consumer
Dr B	Provider/Urologist
Dr C	General practitioner
Dr D	Urologist

Complaint

On 15 October 2002 the Commissioner received a complaint from Mr A concerning the standard of care provided to him by Dr B. The complaint was summarised as follows:

Dr B did not:

Provide services of an appropriate standard to Mr A, in that he:

- *inappropriately pressured Mr A into proceeding with surgery when he had indicated he wished to withdraw consent*
- *did not adequately treat Mr A's urinary problems in an operation on 24 August 2001*
- *discharged Mr A from a Public Hospital, following his operation on 24 August 2001, despite Mr A suffering ongoing bleeding*
- *did not identify the cause of Mr A's ongoing urinary problems following the operation on 24 August 2001, despite two further operations*
- *did not refer Mr A to another specialist in a timely manner for his ongoing urinary problems.*

Provide Mr A with the information a reasonable consumer in Mr A's circumstances would expect to receive. In particular, Dr B:

- *did not explain to Mr A the nature of his urinary condition*
- *did not explain to Mr A the options available to treat his condition, including the expected risks, side effects and benefits*
- *repeatedly reassured Mr A that his condition would improve, following his operation on 24 August 2001, despite several follow-up appointments and no obvious improvement.*

While the following matter was not specifically raised in Mr A's letter of complaint, I became aware of it through further correspondence with Mr A. The following additional issue was investigated:

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

The Public Hospital did not facilitate the fair, simple, speedy and efficient resolution of Mr A's complaint. In particular, it did not:

- *inform Mr A, in writing, that it had received his complaint within 5 working days of its receipt;*
- *inform Mr A that it required more than 20 working days to investigate his complaint, or explain why that was so;*
- *inform Mr A, at least once a month, of the progress of his complaint.*

An investigation was commenced on 17 February 2003.

Information reviewed

- Information from Mr A
- Information from the Public Hospital
- Information from Dr B's registrar
- Information from a house surgeon
- Information from another Public Hospital
- Information from Dr C
- Information from Dr B
- Information from the Accident Compensation Corporation.

Independent expert advice was obtained from Professor John Nacey, urologist.

Information gathered during investigation

Background
In January 1992, Mr A (then aged 60 years) first consulted Dr B about urological problems. Mr A was experiencing difficulty passing urine and emptying his bladder. On examining him, Dr B concluded that Mr A's presenting symptoms warranted further evaluation. Dr B suggested that Mr A undergo further tests, although no further tests were carried out.

On 22 January 2000 Dr C, Mr A's general practitioner, referred him to the Public Hospital urology outpatient clinic for a review of his outflow symptoms and prostate gland. Subsequent to Dr C's referral, Mr A attended a consultation with Dr B on 17 June 2000, for the purpose of having his urological state assessed. On examining him, Dr B considered that Mr A required a transurethral resection of the prostate (TURP). Dr B claimed that he discussed these findings with Mr A in detail. This assertion was disputed by Mr A, who found Dr B's explanations "vague". Mr A was placed on the semi-urgent waiting list for a TURP.

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

At a pre-anaesthetic check on 22 August 2001, the intended procedure was explained to Mr A by the house surgeon. The house surgeon informed my staff that her usual practice is to encourage a patient not to sign consent forms unless he or she is satisfied with the level of information provided. Following the house surgeon's explanation, Mr A signed an informed consent document that noted the treatment to be administered. The consent document states that the signer understands the nature, effects and complications of treatment.

Admission for surgery

Two days later, Mr A was admitted to the day surgery holding ward of the Public Hospital. The admitting nurse present enquired whether Mr A understood the circumstances of his admission. He replied that he did not. The admitting nurse stated:

> "I discussed with the patient and his wife the fact that he had signed his consent form. It seemed that the procedure had been explained at pre-admission clinic but the patient did not understand the reason for surgery, and wanted to know about alternatives to surgery."

The admitting nurse made further enquiries of Mr A, and considered that the house surgeon should be consulted. The house surgeon informed the admitting nurse that she had briefed Mr A about his condition at the pre-admission clinic. She added that if he still did not understand the reason for surgery, the registrar should be summoned.

The admitting nurse paged the registrar. However, it was Dr B who attended Mr A. Mr A describes the circumstances under which he consented to surgery as follows:

> "I came to the hospital on … 24 August 2001 and was very hesitant about proceeding. The admitting nurse recognised and appreciated that I did not wish to progress with the procedure. Mr [B] became very angry with her however she was supportive and advised him that I could change my mind. Mr [B] kicked up a fuss, my wife felt uncomfortable about backing out and I went to have the surgery."

He further states:

> "I have gone through months of hell and everyday, wish that I had not allowed myself to be bullied into the operation … In years gone by I would have stood up for myself. The nurse was right, I could have changed my mind and I regret to this day that I didn't stand my ground."

