Dr B (Neurosurgeon) and Dr C (Neurologist)

Opinion - Case 97HDC6996/JW

Complaint

The Commissioner received a complaint from Mr A about the services provided by Dr B and Dr C. The complaint is that:

- *On 5 March 1997, Mr A was admitted to a private hospital for surgery to relieve the compression of his cervical spinal cord. Dr B carried out the surgery. Post-operatively, Mr A leaked fluid from around the spinal cord. A waterproof dressing subsequently pulled out nylon sutures, which had to be replaced under local anaesthetic.*
- *On 9 March 1997, Mr A developed a calf vein clot after a further operation to stop the leak Mr A's ability to walk has now substantially deteriorated, to a point where Dr B cannot explain it.*
- *On 19 May 1997, Mr A was admitted to the public hospital after a consultation with Dr C. During this stay, Dr B saw Mr A in the ward and asked Mr A if he would walk for him. On one occasion, Mr A attempted to walk whilst holding on to Dr B's hand, whereupon Dr B removed his hand and Mr A fell. Mr A hurt his left clavicle because of this fall.*
- *During Mr A's stay at the public hospital, Mr A agreed to a request by Dr C to be the subject of a demonstration at a lecture he gave to a group of doctors on 21 May 1997. Mr A was not advised of the exact information given to the attendees, or that there would be 40-60 doctors present. He felt humiliated after he was made to walk in front of the group. Moreover; Mr A believes Dr C wanted to show the group that his problems were psychological.*
- *On 26 May 1997, Dr C visited Mr A in his ward. Dr C again attempted to make Mr A walk. On each attempt Mr A fell over. Mr A claims that Dr C shouted at him several times, during and after, he attempted to walk.*

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Dr B (Neurosurgeon) and Dr C (Neurologist)

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Investigation

The Commissioner received the complaint on 22 June 1997 and an investigation was undertaken. Information was obtained from:

Mr A	Consumer
Dr B	Provider/Neurosurgeon
Dr C	Provider/Neurologist
Ms D	Witness
Dr E	Registrar, Gastroenterology, public hospital
Ms F	Charge Nurse, public hospital
Ms G	Continuing Medical Education Co-ordinator, public hospital

Mr A's medical records were obtained and the Commissioner obtained professional advice from two neurologists.

Outcome of Investigation

In 1994 Mr A fell off a step-ladder resulting in him having bad pins and needles and cramps in his right hand. Surgery was performed on Mr A which resolved these symptoms by way of a laminectomy at C34. However, Mr A never regained the grip in his right hand.

In November 1996, Mr A developed cramps and pins and needles in all fingers of his left hand involving also the volar and dorsal aspect of the forearm. Mr A was referred to Dr B. After a MRI scan Mr A was admitted to a private hospital on 5 March 1997 for surgery to relieve the compression on his cervical spinal cord. Dr B carried out the surgery. Post-operatively Mr A leaked fluid from around the spinal cord and was kept sitting up for several days in an attempt to stop the leak.

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Outcome of Investigation *continued*

During that time the dressings were changed frequently and on one occasion a waterproof dressing was used. On 7 March 1997 this waterproof dressing was removed. Upon removal the dressing pulled out the nylon sutures in Mr A's back. Dr B noted in his letter of 28 July 1997:

> *"During this time, the dressings were constantly changed. One nurse had the idea of putting on a completely waterproof dressing to stop the leak This is a very sticky plastic which was applied straight onto the stitches. When it came off it took the stitches out… For other reasons, I have repeatedly left instructions that this particular dressing is not to be applied to back wounds, but staff change and often do not take in all the instructions."*

Dr B replaced the sutures under local anaesthetic. Local anaesthetic was used due to Mr A's asthmatic condition.

The wound continued to leak at the rate of approximately 300ml per day. On 9 March 1997 Mr A was taken into theatre and Dr B re-opened the wound. Dr B found that the source of the leak was coming from a single needle prick in the membrane around the spinal cord. This single needle prick had formed a flat valve so that the spinal fluid flowed outwards only. Dr B sutured a patch down over the pinprick and there was no further leak.

Mr A subsequently developed a calf vein clot. This made walking sore and difficult. An elastic stocking allowed him to continue walking. Dr B saw Mr A as an outpatient twice after the surgery and found that his walking was deteriorating. Dr B could not account for this.

