General Practitioner, Dr B

A Report by the

Health and Disability Commissioner

(Case 00HDC03688)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Consumer / Complainant
Dr B	Provider / General Practitioner
Dr C	General Practitioner
Ms E	Sonographer

Complaint

On 5 April 2000 the Commissioner received a complaint from the consumer, Mrs A, about treatment received from the provider, Dr B. The complaint is that:

- *On 10 March 2000 Mrs A consulted Dr B due to pain and swelling at the back of her knee. During the discussion Ultrasound Guided Sclerotherapy, a treatment for varicose veins, was discussed. Mrs A advised she did not have a problem with her veins.*
- *On 31 March 2000, sclerotherapy treatment was carried out against Mrs A's wishes.*
- *Dr B did not advise Mrs A what procedure he was going to perform.*
- *Mrs A was not given the time to consider her treatment options.*
- *Dr B did not remove either of the two cysts on Mrs A's legs that had been identified by ultrasound.*
- *Mrs A was not given an opportunity to read the consent form and felt pressured to sign it.*

The date of "31 March 2000" referred to in the original notification is incorrect. It is accepted by the parties that the sclerotherapy treatment took place on 13 March 2000.

An investigation was commenced on 19 April 2000.

Information reviewed

- Relevant medical records.
- Responses from Dr B.
- Expert advice from Dr John Barrett, an independent general practitioner with expertise in sclerotherapy treatment.

Information gathered during investigation

On 29 February 2000, Mrs A consulted her general practitioner, Dr C, because of discomfort and swelling at the back of her left knee.

Dr C advised me that Mrs A had venous flare around her left ankle and the vein was inflamed. Dr C arranged a referral to another doctor, Dr B, for further assessment of the problem. She advised me that she arranged this referral at Mrs A's request.

Dr C's consultation note of this date states:

> "Has aching left leg, worse at end of day and at night 3 days. Varicose veins and ? bruising around these. Lower leg and venous flare at ankle. On examination no swelling at knee. No sign DVT [deep vein thrombosis].
>
> Imp [impression] superf [superficial] thrombophlebitis [inflammation of a vein associated with blood clot formation] settling. Refer for further assessment VV."

Mrs A denied that she specifically requested to see Dr B, but rather stated that she agreed to see Dr B at Dr C's suggestion.

Dr C's referral letter to Dr B dated 7 March 2000 states as follows:

> "Thank you for seeing this 59 year old lady for further management of her varicose veins. She had ligation and stripping in 1990 by [Mr D]. Most of the problems now affect her left leg. She had a recent episode of superficial thrombophlebitis but this has now settled. Her current medications are Losec, Estraderm and Amitryptyline 10mgs, nocte [at night]. Thank you for seeing her for further management and assessment."

Dr C advised me that she did not make a decision as to what type of treatment would be appropriate for Mrs A herself, but instead left this for Dr B to decide.

9 March 2000
On 9 March 2000, Mrs A had an appointment with Dr B at a medical centre.

Dr B advised me that Mrs A was referred to him as she had a problem of longstanding varicose veins of approximately 39 years, and had experienced a recent episode of superficial thrombophlebitis that was not settling. She presented with heavy, aching legs that swelled, particularly in hot weather. She had restless leg syndrome at night. Dr B's consultation note for 9 March 2000 states in part:

> "Many sx [symptoms] from the VVS [varicose veins] and sore L leg esp. Back of calf bruised looking x3. OE [on examination] bilat [bilateral] groin scars and SFJ [saphenofemoral junction] incomp [incompetent] L, LSV [long saphenous vein] disease bilat L>R, for UGS [ultrasound guided sclerotherapy (a non-surgical treatment for varicose veins)] after mapping. Bakers cyst L. Map and UGS L next Mon."

Mrs A advised me:

> "At [this] appointment I felt I made it clear to him my concern was the pain and swelling at the back of my knee. My doctor indicated that it could have been a cyst and I advised him of this. He talked to me about Ultrasound Guided Sclerotherapy for varicose veins which I thought would only be performed if necessary ie. I believed the stress on my veins to be coming from the problem in the back of my knee. I was there to have the back of my knee sorted out, not my veins. I was made an appointment for the following Monday for an Ultrasound. [Dr B] told me that he would take it from there. As I was about to leave he asked me what I thought about my veins. I replied 'Nothing'. He then asked if they worried me. I said No. …"

Dr B stated:

> "[Mrs A and I] had a lengthy discussion of the options of treatment as nil, sclerotherapy, or further surgery …"

Dr B explained that by "further surgery" he meant surgery on the varicose veins, to be performed by a general surgeon. He continued:

> "… As usual all costs and risks involved were discussed prior to deciding to proceed with ultrasound venous duplex mapping and then ultrasound guided sclerotherapy (UGS). She was given a detailed colour brochure on the procedure, and was advised that payment is expected on the day of treatment. …"

Mrs A did not accept Dr B's contention that he had discussed the options of treatment (as including "nil [to do nothing], sclerotherapy, or further surgery"). She stated that Dr B only advised her about the sclerotherapy treatment. The options to 'do nothing' or have surgery were not discussed.