In relation to his conversation with Mr A, Dr B recalls:

> "I was in the middle of another operation and, on completing this, I went down to see Mr [A] and explained the procedure once again in detail. I made it very clear to Mr [A] that he had about 14 months to think over the procedure and why did he not raise his concerns before, till just prior to the procedure … I also said to Mr [A] that it would have been proper if he notified my secretary or even myself some time before that he was unsure and reluctant, so that we could have arranged for the next person on the waiting

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

> list to have the operation, as the allocated spot will now be wasted, as we can not find a replacement at such very short notice. I also told Mr [A] that perhaps he should go home and think over and discuss with his general practitioner, and get back to me … I did not kick up a fuss as he claims. I was certainly unhappy that he had 14 months to think over, but became indecisive at the last minute. I also said to him that we cannot force him to have the operation against his wishes, and left the Day Surgery ward."

Following Dr B's departure, the intended surgery and rationale for it were again explained to Mr A by the senior nurse in day surgery at that time. She clarified the situation:

> "I was asked to speak to Mr [A] and his wife about his proposed TURP procedure. I believe we discussed the position of the prostate, symptoms which come when it is enlarged and why a TURP was being proposed in this case."

The admitting nurse then explained to Mr A that he was not required to undergo surgery, and could withdraw his consent. Subsequently, Mr A agreed to proceed with the operation.

Surgery and aftermath
On 24 August 2001, Dr B performed the operation, which consisted of a urethroscopy, cystoscopy, urethral dilatation, and a TURP. Records suggest that the intra-operative period was uneventful, and that in the immediate postoperative period Mr A was stable and had clear urine.

The postoperative nursing notes of 24 and 25 August reveal that Mr A was anxious, experiencing haematuria (blood in his urine), and was troubled by urinary dribbling. On 25 August he did not want to be discharged. Nonetheless he was discharged that evening after a review by Dr B in the early afternoon. According to Dr B, appropriate outpatient support was arranged for the day following Mr A's discharge. Nursing notes received from the Public Hospital, dated 25 August, read: "D/N [district nurse] informed of pt. [patient] discharge".

On 30 August Mr A arrived, by ambulance, at the Public Hospital Emergency Department. Subsequent to his arrival at 7.36am, he was assessed by Dr B's registrar at 9.00am. On examination, Mr A complained of haematuria; in particular, that he had passed several blood clots since midnight. A catheter was introduced by Dr B's registrar. Mr A noted that he found the catheter insertion painful and traumatic. Mr A was discharged at 2.10pm. The nursing notes for this period again indicate that Mr A was distressed about being discharged.

One day later, Mr A re-presented at the Emergency Department, complaining of haematuria. His catheter was flushed and he was again discharged.

On 3 September 2001 Dr B's registrar assessed Mr A, and his catheter was removed. Dr B's registrar noted, in correspondence to Dr C, that no gross haematuria was evident at this time and that Mr A was passing urine without difficulty.

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

Mr A was reviewed by Dr B on 17 September. On examination, Dr B found no haematuria evident, but noted that Mr A complained of urge incontinence. A urodome, draining into a leg bag, was required to manage this condition. Mr A was prescribed oxybutynin and doxepin to alleviate his symptoms. He subsequently attended consultations with Dr B on 24 September, 1 October, 15 October, and 5 November. The incontinence Mr A was experiencing persisted throughout this period, and Dr B observed that he appeared depressed. In light of Mr A's continued incontinence, Dr B arranged for a urethroscopy, cystoscopy, and urethral dilatation to be performed on 9 November 2001.

Mr A consented to the procedures and they were performed on 9 November by Dr B, who noted no apparent abnormalities except some urethral narrowing. The narrowing was addressed by dilatation.

On 26 November 2001, 14 January and 25 February 2002 Mr A's condition was assessed by Dr B. Mr A continued to complain of incontinence, and various interventions were trialled by Dr B without success. Dr B conducted a second urethroscopy and cystoscopy on 8 March 2002. According to Dr B, the results were unremarkable.

On 25 March 2002 Dr B again reviewed Mr A, as his urinary symptoms persisted. On this occasion, Dr B suggested that Mr A seek psychiatric help, an offer he declined. When a further consultation on 15 April revealed no improvement in Mr A's condition, Dr B referred him to Dr D. On 27 May Dr B assessed Mr A and noted no change.

Dr D examined Mr A on 11 July 2002, and diagnosed him with an unstable bladder and sphincter incompetence. These findings are detailed in a letter to Dr B, dated 16 July 2002, but did not result in a further consultation between Dr B and Mr A. Dr B states that he instructed Mr A to return "as and when necessary".

