General and Laparoscopic Surgeon, Dr C

A Report by the

Health and Disability Commissioner

(Case 09HDC01329)

Table of Contents

Executive Summary

1. Between 1992 and 2008 Ms A had a number of laparoscopic surgeries performed by Dr C to repair herniae in her groin and lower abdomen. After surgery in 2007 and 2008, Ms A complained of various complications and pain which was not relieved by the analgesia Dr C prescribed.

2. In March 2008, Ms A sought a second opinion and later had corrective surgery performed by another specialist which immediately resolved her pain.

3. Ms A believes Dr C did not explore her symptoms adequately, did not accurately document her health problems and treated her with a lack of respect during his examinations.

4. Dr C formed the view that Ms A was a drug and alcohol abuser who was drug seeking, rather than needing medication because of her pain. He did not verify this with Ms A and was unable to explain why he formed this impression. He did not keep adequate records. He gave incorrect information to other health providers and ACC, without first discussing with Ms A his intention to do so.

5. Ms A also believes Dr C inadequately completed ACC claims, thus denying her right to funding for surgery to which she believes she was entitled.

Summary of findings

6. I consider that Dr C provided surgery with reasonable care and skill and did not breach Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).

7. Dr C breached Right 1(1) of the Code for failing to treat Ms A with respect during consultations.

8. Dr C breached Right 4(2) of the Code for failing to maintain adequate records.

9. It may have been medically appropriate to give Ms A's history of drug and alcohol use to other surgeons if it was correct. However, it should have been verified and discussed with her before being passed on to other medical professionals and ACC. I consider that Dr C breached Right 4(2) of the Code.

Complaint and investigation

10. On 8 June 2009 the Commissioner received a complaint from Ms B on behalf of her sister, Ms A, about Dr C. The issue the Commissioner identified for investigation was:

- *The appropriateness of care provided by Dr C to Ms A in 2007 and 2008 including the adequacy of the information provided.*

11. Ms A had four primary complaints:

    1. Dr C failed to exercise reasonable skill and care in his diagnosis and treatment, surgery and reporting letters from 13 February 2007 until 26 March 2008.

    2. Dr C did not treat Ms A with respect during examinations on 24 and 26 March 2008.

    3. Dr C provided false information without Ms A's knowledge to her GP and his locum, to other specialists she consulted, and to ACC.

    4. Dr C failed to properly inform Ms A about the ACC claims he made on her behalf, and failed to provide correct and accurate information to ACC on 2 March 2007 and 5 October 2007.

12. An investigation was commenced on 11 December 2009. The parties directly involved in the investigation were:

Ms A	Consumer/complainant
Ms B	Complainant/Ms A's sister
Dr C	Provider/general & laparoscopic surgeon

13. Information was reviewed from:

Dr C	
ACC	
Dr D	General practitioner
Dr E	General and laparoscopic surgeon
Dr F	General and laparoscopic surgeon
Dr G	General and laparoscopic surgeon
Ms H	Friend
Mrs C	Dr C's wife

Also mentioned in this report:

Dr I	Surgeon

14. Independent expert advice was obtained from general and laparoscopic surgeon Dr Garth Poole (**Appendix A**). Dr Poole provided responses to further questions (**Appendix B**).

Information gathered during investigation

Introduction

15. Dr C's association with Ms A began in 1992 when she was first referred to him with early bilateral inguinal hernia.[1] In 1992 laparoscopic hernia repair was a new procedure. Dr C said he explained the differences between a conventional and a laparoscopic repair, with the advantages of the laparoscopic procedure being less visible scarring and a quicker recovery, which he believed would appeal to her as she had a young family.

16. On 24 August 1992, Dr C laparoscopically repaired Ms A's right and left inguinal herniae with mesh.[2] The surgery and her postoperative recovery were uneventful.

17. On 13 January 1998, Ms A returned to Dr C with pain at the 1992 operation sites. Dr C was unable to find any hernia and told her it was probably "localised stitch pains". Dr C advised her then general practitioner that the pain could be related to adhesions. He decided to "hold off" further surgery and await the outcome. He asked Ms A to return if there was any bulging at the operation site. It appears that she had no further problems.

18. On 6 April 2005, Ms A underwent an abdominal hysterectomy performed by Dr I. This resolved some symptoms but did not relieve the abdominal pain and swelling or pressure on her bowel and bladder.

19. On 11 April 2006, Dr I drained an abscess Ms A had developed above her hysterectomy scar.

20. In December 2006, Ms A, who was attending an appointment with her daughter, told Dr C she had lower abdominal pain, swelling and discomfort which had "dramatically increased". Dr C told her to make an appointment to see him.

Appointment 13 February 2007

21. On 13 February 2007, Ms A saw Dr C and told him when the lump first appeared in her right groin and that she had had a cyst in the left groin removed.[3] She said she told Dr C that she had abdominal pain and the abdominal lump was "just like her original double hernia". She described to Dr C her ongoing problems with her bowel and bladder. Ms A told HDC that Dr C identified the hernia on the right side at his examination but did not refer to her symptoms on the left side.

22. Dr C's record of the consultation referred to her symptoms as follows:

> "Open hyst 18/12 ago ([Dr I]).
> No wound infection
> Swelling since - ® side
> - Slowly enlarging

[1] An inguinal hernia is a protrusion of abdominal-cavity contents through the inguinal canal.
[2] It was not known at the time that the mesh used to cover the hernia sac shrank by up to 30% after its insertion and mesh cut to fit could be too small in subsequent years.
[3] Dr I excised an abscess on 11 April 2006.

- No symptoms
- Visible
- Not effecting bladder/bowels

Past [history] – migraines. Light smoker
Hysterectomy
Bilat ing. Hernia repair (me)

FE: good health advice
Exercises regular
[On examination]- slim
Herniation visible above
Lat part of Pfannenstiel[4]
Abd [tick]
HS [normal]
Lungs clear

[Impression] - Incisional hernia

Plan: Open repair [with] ext mesh
Wishes ONS [over night stay]."

23. On 14 February Dr C informed Ms A's general practitioner, Dr D, that Ms A appeared to have recovered well from the hysterectomy in 2005, but had noted a persistent bulge in the right side of the incision. Dr C stated that "A herniation is visible just above the right lateral margin of the Pfannenstiel[5] incision. This does not appear to be coming from my laparoscopic scar". Dr C reported the bulge was slowly enlarging but was not giving her any discomfort and did not appear to be interfering with her bowel or bladder. Dr C further stated that "there was no sign of any inguinal hernia recurrence". He explained that the hernia seemed close to the inguinal canal and that a laparoscopic repair would present problems with the mesh against iliac vessels. He suggested an open repair along the hysterectomy incision site, using external mesh. Ms A claims the information about her symptoms in the record and letter is not correct and does not accurately reflect her presentation as the bulge on the right side was causing her discomfort and was affecting her bladder and bowels.

24. Dr C told HDC that Ms A appeared to have an early incisional hernia in the right groin and her pelvic symptoms were not related to her hernia "popping in and out". Dr C said that it was important to take a precise history rather than automatically assume all her symptoms were caused by the hernia. Ms A advised that her hernia did not pop in and out. It was a large painful lump which was increasing in size.

25. In her complaint to HDC, Ms A's sister Ms B complained that Dr C did not order any scans for Ms A (which might have shown a left inguinal hernia) and did not mention to Ms A that the 1992 operation could have contributed to the problem. Dr C said that scans (whether an ultrasound, CT or MRI scan) are seldom indicated in the diagnosis

[4] Hysterectomy incision.
[5] Pfannenstiel incision is an incision used in pelvic surgery. Ms A had a hysterectomy in 2005 and has a Pfannenstiel incision scar.

of herniae. Many people have minor herniae which could be identified by scanning but should be left alone as they never develop into a hernia which requires intervention. Consequently, scans are an unnecessary and expensive investigation.

26. Dr C said although the surgery was not urgent Ms A decided to proceed without waiting for prior approval from her insurance company. However, Ms A advised HDC that the approval was given on 14 February 2007.

Surgery 22 February 2007

27. On 22 February 2007, Ms A was admitted to a private hospital and Dr C performed an abdominal wall (incisional) hernia repair and direct ring inguinal hernia repair with polypropylene. Dr C said he was unclear whether the incisional hernia resulted from the hysterectomy incision or laparoscopic site as the hernia appeared between the two. According to his operation notes, Dr C fashioned a mesh plug to place directly into the hernia sac, and overlaid this with a second piece of mesh which he stapled and sutured into place.

ACC claim March 2007

28. Dr C supported Ms A's claim for insurance cover. On 27 February 2007 the insurance company requested Dr C to assist Ms A to make a treatment injury claim to ACC by completing ACC45 and ACC2152 forms.

29. On 2 March, Dr C completed an ACC2152 form (Treatment Injury Claim). On the form he recorded that the reason for the treatment injury was an "incisional hernia" for which Ms A had first sought treatment on 13 February 2007. The injury was stated to be "increased swelling right lower abdominal wall" and the causal treatment was "abdominal surgery". He wrote that the injury had "nil yet" effect on her daily activities. Dr C said an ACC45 form was completed on 17 April 2007 and sent to Ms A to sign and post to ACC. Ms A does not recall receiving the form.

