A General Surgeon

A Health Service

A Report by the

Health and Disability Commissioner

(Case 99HDC09888)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Ms A	Consumer
Mr B	Consumer's husband
Dr C	Provider / General Surgeon
Dr D	Registrar
Ms E	Staff Nurse

Independent expert advice was obtained from Dr F, general surgeon.

Complaint

On 9 September 1999 the Commissioner received a complaint from Ms A about Dr C, general surgeon. The complaint is that:

- *On 4 September 1999 prior to removing a seton suture from Ms A's anal sphincter muscle Dr C failed to provide an explanation of what he intended to do and did not inform Ms A of the risks, side effects, consequences and alternatives to performing the procedure.*
- *Dr C did not obtain informed consent from Ms A before he removed the seton suture.*
- *When Dr C removed the seton suture he did not offer or provide any pain relief although:*
  - *his registrar had previously determined pain relief was necessary and had asked a nurse to obtain pain relief before continuing with treatment*
  - *Mr B asked Dr C for pain relief to be given to his wife, Ms A*
  - *Ms A expressed and displayed symptoms of great pain.*
- *After he performed the procedure Dr C did not inform Ms A that he had removed the seton suture, explain why he had removed it, inform Ms A of the consequences of removing it or advise her of the care that was subsequently required.*
- *While Dr C was providing treatment to Ms A he was rude and abrupt and showed no concern for her pain and distress.*

An investigation was commenced on 17 February 2000.

Information reviewed

- Complaint letter and tape recording (recorded on the day after the consultation with Dr C) from Ms A, consumer/complainant.
- Notes of interview with Dr C.
- Relevant medical records held by a public health service.
- Notes of telephone interview and tape recording from Mr B.
- Notes of interview and written information from Dr D, Registrar for Dr C.
- Notes of interview and written information from Ms E (at the time known as Ms G), Staff Nurse.

Information gathered during investigation

Background

Ms A was diagnosed with Crohn's disease in 1996 after a colonscopy and a biopsy performed by Dr C. Crohn's disease is a condition where segments of the alimentary tract become inflamed, thickened and ulcerated. In its chronic form it can cause partial disruption of the intestine, leading to pain, diarrhoea and malabsorption.

Dr C and Dr H, gastroenterologist, jointly managed Ms A's condition. Her major health problem is described in the records as an anal fissure (a break in the skin lining the anal canal), a common complication arising from Crohn's disease. On 9 March 1999 Ms A had an examination under anaesthetic, excision of a peri-anal tag, and a fistulotomy (surgical removal of a fistula, an opening between the anal canal and the surface of the skin). On 25 June 1999 Ms A had a seton placed around her anal sphincter muscle by Dr C to treat the fistula. A seton is a form of treatment in which a thread (similar to a rubber loop or ring) is passed through a fistula and tied in a loop. A seton acts as a wick to drain off pus and can be tightened by looping a suture around it to slowly cut through the fistula over a period of months. This method is used to treat high anal fistulas because it has a reduced risk of causing incontinence. On 19 July 1999 and 30 August 1999 Dr D, Dr C's registrar, tightened the suture holding the seton in place.

On 1 September 1999 Ms A contacted a public hospital as she was in a lot of pain due to the tightening of the suture. She recalled that her pain was more than it had been after the insertion and the previous tightening and had increased so much that she was unable to walk properly or sleep without the aid of codeine and panadol. Ms A said she spoke to Dr C's registrar, Dr D, who advised her to take some pain relief and, if the pain continued, to contact him on 3 September with a view to the suture being cut the following day.

By 3 September 1999 Ms A was still in pain. She made an appointment to see Dr D at a public hospital on 4 September 1999. The purpose of the consultation was to have the suture cut and reduce pressure on the seton.

Consultation on 4 September 1999

Ms A's account

Ms A said that she and her husband, Mr B, attended the appointment with Dr D. They met him and Nurse E at the reception area and went to a bathroom with an examination table in it, at the back of the ward. Dr D asked Ms A to undress. He then left the room. In Dr D's absence Ms A undressed and lay on the bed.

Ms A said that on Dr D's return he told her he would cut the stitch that was tightening the seton. Ms A said she was lying on her side. To cut the stitch Dr D pulled the seton. Ms A said this caused her "excruciating" and "severe" pain. She started to scream, which she said is unusual for her as she can endure a lot of pain as a result of Crohn's disease and is slow to take pain relief.

Dr D then asked Ms A whether she had taken any pain relief that morning and she replied that she had taken some panadol but had some codeine with her, which she then took. Dr D then told her that he would try to cut the suture one more time. The pain relief she had taken had not had time to take effect. On the second attempt Ms A said that the pain was so intense she grasped a cord on the wall and again she screamed and shook and tears rolled down her cheeks. She said that she felt like she was going to vomit.

Ms A said that then Dr D asked Ms E to obtain some morphine and nitrous oxide. He explained that pain relief was necessary as Ms A was in too much stress and pain to continue the procedure without it. He then left the room for a second time.

Ms E said that Dr D was "adamant" that pain relief was required. Ms E said that in her opinion the pain relief ordered by Dr D was "adequate and probably about as good as we could do for her aside from an anaesthetic in an outpatient situation".

Dr C

Ms A recalls that when Dr D had been out of the room for about a minute Dr C came into the room and said to her that he wanted to "have a look at it", with no other greeting. Mr B said, "There were no niceties. He was clearly annoyed." Ms A asked him to be very gentle as she was in a lot of pain. Ms A said that Dr C attempted to cut the stitch.

Ms A said she screamed and was beside herself as she was already in a distressed state. She said that Dr C responded by asking her twice not to scream as it was hurting his ears. She said that the tone of his voice was angry and gruff. Ms A said that she felt Dr C's comments meant that she did not have a right to scream and was screaming for nothing. Ms A recalled that she was totally terrified and thought that Dr C was going to proceed regardless of how she felt about it and that she had no choice in the matter. She said he had no respect for her level of pain. Ms A then said that Dr C asked Dr D to get some scissors, which he left the room to do.

Ms A recalled her husband then asking Dr C whether she could have an injection of some kind for the pain, to which he replied that it would hurt as much as the procedure he was doing and would not work. Ms A recalled being shocked and terrified about what Dr C was going to do and feeling that she had to be quiet. She then asked Dr C what she was expected to do for the pain and he replied that she needed to control it. Ms A said she next asked Dr C whether he could give her any pain relief or something to bite on. Ms A recalled that Dr C told her that she did not need any.

Dr D then returned with the scissors and Dr C twice asked Ms A to hold her buttocks up again in a gruff, angry tone. Mr B said Dr C said, "Hold it up … hold it up or I can't do it."

Ms A said that she was so frightened she tried to plead with her husband to help her as she did not have the strength to stick up for herself, but her voice was broken and he could not understand what she was saying. She was trying to say "wait, wait". She said that her husband and Dr C asked her to relax and then she rolled over for Dr C to attempt to cut the stitch for a second time. Ms A said she was in such a distressed state that she could not think rationally to stop what was being done to her. She then shoved her face into a pillow and bit on it to help with her pain.

Mr B felt that Dr C was not listening to their requests for pain relief prior to undertaking the procedure. He felt that there was nothing he could do to help his wife but hold her hand and urge her to relax. He thought they had no other options but to assent as he had earlier tried to stop Dr C from proceeding without pain relief.