Complaint to the Public Hospital
Mr A lodged a formal complaint with the Chairman of the Public Hospital on 26 August 2002. A copy of Mr A's complaint letter was received by my Office on 15 October 2002. On 7 November 2002, I sent a letter to the Public Hospital advising it of its obligations to respond to complaints under the Code of Health and Disability Services Consumers' Rights.

On 9 December 2002, enquiries were made by my staff about the Public Hospital's response to Mr A. In response to these enquiries, assurances were given that the matter was under investigation and that Mr A would soon receive a response. Mr A advised a member of my staff, on 8 January 2003, that he had not yet received a response from the Public Hospital. The evidence available suggested that although Mr A was kept informed about the progress of his complaint, he did not receive a formal written response from the Public Hospital until approximately 26 March 2003 or shortly thereafter.

In response to my provisional opinion, the Public Hospital informed me that its complaints process was not commenced after the receipt of Mr A's complaint letter, dated 26 August 2002. He explained that this was because of Mr A's concerns about the potential impact on his ongoing care. The Public Hospital noted that Mr A confirmed his complaint in a letter

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

dated 8 October 2002, which was received by the Public Hospital on 14 October 2002. The Public Hospital responded to Mr A by letter dated 17 October 2002. The Public Hospital advised me that their staff were in contact with Mr A about his complaint on an almost weekly basis.

Medical misadventure
I note that the Accident Compensation Corporation found no medical error with respect to Dr B's treatment of Mr A. The ACC also concluded that Mr A had not suffered a medical mishap.

Independent advice to Commissioner

The following independent expert advice was received from Professor John Nacey, urologist:

> "I have been asked to provide an opinion to the Health and Disability Commissioner on case 02/15043. I have read and agree to follow the Commissioner's guidelines for independent advisors.
>
> I graduated MB ChB from the University of Otago in 1977 and undertook specialist training in Urology being awarded Fellowship of the Royal Australasian College of Surgeons in 1984. I subsequently undertook a doctorate by thesis in 1987 (MD, University of Otago, awarded with Distinction). I have practised as a specialist Urologist since 1986 and have maintained an active teaching and research programme for undergraduate and postgraduate students. My specialist research interest is benign and malignant prostate disease and I have published extensively in this field. I am a senior examiner in Urology for the Royal Australasian College of Surgeons, a position I have held since 1997. I am Dean of the Wellington School of Medicine and Health Sciences, a position I hold concurrently with my clinical practice.
>
> **Expert Advice Required**
> I have been asked to provide the following advice to the Commissioner:
>
> 1. On the evidence provided, did Dr [B] perform a TURP on Mr [A] with reasonable care and skill?
>
> 2. Was Mr [A's] discharge on 25 August 2001 appropriate?
>
> 3. Was Dr [B's] treatment of Mr [A], subsequent to performing a TURP on 24 August 2001, appropriate?
>
> 4. Was it reasonable for Dr [B] not to have diagnosed Mr [A] with an unstable bladder and sphincter incompetence?

5. Did Dr [B] refer Mr [A] to another specialist in a timely manner?
6. Please note that it is the Commissioner's role to determine whether Dr [B] inappropriately pressured Mr [A] into proceeding with surgery. Nevertheless, he would appreciate any comment you may wish to make regarding the conversation Dr [B] had with Mr [A] prior to surgery.
7. Are there any aspects of the care provided to Mr [A] which you consider warrants either:

   – Further exploration by an Investigation Officer?
   – Additional comment?

Sources of information
The following documentation has been provided by the Commissioner and reviewed by myself:

Letter of complaint, from Mr [A], received 15 October 2002.

Letter of notification, dated 17 February 2003.

Response to information request from [the Public Hospital], dated 28 July 2003, including:
– a report from […], senior day surgery nurse.

Response to information request from [a] continence advisor, dated 22 July 2003.

Response to information request from Dr [B's registrar], dated 27 July 2003.

Action note detailing the recollections of [the house surgeon], dated 24 October 2003.

Response to information request from [another Public Hospital], dated 14 July 2003 including:
– Outpatient identification form
– Correspondence from [Dr D]
– Correspondence from Dr [C]
– Radiology report, dated 11 July 2002
– Clinical notes

Response to information request from Dr [C], dated 20 July 2003 including:
– Letter of response from Dr [C], dated 20 July 2003
– Correspondence from Dr [C]
– Correspondence from Dr [B]
– Correspondence from Dr [B's registrar]
– Correspondence from [Dr D]
– Correspondence from [the Public Hospital]

– Correspondence from […], patient services, [the Public Hospital]
– Discharge summary, dated 24 August 2001
– Clinical records
– Radiology report, dated 11 July 2002
– Dr [C's] clinical notes