Postoperative issues

30. On 6 March 2007, Ms A referred herself to a public hospital with increasing lethargy, nausea, a headache and abdominal pain. Ms A said she was in a "dreadful state". On examination her observations were within the normal range and her temperature was 36.2ºC (normal temperature is 37ºC). She was examined by a surgical registrar, who prescribed antibiotics which were only to be given if her temperature went above 37.5°C. She remained in hospital overnight for observation. She developed a migraine headache that evening.

31. The following day Ms A was treated with codeine phosphate, tramadol and cyclizine. Her abdominal discomfort had settled. Swabs were taken from her wound but not reported on. Ms A was seen by the surgical consultant and 100ml of "heavily blood stained" fluid was aspirated from a seroma[6] in her wound. She was warned that the seroma was likely to reform. Her blood tests showed no significant abnormalities and she required no antibiotics. She was discharged on 7 March 2007.

[6] Seroma: a blister of blood and/or serum at the operation site which is a part of the healing process. If there is too much serum there is a risk of infection so it is aspirated with a needle and syringe using strictly sterile technique.

32. On 11 March 2007[7], Ms A contacted Dr C. He stated she told him that she had been to the public hospital with a severe wound infection that he would need to drain. Dr C arranged to see Ms A the following day. He recorded: "Apparently went to [public hospital]-asp". He did not record any reference to her saying she had a severe wound infection. He states this is because the wound was not infected.

33. Dr C examined Ms A on 12 March 2007. He said that she had no sign of infection and that the swelling had "all the hallmarks of a seroma", from which he aspirated 40.6ml serosanguineous fluid.[8] He told her it was likely to recur and would need aspiration until it dried up. He aspirated 14ml on 15 March. By 20 March 2007 the wound was dry.

34. Ms A stated that Dr C had to aspirate the wound on at least five occasions but never mentioned the word "seroma". He just told her and her sister the lump would go down in time. Dr C did not administer any pain relief or local anaesthetic for the "removal of the thick, yellow and blood stained fluid" and the procedure was painful. He did not send samples of the fluid to pathology.

35. Dr C explained that is common practice not to use a local anaesthetic (LA) because it stings and means giving two needles instead of one — one to administer the LA and the second to aspirate. In his opinion as the action of the anaesthetic is blocked by any inflammatory process it is worthless. He considers the aspiration procedure is only mildly uncomfortable and is done away from the wound making it more comfortable and less likely to introduce infection. Neither Dr C nor Ms A reported that this was explained to her or that she was given a choice whether to have a LA. Dr C explained that he would not discuss a LA unless it was asked for, in which case it would be given.

36. On 25 June 2007, ACC wrote to Ms A confirming cover for her treatment injury she had on 13 February 2007.

37. On 11 September 2007, Ms A returned to Dr D with abdominal pain and he sent her for a scan. The scan identified no definite hernia or masses to account for her abdominal symptoms. Dr D referred her back to Dr C.

Consultation 3 October 2007

38. On 3 October 2007, Ms A saw Dr C. She took along the scan and she says she told him the pain and swelling had been present since the last time she saw him (in March 2007) and was getting worse. She told him she was finding it difficult to cope because she was feeling so awful. Dr C found a visible swelling and thought he could "palpate a defect in the muscle wall". Dr C said that he explained the laparoscopic onlay mesh repair procedure to her, as well as the risk of adhesions and possible bowel damage and recorded this in the clinical records. In contrast, Ms A advised HDC that Dr C did not tell her he intended to perform a laparoscopic repair or that there were any risks associated with the proposed surgery.

[7] Ms A disputes many of the dates of the consultations as recorded by Dr C. She provided a copy of her diary to HDC to support her recall of events. The dates stated are those in Dr C's records.
[8] A body fluid that is both sticky and bloody.

39. Dr C provided HDC with diagrams that he said he drew on a sheet of paper to explain the procedure to Ms A during the consultation. The page was marked "original" in red pen (**Appendix C**). Dr C said that he explained that further surgery entailed greater risks, particularly an increased level of pain. He advised that the surgery was not urgent but Ms A wanted to proceed quickly. Dr C said Ms A asked him to write to ACC. He told her she had to wait for ACC approval because her insurance company would not pay for the surgery. Ms A recalls that she did not ask Dr C to write to ACC.

40. Ms A told HDC that Dr C did not draw or show her diagrams to explain the herniation or what the surgery entailed. On viewing the diagrams which Dr C supplied to HDC on 19 January 2010, she said it was the first time she had ever seen them. She said most of her consultations with him were very brief and he seemed to want to get her out of his rooms as quickly as possible. Dr C says she did see the diagrams.

41. On the reverse of the page containing the diagram (**Appendix C**) was a handwritten note. The note states:

> "Pt indicates ETOH[9] /drug use/abuse in past
> Nil further."

42. Dr C explained: "I usually write sensitive information after the patient has left the room so as to not appear to be judgmental or confrontational." He said he writes such information on the "back of a page of the clinical notes, so it is not inadvertently seen by those who have no need to know". Dr C said Ms A "must have told him that information during this consultation, otherwise he would not have written it down". The note is handwritten and, although the page shows two printed dates — 1 July 2007 and 17 September 2007, it is unclear when the note was written. The page was not supplied to HDC until January 2010.

43. Ms A told HDC that she has never had a drug problem and would never have told Dr C that she had. There was a period during a very stressful time when she began to drink alcohol to excess, but she has been sober since August 2007. She has never considered she was an alcohol "abuser" and therefore would be unlikely to have told Dr C that she had a problem, and certainly not with drugs. She said "If he had asked me I would have told him. I had an alcohol problem, not a drug problem".

44. Ms A said that Dr C never took any notes during any of his consultations with her and she had never seen her records until they were obtained from ACC. She was devastated to learn what Dr C had written about her because it was without foundation. Dr C advised HDC:

> "I became aware of [Ms A's]… past problem of misuse of alcohol and drugs and wrote it on the back of the diagram I used for the Onlay mesh that was drawn for her on the 3 October [2007]. At that consultation, I warned her that this procedure would likely be more painful than previous operations, and it would be likely that she would need stronger analgesics and therefore recommended an overnight stay

[9] Alcohol

("ONS") instead of the usual day care. I did not ask for details about the drug and alcohol abuse, as she assured me there was no ongoing usage.

…

Whenever I ask a patient to go to their GP for changes in medication I always … let the doctor know so he/she is aware of what the problem is and why the patient has been referred back. Whilst I did not know whether [Ms A's] GP was aware of her previous drug problems I was of the opinion this information was important relevant health information and that is why I passed this information on. The reasons for suggesting she see a Pain Specialist were also outlined, prior to removing a staple that might be causing her symptoms. This advice was ignored."

45. Although Dr C thought the notation "would have been made on 3 October 2007" he said "I cannot remember making these notations or why there are two different notations on the back of the same diagram" (see paragraphs 97 and 98 with regard to the duplication).

46. On 3 October 2007 Dr C wrote to Dr D (copied to ACC) advising that he felt further surgery was required and that it would involve overlaying dual mesh to the affected area. Dr C did not mention Ms A's supposed alcohol or drug problems in this letter.

47. Ms A said that she was at a social gathering at a friend Ms H's house in October or November 2007 and Dr C's wife was also there. Ms A mentioned at the party that she had attended an Alcoholics Anonymous (AA) meeting because her friends thought she was drinking too much. The fact that she no longer drank alcohol was discussed and commended by those present. Ms A believes this is how Dr C got this information. Ms H confirmed Ms A's account of the discussion at the party and said there was no mention of drug use/abuse.

48. Ms A drove Dr C's wife home after the gathering. She said they discussed how she managed in social situations without alcohol.

49. Mrs C confirmed her attendance at Mrs H's home in November 2007 and remembers Ms A being there and driving her home. However, she cannot remember details of the conversations, although she remembers Ms A talking about her daughter and that her husband was involved in a sporting event. She cannot remember Ms A talking about alcohol. Mrs C had not met Ms A before and is sure she would remember a stranger divulging such personal information.

Application to ACC

50. On 4 October 2007, Dr C completed an ACC45 Injury Claim form, stating it was a treatment injury claim for surgery. On 5 October, Dr C completed an ACC2152 form, recording the reason for the treatment injury was a "recurrent groin hernia".

51. On 20 December 2007, ACC declined the claim as it did not meet the criteria for treatment injury. In the report it concluded that Ms A had a recurrent right groin hernia in relation to 2005 surgery and that there was no injury. Ms A believes Dr C provided incorrect information to ACC, which showed that she had a tendency

towards hernia and, as a result, compromised future cover. Dr C, in contrast, states he did not attempt to jeopardise her case or provide incorrect information.

Visit to Dr D

52. On 11 February 2008, Ms A consulted Dr D for a recall smear. She told Dr D she had attended an AA meeting. Dr D recorded in his notes that Ms A:

> "… Is attending AA meetings, believes her antidepressants did not work as she was also drinking. Has much trouble getting off to sleep. Has tried melatonin and herbs etc. Is dysfunctional the next day. Would like to have a PRN [as required] hypnotic".

53. Dr D prescribed Triazolam (one tablet when required).

Surgery — 21 February 2008

54. Ms A underwent surgery on 21 February 2008. She said that she had not seen Dr C since her previous consultation on 3 October 2007. She was seen by the anaesthetist on the day of the surgery.

