Dr B

A Report by the

Health and Disability Commissioner

(Case 00HDC03278)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Ms A	Consumer
Dr B	Provider / General Practitioner
Dr C	Consumer's General Practitioner
Dr D	General Practitioner
Ms E	Registered Nurse and Beauty Therapist
Dr F	Dermatologist

Independent expert advice was sought from Dr Amanda Oakley, dermatologist, and Dr Wendy Isbell, general practitioner.

Complaint

On 27 March 2000 the Commissioner received a complaint from Ms A about services provided by Dr B. The complaint is that:

- *[Dr B] recommended a programme of dermabrasion treatments for [Ms A]'s problem of acne and whiteheads. The information provided by [Dr B] prior to the commencement of the treatment was misleading and inaccurate. He did not adequately warn [Ms A] of the side effects or dangers of this treatment.*
- *[Dr B] did not perform a patch test prior to commencing the dermabrasion treatments.*
- *[Dr B] arranged for [Ms A]'s HIV status to be tested without her knowledge or consent.*
- *Following an unsatisfactory outcome of the treatment for [Ms A], [Dr B] prescribed medication although [Ms A] had advised him she wanted a cosmetic approach to her problem.*
- *[Dr B] understated the severity of potential side effects that could be produced by the medication he prescribed.*
- *The medication prescribed by [Dr B] was inappropriate. In particular, the oral medication could potentially reactivate pre-existing liver problems. [Ms A] had previously made [Dr B] aware of these liver problems.*

Dr B was also notified of the following additional complaint on 13 February 2001:

- *[Dr B] did not inform [Ms A] that the proposed series of micro-dermabrasion treatments should be spaced at monthly intervals.*

An investigation was commenced on 13 April 2000.

Information reviewed

- A full copy of Ms A's ACC medical misadventure file.
- Relevant medical records from Ms A's general practitioner, Dr C.

Information gathered during investigation

Ms A had an ongoing problem of acne and whiteheads. She had seen a dermatologist about this problem, and a number of medications to manage her acne had been tried unsuccessfully. Ms A heard about chemical peels and laser resurfacing, and thought that one of these treatments might be appropriate for her. She telephoned the medical centre to make some enquiries, and was informed that Dr B could offer chemical facial peels, but did not do laser treatment. Ms A decided to make an appointment to discuss the possibility of a chemical peel.

14 September 1999
Ms A's appointment with Dr B took place on 14 September 1999. Ms A advised me that she explained to Dr B that she had come to him for a cosmetic approach to her acne, and did not want medication because of the problems she had experienced in the past. She also advised Dr B that she had a liver problem, which certain medications may aggravate.

A note in Dr B's medical records, dated 14 September 1999, states as follows:

> "Referred … for ?chemical peel, remove scars. Tried variety of meds for acne white heads. Differin caused facial hair, minomicin caused allergic reaction with itchy red palms and liver abnormality, Retinol A caused liver probs. Meds Fe tabs, nil FH. Acne face and ant chest since teenager. Whitehead and blackheads still. …
> Concerned re scarring at this point and considering a chemical peel or laser resurfacing. …"

Dr B could not recall Ms A telling him that she wanted a cosmetic approach and not medication. He advised me that treating the cosmetic side of the problem alone would not be appropriate. Medication was necessary in conjunction with cosmetic treatment, in order to treat the underlying problem.

Dr B advised me that he outlined Ms A's options for treatment, which were chemical peeling, antibiotic therapy, topical AHA creams, and Eryacne (antibiotic) cream. He advised Ms A that she also had the option of laser resurfacing but that he did not offer that treatment; if she wanted it she would need to go elsewhere. He also offered a series of micro-dermabrasion treatments.

Dr B advised me that micro-dermabrasion is a new technology which is a gentler and safer option than conventional dermabrasion treatment. It entails abrading the skin surface with a device that blows aluminium oxide crystals onto the skin, while suctioning debris and dead

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

skin cells at the same time. A series of these treatments is normally required. Dr B said he usually indicates that six to ten treatments are likely to be needed.

Ms A advised:

> "… He informed me he was getting a new machine that would really help my condition. He showed me brochures of the machine and photos of people who had had the procedure done, showing before and after photos. He stipulated this procedure would help my condition. … He said I would end up with a clearer face and it would help stop new whiteheads forming, and that it would clear up whiteheads already on my face. …"

Ms A advised me that Dr B told her that he thought that micro-dermabrasion treatment would be more effective than a chemical peel.

Dr B advised me that Ms A's initial request for a chemical peel "wasn't a realistic request and I responded in a much more medical way and gave her a much broader response about how [the acne problem] should be managed".

Dr B said that he told Ms A that a series of micro-dermabrasion treatments, in combination with appropriate medical therapy, would be a more appropriate way to treat her problem.

Dr B did not have his new micro-dermabrasion machine when he first saw Ms A, but was about to purchase it from Australia. He explained to Ms A what the treatment would entail. He also had advertising material about the treatment, and gave Ms A a brochure about it.

Dr B told Ms A that he would need to run a series of tests before he agreed to any treatment. Ms A agreed to purchase some 'Dermatech' glycolic cream, and to see him again in a month after the tests were completed.

Dr B advised me:

> "She was investigated for hormonal causes of acne and an HIV screen was done as she had a history of substance abuse and had advised me she was Hep C positive. This was fundamental to my agreeing to ongoing procedural treatment."

HIV test

Ms A informed me that Dr B told her he would need to check her Hepatitis B status. Ms A agreed to this. However, at the laboratory, she found out she had also been tested for HIV, which she said she had not consented to. Ms A advised me that she and Dr B had discussed an HIV test. He asked her if she had been tested for HIV, and she confirmed she had. They agreed that she would "ring the lab" to get the result of her earlier test. Ms A advised me that she did make this call to obtain a copy of her old results for Dr B. She advised me that she therefore consented to Dr B viewing her last result, but she was not aware of, and did not consent to, a new test being taken.