Response from Dr [B], dated 30 December 2002 including:
– Letter of response from Dr [B], dated 30 December 2002
– Correspondence from [a general practitioner]
– Correspondence from Dr [C]
– Correspondence from Dr [B]
– Correspondence from Dr [B's registrar]
– Correspondence from [Dr D]
– Medical records
– Discharge summary, dated 24 August 2001
– Priority criteria for prostatectomy
– Clinical notes
– Informed consent form(s)
– History and examination questionnaire
– Clinical priority access criteria
– Post-operative information sheet
– Discharge instructions

Response to information request from [the Public Hospital], dated 27 March 2002 including:
– Medical records
– Correspondence from Mr [A]
– Correspondence from Dr [B]
– Correspondence from [a general practitioner]
– Correspondence from Dr [B's registrar]
– Correspondence from Dr [C]
– Correspondence from [Dr D]
– Correspondence from [the Chairman]
– Correspondence from […], Chief operating officer, [the Public Hospital]
– Report by [the admitting nurse] – day surgery unit
Nursing notes

References
Chilton CP, Morgan RJ, England HR et al. A critical evaluation of the results of transurethral resection of the prostate. British Journal of Urology 50: 542-546, 1978
Mebust WK, Holtgrewe HL. Current status of transurethral prostatectomy: A review of the AUA National Cooperative Study. World Journal of Urology 6: 194-197, 1989

Background
Mr [A] first consulted Dr [B] in October 1992. He was referred by [a city] general practitioner, with symptoms of difficulty passing urine following a fall in January that

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

year. Examination at that time showed Mr [A] to have good bladder emptying and a nodule in the left lobe of his enlarged prostate. In view of Mr [A's] symptoms Dr [B] requested further investigations and had planned to see Mr [A] for further assessment when the results were to hand.

Mr [A] did not proceed with the investigations and did not present to Dr [B] for follow-up.

Dr [B] again saw Mr [A] for assessment in June 2000. The appointment was made following a referral by Dr [C], [a city] general practitioner, dated January 2000, for assessment of further symptoms of difficulty passing urine. At this appointment Dr [B] was also in possession of an additional referral letter for Mr [A]. This was sent by [another city] general practitioner, dated December 1995 and requested that Mr [A] be investigated for his erectile dysfunction.

At this assessment Dr [B] questioned and examined Mr [A] and determined that his symptoms required surgical intervention. The planned procedure was a transurethral prostatectomy. [Comment: This is a relatively common procedure for men with obstruction of the urinary outlet due to an enlarged prostate and is achieved by passing a telescope with an electrical 'cutting device' along the urethra.]

On August 22 2001 Mr [A] presented to [the Public] Hospital for a pre-anaesthetic assessment. The intended procedure was explained to Mr [A] by the house surgeon. At this assessment Mr [A] signed an 'informed consent request for treatment' for the procedure of 'EUA, urethroscopy, cystoscopy, urethral dilatation, BNI x 2 & TUR(P)'. [Comment: this means that Mr [A] may undergo examination under anaesthetic, with a telescopic examination of his urethra and bladder and then undergoing an incision of his bladder neck and transurethral resection of his prostate.] A patient care plan (which includes sections on discharge planning, education and key patient outcomes) was also completed and signed as such by the attending nurse.

Mr [A] was admitted for the procedure on August 24 2001. The admitting nurse […] inquired as to Mr [A's] understanding of the reasons for his admission. He said that he did not understand. The admitting nurse then asked [the house surgeon] to speak to Mr [A]. [The house surgeon] informed the admitting nurse that she had already explained the procedure to Mr [A] at the preadmission clinic. [The house surgeon] suggested that the Registrar should be asked to see Mr [A]. Rather than the Registrar, Dr [B] attended Mr [A]. Dr [B] states that he 'explained the procedure once again and in detail'. Dr [B] also states that he said to Mr [A] that 'perhaps he should go home and think over and discuss with his general practitioner, and get back to me personally once he had made up his mind'.

A short time after this Mr [A] agreed to proceed with the planned operation.

From the information provided the intra-operative course was uneventful.

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

The following day Mr [A] was discharged. From the hospital files it is apparent that Mr [A] was very anxious, but surgically was reported as having 'slightly blood stained' urine and deemed fit for discharge. The medical record states that Mr [A] was 'very agitated about going home' and 'troubled by continuing urinary dribbling'. The record indicates that the nursing staff advised Mr [A] that the symptoms were related to 'IV fluids & oral frusemide & that they will improve'. Mr [A] was discharged at 8pm.

On August 30 2001 Mr [A] presented to the Accident and Emergency Department with bloodstained urine and the passage of blood clots. To improve his urinary drainage and facilitate the passage of the clots a catheter was inserted. Arrangements were made for Mr [A] to attend outpatients on September 3 2001.

On August 31 2001 Mr [A] presented again to the Accident and Emergency Department with further bloodstained urine passing via the catheter. He was reassured by the hospital staff, his outpatient appointment for September 3 confirmed, and referral made to the district nurses for ongoing care.