Mrs A advised that the purpose of the referral to Dr B, as she understood it, was for further diagnosis. An ultrasound would be performed in order to diagnose the problem, and once the ultrasound had been performed, the appropriate treatment would be decided upon. She understood that Dr B would be able to treat her veins if they turned out to be the problem. However, Mrs A did not expect to be having sclerotherapy treatment at her next appointment. She confirmed that Dr B gave her a leaflet about sclerotherapy at their first appointment, but she did not read it because she did not expect to be having this treatment on her next visit.

Discussion about Baker's cysts on 9 March 2000

Mrs A advised me that her GP, Dr C, had mentioned the possibility that she had a Baker's cyst (swelling caused by the escape of synovial fluid) at the back of her left knee.

Mrs A therefore raised this possibility at her appointment with Dr B on 9 March 2000, and told him what Dr C had said. She claimed that Dr B commented that the cyst had not been mentioned in Dr C's letter, but made a note of it in his records. Mrs A said that Dr B made no further comment about the cyst. She thought that Dr B did not seem very interested in the possibility of a cyst.

Dr C's consultation notes do not mention a cyst, and Dr C could not recall this being discussed during her consultation with Mrs A.

Dr B confirmed that Mrs A mentioned the possibility of a cyst on the back of her knee at their initial consultation, which is why he made a note of it. He said he could tell by looking that she had a Baker's cyst, and that it was not necessary to have an ultrasound to diagnose it. However, Dr B advised me that Baker's cysts have no relationship to varicose veins. He advised me that they are related to wear and tear of the knee joint, and are commonly associated with osteoarthritis.

Dr B could not specifically recall what he told Mrs A about her Baker's cyst on 9 March 2000, but advised me that it is likely that he told her that the cyst was unrelated to her varicose veins. He stated that he is likely to have advised that these cysts are often asymptomatic, or you may get a sense of fullness behind the knee. Often people know nothing about them until they rupture, and then get pain down the calf. Dr B advised me that Mrs A presented with quite normal venous symptoms, and he felt confident that Mrs A had two different pathologies. In other words, it was Mrs A's veins, not her cyst(s), that were causing the problems she was experiencing.

13 March 2000 – Ultrasound findings
Mrs A returned to the medical centre for her ultrasound on 13 March 2000. Mrs A told the sonographer of her concerns about a cyst. The sonographer scanned the left leg and found a cyst, then continued with the other leg and found another, smaller cyst.

Ms E, a sonographer employed by a private vascular ultrasound service, performed Mrs A's ultrasound. Ms E worked in the same medical centre as Dr B.

Ms E completed two forms with diagrams and details of the ultrasound findings for each leg. The forms, with an accompanying report, described the mapping of Mrs A's veins in detail, and also noted the presence and size of the Baker's cysts.

The report for the left leg states:

> "Leash of vessels feed LSV in thigh. 14cm above knee is a large perf (6mm) to the bifid SFV. At this point the SFV becomes singular.
>
> - 3cm below knee crease, post branch joins SSV at 10cm and 15cm below crease.
> - 6cm below crease, LSV branches and perforates (3.8mm). No LSV is visible from this point to 14cm below crease, where a competent perforator communicates with the competent distal LSV.
>
> There is a large 40mm x 26mm Baker's cyst in the medial knee with slight extension into the medial calf. Contents are of mixed echogenicity [the extent to which a structure gives rise to reflections of ultrasound waves]. ? has this ruptured recently. Patient describes pain and pigmentation in this region recently."

The report for the right leg states:

> "SFV tied 10yrs ago. There is a 'SFJ' like comm with CFV and a leash of small vessels which feed the LSV just below groin. LSV incomp to 3cm below crease.
>
> Br's
> - 15cm above crease, v small br to SSV 9cm below crease
> - 3cm below crease, sml tortuous branch becomes small and reconnects to LSV slightly proximally.
>
> Perf
> - 8cm above crease, perf br to SFV (3.6mm)
>
> A small 28mm x 9mm Bakers cyst is seen in the medial knee."

Ms E said she advised Dr B of the cysts, and took a picture, which she thought that Dr B should still hold in his notes. Ms E advised me that it is usual for her to tell the doctor all she has seen and take a photograph.

Dr B advised me that long saphenous disease was diagnosed following the ultrasound. He advised me that he was unable to supply photographs of Mrs A's Baker's cysts as none were taken.

Dr B's discussion with Mrs A on 13 March 2000
Dr B advised me that he had a discussion with Mrs A prior to performing the Ultrasound Guided Sclerotherapy (UGS) procedure. He explained that the sonographer normally does the mapping, and he comes in maybe half an hour later and, if appropriate, initiates the UGS procedure. He estimated that in this instance, the gap between the ultrasound and his discussion with Mrs A would have been approximately 20 minutes. He advised:

> "[Mrs A] was noted to have Baker's cysts behind both knees, probably associated with degenerative knee disease, and these would not account for her symptoms or the thrombophlebitis. This was discussed prior to signing a consent form which she complied with and a standard UGS procedure was performed. …"

Mrs A advised me:

> "… [Dr B] came into the room and sat at the end of the bed and was making arrangements to do my veins. I said 'but I have a cyst'. He jumped up slapping his hands on the leather at the end of the bed, saying 'it would only be a little one'. The [sonographer] replied it was quite large and described it. [Dr B] did not heed this or the fact I was getting upset. …"

Dr B's recollection of the events before the sclerotherapy treatment differs. He recalled that after the ultrasound mapping procedure, Mrs A sat up, and they had a discussion about her veins before she signed the consent form. He advised:

> "When I walked into the room, she was sitting upright. That's unusual. They are usually lying down ready for treatment. She was sitting up so I figured there was a problem … [Mrs A] said, look at these Baker's cysts. Will they go away or something? And I said, no."