55. Dr C advised HDC that Ms A was examined preoperatively and it was confirmed that there had been no change in her health status. He did not elaborate on who did the examination and provided no records of any examination. He said it is the private hospital's protocol that a patient is "never taken into a theatre prior to the surgeon speaking to the patient". Dr C stated:

> "A physical examination relevant to the presenting problem was carried out. This included an examination of the cardio-respiratory systems, abdominal organs, and the abdominal wall, paying particular attention to the previous surgical sites and the hernia site. I had previously asked her about possible health problems relating to anaesthesia, such as medications and reactions to previous anaesthetics and so had that information already."

56. Dr C has not provided HDC with records of any consultation with Ms A prior to the surgery or of a pre existing urinary tract infection (UTI). He advised HDC he made no notes "because on questioning there were no changes to her health since she was last seen. This is standard practice." He stated he made no notes of a UTI because "there were no symptoms of such".

57. Ms A is adamant that Dr C did not examine or speak to her prior to the surgery. She said that she was not informed of any risks associated with the procedure and he did not give her antibiotics to guard against infection. She did not sign a consent form apart from the consent for the anaesthesia. She knew she would stay in hospital overnight and go home the next morning if she was well enough. Dr C did not come to see her before she went home. Dr C says he was dealing with an urgent matter but telephoned her in her hospital room and the nursing staff would have contacted him if there were any concerns.

58. Dr C's progress notes are recorded on a loose sheet of paper and state:

"21.2.08

OR

GP

Onlay patch. 2 defects.

UTI → retention."

59. On 22 February, Dr C wrote to Dr D, outlining the operation. He concluded that it was an "uneventful intra-abdominal onlay mesh repair of recurrent incisional hernia". The anaesthetist administered intravenous antibiotics with Ms A's anaesthetic, as is routine practice. Dr C said that this was clean surgery and post-operative antibiotics were not routinely prescribed in such circumstances.

Consultation — 28 February 2008

60. On 28 February 2008, Ms A consulted Dr C with "continued pain, particularly across her pubis and both sides of her groin and pain when urinating". Ms A said she also had acute pain in her right thigh and "festering sores over her pubic area and thighs". This made her feel "ugly, dirty and diseased". She believes she developed a UTI and retention after the operation, which caused her much discomfort, because Dr C had forgotten to insert a catheter. Dr C advised that catheters are not routinely used because the insertion is a common cause of bladder infections.

61. In a letter to Dr D, dated 29 February 2008, Dr C advised that Ms A's postoperative recovery was complicated by a UTI that was "starting just prior to her surgery" this led to "some urinary retention, but settled with antibiotics" and there were "no worrisome findings … today". He told Dr D he wanted to see Ms A in one month. Ms A said that she had no symptoms of a UTI prior to the surgery and would not have gone ahead with the surgery if she had a urinary infection.

GP visit — 7 March 2008

62. On 7 March, Ms A went to see her GP. Dr D was on leave and so she saw his locum. The locum noted Ms A's UTI and a rash on her pubic area. Ms A had one of her regular severe migraines, which was not responding to Nurofen. She requested stronger analgesia and said she had previously had pethidine injections. Ms A was prescribed an antibiotic for "mild folliculitis pubic area" (the rash), Triazolam to help her sleep and Tramal (tramadol hydrochloride) 50mg capsules, Panadeine and Voltaren for pain relief.

63. On 18 March, Ms A saw Dr D who noted "multiple spots over the pubic area at site of removal of pubic hair looks like folliculitis ??pseudomonas".[10] She had been taking Amoxil and applying antibiotic ointment. He prescribed a body wash and oral antibiotics. Wound swabs taken at the time returned negative results.

[10] Pseudomonas aeruginosa is a common bacterium which can cause disease in humans. The symptoms of such infections are generalised inflammation and sepsis.

Locum visit 20 March 2008

64. On 20 March 2008, Ms A, accompanied by her friend Ms H, saw Dr C's on-call locum because she was feeling sick and had developed a severe pain in her right groin and down the top of her right thigh, which had not been present before the operation. The locum performed an ultrasound. He recorded "?Femoral hernia bilateral. RF informed". The locum discussed the hernia and advised care because it might strangulate, and to see Dr G (who was on call for Dr C) if there was any change. Ms A was to continue the antibiotics and analgesia.

Consultation — 24 March 2008

65. Ms B told HDC that her sister got worse over the Easter weekend. Ms B and Ms A were very concerned about hernia strangulation. Ms A was suffering from a severe headache, fever, vomiting and the rash was now more invasive with swelling and pain in both sides of her groin, but more intense pain over the top of her right thigh.

66. Dr C recorded that Ms B phoned him to say that her sister was very ill, with fever, vomiting and pain and he arranged to see her immediately. Ms A, who was accompanied by Ms B, said that she felt "as if flu was coming on" and that she had been assessed last week and had an ultrasound. Ms A said that she felt "awful".

67. Dr C examined Ms A and recorded she did not have jaundice, anaemia or a fever. Ms A was able to take fluids and had finished the antibiotics. He recorded that she had a minor rash over the pubic area and no signs of thrush. He considered this was consistent with the antibiotics she was taking. Dr C told HDC that a wound swab at this stage would have been useless because of the antibiotics. He recorded: "asking for painkillers and sleeping pills…sleeping pills denied". Ms A advised HDC that it was not a minor rash. She says she had "pussy spots" over her pubic area and legs.

68. Ms A and her sister said that Dr C gave them the impression that he thought they were aggressive and hysterical and exaggerating her symptoms. Ms A asked him to prescribe her something to help with her pain and enable her to sleep as she was becoming very stressed by being kept awake at night by the pain. Ms A and Ms B, both told HDC that Ms A "told him that she had been prescribed [Tramal] (tramadol) by [Dr D's] locum". Dr C told HDC he was not aware at the time of the consultation that Dr D's locum had prescribed Tramal.

69. Ms A and her sister said they also told Dr C that the previous night Ms A and Ms B had been with another sister, and Ms A had been in considerable pain. The other sister had Tramal remaining from recent surgery and gave one pill to Ms A. However, Dr C recorded "Also taking [Tramal] – 'from friend'." Dr C advised HDC:

> "I explained that all the indications were that there was no underlying cause for alarm, and that her symptoms should settle promptly on discontinuing the [Tramal]. [Ms A] asked for stronger painkillers. As there was no tenderness over the hernia repair or abdominal wall I prescribed a non-narcotic (Paradex) and arranged for an ultrasound while I was present. Blood tests and urinalysis were also arranged, all done as a precaution. I explained that I would talk to her GP for a prescription of sleeping pills, but as her sister was present, I did not explain

> exactly why as I did not know if [Ms B] was aware of [Ms A's] previous problem with drugs."

70. Dr C advised HDC that the cause of her malaise was probably the effects of antibiotics, Tramal, and anxiety about the possible strangulation of her hernia. He said that he would never prescribe Tramal because of the side effects and advised Ms A to stop taking them. In contrast, Ms A says she was in extreme pain and knew the Tramal was not causing her symptoms because she had previously taken Tramal prescribed by her GP.

71. Ms B said that Dr C made it very clear by his manner and speech that he wanted both of them out of his rooms in the shortest possible time. She advised HDC that she insisted her sister should have pain relief because, knowing her sister's very high pain threshold, she considered pain relief was essential. When they asked to see the scan, he told them it was not possible to do so. He explained to HDC this was because no pictures were taken during the ultrasound and he was present when it was carried out. When they asked for pain relief he said that Ms A should go to a pain specialist. Ms A understood by this that Dr C believed she did not really have any pain and it was all in her head. Ms B felt that he resented answering any of her questions. He did not say anything to her about the possibility of nerve pain from a screw from previous hernia repairs. Dr C told HDC:

> "I was very sorry to read that [Ms A] feels I was rough, arrogant and dismissive towards her. I would like to assure her that I in no way intended to treat her this way and I am sorry that she feels this way. I always strive to treat all my patients with respect and dignity especially when they have concerns about their treatment."

72. Ms B told Dr C that Ms A was going to seek a second opinion. She recalls that he refused to sign the scan report so that it could be shown to general and laparoscopic surgeon Dr E (who they were to approach for a second opinion). Dr C says that as there were no pictures taken or a written report, there was no report for him to sign. Ms B said that Dr C was very insistent that Ms A should see a pain specialist before considering further surgery. Ms B said that Dr C did not take any notes during the examination and did not discuss with Ms A his belief that she had a drug and alcohol problem.

73. Dr C decided to talk to Dr D personally to inform him about Ms A's request for stronger medication and his rationale for prescribing Paradex.

74. On 25 March, Dr C telephoned Dr D and left a message with a nurse at the practice who recorded it in Ms A's notes on 26 March:

> "Apparently there's a [history] of drug/alcohol abuse? [The nurse] called [Dr D] at home who said he didn't know anything about it."

Second opinion sought

75. Ms B said she was "concerned by [Dr C's] attitude and condescending dismissal of her concerns about the extreme nature of her sister's symptoms". On 25 March she

contacted Dr D to request a second opinion for Ms A. Ms B said she "refused to accept that all of [Ms A's] problems were due to taking pain killers".