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Dr B (Neurosurgeon) and Dr C (Neurologist)

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Outcome of Investigation ***continued***

On 12 May 1997 Mr A rang the Neurology Department of the public hospital and explained his symptoms. An outpatient appointment was made for the following day and he was seen by Dr C. During the consultation Dr C advised Mr A that he could assist him to walk within eight days. Mr A was admitted to hospital on 19 May 1997 for intensive neurological physiotherapy. At the time of admission Mr A agreed to Dr C's request to be the subject of a demonstration when he lectured to a group of doctors on 21 May 1997. Prior to his arrival at the demonstration Mr A was advised that the attendees had been told about him. Mr A was not advised of the exact information that had been given to the attendees nor informed that there were to be 40 to 60 doctors present.

Dr C states the seminar was of general practitioners who attended a continuing education meeting in neurology. Dr C reports he was conscious that Mr A might find this environment threatening and therefore explained the circumstances in which the teaching would occur. Dr C recalls he asked Mr A if he would help and explained that he would introduce Mr A to his colleagues, after recounting the history of his condition, and would then ask Mr A to walk so that his walking difficulty could be observed. Dr C states this is his usual practice in any teaching situation.

A nurse brought Mr A to the demonstration by wheelchair. During the demonstration Mr A was required to demonstrate his walking (during which he needed support) and then to lie on a bed and be examined by Dr C. Mr A found the experience of walking with such difficulty humiliating in front of so many people.

Dr C reports that general practitioner teaching sessions are not normally well attended and usually only 12-18 participants are present. Dr C states 44 doctors attended this session and he was not aware so many would come.

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Outcome of Investigation *continued*

Ms G, who was Continuing Medical Education Co-ordinator, arranged and facilitated the seminar. She stated attendance at these seminars was extremely variable and this was one of the best attended that year. She reported that at one seminar only three general practitioners turned up and attendance at these sessions could not be gauged until the seminar actually began. Ms G reports that after the seminar Mr A and a second patient, who also attended at the request of Dr C, were offered a gift voucher. Ms G recalls a nurse informing her Mr A had refused the voucher, which surprised her.

Ms G stated she was extremely surprised to hear Mr A felt humiliated at the seminar. She reports he was treated with respect, as were all patients attending seminars. Ms G stated *"For the life of me I cannot understand why [Mr A] got so het up about it."*

On 27 May 1997 Dr C's view was that Mr A's walking was continuing to deteriorate and he took a firm approach with Mr A. Mr A alleges Dr C told him that his problems were psychological and that he was to walk. Mr A tried to walk and fell to the floor. Dr C told him to get up, which he did, before falling again. Mr A alleges that Dr C shouted at him on several occasions, during and after, he attempted to walk. In Dr C's letter of 30 July 1997 he stated:

"His walking became more bizarre, and as above did not fit any neurological pattern… I did not want to support or condone what I believed was abnormal illness behaviour and therefore I elected not to help the patient to walk for these two reasons. While attempting to walk he fell on two occasions without obvious injury. He was able to lift himself off the floor with the use of a hand rail and without assistance."

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Dr B (Neurosurgeon) and Dr C (Neurologist)

Opinion – Case 97HDC6996/JW, continued

Outcome of Investigation *continued*

In this letter, Dr C also noted:

> *"[Mr A] had been an ACC beneficiary for the previous six years and he had learned some weeks previously that he was to change from an ACC beneficiary to a Superannuitant. I was not able to ascertain the neurological reason for him being an ACC beneficiary. The patient had had a foramenotomy (increasing the size of normal holes in the cervical spine through which nerves passed to the arm) for a problem of pain in the arm. The operation was complicated by a leak of the fluid surrounding the spine, and although able to walk out of the hospital, his gait over the subsequent two months had become progressively worse, needing to use a frame. Because of this, he had recently been supplied with a new walking frame, from the ACC."*

Dr C gave Mr A the options of either walking properly, seeing a psychiatrist or going home. Mr A requested that he see a psychiatrist.