He also advised:

> "She sat bolt upright and asked questions about Baker's cysts and had to be reassured there and then this had nothing to do with Baker's cysts. We were there to treat her varicose veins, and it wouldn't affect the Baker's cysts in any shape or form."

Dr B advised me that he told Mrs A that the Baker's cysts would not account for her present problems. He said that Mrs A did look a bit puzzled, and he could not be sure whether she necessarily understood his explanation. However, he did have quite a lengthy discussion with Mrs A before she signed the consent and they continued with the procedure.

Ms E also recalls Mrs A sitting up and asking Dr B questions after her ultrasound. Ms E could not recall exactly what the questions were, but thinks the gist of them may have been along the lines, "Will the sclerotherapy treatment alleviate my pain?" Ms E could not recall Dr B's responses to the questions. Ms E said she got the impression that Mrs A did not understand why she was being treated. Ms E said that Dr B discussed this with Mrs A prior to the procedure being performed. She advised that Dr B did explain the procedure and its purpose to Mrs A. She also advised me that Dr B does speak rather quickly. Ms E said that it was possible that Mrs A may not have understood what Dr B was saying, although she could not be certain.

Mrs A denied, however, that she 'sat up' as alleged, as she was "too scared" and "quite nervous". Her account was that Dr B "snapped" at her, "Turn on your side" and, when she was unable to, exclaimed, "Can't you lie on your side!" She felt his general demeanour was very hurried and rushed. She therefore remained lying down after the ultrasound.

Dr B was asked whether Mrs A's Baker's cysts could have been removed on 13 March 2000, if she had requested it. Dr B advised me that this was not an option. He explained that removal of Baker's cysts is an orthopaedic operation, and that no general practitioner removes Baker's cysts. If Mrs A wanted her cysts removed, she would need to be referred to an orthopaedic surgeon. Dr B advised me that he explained this to Mrs A. He advised Mrs A she could discuss this with her general practitioner, who he imagined would not treat the cysts at all.

Dr B also told me that it was not his business to refer Mrs A to an orthopaedic surgeon, because she was not his patient. He advised me that Mrs A had been referred to him for a specific procedure.

According to Mrs A, Dr B did not explain anything about the Baker's cysts before he started the sclerotherapy treatment. The only comment he made about the cysts prior to performing the sclerotherapy was that the cyst evident on the ultrasound "would only be a little one".

Mrs A advised that the only other comments that Dr B made about the cysts was when the sclerotherapy procedure was already under way and after it was concluded.

Mrs A stated that during the sclerotherapy procedure, Dr B asked her if she had arthritis, and commented that cysts are sometimes connected with arthritis. Mrs A said that Dr B asked the question about arthritis in "a snappy voice". Mrs A said that Dr B did not tell her anything about what kind of treatment would be required for Baker's cysts, or anything about needing to go elsewhere to have the cysts treated. She advised that this lack of information was what was upsetting her.

In terms of treatment for the cysts, the only other comment made was following the sclerotherapy procedure, when Mrs A stated that Dr B casually remarked that he would let "[Dr C] know about [the] cysts". Dr C is Mrs A's general practitioner.

Ms E, the sonographer, said she could not remember Dr B saying anything about Mrs A's Baker's cysts. She also advised that she could not recall Dr B advising Mrs A anything about the necessary treatment for Baker's cysts.

Consent for sclerotherapy treatment
Mrs A advised me that after Ms E had described the cyst to Dr B:

> "I then had a paper put in front of me by the [sonographer]. She had her hand over the form covering most of the writing on it, showing me where to sign. She said 'sign this so he can do it'. At this stage I felt confused, upset and bullied. I signed the form without reading it or even being given an opportunity to do so. [Dr B] then went on to perform an Ultrasound Guided Sclerotherapy on the veins in my leg."

Ms E, the sonographer, confirmed that Mrs A provided consent for the treatment on the day of the ultrasound. She advised that Mrs A signed a consent form while sitting on the bed after her ultrasound, but she could no longer recall whether she or Dr B gave Mrs A the consent form to sign.

Mrs A advised me that she does not have a complaint about the sonographer who put her hand over the consent form. Mrs A said that the sonographer probably did this without realising, and may not have been aware that Mrs A had not previously consented to the treatment.

Dr B advised me that Mrs A first consented to sclerotherapy treatment on 13 March 2000. He advised:

> "As I say, she was sitting up. There was a discussion with me, the sonographer, me principally, and the patient, and I had to stand there wanting to get on with it and so I had to discuss it with her until she signed the consent form or I wouldn't have continued

> … she seemed happy with my explanation at the time and I presumed that by lying down and accepting the treatment that [she] was happy with the treatment."