Dr B could not recall Ms A mentioning the results of her earlier test. He informed me that he would not agree to such a request. It would not be useful to him to know the result of a past test, as he needed to know Ms A's current HIV status prior to administering treatment. Dr B advised me that he and Ms A discussed the test openly, and she asked for a copy of her result. He would not have agreed to commence the treatment if this test had not been performed.

The tests performed also included a test of Ms A's liver function.

24 November 1999
The tests were performed, and Dr B saw Ms A for the second time on 24 November 1999. Dr B's records on this date note that Ms A had more whiteheads. She was tolerating the Dermatech cream, and her blood test results were fine. Dr B commenced Ms A on Eryacne gel because of the whitehead formation. Dr B's records also state that Ms A was to have six to ten dermabrasions, with review after six treatments, and that her TCA peel (a tricloracetic acid, or chemical peel) was deferred.

Ms A told me her understanding was that the chemical peel was discarded altogether, in favour of the dermabrasion treatments. She said Dr B told her that the treatments would cost $150 each, and that she would need at least six treatments. Dr B did not indicate the maximum number of treatments she would need.

Despite Dr B telling her she would need a minimum of six treatments, Ms A told me she had hoped she would need fewer. She thought she might need only four treatments to eliminate her acne, as this had been the result for a person pictured in the brochure that Dr B had given her.

Ms A supplied a copy of the brochure from Dr B, entitled "The Diamond Dermabrasion Medical Experience – Why Microdermabrasion is right for you". The brochure contains a number of before and after photos of people who have had micro-dermabrasion treatment for active acne or acne scarring. One photograph shows a patient whose active acne had almost completely resolved after four micro-dermabrasion treatments. The caption with this photograph states: "Active Acne on a patient, age 16, who had been suffering from severe acne. After four diamond dermabrasion medical treatments, observable acne condition has vanished." The reverse side of the brochure states in part: "Best results can often be achieved with a series of six treatments to effectively control and focus on problem areas. Thereafter, regular maintenance will ensure skin conditioning." Dr B did not make any specific comment on the photographs when he handed Ms A the brochure.

Discussion of side-effects/risks, and Ms A's expectations of the treatment
Dr B was asked whether he informed Ms A of any risks or side-effects associated with micro-dermabrasion treatments. Dr B could no longer recall specific details of his discussion with Ms A. However, he advised me that normally he would indicate that it is a new, very safe, and usually painless technology. Dr B advised me that he was not aware of anyone world-wide who had been scarred by it. He thinks it is likely he would have told Ms A that the treatment would improve the contour of her face over a series of treatments. He

would have told her that the skin goes a bit red, sometimes a little scabbed, and sometimes there can be bruising to the fine vessels under the eyes. The skin would be expected to heal in five to seven days at the most.

Dr B advised me that he formed the impression that Ms A had unreal expectations of the outcome she could achieve with treatment. He said that this was evident when Ms A first asked for a chemical peel.

Although Dr B could not recall specific details of their discussion, he advised me he would imagine that he would have told Ms A that her whiteheads could not be eliminated when they first discussed micro-dermabrasion. Dr B advised me:

> "… [O]ne of the reasons I deferred the TCA peel was I felt that I wasn't going to achieve what she wanted out of that particular modality of treatment. I know I could have improved her face a lot, but it wouldn't cure her acne forever. She had an ongoing skin condition. One TCA peel doesn't take away your acne, I wasn't happy with that and chose not to perform treatment … Medical micro-dermabrasion on the other hand I knew could give her a significant improvement. I never say to people I'll cure their acne, I never say I'll take it away, I don't use words like that. But I do say I'll significantly improve it and I know I can in any form of acne. You can improve it, it's a very useful modality, especially in combination with some forms of medical treatment."

Dr B advised me that Ms A may have expected that she would have a perfectly smooth face after the treatment. However, he would never promise this to anybody.

First treatment

Ms A's first micro-dermabrasion treatment took place on 25 November 1999. Ms A advised me that Dr B did not administer the actual treatments; a woman named Ms E administered the first two, and another doctor, Dr D, administered the last four. Ms A advised me she has no complaint against the other providers involved in her treatment. This is because her concern is about the information that was provided to her prior to the treatments commencing.

Dr B advised me that he administered the first treatment to Ms A on 25 November 1999, with registered nurse and beauty therapist Ms E present. The note in Dr B's records on 25 November 1999 states:

> "Derm one with [Ms E]. Good peeling. Photos taken. Cont Eryacne and Dermatech. For derm 2 next week."

Ms E confirmed that she was present at Ms A's first dermabrasion treatment with Dr B. Ms E advised me she often attended the first dermabrasion treatment with the patient and Dr B, at which stage it was intended that the treatments would be handed over to her. She contracted to Dr B to do this type of treatment.

Second treatment
Ms A returned for her second treatment on 2 December 1999. Ms E administered this treatment alone. The note in Ms A's medical records on this date states:

> "Derm 2 with [Ms E]. Had breakout the next day after last treatment. Expectations that derm will cure whiteheads. Explained that [treatment] will improve but not necessarily eliminate, and may still need touch-up [treatment] further down the track. Today, still many whiteheads under the skin coming to surface."

Ms E confirmed that she made the above note in the records. Ms E said she gained the impression during the second treatment that Ms A expected one dermabrasion treatment would get rid of her whiteheads. Ms A did not appear to realise that the first treatment was going to make her "break out". Ms E advised me that Ms A thought that the dermabrasion would get rid of her scarring, and generally had high expectations of the treatment. Ms A was clearly unhappy that she had broken out, and did not realise this was going to happen.

Ms E advised me that because it was evident that Ms A had high expectations, she tried to give a thorough explanation of what could be expected from the treatment. Ms E explained to Ms A that the treatment would improve her acne, but would not eliminate it. She told Ms A that the whiteheads that were coming out were old, and had been under the skin previously. Ms E thought she might have told Ms A that she would be likely to require 10 to 15 treatments. Ms E said she thought that Ms A was already aware of how many treatments would be required. Ms E felt that perhaps Ms A had not understood the explanation that Dr B had given her.