At outpatients on September 3 Mr [A] was assessed by Dr [B's registrar] and had his catheter removed. The medical notes record his urine as 'clear'.

On September 17 2001 Mr [A] was assessed at outpatients by Dr [B]. He was noted to have urinary urgency with incontinence and prescribed a combination of Oxybutynin and Doxepin. [Comment: Oxybutynin is part of a class of drugs called anti-cholinergics. These are commonly prescribed by Urologists for patients with urinary frequency and urgency and are widely used in the treatment of incontinence of urine when this is due to bladder overactivity. Doxepin is a tricyclic antidepressant. It is used in the treatment of depression but also has an effect on the bladder where it lessens bladder overactivity. It is not apparent from the information provided what the primary reason for using this drug was but the combination with Oxybutynin is not unusual in patients with intractable urinary symptoms.]

Further consultations were held on September 24, October 1, October 15 and November 5. In view of the continuing incontinence Dr [B] arranged for further assessment. This was performed by means of a cystourethroscopy on November 9 2001. Dr [B] noted a stenosed anterior urethra which required dilatation, but otherwise the appearances of the lower urinary tract were satisfactory. [Comment: Dr [B] was referring to a stricture or annular scarring of the urethra near the tip of the penis. Stricturing in this region after transurethral prostatectomy occurs in about 3% of cases and is usually managed by urethral dilatation.]

Further appointments were held on November 26 2001, January 14 2002 and February 25 2002. The incontinence continued despite modifications to Mr [A's] medication.

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

On March 8 2002 a further cystourethoscopy was performed. No specific abnormality was noted. Following further consultations on March 25 2002 and April 15 2002, and noting no improvement in Mr [A's] symptoms, Dr [B] referred Mr [A] to [Dr D], Urologist of [a city]. [Comment: [Dr D] has a special interest in bladder physiology […]. He is regarded as an […] expert on overactive bladder and incontinence. His skill level, and level of interest in this field, is greater than would be expected from his urological colleagues.]

[Dr D] assessed Mr [A] on July 11 2002. The diagnosis of bladder instability and urinary sphincter incompetence on coughing and straining was made. [Dr D] notes this 'is a rather difficult problem' for Mr [A] and outlines the options of Mr [A] continuing with a urodome [a rubber collecting device worn over the penis and attached to a drainage bag worn on the thigh] or possibly undergoing major surgery in an attempt to assist the problem of the incontinence. [Dr D] advised the positive aspects of continuing with the urodome compared to the 'rather formidable' options of major surgery.

Questions posed by the Commissioner

1. On the evidence provided, did Dr [B] perform a TURP on Mr [A] with reasonable care and skill?

From the information provided, it would appear that Dr [B] did perform the TURP with reasonable care and skill. In support of this are the operation records kept by the anaesthetist which demonstrate an uneventful intra-operative period, Dr [B's] record of the operation, and the medical file describing the <u>immediate</u> post operative period where the patient was stable and had relatively clear urine.

2. Was Mr [A's] discharge on 25 August 2001 appropriate?

From the evidence provided, Mr [A's] discharge was appropriate.

Mr [A] was discharged the day after surgery. From the hospital records it is apparent that he was clinically well and described as having 'slightly blood stained' urine. It is also apparent that he was 'very agitated about going home' and was very anxious. Following catheter removal he had urinary dribbling which the nurses attributed to the intravenous fluid that he had received and the frusemide that he had been prescribed. This is a reasonable assumption. Frusemide is a diuretic [increases the urine output from the body and is used in patients with cardiovascular disease] and would be expected to fill the bladder rapidly. Some degree of urgency in passing urine is common in men after this operation, and the effect would be exacerbated by the Frusemide. It is apparent from the nursing notes that considerable reassurance was provided to Mr [A] and again, the nurses reasonably expected that improvement would occur. It is not unusual for patients to be discharged with some degree of urgency and incontinence.

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

It is noted that the time of discharge was 8pm. Given Mr [A's] state of anxiety it may have been prudent to consider keeping him overnight in hospital. However, the discharge policy and bed state of [the Public] Hospital at that time may have dictated the time of discharge.

3. Was Dr [B's] treatment of Mr [A], subsequent to performing a TURP on 24 August 2001, appropriate?

From the evidence provided, Dr [B's] treatment of Mr [A] subsequent to performing a TURP on 24 August 2001 was appropriate.

The first postoperative complication experienced by Mr [A] was haematuria leading to clot retention of urine. This occurs in approximately 3% of transurethral resections of the prostate. From the hospital records it appears that this was managed expeditiously and by appropriate urinary catheterisation.

