HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Complaints management, clinical indication for surgery, and doctor–patient relationship

1. This Office received a complaint from Ms A about the care provided by private otolaryngologist Dr B. Ms A has a history of allergic rhinitis[1] and had had nose surgery for a deviated nasal septum[2] over 25 years ago. On 16 July 2019 Ms A's general practitioner (GP) referred Ms A to Dr B for treatment of a nasal lesion.[3] Ms A is concerned that Dr B 'overserviced' her by performing surgery and tests that were not clinically indicated, and that he did not inform her adequately about the risks associated with the surgery. In addition, this report considers whether Dr B managed Ms A's complaint appropriately.

2. During an initial appointment on 29 August 2019, Dr B diagnosed a small viral papilloma[4] inside Ms A's left nostril, which he considered required surgical removal.[5] Dr B documented that Ms A 'also expressed a desire to have her general nasal airway improved'. Dr B conducted a nasoendoscopy[6] and discussed additional surgery.

3. Ms A considers that Dr B 'convinced' her to undergo additional surgery (to improve her breathing and reduce her allergies) when she did not raise any concern about this. In response to the provisional decision, Ms A told HDC that she did not express a desire to have her nasal airway improved and did not initiate this conversation. Ms A stated that after conducting a nasoendoscopy to look at the papilloma, Dr B stated that she had reduced airways, drew diagrams to illustrate this, and suggested that she undergo surgery. She considered that Dr B 'upsold' her from the original purpose of her visit, which was to have the papilloma removed.

4. In contrast, Dr B stated that he considered a surgical approach as 'there was a fixed mechanical obstruction and rhinosinusitis[7] that was unlikely to improve with medications alone'. He noted that Ms A graded her nasal blockage as 3–4 out of 5 on a sinusitis symptoms questionnaire form on 29 August 2019. This is supported by the clinical records. In response to the provisional decision, Ms A stated that she filled out the questionnaire at Dr B's request, and with Dr B's suggestion that her breathing was compromised. There is

[1] Nasal inflammation that worsens with increased exposure to specific allergens.
[2] Misalignment of the cartilage and bone that separates the two nasal passages.
[3] The GP referral form stated: '[The nasal lesion] can bleed with trauma.'
[4] A benign (non-cancerous) growth caused by a viral infection, typically the human papillomavirus (HPV).
[5] Dr B also diagnosed Ms A with mechanical nasal obstruction (a physical blockage in the nasal passages that prevents normal airflow), perennial rhinitis with seasonal exacerbation, and post-trauma from her previous nose surgery.
[6] A procedure that involves inserting a thin, flexible tube with a light and camera at the tip (endoscope) to examine the inside of the nasal passages, sinuses, and upper airway.
[7] Inflammation of the sinuses and nasal passages, leading to symptoms such as nasal congestion, discharge, facial pain, and pressure. Chronic sinusitis is defined as lasting 12 weeks or more.

conflicting information as to whether Ms A had chronic sinusitis.[8] Dr B stated that a CBCT scan[9] on 31 October 2019 showed 'significant inflammation of the paranasal sinuses[10] and the cause for the mechanical block'. Dr B provided HDC with a statement from a diagnostic radiologist who said that the CBCT scan showed 'mild maxillary sinus[11] disease'. In response to the provisional decision, Ms A felt that Dr B's and the diagnostic radiologist's findings were at odds with each other.

5. Ms A was provided with a revised surgery estimate, which included four procedures — removal of the papilloma, septoplasty, [12] bilateral turbinoplasties, [13] and bilateral comprehensive functional endoscopic sinus surgery (FESS). [14] Dr B performed the four procedures on 26 June 2020.

Nasoendoscopies

6. Ms A states that she was charged for endoscopies on 31 October 2019 and 15 June 2020,[15] when only a light was shone up her nose. Ms A said that she complained to Dr B via email in October 2019 but states that she did not receive a response. In response to the provisional decision, Ms A stated that these appointments 'were repetitive and provided no further benefit except for [Dr B's] billing'. Ms A told HDC that it is her belief that she underwent only one nasoendoscopy, which took place during her initial appointment. She recalled the procedure as being 'unpleasant', and that 'any further examinations were just the small light … shone up [her] nose'.

7. Dr B told HDC that the repeat nasoendoscopies were appropriate and confirmed that 'inflammation and blockage persisted and would not further improve with medical treatment'. In response to the provisional decision, Dr B stated that a decision to perform an endoscopy is always communicated to his patients, and he recalled Ms A saying that she found the endoscopy unpleasant during his consultation.[16]

Informed consent

8. Ms A is concerned that Dr B did not inform her of the risk of alar collapse[17] prior to undergoing the additional surgery, which has left her with a collapsing left nostril when she inhales deeply.

[8] Discussed further at paragraphs 18(d) and 29.
[9] Cone beam CT scan. This is a specialised 3D imaging technique that uses a cone-shaped X-ray beam to create detailed cross-sectional images of structures in the head, neck, and other areas.
[10] A group of four paired air-filled spaces that surround the nasal cavity.
[11] The maxillary sinus is the largest paranasal sinus.
[12] A procedure to straighten or reposition a deviated nasal septum.
[13] A procedure performed on both sides of the nasal turbinates to reduce their size and improve airflow.
[14] A procedure used to remove blockages in the sinuses.
[15] Ms A stated that her insurer was invoiced $250 for diagnostic imaging.
[16] Dr B stated that in Ms A's case, he used 'ENTop anaesthetic and the finest 2.5mm paediatric scope'.
[17] Also known as nasal valve collapse. This occurs when the nasal sidewalls collapse inwards during inhalation, obstructing the nasal airway. This can lead to breathing difficulties, snoring, and mouth breathing.