Mr B described Ms A's pain as "bloodcurdling". Mr B said he was "absolutely clear" that Dr C told Ms A "absolutely nothing" about his intention to remove the seton. The seton was removed "without any consultation at all". Mr B described Dr C's tone as "belligerent, dismissive, extremely impolite and angry".

After the procedure

After Dr C cut the suture, Ms A recalled that he said to her in the same tone he had used throughout the consultation, "Right that's it, you'll have to come back in another month and have it done all over again and then just walked out of the room – no goodbye." Ms A recalled that she was in a total mess and was given a glass of water by Dr D but she was unable to hold it as her hand was shaking so much. She recalled Ms E then returning with the pain relief and being told by Dr D that it was not required any more. Ms A said that Ms E looked at her with a shocked face and asked whether she was all right. Ms A described Dr D as white and shocked and presumed this was because of what he had witnessed. Ms A said that she responded to Dr D that she was all right because after Dr C had removed the seton, she did feel better and was no longer screaming.

Mr B said that Dr C said, "There it's done you'll have to come back in another month's time for an operation for us to put it back in." Then Dr C left. Mr B thought that meant that Ms A would have to come in to have another stitch put in around the seton.

Ms A said she continued to cry and shake all day, felt like vomiting, and had stomach cramps and nightmares.

Ms A said that it was not until the next day when she was in the shower that she realised Dr C had removed the whole seton rather than just the stitch.

It is clear from Ms A's tape-recorded statement of 5 September 1999 (the day after the consultation) that she found the consultation with Dr C extremely traumatic and said, amongst other things, "He was just really rude, aggressive and controlling and I had no rights and I had no right to say what I would like to happen." Ms A felt at the end of the procedure as though she had been violated. She felt she was treated like a "silly woman that was experiencing pain and shouldn't have been expressing it and that I wasn't even worthy of communication of the whole event".

Mr B said: "It was just absolutely shocking and there are two main things about it that I found extremely objectionable. One is his attitude and the way he spoke to both [Ms A] and myself, particularly [Ms A], the way he was just so absolutely misogynistic towards her and secondly, the fact that he performed an operation without any consultation whatsoever."

Dr C's account

Dr C said that he originally saw Ms A in 1996 or 1997 and had undertaken surgery on two occasions, once to drain an abscess and another time to insert a seton through her fistula. He described her as having a steady downhill path with repeated problems due to Crohn's disease.

Dr C said that he did not know Ms A had contacted Dr D and told him she was very sore after the previous tightening and that he had arranged for her to come to the ward. Dr C said that he came to the ward to do his usual ward round and heard someone screaming. He went to the treatment room and saw Ms A, her husband, a nurse and Dr D. He described Ms A as hysterical, screaming at the top of her voice and extremely upset because of the pain she was in.

Dr C recalled that Dr D told him that Ms A had a seton, which he had tightened, but because she was in pain he had been trying to undo the knot. Dr D also told him that he had made two attempts to do this. Dr C told Dr D that there was no point in trying to undo it as the slipknots went only one way. He said that to get relief the seton needed to be cut.

Dr C said that Dr D was a junior registrar at the time, had just come to the service and had no great experience with Crohn's disease. Dr C said that he told Dr D after their subsequent ward round that it was inappropriate for a patient to appear on the ward without him knowing about it. He also told him the ward was not the place to see a patient and attempt to loosen a seton and that the Emergency Department had a facility to see outpatients in a hurry if he needed a proper clinical room. Dr C described his manner to Dr D as blunt and to the point. Dr C said that he was probably annoyed and angry with Dr D. He confirmed that there is no written record of this conversation.

Dr D did not recall being admonished by Dr C. Dr D said that in 1999 it was not uncommon for patients at a public hospital to be reviewed on the ward, especially if the patient needed to be seen before the next clinic. Dr D also said that it is standard practice for a registrar to review a patient before discussing the situation with the consultant.

Procedure

Dr C said he would have said hello to Ms A and clarified with her what the problem was. Then he would have asked her if he could have a look at what was going on and got her up onto the bed. He would have asked her to lift up her buttocks so he could examine her anus to make sure that she did not have an abscess or something similar. Dr C said he then explained to her that the seton was causing the pain and that normal practice is to cut the seton, as trying to loosen it is usually unsuccessful. This would relieve her pain. He told her that this would take only a second and give instantaneous relief.

Dr C said he just removed Ms A's seton without trying to cut the suture, as he did not believe that trying to loosen the self-tightening type of seton was possible. He said that it is standard practice in New Zealand to insert setons that cannot be loosened. If there is a problem, he usually cuts them, as they are easy enough to reinsert. He said that he thought there was no other reasonable choice for dealing with the problem.

The only other option, apart from removing the seton, was for Ms A to fast for six hours and be given a general anaesthetic. Then he would cut her seton and reinsert another. He considered that removing the seton without doing this was probably the most appropriate thing and he has done so in every case in which he has seen this problem before.

Consent

Dr C said that surgeons do not usually get written consent for the adjustments or removing of setons and he had never had to. Dr C's view was that Ms A impliedly consented to the removal of the seton, as he had explained to her, albeit succinctly, that he needed to remove the seton as it was causing her pain and she had positioned herself in such a way that he could do this, by holding her buttock up. He said that she consented twice by positioning herself – once for him to examine her and a second time for him to cut the seton. This was the method he normally used to obtain consent to this procedure. Dr C said that he could not remember whether Ms A said, "Yes, you may cut it," but he doubted it because it is not the sort of thing that people say.

Dr C said that there are plenty of avenues by which a patient can stop you looking at their bottom if they do not want you to. He said that after he examined Ms A he told her that he needed a pair of scissors so he could cut her seton. While somebody was getting the scissors Ms A had time to say that she did not wish the seton to be removed.

Dr C said that because there was little in the way of side effects and little in the way of risks or none in removing the seton he probably said nothing about these to Ms A. He said the consequences of removing the seton relate to having it reinserted and he really covered that afterwards.

Dr C said he could not tell whether they discussed the need for the seton to be reinserted before or after he removed it. He suspected he would have said something along the lines of, "Look, we need to take the seton out, it'll get rid of your pain and we can deal with all we're going to do or we may have to put it back in at some point."

Dr D's impression was that Dr C was going to examine Ms A and attempt to release the suture. Dr D thought that Dr C asked to have a look and Ms A rolled on her side but he did not recall anything more specific being said. Dr D was only aware that Dr C had cut the seton after Dr C had finished.

Communication

Dr C said it was clear to him in retrospect that Ms A had not fully appreciated what was to happen, and that there was a communication breakdown. He now suspects that when he said he was going to cut the seton, Ms A thought that meant he was going to cut the knot holding it together rather than cutting and removing the seton entirely. Dr C said that although there was clearly a misunderstanding between him and Ms A, he truly had not appreciated this until he read her complaint letter of 6 September 1999 in October 2001. He had not seen the letter before this. He felt that she had had an adequate understanding of what he was doing. If he had realised that she did not understand that he was removing the seton he would have waited until she had regained her composure before explaining and proceeding.

Dr C also said that Ms A just wanted to be rid of the pain and it was not the sort of situation where you could sit down and have a calm discussion with someone and run through the risks and the pros and cons because she was in a great deal of pain and was very, very upset. He said that what he was saying was going completely over her head and that she didn't seem to understand. In addition, he said that the patient was clearly hysterical at the time and screaming, and any form of reasonable discussion with her was impossible. Dr C added that the cause of the lack of communication in this case was that to communicate with someone who is hysterical is very difficult and if someone is in pain often the communication is not well "interpreted". He said that he sees that "quite often" in people when in pain or given pain relief.