The consent form signed by Mrs A reads as follows:

> "13 March 2000
>
> I, [Mrs A], DOB: 19 Dec 1940
> of […]
> have had the following procedure fully discussed and am aware of the possible complications and costs involved. I realise that the procedure may need to be repeated.
>
> I am quite happy to have this performed by [Dr B] and the radiology personnel, and feel adequately informed.
>
> Usual costs: Pre treatment US mapping $300 per leg
> Treatment costs $700 per half hour ($300 US, $400 Sclerotherapy).
> Where medically insured, it is my own responsibility to clarify the level of cover.
>
> Procedure: Ultrasound Sclerotherapy."

Mrs A advised me she felt very upset and pressured during her second appointment with Dr B. She held tears back during the appointment, but burst into tears as soon as she got out of the door.

27 March 2000
Mrs A returned to the medical centre on 27 March 2000 for a follow-up ultrasound. Dr B was not at the medical centre on this occasion, and Mrs A saw Ms E, the sonographer, again. Ms E said that she recalled that Mrs A's veins had not closed off after the treatment, but that this was quite a common occurrence. Ms E thought that Mrs A appeared quite angry and upset. Mrs A told Ms E that she felt that she had been bullied, and had not wanted treatment on her veins. Ms E made the following note in Mrs A's records:

> "US: [Ms E] FU [follow up] UGS lt leg. Small channel in LSV to knee. Pt is very unhappy about being [treated] for VVs when she felt the problem was the Baker's cyst. Felt she was 'bullied' into signing consent. Is not happy about continuing with [treatment] as she says the veins weren't bothering her in the first place."

Dr B confirmed that Mrs A elected not to have any further treatment performed. Mrs A advised me:

> "I still have the cysts, the pain and an uncompleted varicose vein operation. I am stressed out and tearful. …"

Independent advice to Commissioner

The following advice was obtained from Dr John Barrett, an independent general practitioner and a specialist in sclerotherapy:

"Complaints

1. On 10 March 2000 Mrs A consulted [Dr B] due to pain and swelling at the back of her knee. During the discussion 'Ultrasound Guided Sclerotherapy', a treatment for varicose veins was discussed. [Mrs A] advised she did not have a problem with her veins.

Response:

[Mrs A] attended [Dr B] at the request of her general practitioner [Dr C]. The referral note from [Dr C] asks for management of her varicose veins. She notes that [Mrs A] had previously had ligation and stripping in 1990 by [Mr D]. [Dr C] noted that most of her problems now affected her left leg and that [Mrs A] had had a recent superficial thrombophlebitis which had settled.

[Dr B] has noted in his notes that [Mrs A] had symptoms of aching legs, swelling, restless legs at night. He notes that the symptoms were worse in the heat. There were no cosmetic concerns related to the veins. He also notes the recent episode of superficial thrombophlebitis.

On clinical examination [Dr B] noted varicosities in both legs but greater on the left leg and that there was normal leg shape. He noted the bilateral groin scars from the previous vein surgery. A measurement of each leg diameter immediately below the knee demonstrated an insignificant 0.5cm difference L>R. He has also noted that the back of the left calf was bruised looking in three areas. He noted a Baker's cyst behind the left knee.

Mapping by sonographer [Ms E] which was reported on by radiologist [Dr F] confirmed incompetence in a large perforator 14cm above the left knee. The residual long saphenous vein was incompetent to below the knee.

It is apparent from [Dr C's] consultation notes that the symptoms which [Mrs A] attended her about were aching left leg, worse at the end of the day and at night for the previous three days. [Dr C] noted varicose veins and bruising around the lower leg and a venous flare at the ankle. [Dr C] specifically stated there was no swelling at the knee and no sign of deep venous thrombosis. Her impression was that [Mrs A] had a resolving acute superficial thrombophlebitis.

It is my opinion that [Mrs A] did have a problem with her veins which may have resulted in superficial thrombophlebitis causing the recent symptoms in the left leg. The more longstanding symptoms of aching legs, restless legs and swelling documented by [Dr B] were likely to be secondary to the documented incompetence of the perforators and saphenous veins confirmed by ultrasound mapping.

2. On 13 March 2000, sclerotherapy treatment was carried out against [Mrs A's] wishes.

Appropriate treatment for the incompetent vessels was instituted immediately following the ultrasound mapping. It is [Dr B's] contention that he did fully inform [Mrs A] about the reasons for needing to treat the incompetent veins both at the initial consultation and immediately prior to the procedure. This discussion is confirmed by the sonographer [Ms E] who was present at the time. [Ms E] notes in her discussion with [investigation staff] that [Dr B] did explain the procedure and its purpose to [Mrs A].

[Dr B] comments that he noted the Baker's cysts but felt that they would not have accounted for [Mrs A's] symptoms of aching legs or for the recent acute thrombophlebitis in the left leg.

