Dr B, Gynaecologist

A Report by the

Health and Disability Commissioner

(Case 04HDC14298)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Consumer
Dr B	Provider/Locum consultant obstetrician and gynaecologist
Dr C	General practitioner
Dr D	Consultant obstetrician and gynaecologist
Dr E	Urologist
Ms F	Regional Manager, the District Health Board
A District Health Board	Provider

Complaint

On 26 August 2004, the Commissioner received a complaint from Mrs A, via a Health and Disability Consumer Advocacy Service, about the services provided to her by Dr B. The following issues were identified for investigation:

- *Whether Dr B obtained Mrs A's informed consent prior to him performing the Marshall Marchetti Krantz procedure on 28 November 2001.*
- *Whether it was appropriate for Dr B to perform a Marshall Marchetti Krantz procedure on Mrs A on 28 November 2001.*

An investigation was commenced on 3 March 2005.

Information reviewed

Information from:
- Mrs A
- Dr B
- ACC, Medical Misadventure Unit
- A District Health Board.

Independent expert advice was obtained from Dr Pravin Nahar, obstetrician and gynaecologist.

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

Information gathered during investigation

Preoperative consultations
On 25 October 1999, Mrs A, then aged 52, was referred by her general practitioner, Dr C, to the Gynaecology Outpatient Clinic at a public hospital for ongoing difficulties with stress and urge incontinence.

After two years on the waiting list, Mrs A was seen by locum consultant obstetrician and gynaecologist Dr B on 12 November 2001. Mrs A described continuing difficulties with stress and urge incontinence despite vigilantly engaging in pelvic floor exercises. She had been on hormone replacement therapy (HRT), Trisequens, for two years and experienced regular heavy periods. She did not complain of dyspareunia (abnormal pain during sexual intercourse).

Dr B's examination of Mrs A revealed that she had atrophy (shrinking) of her vulva and vagina but that this was within normal limits. Her uterus was in anteversion flexion (abnormally tilted forward, away from the midline) but slightly displaced to her right side, and her cervix was normal but also displaced to the right-hand side. Dr B discovered a solid, palpable pelvic mass of approximately 4cm in diameter, which he queried as a uterine fibroid or a solid ovarian tumour.

An ultrasound scan conducted on the same day confirmed the mass to be a fibroid. The radiology report also documented that a smaller mass in the fundal region of the uterus was consistent with a fibroid, and that there was a mass in the left ovary, indicative of a haemorrhagic cyst.

Dr B saw Mrs A later that day to discuss the results of the ultrasound and options for the treatment of her incontinence. In addition to the hysterectomy, it was proposed that surgery be performed which would help to manage the incontinence. Dr B's notes in relation to Mrs A's treatment options state:

> "… Arrange: Abdo Hyst + BSO [bilateral salpingo-oophorectomy]
> ~~TVT Sling~~ Burch suspension
> [Dr B]"

A consent form, although not fully completed, was signed and dated 12 November 2001 (refer Appendix 1).

Dr B recalls that the TVT sling procedure was crossed out on the consent form before he and Mrs A signed the form. However, Mrs A recalls that the surgical procedure stated on the form was changed from a TVT sling to a Burch colposuspension when she met with the house officer at her presurgical appointment on 26 November 2001. According to her, Dr B had been advised by Dr D and another gynaecologist that a TVT sling could not be performed under general anaesthetic, necessitating a change in procedure to a Burch colposuspension. Mrs A understood that Dr B would be contacting her to discuss the change in procedure before performing the surgery.

Dr B advised that due to the time that has elapsed since the events in question, he is unable to remember the exact nature of the discussion with Mrs A during the consultation on 12 November 2001. However, he believes he would have discussed with her the Burch colposuspension "with the caveat that I may need to alter the form of the colposuspension depending on what I find when I do the hysterectomy". In contrast, Mrs A said that before her operation, Dr B did not discuss other surgical procedures or highlight the possibility that the agreed surgical procedure could be varied. Dr B explained that it is his usual practice to inform patients that surgical procedures such as TVT sling and Burch colposuspension could relieve stress incontinence but not urge incontinence, and to caution them that there was no guarantee of a permanent resolution of the problem despite surgery. He also said that it is his practice to explain to his patients how a particular surgical procedure will be performed.

In Dr B's letter to Mrs A's general practitioner, Dr C, dated 14 November 2001 he wrote:

> "I discussed everything with the patient and she agreed to an abdominal hysterectomy and also a [Burch] colposuspension for her stress incontinence."