Ms A recalled having a discussion with Ms E following the "break-out" that occurred after her first treatment. However, Ms A's recollection is that she was upset about the break-out, and that Ms E explained that sometimes acne gets worse before it gets better. Ms A cannot recollect Ms E telling her that the treatment might not eliminate her acne. Ms A said that no one warned her of this, otherwise she would not have proceeded with the treatment. She also advised me that no one mentioned the possibility that she might require 10 to 15 treatments, and she would not have agreed to this many.

Remaining treatments
As Ms A wanted her next dermabrasion treatment at a time when neither Ms E nor Dr B would be available, Ms E made Ms A's next appointment with Dr D (a partner at the Medical Centre) on 15 December 1999. Dr D's note of this date states:

> "ambivalent re result so far; adhering to skin care regimen. Concerned re eruption of new crops of whiteheads in 'beard' area. Cont Eryacne/Dermatech, see 8/7."

At the next dermabrasion treatment on 22 December 1999, Dr D noted that Ms A's acne was improved:

> "feels result good, most improved centrally. Cont skin cares.
> Extensive dermabrasion L>R cheeks/pre-aural region.
> See 2/52."

On 6 January 2000, at the next treatment, Dr D noted:

> "occ new whiteheads erupting; happy c overall progress
> Extensive dermabrasion R + L cheeks; cont skin cares; rev 10-14/7"

At the last dermabrasion treatment on 19 January 2000, Dr D noted:

> "g result from last extensive abrasion, tho' disappointed c new whiteheads in cheekbone area. Compliant c skincare regime. Skin texture improved, small islands of thickened strat corneum.
> Plan: rebook 2/52 – photos, ? Rx CTZ ?3 further derms."

On 26 January 2000, Ms A returned to the Medical Centre and saw Dr D along with Dr B to advise them that she was not happy with the results of her treatment. She was not happy with her face, and told them it looked scarred and she was still getting whiteheads.

Ms A made a claim to ACC for medical misadventure, because of scarring and continuing acne following the micro-dermabrasion treatments. ACC declined the claim on the basis that there was no evidence that she had suffered medical misadventure.

Medication prescribed
Ms A said that Dr B prescribed her Trisul tab (trimethoprim 80mg and sulphamethoxazole 400mg – also known as Bactrim or co-trimoxazole) at the meeting on 26 January 2000. She told Dr B that because of her liver problem, she could not take the tablets he had prescribed.

Ms A forwarded a copy of the prescription form, signed by Dr D, along with a note written by a pharmacist in a local pharmacy. The note queried the prescription because Bactrim "is contra-indicated in patients with marked liver parenchymal damage" or severe hepatic failure, and should be "used with caution in patients with lesser degrees of hepatic impairment".

Dr B advised me that he was not even in the room when Dr D wrote out the prescription, but there was no problem with the prescription and he would have prescribed the same thing. Ms A claimed that Dr B was present when the medication was prescribed.

Dr D advised me that he thought he probably "ran the prescription past" Dr B to ensure he agreed with it.

I reviewed copies of Ms A's medical records from her usual general practitioner, Dr C. A referral letter dated 14 February 2000 from Dr C to Dr F, dermatologist, states in part:

> "… Ms A suffers from Hepatitis C persistent liver disease and although her liver function is normal at present she must avoid all drugs with a potential for liver toxicity. …"

The reply from Dr F, dated 25 February 2000, stated that the co-trimoxazole prescribed by Dr D "… clearly could reactivate her liver problems".

Dr B advised me that Ms A does not have a liver problem:

> "… [Ms A] has a raised bilirubin in isolation which represents Gilbert's syndrome, a very common condition of familial unconjugated hyperbilirubinaemia. This is not related to her Hep C antibody +ve status and is in fact clinically always benign. This would in no way influence her prescribing ..."

Ms A informed me that she had read a library book about acne that stated that the medication she had been prescribed could cause severe side effects. Ms A advised that the only side effect that Dr B warned her about was mild thrush.

Dr D advised me that he could not specifically recall what side effects were discussed with Ms A when he prescribed the medication. In general, he mentions side effects such as light sensitivity or general antibiotic reaction.

Dr B suggested that Ms A could return for a light chemical peel at no charge. However, Ms A decided against this. Ms A advised me that, on the advice of her general practitioner, she did not take the medication prescribed by Dr D.

General consent issues
Dr B was asked about his usual procedure for obtaining informed consent. He advised that he expects a consent form to be completed for every procedure he performs. Ms A signed a consent form, but he was unable to locate a copy of it. Nothing is noted in Dr B's records about the information given to Ms A, or consent being obtained.

Ms A advised me that she never saw or signed a consent form at any stage of her treatment.

Independent advice to Commissioner

Dermatology advisor
The following expert advice was obtained from Dr Amanda Oakley, independent dermatologist, about the services provided by Dr B:

> "…
>
> **My qualifications and experience relevant to the case**
>
> I have been a Specialist Dermatologist since 1987, vocationally registered with the New Zealand Medical Council. My relevant qualifications are MBChB FRACP. I am a member of the New Zealand Dermatological Society, the British Association of Dermatologists and the American Academy of Dermatology.

I have treated several thousands of patients with acne. I am familiar with medical and surgical approaches to management. I am the author of an extensive section about acne and its treatment on the New Zealand Dermatological Society's web site.

I have no personal experience with micro-dermabrasion, a relatively new technique aimed at the cosmetic surgical and aesthetic market. However, I am familiar with advertising material about micro-dermabrasion. There is scanty information about this procedure published in the scientific medical literature (see enclosed literature). Extensive searching of the Internet has revealed both advertising material and unbiased information from reputable medical organisations.

I have experience with laser resurfacing and superficial and medium depth chemical peels. I work closely with plastic surgeons that perform conventional dermabrasion.

As far as I know, I have never met the patient or the health professionals involved in this case. I will answer the Commissioner's questions to the best of my knowledge and experience.