Subsequently, Mr [A] was noted to have persistent urinary urgency and incontinence. Dr [B] prescribed a combination of Oxybutynin and Doxepin. Oxybutynin is a commonly prescribed drug for what is colloquially known as 'overactive bladder'. It works by suppressing the nerve supply to the bladder thereby reducing bladder pressure, improving functional capacity and reducing urgency. Provided the urinary sphincter is competent it would also be expected to improve or resolve urinary incontinence in this particular context. Some degree of 'overactive bladder' is common in men with prostate obstruction and is due to the bladder developing higher pressure in order to overcome the blockage. Once the blockage is removed (by transurethral prostatectomy) the bladder pressure will often spontaneously reduce and the urgency resolve. Dr [B] waited several months to see whether the symptoms would improve and correctly proceeded to a cystoscopy when it was apparent that there was no useful improvement.

4. Was it reasonable for Dr [B] not to have diagnosed Mr [A] with an unstable bladder and sphincter incompetence?

Dr [B] did recognise the bladder instability in the post operative period and prescribed Oxybutynin as a result. He had assumed that the incontinence was due to the high bladder pressure and not sphincter weakness. It must be emphasised that significant sphincter damage resulting in incontinence is rare after transurethral prostatectomy. Data on incontinence rates after transurethral prostatectomy must be interpreted appropriately and must take into account the severity and duration of the leakage. While the incidence of mild stress incontinence is between 1-3% the incidence of 'significant' incontinence is 0.5%. Incontinence after transurethral prostatectomy requiring surgical intervention by means of artificial urinary sphincters or other major intervention is less than 0.5%. Dr [B's] assumption that Mr [A] did not have significant sphincter damage was reinforced by the postoperative cystoscopies he performed which showed no visible evidence of injury. In real terms this is not always a reliable observation as the visual appearance can be misleading, but at the time can

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

be very reassuring for a surgeon who would not be expecting sphincter damage as an outcome.

5. Did Dr [B] refer Mr [A] to another specialist in a timely manner?

Dr [B's] referral of Mr [A] was timely. It was to be expected that Dr [B] would try all reasonable options before requesting a further opinion. It is important to note that while [Dr D] documented the instability and sphincter incompetence, any earlier appointment would have made no difference to the outcome.

6. Please note that it is the Commissioner's role to determine whether Dr [B] inappropriately pressured Mr [A] into proceeding with surgery. Nevertheless, he would appreciate any comment you may wish to make regarding the conversation Dr [B] had with Mr [A] prior to surgery.

On his own admission, Dr [B] was angry with Mr [A] and clearly conveyed his frustration and anger to him with what Dr [B] interpreted as last minute indecision on Mr [A's] part. It is easy in retrospect to see how the patient, when faced with an angry surgeon, may feel compelled to take what appears to be the path of least resistance and get the operation done. In real terms the complaint has followed a rare complication. If the postoperative course had been uneventful we can only guess that Mr [A] would have been more comfortable that the decision was made to proceed.

7. Are there any aspects of the care provided to Mr [A] which you consider warrants either:

– further exploration by an investigation officer?
– additional comment?

I do not believe there are any aspects of the care provided to Mr [A] that warrant further investigation or comment."

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

Response to Provisional Opinion

Mr A responded to my provisional opinion as follows:

> "1. I cannot dispute that the surgery was done with reasonable care and skill. I am not a medical expert and have at no time disputed that the actual surgery was anything other than 'routine'. My biggest dispute is and has always been that I was bullied into having the surgery when I felt uneasy about having it and that I was 'forced' to go home when I was uncomfortable about going home. At no time was I told that I was entitled to have District Nursing after discharge.
>
> 2. I believe that had I been kept in hospital overnight, in view that I was known to be a bleeder, the outcome would have been significantly better than it now is. I note that you comment on this in your report and I consider that [the Public] Hospital should listen to their patients in situations like this in the future.
>
> 3. In response to this question, I go back to right six of the code and believe that (1)(b) was not conveyed to me during the consultations I had with [Dr B] prior to my surgery. [Dr B] is a very educated man who talks in medical terms that to a layman like me might as well [have] been talking in Chinese or Russian. I felt like a school boy before the headmaster and was frightened to speak or ask questions. [Dr B] did not explain the risks of surgery, his only response was 'hundreds of men like you have this done every year and this fixes the problem'. At no time did [Dr B] say that there was a risk of being left incontinent, he didn't show me any photos or diagrams, he just kept saying that it was routine and straight forward and nothing to worry about.
>
> 4. Unstable bladder and sphincter incompetence. I still believe that this damage did not occur in surgery, but when the catheter was inserted in A&E by [Dr B's] registrar […]. Dr [B's registrar] said 'I don't think I am going to be able to do this job', he then proceeded to 'do it'. It really hurt and caused me extreme pain. I felt like the catheter had bent over and he had to force it in.
>
> 5. I accept that [Dr B] was trying to get things right before seeking another opinion and that the referral to [Dr D] was done as a last bid effort to get things right.
>
> 6. [Dr B] did pressure me to proceed with the procedure when I felt uneasy about it, if he had been gentle and reassuring and perhaps given me more information about the procedure I would have been able to make an informed decision, but I was left feeling that I was putting him out by trying to change my mind."