Dr C also said that at the time "rapid quick action" was needed to break what had become a farcical situation, with Ms A screaming. He said that by removing the cause of the pain he thought he could diffuse the situation, which in retrospect may have been the wrong decision. Dr C said that what he would have done differently was to leave Ms A with her husband and the nurse for a few minutes when she was hysterical right at the start. He would then have done his ward round and gone back in half an hour to have a look. Dr C said that then he could have had more of a discussion with Ms A and tried to help her understand what he was saying.

Dr C said he tried to deal with the issue despite the "drama and carry on" because it was exceptional to hear someone screaming the moment you walk in the ward from a room at the far end of the ward. He had never heard that sort of thing before and the amount of noise associated with the screaming was quite extreme. Ms A was obviously hysterical and he could just either leave it and wait for things to settle down or deal with the root cause, which is what he tried to do. Dr C stated that if the same thing were to happen this Saturday he would no doubt just "settle down" the patient and wait. He said that it was like seeing someone drop something on her foot, that you want to immediately lift it off her foot. He thought that removing the cause of her pain would be helping her.

Manner

Dr C confirmed that he probably did use some words to Ms A like, "Please stop screaming, it hurts my ears," but he thinks that it was more likely that he said something like, "Look, you know, can you keep your voice down? This small room it's you know … you don't need to scream, we're just trying to sort this out." The comment was an attempt to diffuse the situation and to calm her down so the issue could be dealt with. Dr C said that some of his comments were perhaps misinterpreted and unwise in retrospect but were really just an attempt to take the tension out of the situation. He said as written comments they do not seem appropriate but the meaning was simply, "Let's get on and get this sorted out."

Dr C said that his alleged response of "control it" to Ms A, when she said, "I can't help it [screaming], what am I to do?" was not the sort of comment that he would make. (I note that both Ms A and Mr B in their tape recording of 5 September 1999 agree that this comment was made.)

Dr C said that his annoyance with Dr D for not informing him of Ms A's presence might have come across to her but it was always hard to know how people interpret things when they are very sore and very difficult. He said that he might have been a bit brisk or quick with her but was not rude. Dr C said he told Ms A firmly to desist from screaming.

Dr C said he may have led things as opposed to allowing a more "discussive" sort of atmosphere, but that reflected the situation where a patient was in a lot of pain, was hysterical and needed something done to relieve the pain. Dr C said that by "discussive" he meant that where a patient is in acute pain you do not have the luxury of an intelligent discussion. Dr C said that to obtain informed consent in those situations you tend to lead patients and advise them that this will relieve their pain. In this case he advised Ms A to allow him to remove the seton to get relief from her pain.

Dr D described Dr C's manner to Ms A as "pretty brief" and "abrupt" and he used a "firm tone".

Pain relief

Dr C said that Ms A had not taken pain relief at any previous consultations with him. Problems with setons are uncommon. Where a seton is too tight, most of the time patients contact him in the first three days after it has been tightened. He advises them to take some Panadol, have a hot bath, and to call him back in a couple of days if the pain is no better. Usually that deals with the problem. He said that adjustment or removal of the seton is not usually done with any anaesthetic.

Dr C said that on arriving at the treatment room Dr D told him that he had requested some nitrous oxide from the orthopaedic ward, which was at the outpatients' department, after two unsuccessful attempts to loosen the seton. Dr C said the fundamental flaw with the use of nitrous oxide was that it assumed the seton could be loosened. He told Dr D that the nitrous oxide wasn't necessary, as it would not make any difference by the time it arrived. Dr C said he would expect it to take easily half an hour to obtain the nitrous oxide on a Saturday morning. He said to Dr D that all that they needed to do was to cut the seton and this would give instantaneous relief to Ms A. Dr D does not recall any conversation along these lines.

Dr C said that Ms A would have had five seconds of increased pain when he grabbed the end of the seton to free it up enough to put the scissors under it. This is because the seton is basically causing an anal fissure which is very painful. Dr C also said that he did not offer Ms A any pain relief as her pain would be very brief and then she would have complete relief.

Dr C also said that most forms of pain relief are still not good enough for a sudden jabbing pain and that even if Ms A had been given morphine she would still have had pain when the seton was pulled for that second. In addition, one of the difficulties with sedation is that people sometimes become more disinhibited. He said that you see this a lot when doing things like a colonoscopy, where you give a little pain relief and the patient starts screaming and you are not doing a great deal to him or her.

He also said that he did not have any idea whether Ms A had had breakfast; if she had, she might have vomited with narcotics or nitrous oxide. Dr D noted that patients with acute pain are regularly given narcotics whether or not they have eaten.

Dr C said he had a brief discussion with Ms A and Mr B about a local anaesthetic. He told them that it would not be worthwhile. He tried to explain to them that this was an immensely tense sort of situation for them and that putting a needle into Ms A and giving her a local anaesthetic would be more painful than just cutting the seton, as this did not involve touching the patient and was instantaneous.

Dr C acknowledged that he did not consider giving some pain relief to Ms A so that he could discuss with her the issues of the cutting or removal of the seton. He said that was perhaps what he should have done. However, if he had prescribed pain relief medication so he could discuss the issue about removing the seton with Ms A, it would have been some form of narcotic, probably morphine, administered intra-muscularly. If he had given her an injection of pain relief medication she may not have been able to recall any conversation or been able to have a meaningful discussion at all with him, because one of the side effects of narcotics is confusion. He said that Ms A might have woken up the next day confused about whether he had cut the seton or cut the tightening suture, but a better discussion may have been possible if her memory was such that she could remember it afterwards. Dr C also said that in hindsight another option could have been to starve Ms A for six hours and take the seton off and replace it with a new one under general anaesthetic.

Dr C said that he did not recall being present when the medication ordered by Dr D arrived. Ms E stated that she arrived in the examination room with the ordered pain medication just as Dr C was leaving. She estimated that it had taken her approximately five minutes to get the required medication. Dr D believed it may have taken about ten minutes.

After the procedure
Dr C said that after he removed the seton Ms A seemed pain free and much calmer. She was able to move freely and seemed much better. He also described her as stunned, as people are when they have been screaming and suddenly stop.

He said he told Ms A that he had removed the seton, which should get rid of her pain, and that trying to loosen it had not been an effective option. He also explained to her and her husband that he needed to see them again together in ten days' time to talk about examining Ms A under anaesthetic, which would also probably involve reinserting a seton. Dr C said he told them that during the examination he would be looking to see whether there was any other cause for her pain. He said he told them that he would go over that again when he saw them, as this was not the time to do it. Dr C said that he thought he had made it clear to Ms A that he had removed her seton.

Dr C said that he did not go into any "great detail" because Ms A was quite upset, had been sore for a week and been hysterical. She was not in great shape to be sitting down and having a complex discussion about the reinsertion of a seton that had been causing her pain. He thought that was not exactly what she wanted to hear.

He said that he then left Ms A with Ms E to comfort her, give her a cup of tea and security, and settle her down. He said that he thought that he had been present at the consultation for probably 15 minutes. Dr C arrived shortly after Ms E left to get the medication and left shortly after she returned, a consultation time of approximately five to ten minutes.

Dr D said that he could not recall exactly what Dr C said after the consultation. He did not think that Dr C said he had removed the seton. Dr D said that he felt upset after Dr C left the room and he felt partly responsible for the situation, because he had tightened the suture and brought Ms A back to the hospital to have a look at it. He also said that it is not nice to see patients in pain. He said Ms A was shaking and "pretty distressed".