[Mrs A] signed an informed consent form but states that the sonographer had her hand over the form at the time. [Mrs A] in her own statement confirms that she did not state that she did not want treatment and in fact signed the consent form. It is impossible to say whether this was under duress or whether [Mrs A], although upset, did not relay this adequately to [Dr B].

3. [Dr B] did not advise [Mrs A] what procedure he was going to perform.

See above. It is clear that this was discussed.

4. [Mrs A] was not given time to consider her treatment options.

There was a gap of four days between the initial consultation with [Dr B] and the actual treatment. This should have been sufficient time for [Mrs A] to digest the information given to her at the initial consultation and the brochure that was given to her as basic information regarding the procedure. [Mrs A] states that she chose not to read the brochure.

It is true that there was very little time between the mapping procedure performed by [Ms E] and the actual treatment but again both [Dr B] and [Ms E] confirm that the procedure was discussed in the interval of approximately 20 minutes and the confirmation of the Baker's cyst was discussed but dismissed as a cause of her symptoms.

5. [Dr B] did not remove either of the two cysts in [Mrs A's] legs that had been identified by ultrasound.

That is a fact. In practice, Baker's cysts are a reasonably common finding in patients over the age of 50. They are not an uncommon finding during mapping for varicose veins and in my experience have not altered the necessity for treatment of the varicose veins.

The real question is whether the symptoms for which [Mrs A] presented to [Dr C] and then [Dr B] arose from her varicose veins or from the Baker's cysts. There are several indicators that the veins were responsible rather than the Baker's cyst. These are:

a. The fact that the aching was worse at the end of the day which is a common symptom with varicose veins.
b. The fact that [Dr C] notes in her examination records that there was bruising around the varicose veins in the 'lower leg' and a venous flare at the ankle.
c. The fact that [Dr C] did not note swelling at the knee.
d. The fact that Baker's cysts are usually asymptomatic and are often an incidental finding of no clinical relevance.

It is possible that the symptoms that [Mrs A] complained of could have been due to a rupture in the large Baker's cyst and there was an impression from the radiologist that this may have been the case. It is unlikely however that such a rupture would have been responsible for the bruised appearance around the varicose veins which was recorded by both [Dr C] and [Dr B].

Given that the signs of superficial thrombophlebitis had settled by the time [Dr B] saw the patient it is not possible to state whether the proposed diagnosis was correct or not. If the symptoms of aching legs that [Mrs A] complained of were related to the varicose veins (and in my opinion that is likely) then the treatment was highly appropriate.

It is clear from [Dr B's] notes (which are comprehensive and complete) and explanatory letter that he felt that the symptoms had been those of an acute superficial thrombophlebitis rather than Baker's cyst. Whether this differential diagnosis was fully explained to [Mrs A] is difficult to say from the evidence supplied.

6. [Mrs A] was not given an opportunity to read the consent form and felt pressured to sign it.

This I cannot comment on.

In response to the Health and Disability Commissioner's request for expert advice I offer the following:

1. Was the Ultrasound Guided Sclerotherapy treatment necessary to treat the symptoms that [Mrs A] was experiencing at the time of her appointment with [Dr B]?

My opinion is that appropriate treatment was administered by [Dr B] but that clearly from [Mrs A's] point of view there was a communication breakdown that led to her feeling pressured into proceeding with the treatment. Whether this was conveyed to [Dr B] is not clear from [Mrs A's] report. She states that she was upset and cried after the treatment but there is no indication from [Dr B's] or [Ms E's] statements that [Dr B] was aware of her sentiments before and during the treatment.

It appears from the evidence that the first time that it was obvious to the providers that [Mrs A] was upset was at the follow-up consultation on 27th April 2000 when [Mrs A] was seen by [Ms E] but not by [Dr B].

2. Could the Baker's cyst(s) have contributed to the problems [Mrs A] was experiencing?

It is possible that on the left leg the Baker's cyst may have contributed to her symptoms if the cyst had in fact ruptured. On balance however I believe that the clinical findings of [Dr C] and [Dr B] support the fact that the veins were the cause of her symptoms and that there may have been a brief period of acute superficial thrombophlebitis.

3. Was cyst removal indicated for either, or both, of [Mrs A's] cysts at the time of her appointment with [Dr B]? If so what is the procedure for removal and who would perform it?

If the Baker's cysts were not the cause of her symptoms then it would have been inappropriate to remove them. Baker's cyst removal is an uncommon procedure given that most of the cysts do not cause symptoms.

If it was considered that the left Baker's cyst was the cause of [Mrs A's] symptoms then a trial of non steroidal anti-inflammatory tablets would have been appropriate rather than removal. Clearly [Dr B] did not consider that the Baker's cyst was the cause of [Mrs A's] symptoms and that is my opinion also from the evidence provided.

4. What treatment options would you expect [Mrs A] to have been informed about?

With respect to the veins, treatment options would have been:

a. No treatment and wait for possible resolution of the recent acute symptoms. This would not have resolved the other more longstanding symptoms.
b. Compression hosiery worn on a daily basis.
c. Ultrasound Guided Sclerotherapy to the incompetent varicose veins and the relevant saphenous veins.
d. Surgery to the recurrent varicose veins.