Specific questions posed in the Commissioner's letter of request

In particular please advise:

- *Please comment on the general information that you would expect someone about to have micro-dermabrasion treatment to be provided with. Please include specific comment on the safety of micro-dermabrasion treatment. Are there risks and side effects associated with this treatment? If so, which of these would you expect someone having this treatment to be warned about?*

In my opinion, the patient receiving micro-dermabrasion treatment should receive information about the following:

- The indications for treatment
- The relevant contraindications
- Other treatments available for the patient's skin condition
- Relevant investigations
- Recommended pre-treatment and adjunctive treatment
- An outline of the procedure
- Aftercare
- The number of treatments (an expected range)
- The expected outcome
- Side effects, risks and complications
- The cost of the procedure.

Micro-dermabrasion is a modern technique used for superficial skin resurfacing. Its indications are ageing changes, superficial scars and acne. It has become popular in cosmetic surgical and dermatological practices because of its affordability, reliability, uniform results, safety and lack of risk.

The cost of treatment relates to the purchase of an expensive state-of-the-art machine, marketing, its 'cosmetic' nature, training and the time and skill required to conduct the procedure.

On its web site, the American Academy of Facial Plastic and Reconstructive Surgery states: 'Micro-dermabrasion – A mini-peeling with minimal risk of dyspigmentation or scarring that is achieved by projecting aluminium micro-crystals onto the skin (also referred as the 'Power Peel', 'Euro Peel', 'Parisian Peel' and 'Derma Peel'); safe for all skin types.'

Risks of resurfacing in general are:

- Pain during the procedure
- Delayed healing
- Infection with bacteria, yeasts and viruses
- Persistent facial redness
- Temporary photosensitivity
- Sensitivity to irritants (such as soap and anti-acne gels)
- Pigmentary changes (darker and lighter patches), especially in darker skin types and with sun exposure
- Rashes including contact dermatitis and acne
- Scarring, due to deep initial injury, secondary infection or the patient picking at scabs.

The risks relate to the depth of tissue injury. The deeper the injury, the longer the recovery time and the greater the chance of a complication. Micro-dermabrasion is very superficial (although the depth of injury can be varied by the practitioner to a degree), so it doesn't hurt, it doesn't make the skin red for very long and it doesn't result in significant risk of tissue injury (i.e. scarring). The skin recovers in a few days. Therefore the risks above do not need to be discussed except to indicate the advantages of micro-dermabrasion over more invasive therapy.

On the other hand, this gentle treatment will not result in dramatic overnight improvement when there is significant skin pathology.

Scars are due to injury to the deeper layers of the skin, the dermis. Acne scars are due to complex injury and are difficult to improve by any technique. Superficial techniques such as micro-dermabrasion are not useful for deeper acne scars but can improve overall contour by evening out the skin surface. In addition, repeated injury to the epidermis (the outer part of the skin) appears to stimulate new collagen to form – this has been demonstrated with a number of superficial resurfacing techniques.

Whiteheads (properly known as closed comedones) are collections of sebum (skin oil) and dead skin cells blocking up a follicle. They are the precursor lesions for inflammatory acne spots. Resurfacing techniques such as micro-dermabrasion can unplug these comedones by abrading off the surface skin. Resurfacing does not

prevent new lesions forming so if there is active acne, micro-dermabrasion is only effective if accompanied by medical treatment.

Resurfacing can be repeated with improved results. Because of their risks, there are long intervals between treatments for the deeper treatments (at least one year for dermabrasion and CO_2 laser ablation, and three months for TCA peels). Superficial techniques can be repeated weekly to monthly, the frequency depending on the depth of injury and the patient's individual response.

Micro-dermabrasion can be compared with other resurfacing techniques.

- It is much cheaper than laser resurfacing (depth of injury varies with the system).
- It is cheaper and much safer than conventional dermabrasion. Conventional dermabrasion requires a skilled and experienced operator and has a significant risk of deep tissue damage.
- It is cheaper and safer than moderate depth chemical peel e.g. 35% tricloracetic acid (TCA) peel – which is also operator-dependent.
- It is about the same price and similar safety to superficial chemical peel (e.g. glycolic acid in various concentrations, Jessner's solution and 20% TCA). Like micro-dermabrasion, superficial chemical peels are repeated at intervals with multiple treatments required for significant improvement in the skin condition.

Similar results can be obtained with long term use of topical retinoids such as tretinoin (Retin-A) and adapalene (Differin), both of which had been used by the complainant. To a lesser extent, regular use of glycolic acid cream (as recommended by Dr B) can do the same. These are used for similar indications as micro-dermabrasion i.e. photoageing changes and acne. Continued use long term can prevent new acne lesions. Treatments can be used in combination. None of these treatments are effective for everyone, and sometimes (like surgical resurfacing) they paradoxically aggravate comedonal acne.

For the purposes of this report, I have looked for patient information about micro-dermabrasion available on the Internet. I have printed a selection for the Commissioner to review. They relate to various different machines.

- Unsigned information by a practitioner 'Micro-dermabrasion by UBNU, Inc'.
- Information by Chicago New Image Specialists
- Advertising material for 'Megapeel'
- Advertising material for 'MDPeel'
- Patient information about removal of acne scars, from the American Academy of Dermatology
- Patient information about micro-dermabrasion, from the American Society for Aesthetic Plastic Surgery
- Patient information about micro-dermabrasion, from the American Society for Dermatologic Surgery (dated 1998, when the technique had just been introduced)
- News item 'Hollywood "peels" for Oscars' (USA Today).

I have also included:

- advertising material for 'Diamond Dermabrasion'
- an abstract from the scientific literature reporting results of micro-dermabrasion for acne (Dermatol Surg 2001;27:329-31)
- an abstract reporting the results of micro-dermabrasion for facial scarring (Dermatol Surg 1995;21:539-42).

In my opinion, the information is similar to that provided to the complainant by Dr B.