Ms E described Dr C's manner towards Ms A after he had removed her seton as follows: "I felt that he just wanted to leave the room and he was gone. I don't feel he was staying around to deal with anything. He had done the job he wanted to do and was leaving."

After the consultation
Dr C said that later Dr D told him he had received a phone call from Ms A who requested that she see someone else. Dr C assumed that it was over the whole event of the seton causing pain and having about three operations in short succession under general anaesthetic. He said that people get frustrated and change doctors all the time. On 7 September 1999 he wrote to another surgeon asking him to take over the care of Ms A.

Dr D said that Ms A called him the following day and said she did not want to see Dr C again. She said that she had been having nightmares about the consultation. Dr D organised for another surgeon to take over Ms A's care and wrote to Ms A's general practitioner informing him of this. Dr D also offered Ms A psychiatric assistance, which she declined.

Reinsertion of Ms A's seton
In October 1999 Ms A had another seton inserted under general anaesthetic by the surgeon into whose care she had been transferred.

Internal review as a result of Ms A's complaint
A public health board conducted an internal review of Dr C's consultation with Ms A. The review concluded that although in general Dr C's attitudes towards his patients were exemplary, at times he can appear rude or abrupt, even though this is not his intention. Dr C subsequently wrote a letter of apology to Ms A. Dr C stated:

> " …
>
> I am sorry for the communication breakdown which contributed to the distress you suffered during the treatment by me. I apologise unreservedly for appearing to be rude and abrupt. This was certainly never my intention. Please accept my assurances that I always try and act in the best interests of all my patients and I am saddened that you feel that I let you down. …"

Independent advice to Commissioner

The following expert advice was obtained from Dr F, general surgeon:

"**1. In light of [Ms A's] presentation, when [Dr C] saw her on 4 September 1999, what treatment options were available to her?**

There were only two management options available: –

i) loosen the seton
ii) remove the seton

2. Was the removal of the seton by [Dr C] the most appropriate treatment option?

Loosening the seton, and coming back at a later date and carefully tightening it, would be the preferred option, as this would probably save a further surgical procedure. However in the circumstances of this case, with the patient in considerable distress, then removing the seton entirely was appropriate, as it would be easier to find and cut the seton loop rather than trying to find the suture and cut that.

3. Was it appropriate in the circumstances to remove the seton without local anaesthetic or the morphine and nitrous oxide requested?

Whether or not this patient (or any patient for that matter) requires some form of analgesia and/or sedation depends on: –

i) the level of distress or discomfort they are in prior to the procedure;

ii) how difficult the procedure looks to be, having viewed the anal margin, i.e. does the seton look to be readily accessible;

iii) how much pre-procedural counselling had occurred.

The evidence given in this case from the various witnesses, including the patient, would suggest it was not appropriate to do this procedure without some form of sedation or strong analgesia e.g. intravenous medications.

4. How is informed consent usually obtained when a seton is removed? [Dr C] has advised that consent to remove a seton is obtained by agreement and is implied by the patient positioning themselves in a way which enables the seton to be cut.

Seton removal does not usually involve obtaining written informed consent. I fully agree with [Dr C's] comment that removing a seton is similar to removing sutures or inserting or removing an intravenous line. None of these procedures require informed consent. Having fully discussed the proposed procedure, verbal agreement is obtained, and the fact that the patient position themselves in such a way to have the procedure done, implies agreement.

5. [Ms A] stated that she required two operations because the seton was removed. However, [Dr C] stated that [Ms A] required further procedures in regard to peri-anal Crohn's disease. Did [Ms A] require any additional procedures as a direct result of the removal of the seton?

According to the notes supplied, [Ms A] had one further operation for re-insertion of the Seton suture. This was done by [Mr I] on 13/10/99. The consultation she had with [Mr I] prior to that surgery on 22/09/99, led to a decision to put the seton back in. It is therefore reasonable to assume that the operation on the 13/10/99 was because she still required a seton and therefore this operation was a direct result of having had the seton removed. It could be reasonably said however, that had the seton fallen out, (and they sometimes do), rather than been taken out (as it was by [Dr C]), she would have probably still required an 'examination under anaesthesia' (EUA), to make completely sure the fistula had resolved. I therefore do not think she required any additional procedures.

6. [Dr C] advised that 'rapid quick action' was required because of [Ms A's] state. Was this required?

I believe 'rapid quick action' was ill-advised. All the supplied documents from witnesses, including that from [Dr C] agree that this patient was in severe distress. She required a calm and measured approach; a full and concise explanation of the proposed procedure, followed by some form of intravenous sedation/analgesia. Often however, if the rapport established following the explanation is very good, then the need for any sedation, or the level of sedation needed, is much reduced. Rushing in, with little reassurance and no explanation would only make the situation worse.

7. Are there any other issues arising from the supporting information?

This episode reflects poor communication and judgement, where the desire to do what seems a relatively minor procedure quickly at an awkward time (Saturday morning), overrides the real concerns and apprehensions of the patient.

[Dr C's] letter to [Ms A] (on the 3rd May 2000) shows he fully recognizes his shortcomings in this instance and he is not only apologetic but has pledged to do better next time."

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 1
Right to be Treated with Respect

1) *Every consumer has the right to be treated with respect.*

RIGHT 4
Right to Services of an Appropriate Standard

…

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

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

RIGHT 5
Right to Effective Communication

…

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

RIGHT 6
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 –*
   a) *An explanation of his or her condition; and*
   b) *An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; …*

RIGHT 7
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: Breach – Dr C

Lack of respect

In my opinion Dr C breached Right 1(1) of the Code of Health and Disability Services Consumers' Rights, which states that every consumer has the right to be treated with respect.

Throughout the time he was present at the consultation, Dr C did not treat Ms A with respect. Dr C's manner was unfortunate and did not show consideration for the pain and trauma Ms A had been and was going through.

I have reached this opinion for the following reasons:

- Ms A stated, "He was just really rude, aggressive and controlling." Ms A felt as if she was not worthy of being communicated with.

- Ms A said that Dr C stormed in and said, "Right let's have a look at it," without any preliminary greeting.

- Ms A said Dr C told her to "not scream so loud it's hurting my ears", in a gruff and angry tone. Ms A felt that he was angry with her and that she had no right to scream and was being a silly woman by screaming.

- When Ms A asked what she was expected to do about the pain, Dr C told her to "control it, learn to control it". When Ms A asked for something to bite on to help control the pain Dr C told her, "You don't need any of that."

- Dr C told Ms A in the same tone to hold up her buttocks, and then growled at her to open further despite her pain.

- Once Dr C had cut off the seton he said in a gruff voice, "Right that's it, you'll have to come back in another month and have it done again," and walked out of the room.

- Dr C admitted that he probably did use words like telling Ms A to stop screaming as it was hurting his ears. I consider it more probable than not he also told her to control her pain rather than have pain relief. He also said that he was firm and a bit brisk or quick with her, although he denied that he was rude. He also stated that he might have led things as opposed to allowing a more "discussive" atmosphere, because of the pain and distress Ms A was in.

- A review of Ms A's complaint by the Head of the Department of Surgery, a School of Medicine, and the Clinical Director, General and Vascular Surgery, a public hospital concluded that, although in general Dr C's attitudes towards his patients are exemplary, nonetheless at times he can appear rude or abrupt even though this is not intended.