In my opinion the most logical and appropriate treatment for [Mrs A's] post surgical recurrent varicose veins, would be Ultrasound Guided Sclerotherapy.

With respect to the Baker's cysts, the usual management would be to inform the patient of the presence of the cysts, explain that they are generally not something that needs treatment but in some cases if they cause symptoms they can be treated with non steroidal [anti-]inflammatories.

Surgical removal, if necessary, would be outside [Dr B's] domain as a general practitioner or phlebologist. Options for him would be to refer to an orthopaedic specialist directly or refer [Mrs A] back to her referring general practitioner (the latter being preferable).

In fact surgical removal of Baker's cysts is rare. They are usually associated with degenerative joint disease and treatment is best directed at the underlying problem rather than the cyst. The cysts are technically difficult to remove because of the nature of surrounding nerves and blood vessels and they have a tendency to recur.

Summary

It is my opinion that [Dr B's] management of this case was appropriate. Clearly the treatment has not been completed as yet due to reluctance on [Mrs A's] behalf to do so.

If there was any area that could have been better managed it was that of communication between the parties.

[Dr B] clearly feels that he fulfilled his obligation to fully explain the case and the evidence suggests he did. There was however a lot of information for [Mrs A] to absorb and from her perspective clearly she did not feel appropriately informed. There is no evidence to suggest that [Mrs A] conveyed this concern to [Dr B] prior to the procedure.

[Mrs A's] main contention that the Baker's cysts should have been treated rather than the veins is not supported by the facts. The Baker's cysts, in my opinion were an incidental finding and were unlikely to have been the cause of her presenting symptoms. It would have been appropriate however for [Dr B] to convey to [Mrs A's] general practitioner that Baker's cysts were noted clinically on the left leg and by ultrasound on both legs so that further management of these could have been pursued if necessary in the future. Such further management may have been simply acknowledging their presence (ie no treatment) or referral to an orthopaedic surgeon for an opinion.

Because Baker's cysts are relatively common, benign and generally asymptomatic my opinion is that [Dr B's] response to them did not demonstrate a lack of skill, judgement, knowledge or care.

It would be appropriate for [Mrs A] to complete the treatment to her varicose veins with a further treatment of Ultrasound Guided Sclerotherapy. Until this is done any symptoms leading from them are unlikely to resolve."

Code of Health and Disability Services Consumers' Rights

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

RIGHT 4
Right to Services of an Appropriate Standard

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

RIGHT 5
Right to Effective Communication

1) Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided. …
2) Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively.

RIGHT 6
Right to be Fully Informed

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

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

RIGHT 7
Right to Make an Informed Choice and Give Informed Consent

1) 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.

Opinion: No breach

Right 4(1)

Mrs A had the right to services provided with reasonable care and skill. She presented to Dr B on referral from her general practitioner, Dr C, for management of her varicose veins. Dr B advised me she presented with symptoms of heavy, aching legs that swelled in hot weather. Mrs A's left leg was particularly sore, and she had experienced a recent episode of thrombophlebitis. Dr B examined Mrs A and found that she had an absent saphenofemoral junction and long saphenous vein disease. He decided that ultrasound guided sclerotherapy

would be an appropriate way to treat these problems. My advisor accepted that this treatment was appropriate, in light of Mrs A's presenting problems.

Mrs A also had two Baker's cysts, which were not removed by Dr B and for which no treatment was initiated. Dr B explained that, in his view, the Baker's cysts were not Mrs A's key problem and, in any event, removal of Baker's cysts is a procedure performed by an orthopaedic surgeon. My advisor confirmed this.

I accept that it would have been entirely inappropriate for Dr B to attempt surgical removal. If removal was indicated, Dr B could have arranged for Mrs A's usual GP to make the appropriate referral. Dr B believed that such a referral was unnecessary. It is also my advisor's opinion that the clinical findings of Dr C and Dr B suggest that Mrs A's veins were the likely cause of her problems, rather than her cysts.

My advisor informed me that it is possible that Mrs A's left Baker's cyst could have contributed to her symptoms if the cyst had ruptured. I am unable to determine whether this is the case. Ms E, the sonographer, advised me that she took photographs of the Baker's cyst. Dr B denied this.

My advisor informed me that in his view Dr B administered appropriate treatment. Mrs A did have Baker's cysts, but they were unlikely to have been the cause of her presenting symptoms. My advisor informed me that Baker's cysts are relatively common, benign and generally asymptomatic. Accordingly, Dr B's response did not demonstrate a lack of skill, judgement, knowledge or care. I accept my advisor's opinion in this regard. There is no evidence to indicate that the sclerotherapy treatment was inappropriate, even if it were established that Mrs A's left cyst had ruptured. In my opinion Dr B demonstrated reasonable care and skill in his selection of treatment for Mrs A and acted appropriately in not treating the two Baker's cysts identified. Accordingly, Dr B did not breach Right 4(1) of the Code.

Right 6(1)

Failure to advise what procedure was to be performed
Mrs A advised me that Dr B did not advise what procedure he was to perform prior to commencing sclerotherapy treatment. Dr B denied this, and Ms E informed me that Dr B did explain the procedure and its purpose to Mrs A prior to commencing the treatment. In my opinion, it is clear that a discussion did occur prior to the commencement of the treatment, and that it was made clear that sclerotherapy was to be performed. Accordingly, Dr B did not breach Right 6(1) in this respect.