The surgery was scheduled for 28 November 2001. A week before surgery, Mrs A sought a second opinion on 19 November 2001 from Dr D, regarding the specific aspect of the treatment plan that she have her ovaries removed (ie, bilateral salpingo-oophorectomy; BSO). Dr D stated in a letter to ACC on 29 July 2002 that he encouraged Mrs A to consult Dr B before the surgery about her preference to retain her ovaries. Mrs A attempted to contact Dr B, and a message was relayed to her that he would discuss her request with her before the operation. During the presurgical appointment, Mrs A reiterated to the house officer her preference regarding her ovaries.

Elective surgery

Mrs A was admitted for elective surgery on 28 November 2001. Dr B saw Mrs A that morning prior to her receiving her pre-medication at 1.30pm. Dr B discussed the operation with Mrs A, and she restated her desire to retain her ovaries. It was at this point that Dr B said that he crossed out "BSO" on the consent form. Mrs A was not asked to acknowledge the alteration. She recalled that it was very difficult to talk to Dr B at this time, and that "I had to fight really hard with him to retain my ovaries …". Dr B recalls that he readily agreed to retain Mrs A's ovaries. He explained that he had initially suggested removing Mrs A's ovaries because they ceased to function at menopause.

The surgery took place on 28 November 2001. Dr B's operation notes state:

> "Indication: Uterine Fibroid
>
> Total Abdominal Hysterectomy and Marshall Marchetti Krantz suspension [MMK]
>
> Pfannenstiel incision
>
> 3 x uterine pedicles tied on either side
>
> Uterus and Cervix removed
>
> Ovaries left in situ (patient request)
>
> 2 x stay sutures applied on each side of urethra in vaginal fascia and secured to posterior periosteum of the pubis
>
> Abdomen closed in layers with suction drainage under rectus sheath and subcutaneous fat
>
> [Dr B]"

Dr B elected during the surgery to complete an MMK procedure as he was unable to identify the Cooper's ligament. Instead of anchoring the sutures to the Cooper's ligament, he attached sutures to the periosteum of the pubis. Dr B advised that by changing the placement of the sutures, the procedure was altered to a MMK.

Mrs A's postoperative recovery was uneventful, and she was discharged from hospital on 5 December 2001. Dr B's discharge letter of 14 December 2001 to Dr C stated that the principal diagnoses of Mrs A's symptoms were fibroid uterus, and stress and urge incontinence. He advised Dr C that he had performed a MMK suspension of the urethra, and a total abdominal hysterectomy, during which Mrs A's ovaries were retained. Dr B confirmed that the palpable pelvic mass of 4cm diameter (found during the initial consultation) was a uterine fibroid. He informed my Office during the investigation that he had used absorbable vicryl sutures for the procedure, and explained that absorbable sutures remain in place long enough to enable fibrosis to form which hold the MMK suspension to the periosteum of the pubis. However, the actual date of when Dr B first advised Mrs A about the type of suture material he used during the surgery is unclear.

Follow-up consultation

Mrs A attended a follow-up outpatient appointment with Dr B on 10 January 2002. He observed that "everything [had] healed properly except for the vaginal vault which [was] still slightly raw". Dr B's notes state:

> "Post op [operation]
> Stress ulcer post operatively
> Still sore in abdomen
> No discharge:
> No feeling of full bladder

[word unknown] Urge incontinence

[word unknown] [word unknown] Abdominal scar: healed
v/v [vulva and vagina] Atrophic
Vault — not healed completely
Pelvis: No masses
On [word unknown]
Rx [treatment] Ditropan"

According to Mrs A, Dr B "did not listen" to her during this appointment when she remained concerned that something was "wrong".

Postoperative treatment
Following the operation, Mrs A experienced "being in constant pain", having altered sensation of her bladder and severe pain during sexual intercourse. Instead of returning to Dr B, Mrs A consulted Dr D on 25 March 2002. He did not find any abnormality on clinical examination, aside from some tenderness on the right side of her pelvis. An ultrasound scan performed showed no evidence of a haematoma.

As Mrs A continued to be troubled by pain on the right side of the pelvis, Dr D carried out a laparoscopy on 20 June 2002. He found two adhesions of approximately 1cm width each on her right pelvic wall which he divided laparoscopically. As Dr D was unable to diagnose the specific cause of Mrs A's symptoms, he suggested removing the MMK sutures and inserting a TVT Sling simultaneously, but cautioned Mrs A that the procedure could result in the return of her stress incontinence. She agreed to have the sutures removed and was placed on Dr D's waiting list for the surgery to be performed under spinal anaesthesia. He also referred Mrs A to a urologist, as he wanted a specialist's opinion on her lack of bladder sensation before proceeding with surgery to remove the MMK sutures. According to Mrs A, it was through her postoperative consultations with Dr D that she discovered that Dr B had performed a different surgical procedure from that she had consented to.