Consultation — 26 March 2008

76. Ms A and Ms B attended an appointment for a scan with Dr C on 26 March. Ms B stated that Dr C examined Ms A so roughly that Ms B felt obliged to ask him to be more considerate, as Ms A was clearly in "obvious pain" and he was increasing her distress. Dr C says this is incorrect as he did not perform the scan. Dr C recorded his examination as follows:

> "Discussed [with] locum. Pt has requested a 2nd opinion – suggested Dr G.
>
> However turned up for US [ultrasound] — ([with] sister)
>
> - No collection
> - No [abnormality] in pelvis
> - No fem[oral] hernia but bulge seen [with] Valsalva (but not palp[able])
>
> Explained — no obvious hernia
>
> — no collection
>
> — nothing ominous
>
> ? Altered pain pathway ?staple irritating nerve
> Consequences of re-operating in presence of pain pathway … can aggravate and cause later long [term] pain problem.
> Recommended pain specialist first before contemplating surgery. Also second opinion offered. Is apparently seeing [Dr E].
>
> [**Over page**]
>
> 26 Mar contd.
>
> Asking for stronger pain meds —
>
> again explained better to come from GP rather than
>
> *create further problems with drug abuse*
>
> Info faxed to ~~sol~~ [this word struck out] sister @ her request
>
> Suggested [Dr E] call me when he's seen her."

77. Ms B explained to HDC that her sister did not ask Dr C for pain and sleeping pills at this consultation. She had raised the matter on her sister's behalf.

78. Dr C advised HDC that it is simply good medical practice to warn other doctors of possible problems beforehand and denied contacting Dr D in a deliberate attempt to discredit Ms A. Dr C acknowledged this was sensitive information but it was provided as health information which he considered relevant to her medical treatment. In Dr C's opinion not to do so could cause anaesthetic problems, lead to unnecessary investigations, and concerns about aberrant responses to medication or again create a problem with drug use.

Dr C's contact with other providers

79. On 26 March Dr C contacted Dr D's locum who recorded their conversation as follows:

> "… He called back - pleasant lady, apparently has [history] of alcohol and drug use, may have affected her behaviour? Sister is a [professional]. Had incisional hernia repair last month, some swelling at op site. Tendency to somatise symptoms and kept asking for pain killers. Given Paradex, nothing stronger. USS post op showed a small area of swelling which is within normal limits. I mentioned that the sister called yesterday requesting second opinion from [Dr E]. He's quite happy for that to happen and suggested I relay the message about the [history] of alcohol and drug use.
>
> I called [Dr E's] rooms — he's doing endoscopy list. Msg left for him to call me, which he did. [History] related."

80. Dr C wrote to Dr D that day. In the letter he said: "[Ms A] was asking for pain killers and sleeping pills, which she has been prone to do, and which I have not prescribed in the past due to her previous problems. I have given her a prescription for 20 Paradex. It may well be that the [Tramal] is causing all these symptoms and I have advised her to stop taking it. … I might make things worse by giving her my true clinical impression that she has an altered pain pathway, rather than a problem with a hernia." Ms A denies she had been "prone to ask for pain killers and sleeping pills".

81. Dr C is adamant that he must have got the information about alcohol and drug abuse from Ms A. He told HDC "I must have as there are annotations about high alcohol intake and previous drug abuse in my notes." In his view it was not in Ms A's best interests to have further surgery before her pain problems were resolved. Ms A is adamant Dr C did not get information about drug and alcohol abuse from her.

Second opinion — Dr E

82. Ms A saw Dr E on 27 March 2008 for a second opinion about the cause of her abdominal pain. He noted that her main complaint was "pain in the right groin which radiates towards the leg and is aggravated by lying. Her energy levels are low and she feels generally off-colour." Dr E described Ms A as "an ex-drinker and smokes ten cigarettes a day" and noted that she appeared to take very little medication. Ms A demonstrated wide-spread tenderness with voluntary and involuntary guarding but no "absolute anatomical pattern or trigger point to the tenderness". Dr E could not detect any femoral or recurrent hernia, and the area seemed quite firm.

83. Ms A asked about nerve entrapment syndrome which Dr E said was quite possible given the number of surgeries she had had. He reported speaking frankly to Ms B and Ms A about the difficulty of diagnosing nerve entrapment, but said that on some occasions removing screws had been successful. However, there was no guarantee of success because the screws are hard to find laparoscopically. Because of this he recommended she see general and laparoscopic surgeon, Dr G, an authority on laparoscopic hernia repair.

84. Ms B said that during this consultation, Ms A told Dr E that she "had had a drinking problem that had developed along with her symptoms over late 2006 and 2007". She also told him that on 1 August 2007 she had attended a drug and alcohol treatment course, and as a result had been sober ever since. Dr E did not record this.

Second opinion — Dr F

85. On 31 March, Ms A saw Dr F about the abdominal pain. Dr F noted that the scars were well healed but there was a "billowing of the right end of the Pfannenstiel scar" and wondered whether this was a "slightly loose repair or in fact there is a true hernia". On Dr F's recommendation, Ms A had an ultrasound that day.

86. On 14 April, Ms A saw Dr F to discuss the scan results. It showed no evidence of any recurrent hernia. Dr F said he had a long talk with Ms A and said "she is the last candidate [he] would want for speculative surgery". He made it clear it would not be in Ms A's best interests to have further surgery. Dr F advised ACC on 21 July 2008 that the lower part of Ms A's abdomen "undoubtedly [had] some weakness" and thought her pain came from the mesh repair, but could not say if she had nerve entrapment.

Consultation — Dr G

87. On 30 April 2008, Ms A saw Dr G about her abdominal pain. After examination, including review of scans and Dr C's pictures of the mesh placement, Dr G concluded it was possible that one of the screws holding the mesh in place had impacted the nerve. However, as the pain was slowly diminishing, he advised her to wait, in the hope of avoiding surgery. He also advised stretching exercises could be helpful if the pain was caused by scar tissue.

88. Dr G was concerned about Ms A's resolving folliculitis and took swabs which grew Staphylococcus aureus. He commenced her on antibiotics. He was reluctant to operate in case the mesh became infected. He noted that Ms A was waxing and abrading the lesions and he asked her to abstain until the infection cleared.

Dr C's letter to ACC

89. Dr G submitted a treatment injury claim on Ms A's behalf for recurrent incisional hernia and nerve pain following laparoscopic incisional hernia repair on 22 February 2008, naming Dr C as her last health care provider. Dr G intended to perform further surgery to repair a recurrent incisional hernia and remove the screws placed by Dr C.[11]

90. Dr C was asked to comment and wrote to ACC on 11 July 2008 stating:

> "It was difficult to assess [Ms A] in view of previous health problems relating to medication, and for that reason I suggested that she see a pain specialist, and strongly advised not to proceed to any further surgery until this had been assessed. I think it might be worthwhile for [Ms A] to be assessed by ACC personnel."

[11] Dr G submitted a report following Ms A's surgery on 22 July 2008, based on his operation findings. ACC accepted Ms A's claim for nerve pain caused by the screws as a treatment injury but declined the recurrent incisional and bilateral inguinal hernia and seroma claims.

91. Dr C advised HDC that he did not disclose this information in bad faith or to harm Ms A and apologised for any distress it may have caused. His only reason was to ensure other practitioners had complete information so they could help her.

92. Ms B said that Dr C's actions caused Ms A serious mental trauma, particularly after she learned that he had also divulged incorrect information to her general practitioner.

Further surgery

93. Ms A underwent complex hernia surgery on 22 July 2008. Dr G removed the Prolene mesh (placed 15 years previously) and Gortex duel mesh (placed February 2008) both of which had contracted into "3-4cm diameter masses" and repaired bilateral inguinal hernias (which had not been diagnosed pre-operatively) and a small incisional hernia (approximately 1cm in diameter). Dr G removed about 40 titanium screws which Dr C used to secure the mesh during the surgery in 2008. Once these were removed Ms A obtained almost instant relief from the pain. HDC expert Dr Poole stated: "The improvement with tack removal certainly would support nerve impingement as the main cause of upper medial thigh pain." He considers that one of the screws was impacting either the genitofemoral or the ilioinguinal nerve.

94. The ACC advisor said that Ms A was pain free on awaking from the anaesthetic. This was good evidence the pain was due to "some sort of neuropathy associated with the screws placed in February 2008". He said that multiple hernia recurrences in the absence of post-operative wound infections, with competent surgeons performing the surgery, suggested that she had a weak abdominal wall. This is a patient factor and not a treatment injury.

Further clinical records

95. During the course of this investigation, staff from my Office approached Dr C three times for his clinical records and on each occasion more and different information was provided. Dr C explained this arose because he delegated the task of providing the information to staff members. He stated that it was not a deliberate attempt to withhold information.

96. His notes appear to be written on loose paper, with individual pages collected in a folder, some of which are undated. The notes are not reliably maintained in chronological order and lack continuity.

97. On 25 February 2010 HDC inspected Dr C's records and found a further loose sheet of paper with a diagram on one side and a note on the reverse which had not been supplied to HDC previously (**Appendix D**). The note stated:

> "Apparent drug & ETOH use/abuse in past"

The page was undated and apparently unrelated to any consultation he had with Ms A. The diagram was identical to that previously supplied to HDC marked "original" (**Appendix C**). That version had a different note on the reverse:

> "Pt indicates ETOH/drug use/abuse in past
>
> Nil further"

98. When asked for an explanation, Dr C stated:

> "I cannot remember making these notations or why there are two different notations on the back of the same diagram … it is likely they were made on different dates as it would be unlikely that I would write the same thing twice for one consultation."

Response to provisional opinion

99. In response to my provisional opinion Dr C stated that he was "most upset" by my provisional findings. He disagrees that he spoke with Ms A or members of her family inappropriately or without respect.

100. He considers chronic pain is a "significant and common post-operative complication" following hernia repair and a referral to a pain medicine physician "is deemed an excepted [sic] standard of care in such circumstances".