Opinion: Breach

Rights 5(1) and 5(2)

Mrs A had the right to effective communication in a form, language and manner that enabled her to understand the information provided. She also had the right to an environment that enabled her to communicate openly, honestly and effectively with Dr B.

It appears that a breakdown in communication occurred between Dr B and Mrs A at their initial discussion on 9 March 2000. At the conclusion of this appointment, Dr B was of the view that Mrs A was agreeable to having ultrasound guided sclerotherapy performed after her ultrasound, scheduled for the following Monday. This is supported by the record he took on 9 March, which states that Mrs A would be "for UGS after mapping" at her next appointment. Mrs A's understanding was different. She advised me that she understood she would be having an ultrasound to diagnose the cause of the problem behind her knee. In particular, she was concerned about the possibility of a cyst. Mrs A advised me that she understood that ultrasound guided sclerotherapy was a possibility if her veins turned out to be the problem, but that this was yet to be decided. As Mrs A did not expect to be having sclerotherapy treatment at her next appointment, she did not read the brochure on this procedure handed to her by Dr B on 9 March. As a result of this misunderstanding, Dr B and Mrs A had different expectations about what was to occur at her appointment on 13 March.

My advisor was of the opinion that Dr B had no way of knowing that Mrs A was unhappy until she returned for a second ultrasound on 27 March. I disagree. Dr B and Ms E both recalled Mrs A sitting up and asking questions after her ultrasound on 13 March. Dr B advised me that it is unusual for a patient to sit up and ask questions after the ultrasound, so when Mrs A did this he "could see there was a problem …". Mrs A can no longer recall asking questions about her cysts, but recalls feeling upset and scared.

Although the parties' accounts differ, both statements lead me to believe that a breach of Rights 5(1) and (2) occurred.

Dr B's statements (and those of Ms E in confirmation) that Mrs A sat up and asked questions is of concern. Such behaviour should have alerted Dr B to the fact that Mrs A may have been uncomfortable proceeding with the treatment and that she may have needed further information, and time, to consider her options.

Mrs A's statement that she remained lying down as she was "scared" and "quite nervous" owing to Dr B's hurried, rushed and snappish demeanour, is also cause for concern. Such behaviour on the part of a practitioner does not allow effective communication.

There is also the question whether information was relayed to Mrs A in a form and manner that enabled her to understand the information provided. Dr B and Ms E agree that Mrs A may not have understood the information she was provided with. Dr B commented that Mrs A looked "puzzled". Ms E could not be certain whether Mrs A understood, but commented that Dr B does speak rather quickly.

Taking into account the concerns Mrs A was expressing, and Dr B's admission, supported by Ms E, that it was unclear whether Mrs A understood his explanation, it is my view that it would have been prudent for Dr B to have offered Mrs A the opportunity to leave at that point, to further consider her options in her own time. Instead, Mrs A was asked to sign a consent form soon after an ultrasound that had revealed cysts that she was concerned about, and while she was "sitting up" (according to Dr B) and expressing her concerns.

In my opinion, Dr B created an uncomfortable environment which pressured Mrs A into making an immediate decision. His statement to my investigative staff that "I had to stand there wanting to get on with it" further indicates that the environment was pressured.

I acknowledge that there is no evidence to suggest that the proposed sclerotherapy treatment was inappropriate. However, this is irrelevant. Mrs A had the right to make a choice about her treatment, and was under no obligation to have treatment at all if she chose not to.

My advisor considered that, assuming Mrs A was aware on 9 March that she was to have sclerotherapy treatment on 13 March, she did have adequate time to consider her treatment options. In my view, even if it is accepted that Mrs A had several days to consider her treatment options, on 13 March she was showing clear signs that she needed more time. Although Dr B may not have realised Mrs A was close to tears, he did realise that she may not have understood the reasons he recommended sclerotherapy treatment, and that she had concerns about her Baker's cysts.

It is my view that, due to Dr B's expectation that he would be performing sclerotherapy on 13 March, he created an uncomfortable and pressured environment for Mrs A that was not conducive to effective communication. As my advisor noted:

> "If there was any area that could have been better managed, it was that of communication between the parties."

Accordingly, in my opinion Dr B breached Rights 5(1) and (2) of the Code.

Right 6(1)(b)

Mrs A had the right to information that a reasonable patient, in her circumstances, would expect to receive. This included an explanation of the treatment that was to be performed and the options available.

Varicose veins
My advisor informed me that with respect to treatment of Mrs A's veins, he would expect Dr B to offer her treatment options of:

(a) no treatment;

(b) compression hosiery;

(c) ultrasound guided sclerotherapy; or

(d) surgery for recurrent varicose veins.

I have been provided with conflicting information about the options offered to Mrs A. Dr B advised me that at his 9 March 2000 appointment with Mrs A, he advised her that her treatment options were nil, sclerotherapy, or further surgery. Mrs A advised me that Dr B offered sclerotherapy treatment only. In the absence of witnesses, I am unable to reconcile these conflicting accounts.