- Dr D described Dr C's manner toward Ms A as "pretty brief" and "abrupt" and said that he used a "firm tone".

- Mr B, who was present throughout the consultation, described Dr C's manner as "belligerent, dismissive, extremely impolite and angry". Mr B also said that he found the way Dr C spoke to his wife extremely objectionable and "absolutely misogynistic towards her".

- Ms A described Dr D as "white" and "shocked" after her seton had been removed. Ms E said that Dr D was "quite upset" about what had happened during the consultation. Mr B described Dr D as white as a ghost and clearly disturbed after Dr C had left. Although Dr D confirmed that he was "a bit upset", he said this was partly because he felt responsible for Ms A's initial pain and also because Ms A was obviously very sore during her examination by Dr C. Nonetheless, I find it more probable than not that Dr D was also upset by Dr C's manner toward Ms A.

- Dr C was at the consultation for only a brief time.

- Ms A had nightmares as a result of the consultation and for several days following the consultation she remained distressed about the way she had been treated by Dr C. Dr D confirmed that Ms A told him this. Dr D took this information seriously enough to discuss with her the possibility of seeing a psychiatrist and to inform her general practitioner.

I accept that Dr C was angry and alarmed at seeing Ms A in such a state but it was his professional responsibility to treat his patient with respect and consideration. It is not appropriate in these circumstances for a medical practitioner to take out his or her anger and frustration on the patient to the extent that the patient feels belittled and demeaned. It is clear from the evidence that Dr C's manner and actions were disrespectful to Ms A, who needed to be treated gently and with consideration in light of the pain she was experiencing. Accordingly, in my opinion Dr C breached Right 1(1) of the Code.

Pain relief
In my opinion Dr C breached Right 4(3) of the Code of Health and Disability Services Consumers' Rights in respect of this matter by failing to provide pain relief to Ms A in a manner consistent with her needs.

When Dr C met Ms A he said she was hysterical and extremely upset and that the cause appeared to be the pain she was in. Dr C said that Dr D had told him that Ms A had been in pain after her seton was tightened and that he had been trying to loosen it to relieve the pain, but had ordered pain relief before trying again.

Dr D told me that it was too uncomfortable for Ms A to let him loosen her seton without pain relief and that he would have administered it had Dr C not arrived at the consultation. Ms E said that Dr D was "adamant" pain relief was required and that she also thought Ms A should have been given it. Dr C knew Ms A was not only in considerable pain but also distressed as a result of the attempts made by Dr D to loosen the seton. Predictably her pain and distress began to increase in severity once Dr C began examining her and again when he was removing the seton. Mr B described Ms A's pain on the removal of the seton as "blood curdling". Dr D confirmed that Ms A's distress increased when he and Dr C placed tension on the seton during examination or attempts at tightening or removing it. Ms A's pain and distress was obvious by her screaming and her request for something to help cope with the additional pain.

Although I accept Dr C's statement that the adjustment or removal of a seton is usually done without anaesthetic, it is clear that in Ms A's circumstances it was not appropriate to attempt to remove her seton without some form of pain relief.

My independent advisor stated that the relevant factors in deciding whether a patient needs pain relief are the level of distress or discomfort the person is in prior to the procedure, how difficult the procedure appears to be, and how much pre-procedural counselling has occurred. Ms A was highly distressed and had received no pre-procedural counselling. In these circumstances it was not appropriate for Dr C to remove the seton without offering Ms A some form of sedation and/or strong analgesia. Dr C did not offer pain relief and refused the request of Ms A and her husband for the procedure to be halted until pain relief could be given. Dr C made a clinical judgement that pain relief was not necessary as Ms A's pain would be sharp but brief and then would resolve.

Dr C had reservations about using certain forms of pain relief such as nitrous oxide and local anaesthesia. Dr C also said that he felt it would take too long to obtain the nitrous oxide. He estimated it would take half an hour. Dr D believed it may have taken about ten minutes, and Ms E said she thought it did not take her any longer than five minutes to bring morphine to the treatment room.

Dr C chose to remove the seton and therefore had a responsibility to appropriately address the issue of pain relief. In my opinion, in failing to provide pain relief medication to Ms A prior to removing the seton, Dr C did not provide services with reasonable care and skill and therefore breached Right 4(3) of the Code.

Informed consent

Under Right 7(1) of the Code, health services may only be provided to a patient if that patient makes an informed choice and gives informed consent, unless any statutory enactment, the common law or another provision of the Code provides otherwise. Under both the Code and the New Zealand Bill of Rights patients have the right to refuse or withdraw consent to treatment. Obtaining informed consent from a patient is a process involving three steps:

- effective communication
- provision of adequate information
- consent freely given by a competent individual.

This process recognises the autonomy of individual patients.

In this case Dr C stated that he thought he had obtained Ms A's informed consent to the provision of treatment. For the reasons set out below I do not accept that he communicated effectively with Ms A, gave her adequate information, or obtained her freely given informed consent to the removal of the seton.

Dr C also said that Ms A was in no condition to have an explanation made to her or to understand the information provided, because of her high level of pain and distress. Although Ms A was at times clearly incapacitated by her pain, it is clear that her distress abated when the area around the seton was not being touched and she was given time to recover. She asked Dr C to be gentle, requested pain relief and asked for something to bite on. These are not the actions of a person rendered incompetent by pain and distress and unable to make an informed choice and give informed consent. Dr C said that quick fast action was required. However, my advisor clearly stated that quick fast action was not the correct course of action in this case. This was not an emergency situation and there was no urgent need to provide treatment.

Effective communication
In my opinion Dr C breached Right 5(2) of the Code by his failure to create an environment that enabled open, honest, and effective communication with Ms A. I have formed this view for the following reasons:

- Dr C did not establish a relationship with Ms A prior to stating he would examine her. He did not greet her, ask how she was, or say that he was sorry she was so distressed.
- His demeanour was aggressive and angry throughout the consultation.
- Dr C spent no time reassuring Ms A.
- He gave her no time to recover from her distress.
- He responded to questions and comments from Ms A and her husband dismissively and in a way that discouraged further questions or comments.
- Both Ms A and Mr B felt that Dr C was not listening to them and would do what he wanted despite their concerns.
- Both Dr D and Ms E thought that Dr C was abrupt and were concerned about the way Dr C managed the consultation.
- Dr C admitted that, on reflection, he did not encourage a discussive atmosphere.
- The consultation lasted between five and ten minutes and was therefore rushed, with little time to develop a relationship with a highly distressed patient. Ms E said that she was out of the treatment room for about five minutes to obtain the medication requested by Dr D. Dr C was not present on her departure and he left the room within about 30 seconds of her return. Although Dr C said that he was present at the consultation for about 15 minutes, Ms E has provided her recollection of a much briefer time on two separate occasions. Dr D said that Ms E may have been absent for about ten minutes. I find it probable that the consultation lasted between five and ten minutes.

I also accept the advice of my independent advisor that "rapid quick action" was "ill-advised" and that Ms A required a "calm and measured approach, a full and concise explanation of the proposed procedure, followed by some form of intravenous sedation/analgesia". My advisor noted that if sufficient rapport is built up between the patient and the doctor, the need for analgesia or sedation can be reduced. Dr C was not presented with an emergency and I agree with the comment made by my independent advisor that in not taking appropriate steps to establish a relationship with Ms A, and to minimise her distress, or to listen to her concerns, Dr C's actions reflected "poor communication and judgement".