- *In your opinion, how likely is it that either further or heavier micro-dermabrasion treatments would have achieved a better result? Did [Ms A] have a sufficient number of treatments?*

A greater number of treatments and more intensive treatment can be expected to have improved the results by continuing to de-roof comedones and smooth the skin surface. However, it is unlikely that this patient would have achieved a perfect result because she had active acne requiring medical treatment and ice-pick scars – these are too deep to resolve with a superficial resurfacing technique. Even state-of-the-art laser resurfacing can only improve these subjectively by about 50% on average.

The claimant had active acne, with a predominance of comedones. These can be seen very clearly in the photographs supplied by Dr B. He reports that she had used topical retinoids for many months, indicating she had fairly treatment-resistant disease. He recommended glycolic acid cream (which would probably be better tolerated but less effective than retinoids) and later Eryacne (a topical antibiotic).

It is unclear from the notes supplied whether she had received prior systemic treatment for her acne or not. Comedonal acne, if unresponsive to topical agents, may respond to hormonal therapy (Diane-35 and other contraceptive pills, and/or spironolactone). The best treatment of all is oral isotretinoin. Oral isotretinoin is almost exclusively prescribed by specialist dermatologists because of funding and significant risks/side effects.

Specialist dermatologists in New Zealand would not generally recommend micro-dermabrasion as a first-line treatment for active acne because of the efficacy of medical treatment, particularly oral isotretinoin. However, some comedonal acne resists all medical treatment. I do not have a micro-dermabrasion machine. Like others, I de-roof treatment-resistant comedones using diathermy or cautery – this is painful and may scar but is probably more effective than micro-dermabrasion as one 'seeks and destroys' each individual spot.

However, despite the availability of effective treatment of most active acne, acne scarring is a significant problem for many patients. Resurfacing techniques offer hope to improvement but rarely result in complete resolution.

Oral antibiotics are commonly used to control inflammatory acne. A few scratched inflamed spots can be seen in the photographs of the complainant so the prescription of antibiotics by Dr B and later by Dr D was logical.

- *Please comment on [Ms A]'s initial request for a chemical peel. Would a chemical peel have been inappropriate for [Ms A]'s problem? If so please explain why.*

As explained above, chemical peels can be superficial or moderate depth. They can also be 'deep', using phenol, but this technique is rarely used and would not have been offered by Dr B. Superficial peels are comparable to micro-dermabrasion, but the latter has become popular among those who have purchased the equipment because it is reproducible and apparently produces better results. A moderate depth peel is more frequently recommended for photoageing (brown blotches, dry patches, fine wrinkles) rather than active acne or acne scarring. A moderate depth peel results in 7 to 10 days of considerable facial swelling and unsightliness. There is a significant risk of complications.

It is therefore usual to recommend more superficial treatments initially, reserving moderate depth peels for those whose skin problems resist the superficial treatment. The deeper peels are also generally avoided during the summer months as there is a significant risk of sun exposure resulting in unsightly pigmentation. Combination treatments can be done.

- *Please comment on the complaint that [Dr B] did not perform a patch test prior to commencing dermabrasion treatments.*

The term 'patch test' is a misnomer. I believe 'test treatment' or similar term should be used. (Patch test is the term used for an investigative procedure determining the presence of contact allergy in patients with dermatitis.) There is no need for a test treatment prior to micro-dermabrasion because it is so superficial and multiple treatments are required to see significant response.

- *Please comment on the complaint that [Dr B] did not inform [Ms A] that the proposed series of micro-dermabrasion treatments should be spaced at monthly intervals.*

As you will see from the attached literature, micro-dermabrasion can be safely performed at weekly or biweekly intervals. Longer spacing between treatments will delay achieving desired results and is particularly undesirable if there is active acne as it would allow the comedones to reform.

However, the practitioner performing the peels should assess the patient's skin and delay treatment if healing is not complete from any prior procedure.

- *Could you please comment on the advertising literature for micro-dermabrasion treatment that was provided to [Ms A]? In your opinion, is this advertising misleading?*

The advertising material may be considered misleading in that this patient may have had unrealistic expectations from the photographs. I personally find the dramatic before and after pictures of a patient, whose severe acne responded almost completely to treatment, most surprising, and can only imagine she was also undergoing some medical treatment such as oral antibiotics.

The brochure is clearly designed to market the Diamond Dermabrasion in a positive manner and is fairly typical of those produced by cosmetic device companies.

However, I doubt whether the majority of patients would be deceived into believing they would achieve perfect outcomes, any more than they believe the claims made by advertisements for cosmetics in a woman's magazine.

Please also comment on any additional matters which you think should be brought to the Commissioner's attention.

In my opinion, the patient's initial assessment by Dr B was thorough. He investigated her for an underlying hormonal abnormality. He thought of the safety of the health professionals and checked for transmissible infection. He recommended concurrent medical treatment for her acne (without which the micro-dermabrasion, or indeed any so-called 'cosmetic' treatment, would be expected to be disappointing). He discussed other possible treatments.

The adequate medical notes and the numerous documents supplied to me indicate the treatment was discussed adequately with the patient. I do not consider the absence of a signed consent form is a serious problem – health practitioners perform many procedures every day without these. And many consent forms are signed despite inadequate information having been provided or understood.

I have examined the 'before' and 'after' photographs. Although not of professional quality, there is sufficient detail to confirm the presence of significant superficial active acne and quite extensive acne scarring. There is slight postinflammatory patchy redness on the cheeks in the 'post' treatment pictures dated 26 Jan 00. This is mild and not unexpected, arising 7 days after the sixth procedure, and would be expected to fade over a few weeks. Some spots have been picked in both sets of pictures.

On-going skin problems in this patient are not likely to have been caused directly by the micro-dermabrasion.

Depression occurs quite commonly in patients with acne. Effective treatment can be hugely beneficial. Acne patients sometimes also suffer from dysmorphophobia –

they are convinced their skin is in a terrible state even though there is little objective evidence for it.