On 17 October 2002, Mrs A presented as an outpatient at the Urology Clinic of the public hospital. Dr E, urologist, examined her abdomen, pelvis and vagina, and queried whether Mrs A had osteitis pubis (inflammation of the pubis bone). He considered that removing the MMK sutures would be the best way to alleviate Mrs A's symptoms, but informed her of the risk of surgical failure, along with a recurrence of incontinence. On 6 March 2003, Mrs A returned to the Urology Clinic for urodynamics investigation of her bladder function. Dr E confirmed that she had no sensation in her bladder, and made a diagnosis of denervated bladder, and a probable diagnosis of osteitis pubis. He explained to Mrs A that removing the sutures would alleviate but not completely resolve all of her pain. In his report to Dr D, Dr E recommended removing the MMK.

In April 2003, Mrs A had surgery to remove the MMK sutures. However, Dr D was unable to locate the sutures that Dr B had inserted. Dr E was also unsuccessful in locating the MMK sutures during Mrs A's subsequent surgery at a private hospital.

Mrs A continues to experience ongoing symptoms of pain and a lack of bladder sensation.

Subsequent events

ACC "medical mishap" finding
Mrs A made an application to ACC Medical Misadventure Unit on 11 July 2002 for assistance following "loss of bladder sensation and dyspareunia". The claim was declined on 18 February 2003 as "it did not meet the criteria of functional disability lasting more than 28 days".

Mrs A's claim was reconsidered by ACC. Further information was provided that indicated that Mrs A's loss of bladder sensation was related to denervation of the bladder, and a probable diagnosis of osteitis pubis subsequent to the MMK procedure. Additional information was also provided on "functional disability" in relation to Mrs A's loss of bladder sensation. On 7 April 2003, ACC reversed its earlier decision, and upheld that Mrs A's bladder dysfunction and dyspareunia (due to the MMK procedure) met the criteria for medical mishap. However, ACC stated that there was no evidence of medical error and that "in this case, care was of a reasonable standard expected in the circumstances".

Meetings with the District Health Board
On 3 September 2003, a meeting was held between Mrs A and Ms F, Regional Manager — Medical, Family and Clinical Support Services, at the District Health Board. Minutes of the meeting record that Mrs A was concerned about Dr B's treatment of her and of three other women known to her, and that she was concerned about a three-month wait before she could be seen at the Pain Clinic at the public hospital. The minutes document that Mrs A had requested information about the type of sutures used by Dr B (ie, absorbable or non-absorbable sutures), which Ms F agreed to clarify with him and Dr D.

Following the meeting, Ms F telephoned Dr B. He expressed regret upon hearing about Mrs A's ongoing symptoms, and clarified that he did not use non-absorbable sutures during her surgery. However, Ms F recorded in her file notes that Dr B had "used non-absorbable sutures as that was the norm". On 8 September 2003, Ms F spoke to Dr D who mentioned that he had been unsuccessful in locating the MMK sutures, and queried whether they were buried amidst the large amount of scar tissue he had observed. Ms F contacted Mrs A on 16 September 2003, and updated her on the discussion with Drs B and D. Mrs A recalled Ms F informing her that Dr B had used non-absorbable sutures.

A subsequent meeting was held between Mr and Mrs A, the Chief Medical Advisor and the Complaint Co-ordinator on 5 August 2004. The purpose of the meeting was

to discuss Mr and Mrs A's intention to seek financial compensation from the District Health Board in regard to the operation performed by Dr B. Following the meeting, Mrs A lodged a complaint with my Office.

Independent advice to Commissioner

Initial advice
The following expert advice was obtained from Dr Pravin Nahar, obstetrician and gynaecologist:

> "I have been asked to provide an opinion to the Commissioner on case number 04HDC14298. I have read and agree to follow the Commissioner's guidelines for Independent Advisors.
>
> My professional qualifications include MBBS (1982) MD (1988), MRCOG (1990), FRANZCOG (1996), FRCOG (2003). I am currently a vocational registered medical practitioner in New Zealand. I am a practicing Gynaecologist working in both the public and private sector. As a general Gynaecologist, I treat women with problems of urinary incontinence. I used to perform operative procedures such as Burch colposuspension that is now largely superseded by TVT. I have been engaged in clinical gynaecology for over twenty years now.
>
> In giving my opinion, I have read and considered all the available information as outlined […].
>
> In relation to this complaint, I would like to point out the following observations that I made from the documentation related to the above complaint:
>
> - There is no documentary (in clinical records) evidence that [Dr B] discussed with [Mrs A] regarding the benefits and risks of proposed surgery at the time of consultation on 12 November 2001.
> - There is no documentation (in clinical records) what discussion took place between [Dr B] and [Mrs A] before she was taken to the theatre on 28 November 2001.
> - There is no documentation in the operation notes why [Dr B] chose to perform Marshall Marchetti Krantz procedure instead of Burch colposuspension.
> - There is no documentation (in clinical records) to show that [Dr B] ever (either during her stay in the hospital or on 10 January 2002) explained to [Mrs A] regarding MMK procedure that he had performed instead of Burch colposuspension.