In a conversation with one of my staff on 14 May 2004, Mr A clarified that he did question whether Dr B performed his surgery with reasonable care and skill. He further noted that not all prostate operations could be the same, and posed the question: "Why did he [Dr B] take me back to theatre twice?"

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

Code of Health and Disability Services Consumers' Rights

The following rights in the Code of Health and Disability Services Consumers' Rights (the Code) are applicable to this complaint:

RIGHT 4

(1) Every consumer has the right to have services provided with reasonable care and skill.

RIGHT 5

Right to Effective Communication

(2) Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively.

RIGHT 6

(1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –

(a) An explanation of his or her condition; and

(b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; …

RIGHT 7

(7) Every consumer has the right to refuse services and to withdraw consent to services.

RIGHT 10

(4) Every provider must inform a consumer about progress of the consumer's complaint at intervals of not more than 1 month.

…

(6) Every provider, unless an employee of a provider, must have a complaints procedure that ensures that –

(a) The complaint is acknowledged in writing within 5 working days of receipt, unless it has been resolved to the satisfaction of the consumer within that period.

…

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

(7) Within 10 working days of giving written acknowledgement of a complaint, the provider must, –

…

(b) if it decides that more time is needed to investigate the complaint, –

…

(ii) if that additional time is more than 20 working days, inform the consumer of that determination and of the reasons for it.

Opinion: Dr B – No Breach

Withdrawal of consent to treatment

Mr A did not refuse consent to a transurethral resection of his prostate on 24 August 2001. However, subsequent to giving his consent to the proposed procedure, at a pre-anaesthetic check on 22 August, he was very hesitant about proceeding. This hesitancy was evident to Dr B at his meeting with Mr A on 24 August. In relation to Dr B's response to Mr A's hesitancy, I note the comments of my advisor, Professor Nacey:

> "On his own admission, Dr [B] was angry with Mr [A] and clearly conveyed his frustration and anger to him with what Dr [B] interpreted as last minute indecision on Mr [A's] part. It is easy in retrospect to see how the patient, when faced with an angry surgeon, may feel compelled to take what appears to be the path of least resistance and get the operation done."

Irrespective of his reasons for doing so, a patient always has the right to refuse or withdraw consent to medical treatment. This principle is affirmed in right 7(7) of the Code and is consistent with section 11 of the New Zealand Bill of Rights Act 1990, and the common law as interpreted by T A Gresson J in *Smith v Auckland Hospital Board* [1965] NZLR 191, 219:

> "An individual patient must … always retain the right to decline operative investigation or treatment however unreasonable or foolish this may appear in the eyes of his medical advisors."

It is clear that Dr B unequivocally conveyed his anger to Mr A. However, despite Dr B's evident frustration, he presented Mr A with the option of withdrawing his consent. He also advised Mr A to return home and discuss the matter with his general practitioner if he was unsure whether to proceed. Dr B gave Mr A this advice on the basis that he could return for further treatment following consultation with his general practitioner. I consider that Dr B's actions were consistent with acknowledging Mr A's right to withdraw his consent to treatment. Accordingly, I find that Dr B did not breach right 7(7) of the Code.

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

Nonetheless, Dr B's conduct in his conversation with Mr A was suboptimal. In response to my provisional opinion, Mr A stated: "I was left feeling that I was putting him out by trying to change my mind." Mr A felt afraid to ask Dr B questions about his surgery. Dr B's response to Mr A's hesitancy displayed a marked lack of insight into his patient's circumstances. Although Dr B did not breach the Code, I note that right 5(2) of the Code affirms a patient's right to an environment that enables open, honest and effective communication. Dr B's conduct was not conducive to such an environment and, consequently, left Mr A feeling that he could not discuss his anxiety about proceeding with surgery.

Treatment and follow-up care

Right 4(1) of the Code affirms a patient's right to receive services of an appropriate standard. Professor Nacey considered that the clinical records relating to Mr A's surgery and immediate postoperative condition indicate that Dr B performed a TURP on 24 August 2001 with reasonable care and skill. In particular, he noted that the intra-operative period was uneventful and that Mr A was stable, with clear urine, in the immediate postoperative period. Mr A attended follow-up consultations with Dr B on 13 occasions between September 2001 and May 2002, including two cystourethroscopies performed by Dr B on 9 November 2001 and 8 March 2002. Professor Nacey stated that Dr B appropriately addressed Mr A's postoperative complications via urinary catheterisation and the prescription of oxybutynin and doxepin. When Mr A's symptoms persisted, Dr B correctly decided to perform cystoscopies.