I note Dr C has attached blood test results taken over several results. Most are normal or show slight increase in bilirubin, consistent with Gilbert's syndrome (a harmless enzyme deficiency). However, there was a significant mild hepatitis in 1997. Dr B may have been unaware of this. Was it hepatitis C, or was it the reported reaction to minocycline? The more recent hepatitis C test results would be consistent with an active hepatitis infection in the past (there are antibodies to this virus), which has now resolved (the viral RNA is negative). There is no evidence for ongoing liver disease as far as I can see from these results (but I am not a liver specialist of course).

I understand the Commissioner has sought separate advice about Ms A's complaint about allegedly inappropriate medication being prescribed. However, I would like to comment about this.

The notes indicate Dr B prescribed doxycycline as well as topical agents. I am not sure if the patient took these, but I suspect from the correspondence that she did not. Although tetracyclines such as minocycline (which Dr B's notes indicate had resulted in liver dysfunction in the past) or doxycycline are usually prescribed for acne, trimethoprim and sulphamethoxasole (as prescribed by Dr D) are also recognised treatments for acne. They are quite effective for inflammatory spots, but unhelpful for comedones. Sulphamethoxasole can cause serious allergic reactions. It would not be expected to cause a problem with this patient's liver because her liver function was normal at the time of prescription. All antibiotics may rarely cause liver dysfunction or allergic reactions however.

To advise the Commissioner whether, in your professional opinion, [Dr B] provided [Ms A] with services with reasonable care and skill, and that complied with relevant professional standards.

In my professional opinion, and according to the extensive information supplied to me, Dr B provided Ms A with services with reasonable care and skill, and that complied with relevant professional standards."

I sought some further information from my dermatology advisor. Dr Oakley clarified that it was appropriate for the micro-dermabrasion to be performed in conjunction with the topical medication (creams) which Dr B prescribed on their own, whether or not the oral medication (doxycycline) was also taken.

Dr Oakley also indicated that it is not rare for treatments (such as micro-dermabrasion and medication) to be ineffective for some people, or to sometimes aggravate comedonal acne. Ms A should have been warned of this possible outcome prior to the treatment commencing.

General practitioner advisor
The following expert advice was obtained from Dr Wendy Isbell, an independent general practitioner, about the appropriateness of the medication prescribed to Ms A:

"…

1. Is there evidence that [Ms A] has a liver problem and/or Hepatitis C?

From the information given, Ms A suffered from Hepatitis C in early 1995. At that time her Hepatitis C antigen was positive. Later, her Hepatitis C antibodies were positive, indicating that her body had formed antibodies and was immune to Hepatitis C. She did not have an ongoing condition of Hepatitis C, as she had a negative PCR RNA test.

Her liver enzyme tests were high at the onset, but were normal from 1995, indicating no further liver damage from Hepatitis C infection.

I agree with Dr B that Ms A probably has Gilbert's syndrome (for more information on Gilbert's syndrome refer to Appendix A). This is from evidence that her total bilirubin ranged from normal to early 30s on different occasions, while at the same time she had normal liver enzymes.

2. Does the medication Co-trimoxazole have potential for liver toxicity in patients with Hepatitis C persistent liver disease?

First of all, there is no evidence that Ms A has Hepatitis C persistent liver disease.

In the report, there is a note written by a pharmacist saying that Bactrim (Co-trimoxazole) is contraindicated in patients with marked liver parenchymal (tissue) damage, or severe hepatic (liver) failure, and should be used in caution with patients with lesser degrees of hepatic impairment.

These conditions represent marked impairment of the liver, whereas at the time the Co-trimoxazole was prescribed, there was no evidence of hepatic (liver) impairment.

3. Please advise whether the medication prescribed was inappropriate.

In 1997, after being prescribed an erythromycin antibiotic, Ms A developed markedly abnormal liver function tests, and they resolved over time. It was interpreted that this increase was due to the erythromycin. In practice, one would have to assume that the erythromycin had caused the change in liver tests, and would therefore have to avoid erythromycin at a later stage.

Co-trimoxazole is not related to erythromycin, and therefore there would be no contraindication to prescribe this. However, once one has had abnormal liver function tests with one antibiotic, care would have to be taken with others as well. I think that it would be appropriate to prescribe Co-trimoxazole, although a

dermatologist would be better able to say whether it was the best drug for this condition.

4. Potential side effects by Co-Trimoxazole.

In the New Ethicals Catalogue May to November 2001, the only patient information that is recommended is that of possible photosensitivity (sensitivity to sunlight), and the importance of maintaining an adequate urine output. Appendix B contains the full listing for Co-trimoxazole.

Thank you for asking me to comment on this case. I trust my opinion is useful to you.

Appendix A: Gilbert's syndrome

In the body, red blood cells break down in a series of steps, to produce bilirubin, which is the coloured part of bile. The bilirubin is excreted from the liver into the gall bladder and then into the small bowel.

Gilbert's syndrome is characterised by a mild increase in bilirubin, from one stage of the breakdown, and is caused by a lack of one particular enzyme in the liver. Standard liver enzyme tests are normal and liver biopsies are normal.

Gilbert's syndrome is usually diagnosed by chance, on a standard liver function blood test.

The bilirubin levels are high, ranging from normal up to 51 (normal at our local laboratory being 15). The levels may fluctuate substantially, and are more elevated with stress, fatigue, alcohol use, reduced caloric intake and intercurrent illness.

Gilbert's syndrome is common, with many series placing its prevalence at 8% or more.

Drug metabolism is reported to normal in patients with Gilbert's syndrome, apart from one anti cancer agent.

Appendix B: New Ethicals Catalogue

BACTRIM
Co-trimoxazole (trimethoprim/sulphamethoxazole)

Syrup: 40/200mg per 5ml (240mg), 100ml ($3.25) NS.