In support of my comments and advice, I am [providing] references from 2 recognised textbooks.[1,2] I am also providing an abstract from the latest Cochrane Database on the subject.[3]

1. Comments on care provided by [Dr B]:

[Mrs A] presented with a mixed symptom of Stress and Urge urinary incontinence. When surgical treatment of stress incontinence in the presence of urge incontinence is planned, urodynamic investigations are recommended to confirm the diagnosis. These tests provide indication towards the success rate of surgery as well as postoperative urinary problems. While most textbooks on urogynaecology recommend to perform urodynamic investigations in all cases of stress incontinence, many practising general gynaecologists in New Zealand and worldwide continue to perform surgical procedures for stress incontinence without such investigations.

In my opinion, [Mrs A] should have been offered urodynamics before her surgical treatment because she presented with a mixed symptom of stress as well as urge incontinence. Failure to organise these generally available tests (at least a basic cystometry) would be viewed with **moderate disapproval** from a peer group of general gynaecologists.

2. What information should [Dr B] have given to [Mrs A] prior to her surgery on 28 November 2001?

Success rate and possible common complications are important aspects for discussion before an operation for stress incontinence is undertaken. This is important because none of the procedures available for the treatment of stress incontinence has a long-term success rate of more than 90%. Impaired bladder function is not uncommon after such surgery and may have long-standing consequences. As mentioned above, I find no documentation to confirm that such discussion took place between [Dr B] and [Mrs A]. There is also no documentation regarding hysterectomy and removal of ovaries. It is apparent from [Mrs A's] visit to [Dr D] for a second opinion before the surgery that pros and cons of the removal of ovaries were not fully discussed with her. In the absence of any documentary evidence in the clinical records, I shall conclude that **[Dr B] failed to observe reasonable care** that would be expected from a specialist gynaecologist in New Zealand at that time.

3. What information should [Dr B] have given to [Mrs A] following her surgery?

In the present circumstances, it would be expected that [Dr B] should have explained to [Mrs A] that he had performed a different procedure to what was intended.

4. In addition, please advise whether it was appropriate to schedule [Mrs A] for:
i) a Burch colposuspension
ii) an abdominal hysterectomy
iii) these two procedures together.

It is a common practice to schedule abdominal hysterectomy and Burch colposuspension together if stress incontinence is associated with other gynaecological symptoms or disease requiring abdominal hysterectomy. In the present case, it was quite appropriate for [Dr B] to schedule the procedures together.

5. Was it appropriate to have performed a Marshall Marchetti Krantz procedure instead of a [Burch] colposuspension? If so, on what basis? Please comment on the risks and benefits of this alternative.

Burch colposuspension and MMK procedure are both retropubic operations performed for stress incontinence of urine in females. Historically, MMK procedure is more popular in America, while Burch procedure is the procedure of choice in most of the Commonwealth group of countries. Their success rates are similar and the choice of procedure depends largely on the operating surgeon. The complications of both procedures are similar. However, osteitis pubis is a complication that is somewhat unique to MMK procedure rather than Burch because of placement of sutures directly on the periosteum behind the pubic bone.

At the time of operation, [Dr B] performed MMK procedure instead of the intended Burch colposuspension. He did not document the reason for this change in the operation notes. In his report, he has mentioned that this was done as he failed to identify the Cooper's ligaments. While this change of procedure is **not a major departure from the intended procedure**, I would have expected [Dr B] to document this properly. He should also have explained this to [Mrs A] during her postoperative stay in the hospital.

6. Please explain the risks and benefits of a [Burch] colposuspension.

Burch colposuspension is a well-recognised operation for the treatment of stress incontinence of urine in females. The reported cure rates have been between 69–88%.[3] The important complications of Burch colposuspension include haemorrhage, urinary infection, impaired bladder functions (voiding difficulties, urge incontinence, altered sensation of bladder, etc.), pelvic pain and enterocele. While these complications are common to most of the retropubic procedures including Burch and MMK, osteitis pubis is a rare complication that is rather unique to MMK procedure.