101. He apologised to Ms A and said he was sorry she has suffered upset and distress at the way he treated her and managed her care.

History of laparoscopic surgery — an overview

102. My expert advisor, Dr Garth Poole, explained that the 16 years over which Ms A had laparoscopic surgery were the "most explosive technical period in hernia history". 1992 was the beginning of laparoscopic technique to repair herniae but because laparoscopic surgery can be clinically demanding, other surgeons began to use open mesh to close off the defect. Herniae commonly recur and while both techniques reduced the incidence of recurrence from 20% to around 5%, open mesh repair (which Ms A had in 2007) raised additional issues. Ms A's experiences demonstrate a number of these issues. For example, the mesh used in 1992 was prone to shinkage and was then too small, and the plug and patch techniques left bulky irritating mesh in slim patients. Abdominal and prostate surgery can destroy a previously good repair and dual mesh was hard to fix without using multiple screws which were later found to cause pain.

103. Ms A had her surgeries between 1992 and 2008 and, according to Dr Poole, Ms A's experiences reflect the learning taking place at the time. This investigation relates to her hernia repair surgeries in 2007 and 2008. However, the information supplied by Dr Poole shows that Ms A's 1992 inguinal hernia repairs and her 2005 hysterectomy impacted on these later surgeries.

Opinion: Breach — Dr C

Introduction

104. This investigation is about the importance of treating patients with respect, communicating with them effectively, and recording consultations accurately and

completely. It is also about the necessity, when a doctor transfers information about a patient to other doctors or agencies, that the information is correct, complete and accurate, that the patient knows the information being sent, and the intended recipient.[12]

105. Dr C performed a number of surgeries on Ms A between 1992 and 2008. Following surgery on 22 February 2007, she reported she was in pain and feeling unwell. From that time, Dr C appears to have become increasingly impatient with her symptoms and developed the view that she was drug seeking because, in his opinion, she was a drug and alcohol abuser.

106. Following further surgery on 21 February 2008 Ms A again reported pain and illness. In March 2008 Dr C's locum recorded the possibility of two femoral hernias and warned her to seek advice if there was any change in them. She saw Dr C on 24 March 2008 because of her concerns that her symptoms meant the hernias were strangulating. Dr C refused to prescribe stronger medication to relieve her pain or help her sleep, and referred her back to her GP, Dr D.

107. He did not discuss with Ms A his opinion that she abused drugs and alcohol. However, he reported his opinion to other medical professionals involved in her care and to ACC.

Respect during examinations

108. Following the surgery in 2007 Ms A tried to explain to Dr C that she was still suffering many of her preoperative symptoms and experiencing pain. Dr C gave her the impression he thought she was exaggerating and told her some pain and swelling was normal.

109. By 24 March 2008, Ms A's sister Ms B was very worried about the possibility of her sister's hernia strangulating, and her worsening physical condition. Both Ms A and her sister felt Dr C was dismissive of their concerns and resented answering questions. They felt he wanted to end the consultations as soon as possible. Ms A and those who accompanied her to consultations reported that he was brusque and perfunctory.[13]

110. Ms A complained that Dr C drained her seroma without pain relief. I accept that a local anaesthetic may have caused additional discomfort and may not have been effective. I note Dr Poole's advice that it is common practice to aspirate wounds without local anaesthetic. He stated that a patient may request local anaesthetic and should be given it.

[12] New Zealand Medical Association *Code of Ethics* (2008) paragraph 15 "When appropriate, doctors should communicate with colleagues who are involved in the care of the same patient. This communication should respect patient confidentiality and be confined to necessary information. Patients should be aware of this information sharing which enables the delivery of good quality medical care".

[13] Ms A attended the consultation on 3 October 2007 alone. Ms A had support persons present at each of the consultations on 20 March 2008, 24 March 2008 and 26 March 2008.

111. On 26 March 2008, Ms B intervened because Dr C was rough when he examined Ms A. He did not explain why it was not possible for them to see the scan and did not discuss the possibility of nerve entrapment, even though he recorded "?Staple irritating nerve".

112. In a similar case the Commissioner said (05HDC09254):

> "I am concerned by this dismissive approach to Patient A's concerns which, in my view, was inappropriate and unprofessional. Dr B failed to treat Patient A with respect, in breach of Right 1 of the Code."

113. Dr C advised HDC that he did not intend to be rough, arrogant or dismissive and he is sorry that Ms A felt this way.

114. Dr C had concluded that Ms A was inclined to somatise[14] her problems and kept asking for painkillers. I accept that a referral to a pain specialist may have been appropriate, but Dr C should have explained his reasons, taking care not to give the impression that he did not believe Ms A was in pain.

115. Dr C was dismissive of Ms A's concerns and disregarded the extent of the pain caused by his examinations.

116. Dr C failed to treat Ms A with respect and so breached Right 1(1) of the Code.[15]

Incorrect information given to GP and locum, and specialists

117. When Ms A obtained her clinical records it became clear to her that Dr C thought she was a drug and alcohol abuser. She was outraged and hurt that, without checking the veracity of this information with her, he ensured it was passed on to Dr D and his locum, Dr E, and ACC.

118. In Dr C's opinion, the information that Ms A was a drug and alcohol abuser was important clinical information and it was appropriate to ask Dr D and his locum to ensure it was passed on to other medical practitioners involved with Ms A and to advise ACC of it. He acknowledged that he did not discuss his conclusions with Ms A.

119. Ms A said:

> "[t]he complaint is not that confidential information was passed on to other practitioners without [my] consent. It is that to protect his own reputation, [Dr C] falsely told other practitioners that [I] had a history of drug and alcohol abuse and that the reported symptoms were not to be believed, and implied that [I] was not seeking treatment, but prescription drugs."

120. Dr C stated:

[14] Somatisation is the process by which psychologic distress is expressed as physical symptoms
[15] Right 1(1) Every consumer has the right to be treated with respect.

> "[Ms B's] allegations that I gave this information out as a calculated way to sabotage her subsequent diagnosis and treatment or to undermine her ACC claim are completely untrue and incorrect. … [Ms A] was very much aware that I reported to [Dr D] (her GP who was aware of this information as it is recorded in his notes) about all aspects of her treatment and management, and this information was to be provided to the specialists that I referred her to."

121. Ms A said that she has never considered herself a drug or alcohol abuser and would never have told Dr C that she was. She acknowledged that at one time when she was under stress she recognised that she was drinking to excess and had attended a meeting at Alcoholics Anonymous (AA). She said she has been sober since August 2007 and has never been a drug abuser. She was adamant that she never discussed this with Dr C and this is supported by third parties present at her consultations.[16] In her view, he must have obtained this information from someone else. She suggested the source was Dr C's wife, who attended a social gathering with Ms A in October 2007 where her attendance at AA was discussed.[17] However, Dr C's wife denied hearing the conversation about Ms A's alcohol use at the party.

122. Dr C told HDC that Ms A "must have" told him about her drug and alcohol abuse, otherwise he would not have written it down. He acknowledged he did not record it at the time of the consultations and said he did not ask for any details because Ms A assured him there was no ongoing usage.

123. I consider it was essential for Dr C to obtain a thorough understanding of the nature of the problems he believed Ms A had and record the details of these conversations to minimise the potential harm to her.

124. The second issue is Dr C giving this information to other medical professionals and ACC without having verified it or consulted Ms A. The Medical Council of New Zealand guidelines[18] require that a doctor discuss the proposed dissemination of information with the patient. Rule 2 of the Health Information Privacy Code 1994 requires health information to be collected directly from the individual concerned. Rule 3 provides that if it is being collected the person should be aware it is being collected, why it is being collected and the intended recipients. Rule 8 requires that the information must be checked to ensure it is accurate before it is used.

125. On 24 March 2008 Dr C told Ms A he would not prescribe sleeping tablets or stronger pain medication and referred her to her GP, Dr D. He appears to have been influenced by her sister saying that another sister had given her a Tramal tablet when she was in pain the previous evening and, although he was told, he seems not to have been aware that she had previously been prescribed Tramal by her GP's locum.

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[16] Dr C asserts he made the first notation "Pt indicates ETOH/drug abuse/abuse in past Nil further" at some time following the consultation on 3 October 2007 which Ms A attended alone. The record "asking for pain killers & sleeping pills" was made on 24 March 2008. Ms A had support persons present at each of the consultations on 20 March 2008, 24 March 2008 and 26 March 2008.

[17] The conversation was confirmed by Ms H who also attended the function.

[18] Medical Council of New Zealand *You and Your Doctor: A guide to your relationship with your doctor*, October 2006 p3 states: "Respect for your Privacy … If your doctor wants to share information about you with other people, he or she must explain why this is important."

126. The following day he telephoned her GP and left a message with his nurse about Ms A's drug and alcohol abuse. He spoke to the GP's locum and asked him to ensure this information was given to the specialist from whom she sought a second opinion. He then wrote to the GP stating Ms A had been "asking for pain killers and sleeping pills, which she has been prone to do, and which I have not prescribed in the past due to her previous problems". He gave similar information to ACC. Ms A knew nothing of Dr C's actions until some time later.

127. Although Dr C said he acted in good faith and in Ms A's best interests, I accept the evidence from her and others who attended the consultations after 20 March 2008 that he did not verify the information with her before he disseminated it to others. This was unacceptable and could have had a deleterious effect on her treatment by other providers.