I acknowledge Mr A's concerns about his continuing urinary incontinence. According to Professor Nacey, the incidence of "significant" incontinence in patients who have undergone a TURP is 0.5%, and incontinence requiring artificial urinary schincters or other major surgical intervention occurs in fewer than 0.5% of patients. Despite the debilitating nature of Mr A's condition, his complications do not mean that Dr B's treatment was inadequate. In my opinion, Dr B did not breach the Code in his treatment or subsequent care of Mr A.

Discharge

Mr A's medical records indicate that when he was discharged from the Public Hospital on 25 August 2001, he was suffering from a minor degree of haematuria. However, my expert advisor noted that these records also indicate that Mr A was "clinically well". Although Mr A was troubled by urinary dribbling, Professor Nacey observed that it is not unusual for patients to be discharged with some degree of incontinence and urgency. Urgency is common in men after operations of this kind, and would have been exacerbated by the frusemide Mr A was taking. In the circumstances, Mr A's discharge was appropriate and Dr B did not breach the Code.

Postoperative care

Subsequent to performing the transurethral prostatectomy on 24 August 2001, Dr B treated Mr A for a period of approximately 6.5 months. He prescribed oxybutynin and doxepin when Mr A experienced persistent urinary urgency and incontinence. Dr B then waited several months to see whether Mr A's symptoms would improve. According to Professor

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

Nacey, Dr B correctly proceeded to cystoscopy when no real improvement was apparent. Professor Nacey noted:

> "Dr [B's] assumption that Mr [A] did not have significant sphincter damage was reinforced by the postoperative cystoscopies he performed which showed no visible evidence of injury."

Subsequently, Mr A consulted Dr D on 11 July 2002, and was diagnosed with an unstable bladder and sphincter incompetence. Dr B had identified Mr A's unstable bladder during the postoperative period, and prescribed oxybutynin as a result. In relation to Dr D's diagnosis of sphincter incompetence, I acknowledge his reputation as an international expert on incontinence. In light of the rarity of significant sphincter damage resulting from a transurethral prostatectomy, I consider it reasonable that Dr B did not diagnose Mr A with sphincter incompetence. Consequently, I do not consider that Dr B breached the Code in this respect.

Information disclosure
Right 6 of the Code affirms a patient's right to receive information that a reasonable patient, in that patient's circumstances, would expect to receive. Dr B claimed to have discussed his findings in detail with Mr A, at their consultation on 17 June 2000. At a pre-anaesthetic check on 22 August 2001, Mr A also signed an informed consent document stating that the signer understands the nature, effects and complications of treatment. The house surgeon present stated that her normal practice is to discourage a patient from signing consent forms unless he or she is satisfied with the information provided.

According to Dr B, he explained the intended procedure to Mr A again on 24 August 2001. This explanation was further clarified by the senior nurse in day surgery at that time. Informed consent does not require that health providers *ensure* understanding, rather that they *enable* understanding. I am satisfied that reasonable actions were taken, by Dr B and others, to enable Mr A to understand the nature and potential complications of treatment. In other words, it was reasonable for Dr B to assume that Mr A had been provided with adequate information to make an informed decision. Therefore, I consider that Dr B did not breach the Code in this respect.

Opinion: Public Hospital – No Breach

Complaints procedure
Right 10(6)(a) of the Code specifies that every provider must have a complaints procedure that ensures a complaint is acknowledged, in writing, within five working days of its receipt. Mr A lodged his complaint with the Public Hospital on 26 August 2002. However, the hospital informed me that its complaints process was not commenced after the receipt of Mr A's complaint letter, dated 26 August 2002. The hospital explained that this was because of Mr A's concerns about the potential impact on his ongoing care. The hospital noted that

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

Mr A confirmed his complaint in a letter dated 8 October 2002, which was received by the Public Hospital on 14 October 2002. As the Public Hospital's response to Mr A was dated 17 October 2002, I do not consider that it breached right 10(6)(a) of the Code.

Public Hospital staff were in contact with Mr A about his complaint on a regular basis. In these circumstances, I am satisfied that the Public Hospital kept Mr A appropriately updated on the progress of his complaint, and did not breach right 10(4) or right 10(7)(b)(ii) of the Code.

Vicarious liability

As Dr B did not breach the Code, no issue of vicarious liability arises with respect to the Public Hospital.

Follow-up actions

Medical Council of New Zealand
A copy of this report will be sent to the Medical Council of New Zealand and the Royal Australasian College of Surgeons.

Accident Compensation Corporation
A copy of this report will be sent to the Accident Compensation Corporation.

Education
A copy of my final report, with details identifying the parties removed, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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