7. Are [Dr B's] clinical records of an appropriate standard? If not, why not?

I have already commented on lack of adequate documentation in the clinical records on the part of [Dr B]. These include the initial consultation, operation notes as well as post-operative consultations. I note from his report that he started work in New Zealand only 8 days before he saw [Mrs A] in the clinic. This may be an acceptable standard of record keeping in the place where he had been working before. However, in my opinion, [Dr B's] clinical records were not of an appropriate standard that could be expected from a general gynaecologist in New Zealand. Most of our peers will view this with **moderate disapproval**.

8. Are there any aspects of the care provided by [Dr B] that you consider warrant additional comment?

It is apparent that there was a lack of communication between [Dr B] and [Mrs A]. There was also a misunderstanding whether absorbable or non-absorbable sutures were used for the MMK procedure. **Lack of proper counselling and sub-optimal record keeping** are the highlights of the present complaint. In my opinion, these issues were largely related to the way of practice that [Dr B] was used to before starting to work in New Zealand. From the available documentation, it would be inappropriate to judge his competency with regards to surgical skill.

In the context of the present complaint, I would like to make a remark on the diagnosis of osteitis pubis. It is to be noted that the diagnosis has not been confirmed or substantiated with further investigations. The correspondence (dated 18 October 2002) from [Dr E], the urologist, raises this as a 'probable' cause of her ongoing pain. It is not clear from the available documents whether some form of radiological investigations, such as CT scan or MRI were performed to confirm the diagnosis of osteitis pubis as well the presence of any suture material behind the pubic bones.

References:

1. Walters MD & Karram MM. In *Urogynecology & Pelvic Reconstructive Surgery*. 2nd edn, 1999

- Recommended indications for urodynamic tests. Ch 5, p53
- Description of retropubic operations and their complications. Ch 14, p159–169

2. Stanton SL & Tanagho EA. *Surgery of Female Incontinence*, 2nd edn, 1986

3. Lapitan MC, Cody DJ & Grant AM. Open retropubic colposuspension for urinary incontinence in women. Cochrane Database of Systemic Reviews. 2, 2005"

Further advice
Dr Nahar was contacted for clarification. He provided the following advice on 14 September 2005 by telephone:

Burch colposuspension and MMK procedure
Dr Nahar clarified that the Burch colposuspension and MMK were similar surgical procedures for the treatment of stress incontinence. In the Burch colposuspension, sutures are attached to the Cooper's ligament and in the MMK procedure, the sutures are attached to the periosteum behind the pubic bone.

Dr Nahar explained that the choice of procedure was largely dependent on the operating surgeon.

Urodynamic studies
Dr Nahar advised that the results of urodynamic studies would have no bearing on the choice of procedure adopted by the operating surgeon. However, he explained that urodynamic studies were useful for patients presenting with mixed symptoms of both stress and urge incontinence as it ascertains the extent in which the problem is attributed to stress and urge incontinence, respectively. Where the problem is largely one of stress incontinence, Dr Nahar considered surgery to be the only viable option but stated that it would not be effective for treating urge incontinence. He clarified that presentations of stress incontinence alone did not necessitate a presurgical urodynamic investigation. In relation to Mrs A, Dr Nahar stated that it would not have been possible for Dr B to have discussed fully the different treatment options, without having requested a urodynamic investigation of her incontinence.

The following advice was provided on 14 February 2006:

Recording of suture material used

Dr Nahar commented that it is appropriate to use either absorbable or non-absorbable sutures in the MMK procedure, and the choice of suture depends on the gynaecologist performing the surgery. Given that both types of sutures are suitable, he advised that Dr B should have specified the suture material used in his operation note. Dr Nahar considered it reasonable to exclude details about the suture material used in the operation note if the nature of a particular surgery is such that only one type of suture material is appropriate. As the MMK procedure does not fall within the latter category, it would be prudent practice for the gynaecologist involved to record in the operation note details of the suture material used.

Code of Health and Disability Services Consumers' Rights

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

RIGHT 4
Right to Services of an Appropriate Standard

…

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.

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.

Relevant standards

The Medical Council of New Zealand publication *Good Medical Practice — A Guide for Doctors* (2000) states that doctors must:

> "keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed;" pp 3–4.

Opinion: Breach — Dr B

Documentation
Right 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code) states that patients have the right to have services provided according to relevant professional standards, such as those from the Medical Council of New Zealand. This includes the responsibility of providers to adequately document consultations with patients.

Dr B saw Mrs A on three occasions: at an outpatient clinic on 12 November 2001, the morning before he performed her operation on 28 November 2001, and at a follow-up outpatient appointment on 10 January 2002. My expert commented on the inadequacy of Dr B's documentation for each of these consultations.