Baker's cysts
With regard to the Baker's cysts, my advisor informed me that he would expect Mrs A to be informed that they can be treated with non-steroidal anti-inflammatories, or that she could be referred to a surgeon for surgical removal to be considered.

It is agreed that Dr B and Mrs A had a brief discussion about her Baker's cysts at the initial consultation on 9 March, although the extent of that discussion is disputed. What is clear is that Baker's cysts were discussed on 13 March. According to Dr B and Ms E, the sonographer, Mrs A sat up after her ultrasound and started asking questions about them. Dr B advised me that he informed Mrs A her cysts could be surgically removed, and that he could refer her back to Dr C for an appropriate referral. He did not inform her that the cysts could be treated with non-steroidal anti-inflammatories.

Mrs A advised me that Dr B did not explain anything about the Baker's cysts before he started the sclerotherapy treatment. Further, he did not give her information about her treatment options for the cysts, and did not tell her anything about what kind of treatment would be required for Baker's cysts. She advised me that this lack of information was what upset her.

Ms E, the sonographer, recalled Mrs A asking Dr B questions, but could not recall Dr B's answers. Ms E advised me that Dr B did explain the sclerotherapy procedure and its purpose to Mrs A.

My advisor stated that both Dr B and Ms E also confirmed that the Baker's cysts were discussed with Mrs A, but dismissed as a cause of her symptoms. This is not correct. Ms E advised me she cannot recall Dr B offering Mrs A any information about Baker's cysts. Furthermore, she has no specific recollection of the necessary treatment for Baker's cysts being discussed.

I find the evidence of Mrs A and Ms E more credible in this instance. I do not believe that Dr B provided Mrs A with a full explanation of the treatment options available to her. Accordingly, in my view Dr B breached Right 6(1)(b) of the Code in relation to this matter.

Right 7(1)

Dr B was entitled to provide services to Mrs A only if she had made an informed choice and given informed consent for those services to be performed. In my view, in order for a patient to give *informed* consent to services, it is first necessary for effective communication to occur. Secondly, adequate information needs to be provided. Only after these initial two steps is the patient able to make an informed choice about proposed treatment.

Dr B advised me that Mrs A provided consent to the sclerotherapy treatment because they had a discussion, following which she signed a consent form, lay down and accepted the treatment. However, in my view this does not indicate that Mrs A gave *informed* consent.

For the reasons I have previously outlined, in my view Dr B did not communicate effectively with Mrs A. He did not provide an environment that allowed her to consider her options openly, or to understand the information provided. As my advisor stated:

> "My opinion is that appropriate treatment was administered by [Dr B], but that clearly from [Mrs A's] point of view, there was a communication breakdown that led to her feeling pressured into proceeding with the treatment."

In these circumstances it was not possible for Mrs A to give informed consent to the sclerotherapy treatment.

My advisor commented that Mrs A did not state she did not want treatment, and she signed a consent form. I accept that this is the case. However, I believe that the reason that Mrs A did not say that she did not want the treatment was because of the uncomfortable and pressured environment that had been created by Dr B.

In any event, documentary evidence of consent is not sufficient in itself to indicate that informed consent has been given.

It follows that, in my opinion, Dr B breached Right 7(1) of the Code.

Actions

I recommend that Dr B take the following actions:

- Apologise to Mrs A in writing for his breaches of the Code. The apology is to be sent to my Office and will be forwarded to Mrs A.
- Review his practice in light of this report.

Further actions

- In accordance with section 45(f) of the Health and Disability Commissioner Act 1994, I will refer this matter to the Director of Proceedings to determine whether any further action should be taken.

- A copy of this opinion will be sent to the Medical Council of New Zealand with a recommendation that it review Dr B's competence to practise medicine, in relation to issues of communication, information and consent.

- A copy of this opinion, identifying Dr B but with all other identifying features removed, will be sent to the President of the Royal New Zealand College of General Practitioners, to enable a senior member of the College to discuss with Dr B why he is receiving a disproportionate number of complaints raising similar issues.

- A copy of this opinion, with all identifying features removed, will be sent to the Royal New Zealand College of General Practitioners, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Other comment

Dr B has been subject to five other complaints that have been investigated by the Health and Disability Commissioner since December 1999.

Two of the complaints resulted in no further action by the Commissioner. The other three complaints resulted in the following findings:

- File No 99HDC13348 – Breach of Right 6(1)(b) (adequate information). Recommendation of an apology and self review of practice.

- File No 00HDC03278 – Breach of Right 6(1)(b) (adequate information). Recommendation of an apology and self review of practice.

- File No 01HDC02274 (pending) – This complaint has been investigated and a provisional opinion will be issued shortly.

I am concerned by the recurrent pattern evident from the above complaints and my investigation findings. For these reasons, I have recommended that the Director of Proceedings, the Medical Council of New Zealand, and the Royal New Zealand College of General Practitioners take the further actions noted above.

Addendum

The Director of Proceedings considered this matter and decided not to issue proceedings before the Medical Practitioners Disciplinary Tribunal or the Human Rights Review Tribunal.