Shortly after Mr A was admitted to the public hospital, Dr B saw Mr A in the neurology ward and asked him how his walking was. Dr B's letter of 28 July 1997 states:

> *"I got him to walk holding my hand, then let him go unexpectedly to see whether he managed to balance. I was quite surprised that he fell. Clearly, I had misassessed the situation, though there was no ill will in what I did… You will note that [Dr C's] letter states that he tried the same test and [Mr A] fell then too. It is a standard test of the gait…"*

On 27 May 1997 Dr C apologised to Mr A for humiliating him and explained his intention was to try and persuade him to walk. On 28 May 1997 Mr A was assessed by a psychiatric registrar who advised Mr A that there were no psychological problems evident. Mr A was discharged from hospital on 30 May 1997. He currently walks with the aid of crutches, falls frequently and is unable to drive a car.

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Dr B (Neurosurgeon) and Dr C (Neurologist)

Opinion – Case 97HDC6996/JW, continued

Outcome of Investigation *continued*

The Commissioner sought professional advice from two neurologists in relation to Dr B's and Dr C's actions in relation to Mr A's complaint. The Commissioner asked whether Dr B provided Mr A with surgical and recovery services that complied with professional and other standards. The specific issues that the Commissioner requested advice on were:

- How commonly does a fluid leak of several days duration occur following surgery for decompression of the cervical spinal cord?
- How reasonable were the actions taken by Dr B to stop the leak following surgery?
- Was Dr B's use of nylon sutures reasonable in the circumstances?
- What is your view of Dr B letting go of Mr A when checking his balance?
- Are there any other issues arising from the supporting information enclosed?

The Commissioner's advisor responded to each requested issue as follows:

- *"The risk of unintended "incidental" durotomy following a laminectomy is 0.3% - 13%. The risk increases to up to 18% in re-do operations as is the case with [Mr A]… Although not frequent, unintended durotomy is not an unusual occurrence, and alone, is not considered an act of malpractice."*
- *"It is the usual practice to treat post-operative cerebrospinal fluid leaks after operations on the spine conservatively to start with… If conservative treatment fails, surgical intervention in the form of suturing the opening in the dura with or without leaving a fat or muscle graft over the suture line. This is what was done in this case."*
- *"The use of nylon for suturing the skin in operations on the spine is a common and perfectly accepted practice. I among others suture the skin with nylon."*
- *"The usual method of checking balance is first to examine the patient supine to assess the power in the lower limbs. If it is thought that there is reasonable power, the patient is allowed to walk first with support, then without."*

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Dr B (Neurosurgeon) and Dr C (Neurologist)

Opinion – Case 97HDC6996/JW, continued

Outcome of Investigation *continued*

- *"In my view, the care and service provided by [Dr B] between 5 March and mid-May 1997 was within the accepted standards. The series of misfortunes which took place do not amount to negligence or malpractice."*

The Commissioner also received advice from a second neurologist in relation to Dr C's actions. The Commissioner's advisor was requested to provide information on whether Dr C provided Mr A with neurological services that complied with professional and other standards. The Commissioner requested that the advisor address the following issues:

- How reasonable was Dr C's request of Mr A to demonstrate his walking difficulties in front of a group of doctors?
- What is your view of any risks involved in Dr C's use of a "firm stand" with Mr A on 26 May 1997?
- Are there any other issues arising from the supporting information enclosed?

The Commissioner's advisor noted:

> *"As you know, the information is conflicting. On the one hand [Mr A] describes a humiliating experience under the care of [Dr C] and alleges behaviour which is inappropriate for a medical practitioner. On the other hand, however, [Dr C] describes a logically based series of measures designed to rehabilitate [Mr A]."*

and

> *"The assessment and management of such patients is fraught with diagnostic uncertainty, and the outcome of treatment is often not satisfactory for either the patient or the medical practitioner."*

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Dr B (Neurosurgeon) and Dr C (Neurologist)

Opinion – Case 97HDC6996/JW, continued

Outcome of Investigation *continued*

In addressing the specific issues raised by the Commissioner, the Commissioner's advisor noted that:

- *"If it was true that [Dr C] humiliated [Mr A] in front of 40-60 trainee doctors, regardless of whether [Mr A] agreed to attend the presentation or not, then [Mr A] deserved the apology delivered to him by [Dr C]. I believe that, to a certain extent, [Dr C] has conceded that there was some basis for [Mr A's] complaint regarding this teaching session."*

In relation to the risks involved in Dr C's use of a "firm stand" with Mr A, the Commissioner's advisor noted:

- *"Of more concern, however, [Mr A] describes an event of 26.5.97 where [Dr C] allegedly shouted at him and spoke to him in a harsh manner. He was reportedly forced to walk when he could not. [Mr A] describes falling to the ground and having [Dr C] shout at him and demand that he stand up and walk. According to [Mr A], he was degraded in front of the hospital staff and possibly the patients in the same ward."*

  "If these allegations are true, they are a serious misuse of authority and represent behaviour unacceptable for a medical practitioner."