128. Dr C should have discussed the issues of drug and alcohol abuse with Ms A, explained "altered pain pathways" and the role of a pain specialist, and the need for other health professionals to be aware of these matters when treating her. His failure to do this breached the Medical Council of New Zealand guidelines and Rules 2, 3 and 8 of the Health Information Privacy Code. As a result he breached Right 4(2) of the Code.[19]

Clinical records

129. In accordance with Right 4(2) of the Code, and relevant standards from Medical Council of New Zealand,[20] medical practitioners have an ethical and professional duty to maintain adequate records as part of good quality care. Records are an essential tool for patient management, for communicating with other doctors and health professionals, and for ensuring continuity of care.

130. Ms A said Dr C did not take notes during any of her consultations with him, did not record everything she told him about her symptoms, recorded incorrect dates for consultations and provided misleading information to other practitioners. In her opinion, Dr C could have no reliable recall of any of their consultations because his notes are inadequate. His consultations were very brief and she had the impression he wanted to finish the consultations as rapidly as possible. Dr C agrees that he recorded "sensitive information" subsequent to the consultations and made no record at all of the preoperative assessment he claims he performed.

131. During the course of this investigation staff from my Office approached Dr C three times for his clinical records and on each occasion different information was provided. His notes appear to be written on loose paper, with individual undated pages lacking continuity. My investigators visited his rooms in order to gain some understanding of his records. As discussed in paragraphs 95 to 98 (above) they found a further undated document that referred to alcohol and drug use, but using different wording. With regard to the varying information provided to HDC, Dr C stated:

[19] Right 4(2) of the Code states: Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.
[20] New Zealand Medical Council statement: *Maintenance and Retention of Patient Records,* 2005.

> "I note that the wording in my two notations is different, however I can no longer recall why this is so ... [I] do not recall whether or not I made these notes at the same time it is likely they were made on different dates as it would be unlikely that I would write the same thing twice for one consultation."

132. Given that this is important medical information, I find it concerning that Dr C either would not or could not give an explanation. Dr C cannot rely on his records to accurately corroborate his account of events.

133. Baragwanath J decided in *Patient A v Nelson–Marlborough District Health Board*[21] that it is through the medical record that health care providers have the power to produce definitive proof of a particular matter (in that case, that a patient had been specifically informed of a particular risk by a doctor). As the Commissioner stated in opinion 08HDC10236:[22]

> "In my view this applies to all health professionals who are obliged to keep appropriate patient records. Health professionals whose evidence is based solely on their subsequent recollections (in the absence of written records offering definitive proof) may find their evidence discounted. Furthermore, the failure to record medications given is poor practice, affects continuity of care, and puts patients at real risk of harm."

134. Dr C has an ethical duty to maintain adequate records of his consultations.[23] The information they contain must be clear and accurate and the records should be made at the time of the consultation or as soon as possible afterwards. In my opinion his records are inadequate and a clear breach of Medical Council guidelines. Accordingly, Dr C failed in his ethical duty to maintain appropriate professional medical records and breached Right 4(2) of the Code.

Surgical standards

135. Ms A and Ms B said that Dr C failed to provide Ms A with surgical services with reasonable care and skill from February 2007 to March 2008. It is apparent that Dr C supplemented his notes, in his response to the complaint, with explanations based on his recall. It is very difficult to establish the extent to which his explanations are based on the clinical record, as opposed to his memory of events. The absence of a permanent and contemporaneous record makes the task of verifying the accuracy of his recall very difficult. The paucity of notes has impeded my investigation into whether Dr C provided appropriate clinical care to Ms A.

136. My expert advisor, Dr Poole, explained that to understand the problems Ms A experienced, one must be mindful of the history of laparoscopic hernia surgery, because Ms A's problems arose following a laparoscopic repair of bilateral inguinal

[21] *Patient A v Nelson–Marlborough District Health Board* (HC BLE CIV–2003–406–14, 15 March 2005).
[22] 08HDC10236, 28 November 2008, page 11.
[23] Medical Council of New Zealand statement "The maintenance and retention of patient records" October 2005 provides "You must keep clear and accurate patient records that report relevant clinical findings, decisions made, information given to patients, any drugs or other treatment prescribed".

herniae performed by Dr C in 1992. She had two further hernia surgeries with Dr C on 22 February 2007 and 21 February 2008.

Surgery in 2007

137. Dr Poole advised me that the diagnosis of recurrent hernia can be difficult and scans are of limited value. The diagnosis is made by taking a thorough medical history, which he considers Dr C appears to have done. Dr C diagnosed a right-sided incisional hernia and decided on a surgical plan of open surgery and repair with "plug and patch". Dr Poole said that, in hindsight, Dr C could have checked the left side with a laparoscope. The mesh placed in 1992 was probably at the end of its useful life by 2007 and the hysterectomy performed in 2005 may have dislodged the mesh further. Nevertheless, overall it is Dr Poole's opinion that the choice of operation was reasonable, given Dr C's certainty about the incisional (abdominal wall) hernia.

138. Postoperatively, Ms A developed a seroma, but there is no evidence her wound was infected. Ms A required repeated aspirations until the wound was dry. Dr C was satisfied the wound was not infected and he advised Dr D that Ms A's postoperative course was uneventful. I note that Dr C did not refer to the lump as a "seroma" or explain the aspiration process to Ms A.

139. Dr Poole said that Ms A's postoperative course was not uneventful but her recovery was not out of keeping with this level and type of surgery. Seroma are a very common complication experienced by almost all patients.

140. I am satisfied that Dr C took an adequate medical history in February 2007 and recorded his findings. He could have looked at the left side with the laparoscope but it appears he had no obvious reason for doing so. Dr C's choice of surgery was appropriate and the seroma was an expected event and not a wound infection. Although Dr C should have discussed the probability of a seroma with Ms A, it is my opinion that Dr C provided services with reasonable care and skill in 2007 and he did not breach Right 4(1) of the Code.

Surgery in 2008

141. Ms A saw Dr C on 3 October 2007 and advised HDC that she did not see him again before her surgery in February 2008. She said Dr C did not assess her suitability for surgery beforehand or see her before she went home the following day.

142. Dr C stated that Ms A was seen before her surgery on 21 February 2008 and she was examined by the anaesthetist. However, he does not say who saw her and no details of a preoperative assessment are recorded in her notes. I consider it was essential that a preoperative assessment was performed and the findings recorded in Ms A's records.

143. Dr Poole advised that Dr C made his preoperative diagnosis of right-sided recurrent hernia on clinical findings, which was appropriate. An ultrasound would be of limited value. He assumed Dr C would have checked the left side during the procedure as it is easy to see laparoscopically. He considered the left-hand hernia found subsequently by Dr G "was either absent or occult" as Dr C did not find it

preoperatively. Dr C repaired the hernia with onlay mesh. Dr Poole explained that the technique Dr C used to secure the mesh would have put sensory nerves at risk "but it was still a feasible option" when other options had failed.

144. This was clean surgery and, in accord with current practice, antibiotics were given intravenously when Ms A had her anaesthetic. Dr C reported to Dr D that Ms A had a urinary tract infection which was "starting just prior to her surgery" and after surgery she developed urinary retention which responded to antibiotics. However, he acknowledges she had no symptoms of a urinary tract infection prior to surgery. My expert, Dr Poole, advised that urinary retention can occur from sensory overload and the tacks may have caused the problem.

145. Ms A's pain continued and a scan taken over the Easter weekend revealed possible femoral herniae. Ms B also reported that Ms A was suffering from a pubic rash, severe headache, fever, nausea and vomiting. Ms A told Dr C she felt as though the "flu" was coming on. However, Dr C could find no fever. She had been taking antibiotics and analgesia (Tramal) and he described "a minor rash over her pubic area". Dr C said he explained there was no cause for alarm and that stopping the Tramal and continuing the antibiotics would solve the problems.

146. Dr Poole outlined a number of possible causes for Ms A's postoperative symptoms including the actual surgical repair in the groin area, the possibility of involving sensory nerves and anatomical changes from previous surgeries. Urinary retention and even the skin rashes could all be put down to irritation of sensory nerves, such as the genitofemoral nerve entrapment that Dr G corrected.

147. Dr C doubted whether Ms A should have further surgery at this time when they had no firm diagnosis, which Dr Poole found to be entirely appropriate. This is supported to varying degrees by Drs E, F, and G.

148. I am guided by Dr Poole who explained the difficulties of what he termed pioneering techniques in laparoscopic surgery from 1992 and how that impacted on Ms A's experiences. Taking this into account I conclude that Dr C's surgery and postoperative care was reasonable in the circumstances and he did not breach Right 4(1) of the Code.

Conclusion

149. Dr C failed to treat Ms A with respect and so breached Right 1(1) of the Code. His failure to verify information about her and make her aware of his intention to share the information before he disseminated it to others breached Right 4(2) of the Code. His failure to maintain appropriate professional medical records breached Right 4(2) of the Code.

Recommendations

150. I recommend that Dr C:

- Apologise to Ms A for breaching the Code. This apology is to be sent to HDC by 27 May 2011 and will be forwarded to Ms A.

- Undertake a communication skills course by **31 August 2011**, and advise HDC when he has completed the course.

- Reorganise his medical records in light of this report, to comply with professional ethical standards.

- Advise HDC by **3 June 2011** what steps he has taken to improve his medical records practice.