Tablet: 80/400mg (480mg), 50s $7.94) NS

USE: Antibacterial – sulphonamide (broad spectrum). (Adults and children over 12 years, 960mg twice daily. Severe infections, 1440mg, twice daily. Minimum dosage and dosage for long term treatment, 480mg twice daily. Children 6 to 12 years,

480mg twice daily. Children 6 months to 5 years, 240mg twice daily. Children 6 weeks to 5 months, 120mg twice daily.)

Contraindications: Marked liver parenchymal damage; severe renal impairment; premature and newborn infants (first 6 weeks).

Precautions: Haematological disorders; renal and liver impairment, the elderly, G-6-PD deficiency; severe allergy and asthma; porphyria and thyroid dysfunction; pregnancy, breast-feeding.

Adverse Effects: Occasionally GI intolerance e.g. nausea, stomatitis, diarrhoea; skin reactions (rarely, severe); folic acid deficiency, mild and transient haematological abnormalities. Rarely megaloblastic anaemia, purpura, agranulocytosis, hyperkalaemia, hypoglycemia.

Interactions: Increased incidence thrombocytopenia with thiazide diuretics in the elderly. Dosage reduction of digoxin, warfarin, phenytoin, hypoglycaemics may be required. Possible megaloblastic anaemia with high dose pyrimethamine. Potentiates nephrotoxicity, cyclosporin. May decrease antidepressant effects of tricyclics. May increase concomitant methotrexate levels.

Patient information: Possible photosensitivity. Maintain adequate urine output."

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.

…

3) Every consumer has the right to have services provided in a manner consistent with his or her needs.

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.

…

6) Where informed consent to a health care procedure is required, it must be in writing if –

…

(d) There is a significant risk of adverse effects on the consumer.

Opinion:
No Breach

Right 4(1)

Patch test
Ms A advised me that Dr B did not perform a patch test prior to commencing her micro-dermabrasion treatment. My advisor informed me that the term "patch test" is a misnomer, and that Ms A was referring to a "test treatment". I accept the opinion of my advisor that a test treatment was unnecessary prior to micro-dermabrasion treatments, which are superficial. In my opinion, Dr B did not breach Right 4(1) of the Code in this respect.

Spacing between treatments
The information gathered during my investigation suggests that micro-dermabrasion is much safer than conventional dermabrasion, because it is a superficial treatment. I accept the advice of my dermatology advisor that micro-dermabrasion treatment can be safely performed at weekly or biweekly intervals. Accordingly, Dr B did not breach Right 4(1) of the Code in giving advice about the spacing of treatments.

Right 4(3)

Ms A's request for a cosmetic approach
Ms A advised me that she requested a cosmetic approach to her acne problem when she first saw Dr B, and did not want medication. Dr B did not recall Ms A advising him of this. My dermatology advisor supported Dr B's advice that it would be inappropriate to perform micro-dermabrasion treatment without medical treatment. In my advisor's opinion, Dr B did accompany Ms A's treatment with appropriate medication, in light of the medicated creams and doxycycline which he prescribed.

Ms A advised me that she took the doxycycline capsules because she thought they were a mild antibiotic. She also had no objection to using the medicated creams prescribed by Dr B. Ms A did not want to take medication that aggravated her liver problem, but had no objection to any other medication prescribed.

Ms A's willingness to take the doxycycline and use the creams is contrary to her claim that she specified she wanted a cosmetic approach only. There is no evidence to support the complaint that Dr B prescribed medication contrary to Ms A's request. In my opinion, Dr B provided services to Ms A in a manner consistent with her needs, and therefore did not breach Right 4(3) of the Code.

Right 6(1)

General information provided prior to Ms A's treatment
Ms A had the right to receive the information that a reasonable consumer would expect to receive in her circumstances at that time. In my opinion, Dr B and Ms A did have a detailed discussion prior to her agreeing to undergo a series of micro-dermabrasion treatments.

During this discussion, Dr B advised Ms A that micro-dermabrasion was a relatively new, safe and usually painless technology. He described the treatment and what it would entail. Ms A and Dr B both recalled that he indicated a minimum of six treatments would be required, although Ms A did not accept that a maximum was specified. Ms A advised me that she hoped she would require only four treatments, because of a photograph in the brochure that Dr B gave her.

I do not believe that Dr B can be held responsible for Ms A's expectation in this regard. He clearly indicated that at least six treatments would be required, and this is documented in his notes. He did not make a specific reference to the photographs when he gave Ms A the brochure. I also note that the reverse side of the brochure indicates that the need for six treatments is common.

Ms A and Dr B agree that he warned her that her skin may be a bit red for a few days. Dr B advised me that he usually indicates the skin may be a bit scabbed or bruised.

Dr B advised me he offered Ms A a "range of choices" of treatment, which included options of laser treatment (available elsewhere), antibiotic therapy, topical AHA creams, micro-

dermabrasion or a chemical peel. Dr B advised me that after their discussion, the chemical peel was deferred.

Ms A advised me that the only options offered by Dr B were the dermabrasion treatment and topical creams. She stated that the chemical peel was discarded in favour of micro-dermabrasion treatment. I am unable to reconcile these conflicting accounts in the absence of independent witnesses.

My dermatology advisor informed me that she would expect someone about to undergo micro-dermabrasion treatment to be provided with information about indications and contraindications for treatment, other treatment options available, relevant investigations, recommended pre-treatment and adjunctive treatment, a treatment outline, the number of treatments, and information on the number of treatments, aftercare and cost.

On balance, I am satisfied that Dr B did provide adequate general information about the proposed micro-dermabrasion treatment and therefore did not breach Right 6(1) of the Code.

Right 7(1)

HIV test
Ms A advised me that in her initial discussion with Dr B, he informed her that she would need to be tested for HIV prior to any treatment commencing. Ms A advised me that she told Dr B that she had been tested for HIV previously, and they agreed that she would "ring the laboratory" to get the result of her earlier test. Ms A made this call, and also went to the laboratory to be tested for hepatitis B. However, she said she did not realise that Dr B had ordered a fresh HIV test.