A phone interview was subsequently conducted on 18 January 1999 with Ms D. Ms D was a witness to the events that occurred on 26 May 1997. She stated:

"[Dr C] ordered [Mr A] to get out of bed. [Dr C] got very impatient, and wanted [Mr A] to walk without his walker. [Mr A] said he couldn't, and [Dr C] said "of course you can." [Dr C] yelled at [Mr A] and treated him worse than a dog. That this was done to anyone, particularly in front of people, was appalling.

[Dr C] then pushed [Mr A] and [Mr A] fell. He was given little assistance, with only the nurse and house surgeon assisting him to get up. [Dr C] did not help him.

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Dr B (Neurosurgeon) and Dr C (Neurologist)

Opinion – Case 97HDC6996/JW, continued

Outcome of Investigation *continued*

[Mr A] then walked with his walker, with [Dr C] walking alongside him, yelling at him. Words to the effect of "it's all in your mind, pull yourself together, it's all a big act, no one can find anything wrong with you", etc.

When [Mr A] reached the outside of the cubicle door, he fell again."

Ms D advised that she had been a nurse and stated:

"It is the most horrifying thing I have ever witnessed, a doctor treating a patient like that."

Dr C states Mr A did fall but this occurred in the corridor where it could not have been witnessed by other patients. Dr C states "*the claim that I pushed the patient is totally incorrect.*"

In a letter to the Health and Disability Commissioner of 12 August 1999 Dr E, Gastroenterology Registrar stated:

"I had not been directly involved in [Mr A's] care, but attended the ward round on 26 May [1997] as the Neurology Registrar. In [Mr A's] case, [Dr C] was concerned that [Mr A] had a psychological, rather than a neuroanatomical, disorder. [Dr C] provided active and firm encouragement for [Mr A] to walk unaided during his assessment on the ward round. This firm encouragement was similar to what I had experienced with other senior Neurology Consultants. I do not recall [Dr C] shouting at [Mr A].

[Mr A] did fall during the assessment, however, not in a manner that would, or did, sustain injury."

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Dr B (Neurosurgeon) and Dr C (Neurologist)

Opinion – Case 97HDC6996/JW, continued

Outcome of Investigation *continued*

In a letter of 3 February 1999 to the Health and Disability Commissioner, Dr C noted:

> *"I did not tell other colleagues that [Mr A's] problems were psychological before the clinical demonstration. I was conscious of the need to be sensitive to [Mr A] in the situation of a clinical demonstration to General Practitioner colleagues, and I was appreciative for him agreeing to attend the meeting. I realised that this could be potentially threatening for him, and I made every effort to ensure that he felt comfortable… In this teaching exercise, which [Mr A] had kindly agreed to, the purpose was not to tell other colleagues what the problem was, but for them to be able to discuss the problem (which was done in [Mr A's] absence)."*
>
> *"In reference to [Mr A's] letter of May 1996, I would state that I certainly did not shout at [Mr A]… I perceived he was at risk of falling, and did not want to support or condone what I believed was abnormal illness behaviour, and therefore I elected not to help the patient walk for this reason. [Mr A] did not have any symptoms of neurological abnormality. Given this, he should not have fallen in the way that he did, when requested to walk into the corridor. It was certainly not my intention that [Mr A] should fall, and I do not accept that asking him to walk into the corridor as I did, would be regarded as an assault."*
>
> *"[Mr A's] actions verged on a hysterical response and it is likely that with these difficulties walking the problem could have been misinterpreted by other patients… It is likely that I was firm and definite and perhaps somewhat authoritarian in a measured and considered way in trying to get [Mr A] to walk."*
>
> *"Certainly it was not my intention to embarrass the patient in front of others, though his actions of collapsing in the corridor and his demonstration of abnormal illness behaviour by beginning to jerk on the bed when I walked into the room may have suggested to other patients that he had a greater disability that was real."*

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Dr B (Neurosurgeon) and Dr C (Neurologist)

Opinion – Case 97HDC6996/JW, continued

Outcome of Investigation *continued*

"On realising that the patient had been upset at the way I managed his care, I did apologise to him, and although I don't recall the details of that apology, it would have been in the general form that I would have apologised not so much for my action, but that my action had upset him."