Dr C had a responsibility to ensure that before removing her seton he and Ms A were able to communicate effectively with each other. Dr C acknowledged this to me by saying that if he was dealing with the same situation this Saturday he would no doubt just "settle down [Ms A] and just wait" and that to proceed with a lot of what he was saying going completely over her head was "a mistake I probably made".

In my opinion, by failing to ensure that Ms A was provided with an environment that enabled both her and Dr C to communicate with each other effectively, Dr C breached Right 5(2) of the Code.

Adequate information
In my opinion, Dr C also breached Right 6(1) of the Code by failing to give Ms A adequate information about the proposed procedure.

I do not accept Dr C's evidence that he explained to Ms A, after he had examined her, that he intended to remove her seton. In fact I think it is more probable that Dr C gave no indication to Ms A about his proposed action, apart from an indication that he was going to cut what she thought was the suture, when he asked Dr D to obtain some scissors. Dr C said that Ms A may have misinterpreted his statement because of her hysteria. I do not accept this. I have formed this view for the following reasons:

- Ms A stated that Dr C did not consult with her about removing her seton and that she did not realise he had done this until the following day. She thought he would examine her and loosen or cut the suture that had been put in place to tighten the seton.
- Mr B, who was present throughout the consultation, stated to me that he was "absolutely clear" that Dr C told Ms A "absolutely nothing" about his intention to remove the seton. He also said that Ms A's seton was removed "without any consultation at all".
- It is consistent with Dr C's manner towards Ms A and his belief that "rapid quick action" was required.
- Dr D, who was in the room for most of the consultation, had the impression that Dr C intended to examine Ms A and try to loosen or cut the suture tightening the seton. He was not aware that Dr C intended to remove the seton.

Dr C did not explain why he thought it was best to remove the seton, or the consequences of removing the seton. Dr C also failed to explain why in his opinion he could not loosen or cut the suture surrounding the seton. Dr C did not offer Ms A any options (for example, the removal and reinsertion of the seton under general anaesthetic later that day) and did not fully discuss pain relief options with her. Given that Ms A had a chronic condition and was used to constant medical care, this was information that a reasonable patient would have expected to receive.

Dr C also failed to give Ms A adequate information after he removed the seton. Although Dr C said that he told Ms A he had removed her seton and that it might need to be reinserted, I accept Ms A's statement that Dr C used words such as, "Right, that's it, you'll have to come back in another month and have it done all over again" before leaving. This is consistent with Mr B's version of what Dr C said: "It's out. Come back in a month." Ms E described Dr C's manner toward Ms A after he had removed her seton as follows: "I felt that he just wanted to leave the room and he was gone. I don't feel that he was staying around to deal with anything. He had done the job that he wanted to do and he was leaving." In addition, Dr C told me that he had not gone into "great detail" when explaining to Ms A.

Dr C's explanation to Ms A was inadequate and symptomatic of his manner during the consultation and his failure to communicate effectively with Ms A regarding his intention to remove her seton in the first place. It is not surprising, therefore, that Ms A thought that the seton had been loosened and did not realise it had been removed till later when she was at home. She and her husband thought she was to come back in a month to have the seton tightened.

I accept that Ms A was still in considerable distress after her seton had been removed, even if her pain and discomfort had decreased. Nonetheless, while Dr C said that she was not in "great form" to be sitting down and having a complex discussion about the reinsertion of a seton that had been causing her pain, he still had a responsibility to make a reasonable attempt to ensure that she received the appropriate information, taking into account her distress. If an explanation was not possible within a reasonable period, he could have communicated with Ms A at a later time. In making an abrupt statement and leaving, Dr C did not give Ms A an opportunity to ask him any questions or seek an explanation of what had occurred.

For these reasons, in my opinion Dr C breached Right 6(1)(a) and (b) of the Code.

Consent to removal of seton
In my opinion Dr C breached Right 7(1) of the Code as a result of his failure to provide an environment within which he and Ms A could communicate effectively, and his failure to adequately inform Ms A of his intended actions. The lack of effective communication and provision of inadequate information resulted in Dr C failing to obtain Ms A's informed consent to the removal of the seton. I accept the advice of my independent advisor that seton removal usually does not involve written consent. However, actual consent must always be obtained before a health service is provided.

Dr C said that consent could be inferred because Ms A positioned herself so that he could access the seton. I disagree. In the absence of effective communication and adequate information, a patient's consent cannot be implied by her positioning herself for a procedure that she does not know she is about to undergo.

In addition to being fully informed, consent must be freely given (Health and Disability Commissioner Act 1994, s 2 definition of "informed consent"). I am satisfied that Dr C explained to Ms A that he needed to examine her and that she consented to this by saying, "Please be gentle," and rolling on to her side so that he could examine her. However, Ms A believed that she had no choice but to submit to what she believed was going to be an examination and attempt to loosen the seton. Dr C did not appear to be listening to any of her and her husband's concerns and seemed determined to carry out the procedure whatever they said. Both Ms A and Mr B felt disempowered by the environment in which the consultation occurred and by Dr C's manner.

It follows that in my opinion Dr C provided services without Ms A's informed consent and breached Right 7(1) of the Code.

Other relevant factors

I have taken into account the following additional factors in relation to this investigation:

- Dr C was angry with Dr D for not informing him that he had made an appointment to see Ms A in the Ward, causing her what he considered unnecessary pain, and attempting to loosen the seton in the treatment room, which was an inappropriate place for the procedure.
- Dr C did not cause Ms A's initial pain and distress, which resulted from Dr D attempting to loosen Ms A's seton.
- Dr C had not previously encountered anyone displaying the level of Ms A's distress, particularly her screaming.
- Dr C acknowledged that, with hindsight, he should have waited until Ms A was calmer so that he could properly discuss the course of action he proposed to take and she could decide what to do.
- Dr C wrote a letter of apology to Ms A.

It is my opinion that the first two factors contributed significantly to Dr C's decision to take rapid quick action in treating Ms A and therefore to his breaches of the Code. Nonetheless, Dr C was a senior and experienced health professional who should have dealt with Ms A's situation much more appropriately than he did.

Response to provisional opinion

Ms A and Dr C both responded to my provisional opinion. Although their responses have not persuaded me to alter my view of the circumstances of this case, I have attached them to my opinion in full as appendices.

I accept that the remorse expressed by Dr C in his response is sincere and that he has learnt from this experience. I also acknowledge his statements that he has reviewed his practice in the light of my report and will do so again and that he has apologised to Ms A. However, I remain of the opinion that this matter should be referred to the Director of Proceedings, as Dr C's actions fell well short of an acceptable standard of clinical practice resulting in considerable pain and distress to Ms A.

I also acknowledge Dr C's comments about the length of time this investigation has taken. This was partly due to Ms A's tape recording of her recollection of events becoming available only toward the end of the investigation. The contents of the tape recording made it important to conduct interviews of those involved.

Dr D and the public health board informed me that they did not wish to make any comments on my provisional opinion. I did not receive any response from Ms E.

Vicarious liability

Employers are vicariously liable under section 72(2) of the Health and Disability Commissioner Act 1994 for ensuring that employees comply with the Code of Health and Disability Services Consumers' Rights. However, under section 72(5) employing authorities have a defence if they have taken steps as were reasonably practicable to prevent their employee from breaching the Code.