As the result of inadequate documentation, it is not clear what was explained to Mrs A with regard to the Burch colposuspension procedure, and the benefits and risks of the operation, or indeed when Mrs A actually consented to the operation. In addition, there is no documentation of Dr B's discussion with Mrs A on the morning of 28 November 2001.

I accept Dr B's explanation that he performed a MMK procedure rather than a Burch colposuspension as he was unable to identify the Cooper's ligament in the course of surgery. However, he failed to document in his operation notes the reason for the change. Furthermore, Dr B's operation notes were inadequate as he did not specify the type of suture material used, although it transpired that he had used absorbable vicryl sutures. I note my expert's comment that it is necessary to record such information when performing the MMK procedure, since both absorbable and non-absorbable sutures are appropriate. Dr B's omission became significant when subsequent surgeons (Drs D and E) attempted in vain to locate the sutures to alleviate Mrs A's postoperative symptoms.

In addition, it is unclear whether Dr B informed Mrs A of the outcome of her surgery, and explained the different surgical procedure he adopted (either during her stay in hospital or during the follow-up appointment on 10 January 2002), due to the lack of documentation on any postoperative discussions of this nature.

The consent form signed by Mrs A contains a general provision for the surgeon to perform further or alternative surgery in the event the surgeon discovers some condition or complication that requires immediate further or alternative surgical treatment. The patient is required to indicate whether he or she is agreeable to further or alternative surgery in such situations. It is unfortunate that this part of the consent form was not completed. Had Dr B been vigilant in highlighting that particular provision to Mrs A, he would have been alerted to her position about having an alternative surgical procedure before the actual operation.

Dr B advised that his usual practice involves explaining to patients that surgical procedures are effective for treating stress incontinence, but not urge incontinence; that surgery does not guarantee a permanent resolution of the problem; and that possible additional or altered procedures may be necessary during surgery. However, he could not provide specific details of the information that he had conveyed during Mrs A's consultations with him. I note Dr B's comment that with the lapse of time (three and a half years following the event), he was unable to recall the details of his discussions with Mrs A. Nevertheless, it is because of the need to communicate effectively with other providers, and to provide an accurate contemporaneous account of discussions with the patient and any agreed actions, that consultations with patients must be adequately documented. This is in line with the Medical Council of New Zealand's requirement which states that doctors must "keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed".

In my view, by not documenting or inadequately documenting his consultations with Mrs A, Dr B failed to provide services that complied with professional standards. Accordingly, Dr B breached Right 4(2) of the Code.

Informed consent

Mrs A presented to Dr B with mixed symptoms of both stress and urge incontinence. Dr B examined Mrs A's abdomen, vagina and vulva, and referred her for an ultrasound scan. Later that day, Dr B discussed with Mrs A the results of her ultrasound scan and possible treatment options. I note that in his letter of 14 November 2001, Dr B advised Dr C that he had discussed "everything" with Mrs A, and that she had consented to an abdominal hysterectomy and a Burch colposuspension. However, due to insufficient details in his clinical records, and the time that had elapsed since the events in question, it is not possible to ascertain what treatment options had been discussed with Mrs A prior to her surgery, and which surgical procedure(s) she had elected. What is not disputed is that Mrs A consented to having elective surgery to treat her incontinence.

Dr B did not order urodynamic investigations that would have indicated the degree to which Mrs A's symptoms were related to stress incontinence as opposed to urge incontinence. I note Dr B's comment that additional time is incurred in arranging urodynamic investigations, and from his experience many gynaecologists perform surgery on clinical presentations only. There is no indication that he had considered and advised Mrs A to undergo such investigation. According to my independent expert, the lack of urodynamic investigations limited the extent of Dr B's advice since he had no indication of the various degrees to which Mrs A's incontinence related to urge and stress incontinence. Therefore, it was not possible for him to have discussed all appropriate treatment options with Mrs A, including the need for corrective surgery.

The surgery Dr B ultimately performed for treating Mrs A's incontinence (the MMK procedure) differed from what she had consented to (a Burch colposuspension). Dr B advised that, because he was unable to locate the Cooper's ligament, sutures were attached to the periosteum behind the pubic bone, which altered the procedure to a MMK.

My independent expert considered it acceptable in the circumstances for Dr B to perform the MMK procedure. He pointed out that the success rates and complications of the MMK procedure are similar to Burch colposuspension, except for osteitis pubis which is a rare complication, unique to the MMK procedure.

Although it is clear that Mrs A consented to surgical intervention for her incontinence, the key issue is whether her consent was given after receiving full information from Dr B. Right 7(1) of the Code provides that services may be provided to a patient only if the patient makes an informed choice and gives informed consent. I consider that, in the absence of the urodynamic investigations, Dr B was not in a position where he was fully able to advise Mrs A of her treatment options, and that Mrs A was therefore unable to give a truly informed consent. In these circumstances, Dr B breached Right 7(1) of the Code.