"I was conscious that some patients in this situation may end up "professional cripples." [Mr A] had already obtained a new walking frame, prior to his admission, which may have also reinforced abnormal illness behaviour."

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Dr B (Neurosurgeon) and Dr C (Neurologist)

Opinion – Case 97HDC6996/JW, continued

Code of Health and Disability Services Consumers' Rights

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.

RIGHT 5
Right to Effective Communication

1) Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter.

RIGHT 9
Rights in Respect of Teaching or Research

The rights in this Code extend to those occasions when a consumer is participating in, or it is proposed that a consumer participate in, teaching or research.

3 Provider Compliance

1) A provider is not in breach of this Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in this Code.
2) The onus is on the provider to prove that it took reasonable actions.
3) For the purposes of this clause, "the circumstances" means all the relevant circumstances, including the consumer's clinical circumstances and the provider's resource constraints.

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Dr B (Neurosurgeon) and Dr C (Neurologist)

Opinion – Case 97HDC6996/JW, continued

Opinion: No Breach Dr B

In my opinion, Dr B did not breach Right 4 of the Code of Health and Disability Services Consumers' Rights as follows:

- While Mr A suffered an unintended "incidental" durotomy following laminectomy, ie fluid leaking from the base of the spinal cord, cannot be attributed to Dr B. Although not frequent, unintended durotomy is not an unusual occurrence, and alone, is not considered an act of malpractice.

- Dr B undertook reasonable actions to stop the leak post-operatively. Dr B re-sutured a patch of skin over the CSF leak under local anaesthetic. Mr A was then confined to bed rest in the sitting position in order to reduce the pressure on the leakage site. These actions were entirely reasonable.

- Dr B's use of nylon for suturing the skin was reasonable in the circumstances and in fact is a common and perfectly acceptable practice for this type of operation.

- Dr B met appropriate standards when he let go of Mr A to check his balance. The usual method of checking balance is first to examine the patient supine to assess the power in the lower limbs and then to encourage the patient to walk both with and without support. Dr B allowed Mr A to walk first with support, then without support. This is a common test of gait. Dr B did not expect Mr A to fall and there was no ill will in Dr B's actions.

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Dr B (Neurosurgeon) and Dr C (Neurologist)

Opinion – Case 97HDC6996/JW, continued

Opinion: Dr C

In my opinion, Dr C breached Right 5(1) and Right 9 of the Code of Health and Disability Services Consumers' Rights. Dr C should have effectively communicated with Mr A that attendance at the demonstration could involve a large number of doctors and told Mr A the purpose of his attendance. In my opinion, regardless of whether Mr A agreed to attend the presentation or not, the fact that Mr A felt humiliated indicates that he was not fully aware of what was going to occur at this demonstration.

In my opinion, Dr C did not breach Right 4(2) of the Code of Rights. By requiring Mr A to walk, Dr C was merely carrying out a standard test of gait. Dr C believed that Mr A was able to walk without support. Although he was wrong, this is the usual method used to examine a patient's balance. In my opinion this aspect of Dr C's service was of an appropriate standard and complied with his duties as a provider under the Code.

In my opinion, there is insufficient evidence to form an opinion about the incidents on which Mr A states that Dr C forced him to walk and shouted at him several times. Therefore in my opinion, Dr C did not breach the Code.

Actions: Dr C

I recommend that Dr C takes the following actions:

- Provides a written apology to Mr A for his lack of effective communication regarding the demonstration. This apology should be sent to the Commissioner who will forward it to Mr A.

- Fully informs patients of what is involved if he requests their participation in any teaching or research. This includes explaining what the patient will be required to do, the number and nature of the attendees and any prior information that these attendees may have about the patient.

- Familiarises himself with the Code of Health and Disability Services Rights and his obligations to consumers.

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Dr B (Neurosurgeon) and Dr C (Neurologist)

Opinion – Case 97HDC6996/JW, continued

Actions: The public hospital

I suggest that the public hospital takes the following actions:

- In situations where a consumer is participating in teaching or a research session, offer the consumer the opportunity to take a support person.

- Ensures all employees are aware of consumers' rights regarding involvement in any teaching or research session and that written consent is obtained.

Other Actions

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