Although Dr C breached Rights 1(1), 4(3), 5(2), 6(1) and 7(1) of the Code, in my opinion his employer, a public health service (now a District Health Board) is not vicariously liable for his breaches of the Code. Dr C showed a marked lack of judgement in his provision of health services to Ms A. I do not believe that his employers could reasonably have been expected to take steps to prevent his actions.

Actions

- I have decided to refer this matter to the Director of Proceedings in accordance with section 45(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any further action should be taken in relation to Dr C.
- A copy of this opinion will be sent to the Medical Council of New Zealand.
- A copy of this opinion, identifying Dr C, but with all other personal identifying features removed, will be sent to the New Zealand Committee of the Royal Australasian College of Surgeons.
- An anonymised copy of this opinion will be sent to the Royal Australasian College of Surgeons, for educational purposes.

Other Comments

Dr D's actions

I accept Dr C's statement that Dr D should have informed him of the appointment he had made with Ms A. While Dr D told me it was "standard practice" for a registrar to review a patient before discussion with the consultant, Dr D went further than this in attempting to loosen Ms A's seton. This was unwise considering that he said he had probably tightened fewer than 20 setons and could not remember ever loosening a seton prior to the consultation with Ms A. If Dr D had spoken to Dr C about Ms A's situation prior to the consultation, it is probable that the situation would have been managed more appropriately.

Keeping appropriate records

Dr C, Dr D and Ms E failed to make a contemporaneous written note of the consultation with Ms A on 4 September 1999.

The main reason given was that Ms A's clinical file had not been available and that this was usual for outpatient appointments taking place on the ward that were scheduled at short notice.

I take this opportunity to remind the health board, Dr C, Dr D and Ms E of the obligation under Right 4(2) of the Code to ensure that appropriate records are kept, in keeping with professional and ethical standards.

I note that Ms E has taken positive action to address this issue and has discussed the problem with her team leader.

Length of investigation

Important evidence relevant to this investigation was obtained in interviews with Dr C, Dr D and Ms E in October 2001. This was over two years after the consultation with Ms A. I thank them for their co-operation in providing information about the events under review. I also thank management staff at a public hospital for their assistance in facilitating the interviews and providing my staff with an appropriate venue.

Addendum

The Director of Proceedings laid before the Medical Practitioners Disciplinary Tribunal a charge alleging conduct unbecoming a medical practitioner. The charge was upheld by the Tribunal on 13 November 2002 and it imposed a penalty of censure, and a $4000.00 fine. Costs were fixed at 33% of the costs of the investigation, prosecution and hearing of the charge. The Tribunal also ordered publication of the orders in the New Zealand Medical Journal.

Appendix 1

Response to 'Information Gathered' section of Provisional Opinion – Ms A – Complainant

"I have just read the summary of the events relating to [Dr C's] treatment of me and his statement and would like to reply to this.

[Dr C] firstly describes me as Hysterical. This is a very unusual word to use. I looked it up in the dictionary, which describes it to be 'uncontrollable', which was far from what I was experiencing. I think that the main problem was that [Dr C] had too much control over me. In my statement [Dr C] ordered me to hold my buttocks and to be quiet. I don't think that a hysterical person could perform these actions.

I was in a vulnerable state, yes, I was upset and tears were rolling down my face, but not hysterical. He uses this word often and seems to imply that I was screaming uncontrollably and constantly. I would like to point out that I only screamed when great pain was being inflicted on me and I stopped screaming when either doctor would stop tugging on the setons. Also, I would grab at the cord on the wall or a hand or pillow to disperse the pain somehow to stay still while either [Dr C] was trying to cut.

In my opinion my screams were only an involuntary response and were controlled as best as I could under the circumstances.

If [Dr C] thought that I was hysterical, why then did he proceed to operate on me? Why did he not think to give me a sedative or allow me time to compose myself?

<u>Procedure:</u>
[Dr C] seems to have a vague memory of the situation and [Dr D] verifies that [Dr C] has a different slant on the situation even to the point of not having had a conversation that [Dr C] says he had with [Dr D]. Which brings me to the reality of his manner toward me. It seems that [Dr C] firstly was obviously very annoyed that I was screaming and that I was in a Ward. This attitude was definitely brought into the room when he entered and he had an agenda and [Dr D], [Mr B] and I had no idea what it was. By his actions I can only assume that it was to deal with me as quickly as possible and get me out of the ward, regardless of my will, my suffering, my approval or disapproval. It was almost like he wanted to torture me for screaming and that I shouldn't be there and he knew better than anyone else in the room what and how this procedure was to be executed.

He most definitely didn't say hello to me or my husband. His first words to me were "Let's have a look". He says he asked me to get up on the bed, yet I was already lying on my side on the bed. At no time did he discuss anything about what he was about to do. He was short, abrupt and rude. My husband and I both have no recollection of any explanation as to his actions. As much as [Dr C] has opinions on what and why he cut the setons, it remained in his head and was not voiced to anyone in the room.

[Dr C] states that he could have waited 6 hours and operated to remove the setons and replace with another. Why was this not discussed with me or my husband? The end result was I had to have an operation to reinsert it anyway. So why then didn't [Dr C] take the less traumatic and less painful route for me? If I was under anaesthetic I would be out of pain and my setons easily accessible. I was in pain only when I walked and when a Dr pulled on it. Why was this not presented as an option to me or my husband? I can only surmise that it was because he didn't care for my wellbeing, only his own ego. He wanted me out of the hospital as quickly as possible regardless of the extra discomfort he would inflict on me.

Consent:
At no point did [Dr C] get my consent to remove the seton. [Dr D] had told me he was going to cut the stitch. [Dr C] had so little communication with me. He entered the room and took over. I could only assume that he was trying to continue what [Dr D] had started. I had lifted my buttock for Dr D to cut the stitch and I was lifting my buttock again so that [Dr C] could cut the stitch. Not to remove the whole seton. I must also point out that I was bullied into lifting my buttock by [Dr C]. I was frightened and shocked at the first instance and I thought he was just going to have a look, when he tugged on the seton I screamed and couldn't believe he was trying to do what [Dr D] failed to do without the morphine. The second time I lifted my buttock was only because he was ordering me to. I was intimidated by his abrupt tone and refusal of medication and because no one in the room was offering other options I submitted to his will.

[Dr C] never said he was going to cut the seton. He had refused me medication, he had refused me something to bite on … I was terrified. I was literally whimpering and couldn't get a word out that was understandable even to my husband.

My power was taken away by his arrogance and over bearing authority. While in this state how was I expected to react? If a puppy is being beaten or intimidated up by a bigger stronger dog, it will cowl in the corner making submissive actions to try to deal with the situation. This is how I reacted. [Dr C] seems to have a lot of opinions on how I should have reacted and communicated under this torture, which in turn is probably why he treated me as he did. If he was aware enough to evaluate the situation without clouding it with his brush, he may have had some compassion. [Dr D] verifies that nothing more was said other than wanting to cut the stitch. After reading [Dr C's] views it seems to me that [Dr C] was in a world of his own, thinking he was communicating all yet was communicating nothing other than abusive, army like commands.

Communication
Again both my husband and I were not explained to clearly what he was about to do and that it was any different than what [Dr D] had performed.

On one hand [Dr C] says he explained all this to me and on the other he says that I was in too distressed state to communicate. I find this statement contradictory. If he felt I was too hysterical to talk to, why did he continue? Also I had a representative in the room, my husband who was not experiencing any pain at all, why was he not communicated to? Again

I was not screaming uncontrollably all the time, only when the seton was pulled. The rest of the time I was more subdued and was aware enough of the situation to remember and recall every minor detail. When he first entered the room I was not screaming. My husband who was not in pain at all recalls the situation as I do, so can [Dr C] explain why we both can adamantly state no consent to remove the whole seton was given and no discussion took place? Also I was not given any pain relief that may have clouded my memory of the situation.