Opinion: No Breach — The District Health Board

Vicarious liability

In addition to any direct liability for a breach of the Code, employers may be vicariously liable under section 72(2) of the Health and Disability Commissioner Act 1994 for any breach of the Code by an employee. Under section 72(5) of the Act, it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the act or omissions leading to an employee's breach of the Code.

Dr B was employed as a locum consultant in obstetrics and gynaecology by the District Health Board at the time of the events in question. In the course of surgery, he decided to perform the MMK procedure rather than the Burch colposuspension when he had difficulty identifying the Cooper's ligament. The reasons for changing the surgical procedure were not documented in his clinical records, nor did Dr B explain the change to Mrs A following her operation. I am satisfied that Dr B's breach of the Code resulted from independent clinical practice (from poor communication and counselling), and therefore the District Health Board is not vicariously liable for his breach of the Code.

Dr B advised me that he did not receive any orientation from the public hospital regarding its expectation about documentation. Having recently arrived in New Zealand (his initial consultation with Mrs A took place eight days after his arrival), he carried on medical practice in the same way as he did in his home country. Dr B

explained that he was used to discussing consent issues, pre- and postoperatively, orally with his patients without making extensive notes as this was acceptable to patients in his previous practice. He thought that a letter to Mrs A's general practitioner where he mentioned the surgical procedure that was discussed and signed by Mrs A was sufficient to indicate informed consent.

In contrast, the District Health Board was of the view that the orientation they provided to Dr B was appropriate for the level in which he had been employed. Given Dr B's appointment as a locum consultant, he was expected to have knowledge and expertise at consultant level, including a good understanding of the need for documenting the consent process and details of the care and treatment provided. During Dr B's employment at the public hospital, he received clinical oversight from one of his peers that included regular meetings, reviewing his discharge summaries, and guidance on policies and procedures.

It is clear that orientation was provided by the District Health Board to Dr B. Whether the bulk of the orientation occurred during the early months of his employment is unclear, and it may be the case that Dr B required additional orientation on the importance of complete documentation to comply with the Code and the standard established by the Medical Council of New Zealand. Nevertheless, as Dr B was employed as a locum consultant, it was not unreasonable for the District Health Board to expect him to demonstrate the knowledge and expertise (including good record-keeping) required of a clinician at consultant level. I agree with my advisor that the lack of proper counselling by Dr B to Mrs A and his sub-optimal record keeping were largely related to the way of practice he was accustomed to before starting work in New Zealand. Therefore, I am satisfied that the District Health Board is not vicariously liable for Dr B's breach of the Code.

Other comments

Communication
Mrs A found it very difficult to discuss her care and treatment with Dr B. She described being "left wondering what he actually did do during this operation" and she felt that Dr B did not listen to her.

My independent expert commented that, following surgery, Dr B should have informed Mrs A of the different surgical procedure he performed. There is no evidence in the clinical records that any such discussion took place. It is regrettable that Dr B does not appear to have fully communicated with Mrs A about the outcome of the surgery, and that she was left feeling unsure about certain aspects of her surgery.

Dr B stated that English is not his native tongue and acknowledged that this may have led to some misunderstanding of issues in this complaint. I also acknowledge that Dr

B had been in New Zealand for only eight days at the time of his initial consultation with Mrs A. Right 5 of the Code affirms that "every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided". This case highlights the potential difficulties in communication, especially for overseas-trained doctors who have recently arrived in New Zealand and whose first language is not English. It is important to fully explore issues and any concerns of the patient, and clearly explain any changes to the original treatment plan, including the reasons for such changes. Dr B advised me that he has reviewed his practice following receipt of Mrs A's complaint, and in light of my decision. He commented that his current practice is a long way removed from what it was when he treated Mrs A.

Recommendations

I confirm that Dr B has met the following recommendations:

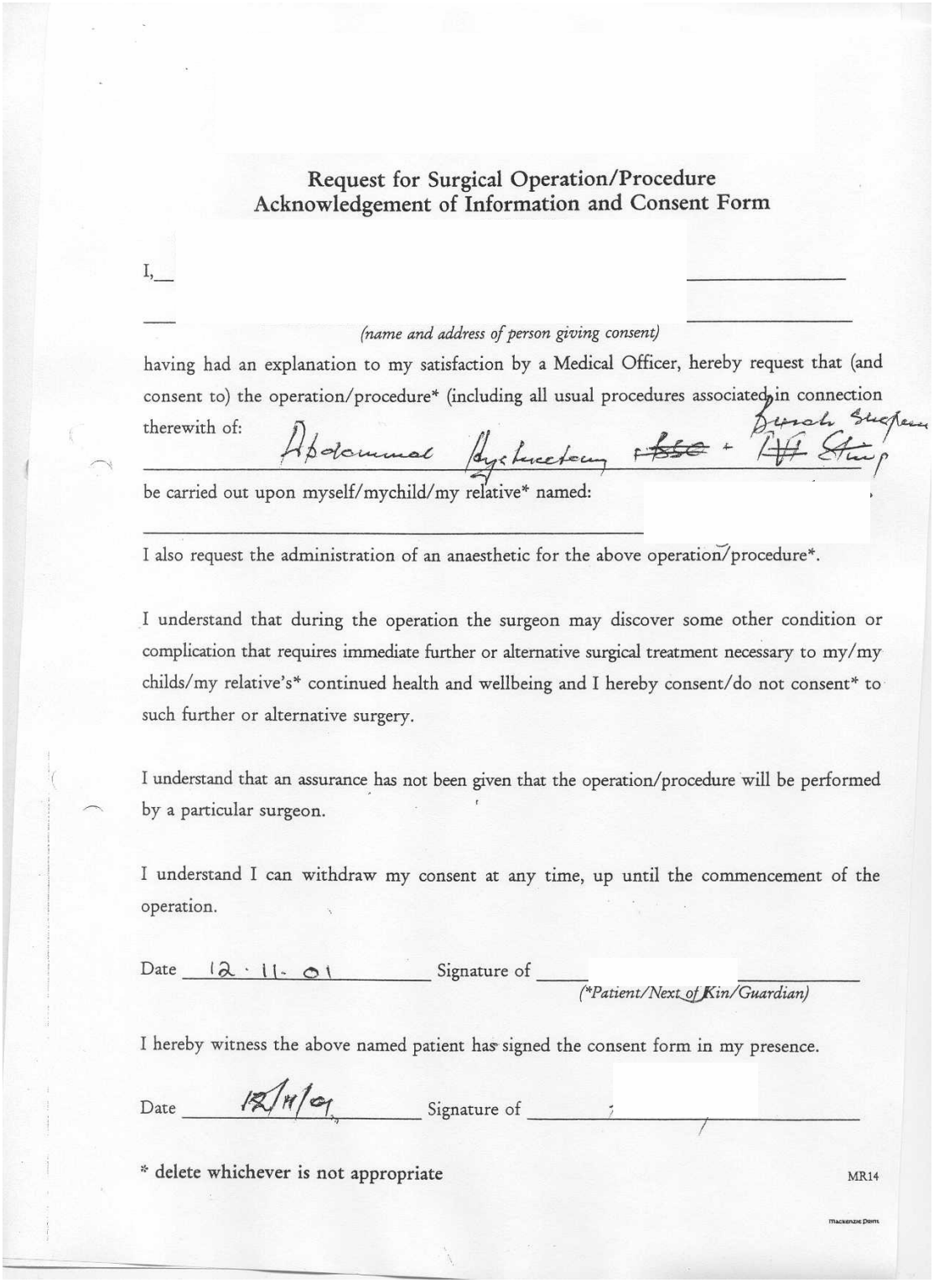
- Apologised in writing to Mrs A for his breach of the Code.
- Reviewed his practice in light of this report.

Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand with the recommendation that the Council consider whether a review of Dr B's competence is warranted, and to the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.
- A copy of my final report, with details identifying the parties removed, will be sent to Women's Health Action Trust and the Federation of Women's Health Council Aotearoa, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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

Appendix 1



Request for Surgical Operation/Procedure
Acknowledgement of Information and Consent Form

I,__ _____

___ _____

(name and address of person giving consent)

having had an explanation to my satisfaction by a Medical Officer, hereby request that (and consent to) the operation/procedure* (including all usual procedures associated in connection therewith of: Abdominal Hysterectomy ~~+BSO~~ + ~~TVH~~ Bimanual Suspension

be carried out upon myself/mychild/my relative* named:

I also request the administration of an anaesthetic for the above operation/procedure*.

I understand that during the operation the surgeon may discover some other condition or complication that requires immediate further or alternative surgical treatment necessary to my/my childs/my relative's* continued health and wellbeing and I hereby consent/do not consent* to such further or alternative surgery.

I understand that an assurance has not been given that the operation/procedure will be performed by a particular surgeon.

I understand I can withdraw my consent at any time, up until the commencement of the operation.

Date 12.11.01 Signature of _____
*(*Patient/Next of Kin/Guardian)*

I hereby witness the above named patient has signed the consent form in my presence.

Date 12/11/01 Signature of _____

* delete whichever is not appropriate

MR14

Mackenzie Print

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