Dr B denied Ms A's claim, and advised me that the HIV test was discussed openly. I accept Dr B's advice that, if he was concerned about Ms A's HIV status, it would have been inappropriate for him to rely on the results of an old test. I note that both Dr B and Ms A agree that there was discussion regarding the HIV test. However, I do not believe that Dr B would have agreed to rely on an old test. I believe that a misunderstanding occurred during this discussion and that Ms A believed that she was to obtain her old result. Dr B assumed from the discussion that Ms A had consented to a fresh HIV test being performed. I think that Dr B made an honest and understandable mistake, and acted reasonably in proceeding to order an HIV test in these circumstances. Accordingly, in my opinion Dr B did not breach Right 7(1) of the Code.

Opinion:
Breach

Right 6(1)

My dermatology advisor informed me that she would expect someone about to undergo micro-dermabrasion treatment to be informed of the likely outcome of the treatment, and relevant side effects, risks and complications. My advisor informed me that no treatment, including medication/micro-dermabrasion, is effective for everyone and "sometimes … they paradoxically aggravate comedonal acne". My advisor informed me that this risk is not rare and, along with the possibility that treatment may not be completely effective, should be discussed with the patient.

Ms A advised me that Dr B never told her at any time that the treatment may not be 100% effective. He provided her with only positive information about the treatment, apart from advising her that her skin might be red for a day or two after treatment. Ms A advised me that Dr B told her that her skin would be smooth after the treatment, and she interpreted this to mean that her acne would be gone.

Dr B advised me that although he cannot recall the specific details of his discussion with Ms A, he would have informed her that the treatment might not eliminate her whiteheads. He also advised me that micro-dermabrasion treatment is a low risk treatment; the only risk he is likely to have mentioned is that the treatment could temporarily make Ms A's skin a little red, scabbed, or bruised. It is likely he told Ms A that treatment would significantly improve her acne and would improve the contour of her face over a series of treatments. I accept Dr B's advice that he "does not make promises" about what can be expected from acne treatment, and that he never advises anyone that they will have a perfectly smooth face after treatment.

Ms A and Dr B have supplied conflicting information about whether a consent form was signed. Dr B's records do not refer to consent being given to micro-dermabrasion treatments, nor do they indicate what information was given about the treatment during the consultation. Nevertheless, I agree with my advisor that the absence of a consent form does not in itself indicate that Ms A did not consent to the treatment.

However, both Dr B and Ms E advised me that they formed the impression that Ms A had high expectations about what could be achieved from micro-dermabrasion treatment. Ms E documented this at the time of Ms A's second dermabrasion treatment. Dr B advised me that it was evident to him that Ms A had unrealistic expectations when she first asked for a chemical peel.

In my opinion, in light of Ms A's apparent expectations, Dr B had a responsibility to ensure that he fully informed her on all aspects of the treatment. This should have included explicit advice that the treatment might not be effective for her, as well as a warning that treatment may sometimes "paradoxically aggravate comedonal acne". Dr B thought he would have told Ms A her acne would not be eliminated, although he could not specifically recall stating

this. He did not warn Ms A that her acne might be aggravated by the treatment. I accept the advice of my advisor that there is no evidence that Ms A's acne actually was aggravated by the micro-dermabrasion treatment. Nevertheless, Dr B should have informed her of this risk, in addition to directly stating that her acne might not be eliminated by the treatment. It is not sufficient that he "did not make any promises".

In my opinion Dr B did not provide Ms A with adequate information about the possible outcome, side effects and risks of her treatment. By his failure to disclose sufficient information, Dr B breached Right 6(1) of the Code.

Actions

I recommend that Dr B take the following actions:

- Apologise in writing to Ms A for his breach of the Code. This apology is to be sent to the Commissioner and will be forwarded to Ms A.
- Review his practice, in particular in relation to information disclosure and documentation of consent, in light of this report.

Further actions

- A copy of this opinion will be sent to the Medical Council of New Zealand.
- An anonymised copy of this opinion will be sent to the Royal New Zealand College of General Practitioners and the New Zealand Dermatology Society, for educational purposes.

Other comments

Medication prescribed and side effects
Part of Ms A's complaint is that Dr B inappropriately prescribed co-trimoxazole (Bactrim) and did not warn her of its side effects. However, the prescription form was signed by Dr D. Dr B advised me that he was not even in the room when Dr D wrote out the prescription, although Ms A disputed this. The doctor who signs a prescription form is responsible for that prescription, and for informing the patient of any relevant side effects of the prescribed medication. Accordingly, in my view Dr B was not responsible for this prescription.

In any event, there is no evidence that the prescription was inappropriate. My general practitioner advisor informed me that Ms A's liver enzyme tests were high at the onset of her hepatitis C, but were normal from 1995, indicating no further liver damage from hepatitis C infection. Dr B had appropriately carried out liver function tests prior to Ms A's treatment. I accept the opinion of my general practitioner advisor that it was appropriate to prescribe co-trimoxazole in light of Ms A's normal liver function tests. I also note that although Dr D could not specifically recall what he told Ms A about the medication, he would normally advise of side effects such as light sensitivity and antibiotic reaction. There is no evidence to suggest that Ms A should have been warned about other severe side effects.

Advertising material

Dr B supplied Ms A with a brochure about micro-dermabrasion treatments, which included before and after photographs of a person whose active acne resolved after four treatments. Dr B did not make any specific reference to the pictures included in the brochure when he gave it to Ms A. Dr B did advise Ms A that she was likely to require at least six treatments. Accordingly, I do not believe that he directly contributed to her belief that her acne might resolve with four treatments, based on pictures in the brochure.

However, advertising material such as this brochure should be used with caution, particularly when given to a patient who may already have unrealistic expectations of what a treatment may achieve. In my opinion, use of this type of advertising material should always be accompanied with a detailed explanation of what the treatment can realistically be expected to achieve.

Written consent to HIV test

In light of the significant risk of adverse psychological effects on a patient who discovers, from a blood test, that she is HIV positive, Dr B should have obtained written consent to the HIV test, in accordance with Right 7(6)(d) of the Code.