[Dr C] calls the situation farcical. The only person in the room that considered it so was [Dr C]. I was lying on my side, recovering, not screaming, pain relief was ordered and all parties were happy with that decision. The situation became farcical upon [Dr C's] entrance to the room. He had a different opinion on how to handle the situation to a speedier conclusion, not for my benefit but for his own. He made choices for me re pain relief and the time it would take to conclude the situation. I was quite happy to continue down [Dr D's] route and receive pain relief. [Dr C] overrode all other options for his own outcome, which was to speed up the process disregarding my needs. He knew best in his own mind.

Manner:
Again what [Dr C] said and in his own mind would have liked to think he said, are 2 different things. His recollection of specific communications seems to be very vague and patchy to say the least.

During the whole fiasco I screamed 3 times (twice with [Dr D] and once with [Dr C]). These times were only when the seton was being pulled. [Dr C's] reaction to my 3rd scream (which was his first attempt to look) was most definitely rude and abrupt and told me to stop screaming as it hurt his ears. He confirms that he said this. If his main concern was for me and my pain and getting me out of pain quickly, why was he so worried about his ears?

It is clear to me that he decided that my reactions were inappropriate and was in some way taking his annoyance out on me.

Pain Relief:
Again [Dr C] seems to have conversations in his own head which never reached his lips. Again [Dr C] says he made the decision for me not to have pain relief, he decided to do it his way.

I have been on morphine before when having severe anal fistula. The morphine took the pain away completely and I couldn't feel any pain when before I was feeling a 10 out of 10 level of pain. The anal fistula could be likened to the seton being too tight and in the same area. So having had this knowledge I would assume that if administered it would have dulled my pain completely. While on morphine in the hospital, I can assure you that it did not make me hysterical and uninhibited but had a sedative effect.

When [Dr C] describes what a patient experiences during a colonoscopy it is completely different. The drug given during a colonoscopy has a semi-anaesthetic effect and can cause disorientation when a patient goes in and out of consciousness. I have had 2-3 of these and my case notes show I never become uninhibited causing any trouble. But anyway, shouldn't that decision be given to me and not made by [Dr C] from his vast experience of how he thinks I could react? If he had more knowledge of my past history he would not have come to the conclusion that he did. [Dr C] states he had no knowledge of what I had eaten that morning. This clarifies even more his lack of communication with me or my husband. Why didn't he simply ask what I had eaten that morning?

Again [Dr C's] imaginary discussion about pain relief seems to fill a paragraph in his own head, when the words spoken were as much as four.

On one hand he wants me to stay focused so he can communicate with me and on the other he says I'm too hysterical to have a rational discussion. Then he says he communicated all his actions and ramifications to me, neither my husband or I and [Dr D] have no recollection of this. I was not given any morphine, so seemingly my memory should be clear. Also, what of my husband's recollection of his attitude and communication?

<u>After the procedure:</u>
Again I was not allowed to scream as [Dr C] had told me to control it. I had to stay silent and bury my head in the pillow. After he had completed the cut, I was not calm in any way shape or form. I was crying, shaking, felt like vomiting. My rights had been violated. I felt violated and was pleased that his torture was over and that he and his demeaning attitude had left the room. [Dr C] again had a discussion in his own head that never reached me or my husband's ears regarding possible further treatment.

<u>After the consultation:</u>
I was offered psychiatric assistance but turned it down. I discussed with [Dr D] that I had heard that sometimes getting this kind of help can prolong the suffering further, so I opted to not have treatment even though I felt unhinged by the events.

<u>Internal Review:</u>
[Dr C] sent me an apology letter only after I had requested him to do so. I can only assume he wouldn't have bothered doing so unless prompted.

<u>Summary:</u>
I am still affected by [Dr C's] actions and become emotional when reading the events. This situation has changed my trust in the health care system and practitioners alike. I deal with a lot of different people in my field of business and have never been so unfairly treated as I was that day. I think as a NZ citizen that I have certain rights and that these have been clearly violated. I feel that [Dr C] should be made accountable for his omissions and barbaric procedures so that no other person is treated as I have been."

Appendix 2

Response to Provisional Opinion – Dr C– General Surgeon

"Thank you for your letter and provisional opinion.

I have now had the opportunity to read the provisional opinion and to digest its contents and your conclusions and proposed action. While there are some matters of detail as to what occurred or did not occur with which I disagree, overall I accept your findings.

I did not handle the matter well and I am very sorry that occurred. I obviously upset [Ms A] and [Mr B] and I repeat my apology for that. It was never my intention that that should occur. I have taken on board their comments and your's.

Indeed as soon as I was aware of the patient's concerns I reviewed the matter and apologised to her. It is two years since I sent a formal letter of apology to [Ms A] and I repeat some of the comments I made then as I believe they are still very relevant.

(i) *"I would now like to take this opportunity to respond to you directly so that I can offer you my sincere apologies."*

I repeat those apologies again.

(ii) *"The issues you raised … were of great concern to me as I place great importance on achieving good communication between myself and my patients."*

The issues still are of great concern to me and in the two years since then I have striven to ensure good communication at all times.

(iii) *"I can now see the advantages to you if I had approached this in a different way."*

My manner of dealing with such a situation (or something similar) would now be quite different. I acknowledged this to [Ms A] and during my interview with the Health and Disability Staff. I agree with the comments of your advisor that leaving the situation to settle rather than trying to achieve immediate relief of the situation would have avoided the problems which arose. This has been a very salutary lesson for me and one which I will never forget.

(iv) *"I have reflected on your experience and have taken on board that I was seen as abrupt and uncaring."*

"I apologise unreservedly for appearing to be rude and abrupt. That was certainly never my intention."

As mentioned in my letter of apology I have reflected very much on this issue and pay special attention to this and good communication with each and every patient.

(v) *"Please accept my assurances that I always try to act in the very best interests of all my patients and I am saddened that you feel I let you down."*

I was and remain saddened that I let the patient down in my dealings with her. My error of judgement in trying to bring quick relief to her pain and suffering has led to a domino effect because I obviously believed I needed to act quickly. On reflection and with the benefit of hindsight that was not the case and I would do things quite differently now.

(vi) *"I appreciate you raising your concerns as the reflection that resulted can only assist in ensuring my care to future patients is enhanced."*

I have learnt a great deal from this matter and the lessons learnt have been put into practice. I am confident that there will be no repeat of the lapse of judgement which I displayed in [Ms A's] case.

Conclusion

I am certainly willing to review my practice in light of the report. Indeed I had already done so following the complaint and will do so again.

Given the length of time since the consultation in question (over 2 ½ years) and the steps I have taken since then I believe that referring the matter to the Director of Proceedings is unnecessary.

I have accepted the report and my failings. I have learnt from them and taken the necessary steps to ensure there is no repeat. I have apologised to [Ms A] at an early stage and repeated those apologies. Having this investigation hanging over me for the last couple of years has been a totally unpleasant experience and I feel that some closure needs to be brought to the process. Referring the matter to the Director will in my view just cause further stress and anguish to me without any positive outcome for me or my patients. Any educative outcome is well covered by the other proposed actions in circulating the findings to the relevant bodies"