Follow-up actions

- A copy of the final report will be sent to the Medical Council of New Zealand with the recommendation that an audit of Dr C's medical records be conducted to ensure they comply with professional standards.

- A copy of the final report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Privacy Commissioner and the Royal Australasian College of Surgeons.

- A copy of the final report with details identifying the parties removed, except the expert who advised on this case will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent general surgeon expert advice — Dr Garth Poole

"My name is Garth Poole. I hold the following positions and qualifications:

- General Surgeon and Deputy HOD CMDHB
- Past President of NZAGS
- Past National Supervisor of Basic Surgical Training
- FRACS MBChB
- Director Laparoscopy Unit Middlemore Hospital (over 8000 cases)

To form my opinion I have reviewed the following documents provided by the HDC:

Pages from HDC 01–112 including:

- Correspondence from [Ms B]
- Correspondence from [Dr C]
- Correspondence from other Specialists and General Practitioners
- Clinical notes

Introduction
[Ms A] underwent several operations from 1992 until 2008 to treat multiple hernias in the lower abdominal wall. I have been asked to examine three aspects of this treatment as they pertain to the involvement of [Dr C].

1) Hernia diagnosis and treatment 2007and 2008
The 16 year period of treatment covers the most explosive technical period in hernia history. 1992 was the beginning of laparoscopic hernia repair. Because laparoscopy is technically demanding other surgeons began the era of open mesh repair. These two techniques reduced the recurrence rate of surgery from around 20% in historical sutured surgery to about 5% with mesh.

There were, however, several learning issues that were encountered and this case illustrates many of these.

The internationally recognised issues that may be relevant here are:

1) Early (1992) laparoscopic repair often used a mesh that was too small after shrinkage;

2) Plug and patch surgery can leave a bulky, irritating mesh in slim patients;

3) Hysterectomy and prostate incisions can destroy a good previous mesh repair;

4) Dual mesh is hard to fix without multiple screws;

5) Tacks and screws can cause pain.

February 2007
There is disagreement as to whether there were symptoms on both sides, or just on one side. The notes from [Dr C] 14/2/07 recorded a self-referral from [Ms A], therefore there is no objective patient/GP evidence of a problem on the left side.

[Dr C] records a right-sided probable incisional hernia and decides on an open surgical plan to fix it with a plug and patch.

This hernia has probably come about because of the hysterectomy. The contracted mesh from 1992 was possibly at its limit to cover the area and the hysterectomy incision can dislodge the mesh further. This can also be seen in prostate surgery. Modern mesh size makes this less likely to occur.

The diagnosis of recurrence after mesh can be very difficult and scans have limited value. The best tool is a good history and examination. There is no evidence that this did not occur in the notes of [Dr C].

In retrospect, a diagnostic laparoscopy may have been useful to look at both sides.

The operation performed of "plug and patch" can have limitations if all defects are not identified. There is also an issue of "mesh load" in a slim woman. Overall this operation was a reasonable choice.

February 2008
Again a diagnosis of recurrent hernia was made clinically, which was appropriate. Scans have significant limitations after double mesh surgery. No mention at subsequent laparoscopic operation is made of a recurrent hernia on the left side, which would have been easy to see at laparoscopy, so presumably the left hernia found by [Dr G] was either absent or occult.

The operation of onlay with dual mesh has the benefit of minimal adhesions and no shrinkage. The major problem is with fixation, as the mesh requires mechanical fixation with tacks or sutures or both. This is reasonable in the midline of the abdomen, but is difficult in the groin due to the anatomical angles and vital structures. The need to fix in a circular fashion may put sensory nerves at risk.

However this option is still a feasible operation in a desperate situation.

2) [Dr C] did not use local anaesthetic while aspirating a wound
It is common practice to aspirate wounds without local anaesthetic. A patient may request local anaesthetic and should be given it. However in a region with scars this is often not required due to numbness.

3) [Dr C] allegedly breached patient confidentiality by informing other health professionals about misuse of dugs and alcohol
Surgeons utilise a very diseased-based model, usually without judgement. A history of recreational or prescription drug misuse and/or alcohol dependency are just two more diseases that are a very relevant part of the history of a surgical patient. Over 30 percent of abdominal pain diagnoses have a significant psychological contribution.

Anaesthesia requires full disclosure of drug tolerance.

Modern GP referral letters come to the hospital with all previous diseases printed off from a decade of GP contacts. Many of these are irrelevant and embarrassing such as "termination of pregnancy 10 years ago" in a woman with gallstones. Drug and alcohol history is however very relevant.

Summary
The frustration of the complainant about the need to have multiple operations on the lower abdomen over 16 years is obvious. [Dr C] would almost certainly like to have the chance to do some things differently if he had his time over again.

Errors were made, in my view, but these were not due to a lack of clinical judgement, care or operative skill. Many can be put down to the evolving knowledge of laparoscopy and the use of prosthetics in the human abdominal wall.

The operative choices and execution demonstrate reasonable skill."

Appendix B: Further expert advice — Dr Garth Poole

"I have reviewed the following documents provided by the HDC:

Pages from HDC 01–180 including:

- Correspondence from [Ms B]
- Correspondence from [Dr C]
- Correspondence from other Specialists and General Practitioners
- Clinical notes
- Operative notes
- Legal correspondence from [Ms A's barrister]

General introduction and technical background
[Ms A] underwent several operations from 1992 until 2008 to treat multiple hernias in the lower abdominal wall.

In 1992 laparoscopic hernia repair (keyhole) was popularised. Laparoscopic hernia repair remains technically demanding and is only routinely offered by 30 percent of surgeons in the developed world.

Open mesh repair (through a larger cut) has improved dramatically since 1990. Both open mesh and laparoscopic repair have combined to reduce the recurrence rate of surgery from around 20% in historical open sutured surgery to 2–5% with mesh.

There are several learning issues that have been encountered:

1) Early (1992) laparoscopic repair often used a mesh that was too small after shrinkage

2) Plug and patch surgery can leave a bulky, irritating mesh in slim patients

3) Hysterectomy and prostate incisions can destroy a good previous mesh repair

4) Dual mesh is hard to fix without multiple screws

5) Tacks and screws can cause nerve entrapment pain

Direct inguinal hernia recurrence was common in the early history of laparoscopic repair. This is because the mesh has not been overlapped over the central bone or has been too small. Shrinkage is inevitable and should be compensated for by excess mesh. Modem mesh size makes this less likely to occur.

I have been asked by the Commissioner to comment on the following aspects of care from [Dr C]:

1) The standard of hernia surgery performed on [Ms A] in February 2007

a) Did [Dr C] factor in the hysterectomy as a cause of hernia?

b) Could [Dr C] check the old mesh through his open surgery?
c) Was the recovery uneventful?

a) Did [Dr C] factor in the hysterectomy as a cause of hernia?

There is preoperative disagreement as to whether there were bilateral or unilateral symptoms. The notes from [Dr C] on 14/2/07 recorded a self-referral from [Ms A], therefore there is no objective patient/GP evidence of a problem on the left side. The diagnosis of recurrence after previous mesh hernia surgery can be very difficult and scans have limited value. The best tool is a good history and examination. There is no evidence that this did not occur in the notes of [Dr C].

[Dr C] diagnosed and recorded a right-sided probable incisional hernia and decided on an open surgical plan to fix it with a plug and patch. He was unsure whether the hernia was from his laparoscopy or the hysterectomy. He did not appear to consider a recurrence of the previous inguinal hernia. His logic for open surgery was that there was already a gynaecological scar that could be used for access. He was also certain about the position of the defect. A recurrent inguinal hernia was only diagnosed at surgery. This recurrent hernia has probably come about because of the hysterectomy. The contracted mesh from 1992 was possibly at its limits to cover the area and the hysterectomy incision may have dislodged the mesh further.

b) Could [Dr C] have checked the old mesh through his open surgery [incision]?

In retrospect a diagnostic laparoscopy may have been useful to look at both sides. This would also enable a clear assessment of the right side, because the operative finding of direct hernia recurrence was unexpected. The operation performed of "plug and patch" can have limitations if all defects are not identified. Assessment of the previous mesh was not fully feasible through the open cut. Overall this operation was a reasonable choice given the certainty of diagnosis preoperatively. In retrospect, skilled laparoscopy may have been a better option for diagnosis.

c) Was the recovery uneventful?

The postoperative course was not uneventful but was not out of keeping with the level of surgery. Recurrent open hernia surgery has a complication rate approaching 100% if patients are followed assiduously. Seroma is the most common problem. Informed consent and a consistent message from all health providers usually reduces stress and allows natural settling.

2) The standard of surgery in February 2008

a) Should [Dr C] have checked the 1992 mesh?

The 1992 mesh would have had considerable biological ingrowth and would have only been visible as lumpy peritoneum. Any important defect would have shown clearly by a hollow in the peritoneum around the edge of the mesh. This is what occurred on the right side and led to the placement of dual mesh. [Dr C] would have checked carefully for defects on both sides.

A diagnosis of recurrent hernia was made clinically, which was appropriate. Scans have significant limitations after double mesh surgery. No mention at the subsequent laparoscopic operation is made of a recurrent hernia on the left side. This would have been easy to see at laparoscopy so presumably the left hernia found by [Dr G] was either absent at that stage or occult.

The operation of 'onlay with dual mesh' has the benefit of minimal adhesions and minimal shrinkage. The major problem is with fixation. The mesh requires mechanical fixation with tacks or sutures or both. This is reasonable in the midline of the abdomen but is difficult in the groin due to the anatomical angles and vital structures. The need to fix in a circular fashion may put sensory nerves at risk. However this option is still a feasible operation in a situation where other options have failed, or used up the usual areas of access.

b) Was the operation 'desperate'?

This operation was not desperate in a time sense. This word 'desperate' was used in previous correspondence to imply that the surgeon was running out of technical options.

c) Was urine infection, urine retention and rash the consequence of surgery?

In my opinion the alleged nerve damage that was treated by [Dr G] is just as likely to be the ilioinguinal nerve as the genitofemoral. The position of the mesh and tacks, the distribution of the numbness, the urinary symptoms and even the skin changes may be rare side effects of the irritation of this nerve.

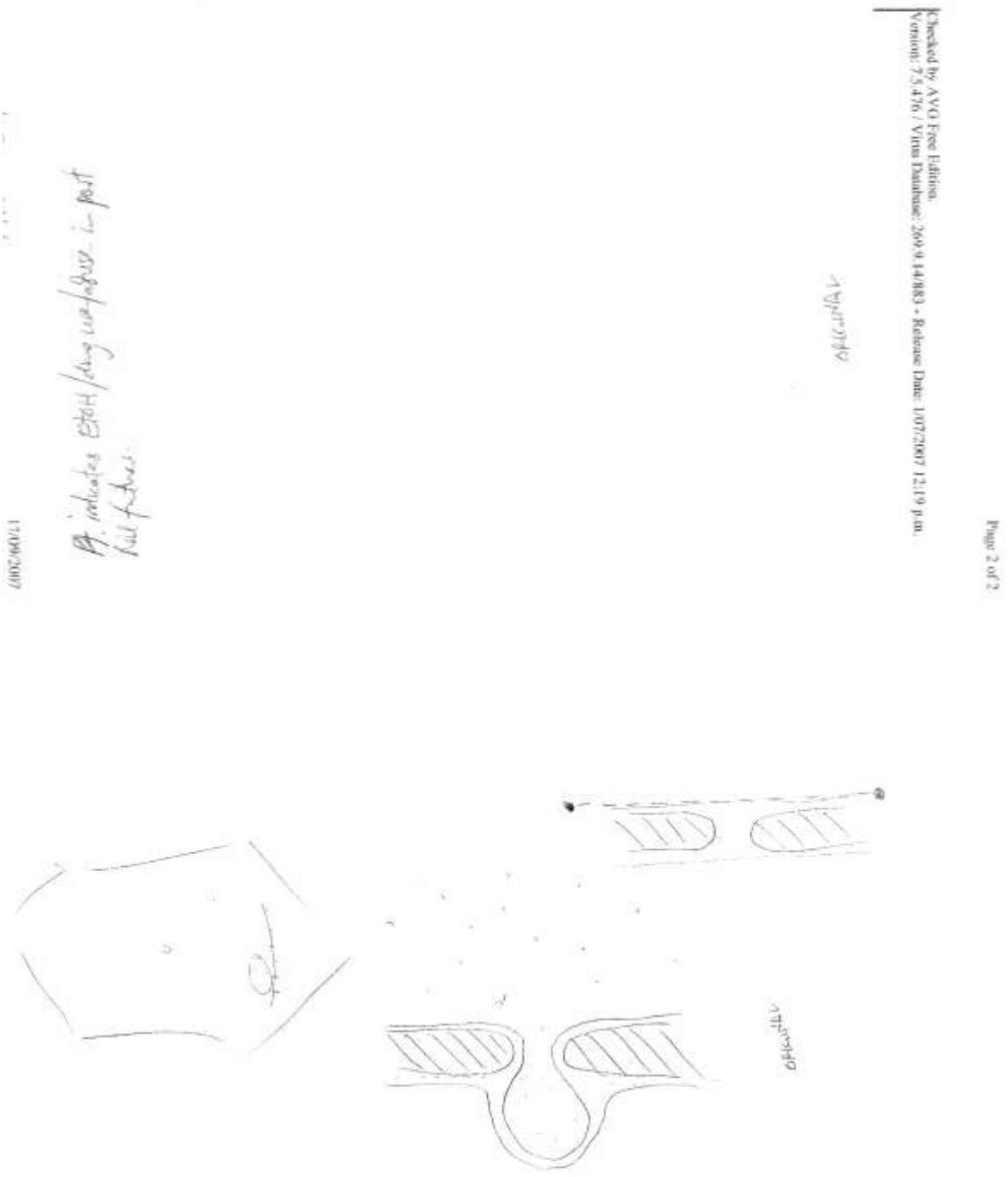
Retention can occur from sensory overload from surgery after anaesthesia. If this was the case then tacks may have caused the problem. Altered anatomy from previous surgery puts the nerve more at risk, even with careful tacking technique. The requirements of dual mesh fixation need more tacks. The improvement with tack removal certainly would support nerve impingement as the main cause of upper medial thigh pain.

3) The apparent reluctance of [Dr C] to recommend further surgery in 2008

It is entirely appropriate for a surgeon to constantly question whether surgery is indicated. Three other specialists ([Drs E, F and G]) showed varying degrees of reluctance to operate in the absence of a clear diagnosis that could be helped by surgery. It is not my view that the interpersonal and other health issues alluded to in the documents would have had any bearing on the plan if an obvious diagnosis was evident. In the absence of such a diagnosis it may be that, in retrospect, [Dr C] cast the net too wide in looking for a non-surgical cause for the problems.

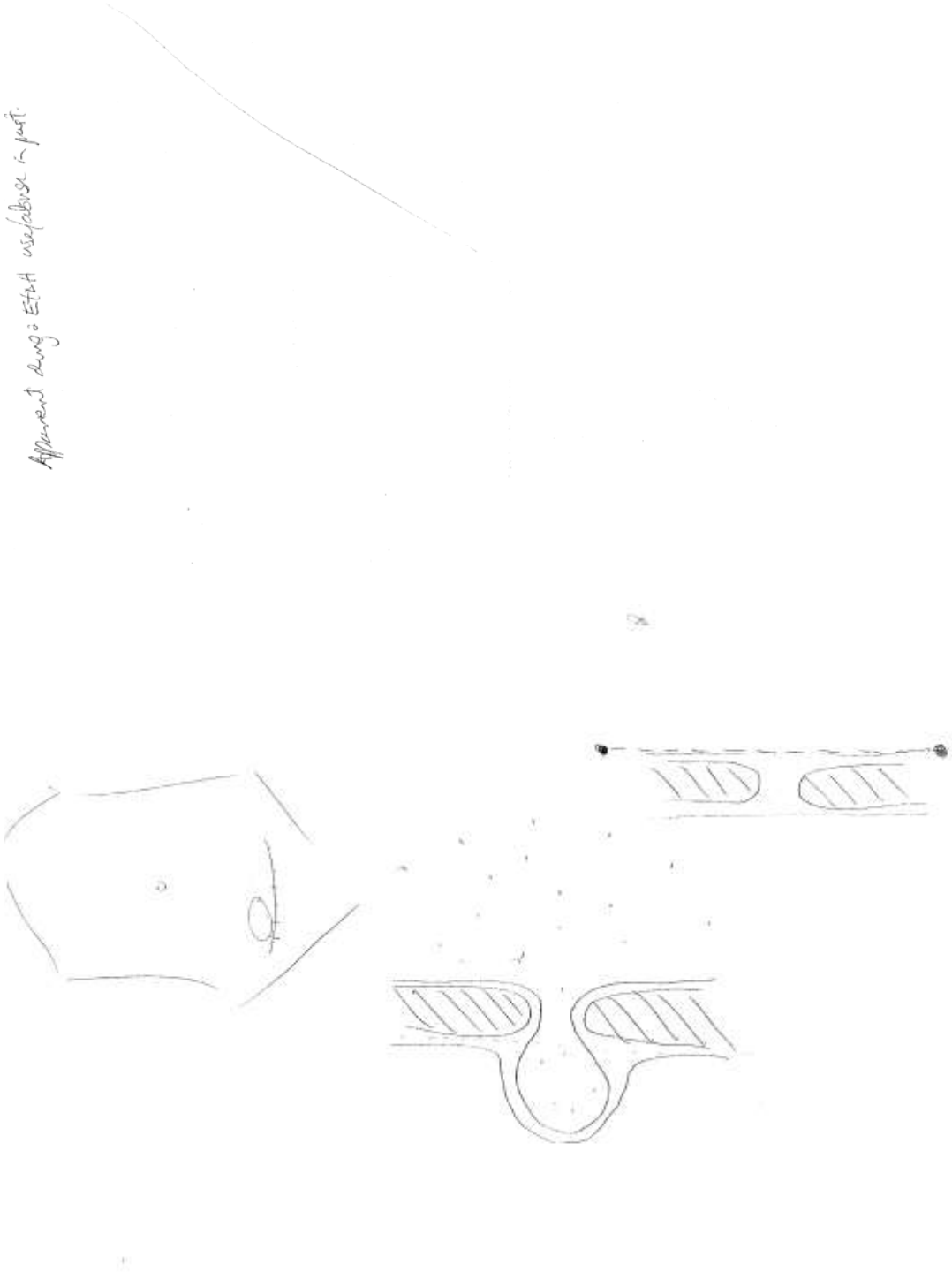
Subsequently the non-operative plan has proven to be wrong by the good results from [Dr G's] surgery."

Appendix C



Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix D



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