9. Dr B considers that he fulfilled his obligation to provide clear explanations and informed consent, but he acknowledged that Ms A was not advised of a risk of alar collapse, as 'no surgery was planned to that area'.[18] He noted that the Royal Australasian College of Surgeons (RACS) 'guide for patients' does not indicate that normally a risk of alar collapse is discussed with a patient having a septoplasty or FESS with septoplasty. Dr B provided HDC with a statement from a plastic surgeon, who advised that '[a]lar rim insufficiency after sinus surgery is unusual'. In response to the provisional decision, Dr B stated that the RACS rhinology group has since 'adopted specific risk descriptors in their consents',[19] due to the complexity of this situation.

10. In addition, Ms A said that she was 'alarmed' by the proposed septoplasty on the surgery estimate, as 'this [was] not something Dr B discussed'. Ms A emailed Dr B on 10 March 2020,[20] and Dr B's administrator replied that Dr B said that he would work on the part of the septum that is 'next to the sinus not the front part'. Dr B stated that on at least two occasions (31 October 2019 and 15 June 2020) an explanation of the findings and the plan for the septoplasty were explained to Ms A (including with the use of drawings of the planned surgery).

11. In response to the provisional decision, Dr B submitted that he 'did his best' to explain the clinical, endoscopic and radiological findings' to Ms A and how these related to her symptoms and concerns. Dr B stated that he disagreed with the proposition that Ms A was not given adequate time to ask questions, and he noted that she 'was permitted at any time, to defer her treatment' or 'to discuss the proposed treatment plan with her GP'.

Complaints management and ending doctor–patient relationship

12. Ms A is concerned that Dr B did not address her nostril collapse following the surgery and ended the doctor–patient relationship suddenly. Ms A said that she first informed Dr B of this issue on 28 June 2020, but this was not addressed explicitly in his text messages or email correspondence.[21] Ms A said that on 13 August 2020 (the third follow-up appointment) she queried Dr B's comments that it was a 'good outcome' and 'as expected'. She stated:

> 'The way I was treated at the last appointment was also extremely humiliating with [Dr B] outright refusing to discuss the issue, saying he no longer wants to treat me and asking me to leave.'

[18] Dr B stated that it was agreed that Ms A's septum would be left 'as it was' (as close to the midline as possible) and that this was achieved during surgery.
[19] Dr B stated that this included the risk of 'alar risk mobility and collapse' and that 'the patient may experience "nasal obstruction" meaning revision surgery could be required'.
[20] Ms A stated: '[T]he work we discussed is to remove a papilloma and some turbinoplasty to improve my airways.'
[21] In response, Ms A was told to rinse her nose gently and apply ointment (as this would prevent crusting, which can cause nasal collapse).

13. Ms A emailed the clinic with a complaint on the same day. She told HDC that she has not received a response from Dr B or the clinic, and she did not receive a clinic letter for this appointment.

14. Ms A said that she recorded the final appointment,[22] which Dr B considers was 'wholly unacceptable'. In response to the provisional decision, Dr B told HDC that 'something certainly didn't feel right about the way [Ms A] engaged in the [final appointment] and what was being explained to her'.

15. Dr B stated that Ms A's soft-tissue alar collapse was caused by 'supra-physiological' (forced) breathing.[23] He noted that normal breathing post-nasal surgery may take up to 12 months. He said that Ms A was 'overly dramatic in demonstrating her alar collapse' and became upset when video images showed that the septum and adjacent areas were not out of place or a cause for complaint. In response to the provisional decision, Dr B stated that he felt that Ms A was not willing to listen to his explanation of the findings post-surgery, and was not interested in viewing the video endoscopy or formatting a treatment plan going forward.

16. Dr B told HDC that he knew that Ms A could be 'very unpleasant and aggressive' and, as he did not wish to get into an argument with her, he 'simply stood up and terminated the consultation'. In response to the provisional decision, Ms A stated that she disagreed with Dr B's comments but noted that she was 'certainly disgruntled' with how she had been treated at all her appointments and pre-surgery (on 26 June 2020).

17. Dr B stated that he wrote a 'full report' to Ms A's GP on the same day and advised Ms A to seek the guidance of another ear, nose and throat surgeon.[24] In response to the provisional decision, Dr B stated:

> '[W]e responded to [Ms A's] complaint, prepared a summary of future treatment options, and followed her up to ensure the area of concern was rechecked on 12 December [2021].'

Independent clinical advice

18. Independent clinical advice was provided by otolaryngologist Dr Chris Thomson (Appendix A). In summary, Dr Thomson advised the following:

a) Not addressing [Ms A's] post-surgery concerns — mild departure.

b) Not disclosing the risk of alar collapse following nasal surgery — mild departure.

c) Proposing septoplasty and turbinoplasty when [Ms A] was not concerned about her nasal airway — moderate departure.

[22] However, Ms A was unable to provide this to HDC as she had deleted it.
[23] Dr B said that this was related to Ms A's 'own anatomy aggravated by the old rhinoplasty scar[r]ing apparent inside of the nose' and that he did not modify or narrow that part of her nasal airway.
[24] In addition, Dr B stated that as he did not receive a request for her file to go to another surgeon, he considered it his 'ethical duty' to write a letter to Ms A's GP on 6 April 2021 (to remind Ms A that further follow-up on her histology report was important).

d) Misrepresenting the CBCT scan findings to justify additional surgery — serious departure.

Response to provisional decision

Ms A

19. Ms A was provided with the opportunity to respond to the 'information gathered' section of the provisional decision. Ms A told HDC that she was very pleased to hear that there are new processes and suggested that improvements around patient respect and wait times would also be appropriate. Further comments made by Ms A have been incorporated into this report where relevant.

Dr B

20. Dr B was provided with an opportunity to respond to the provisional decision. Dr B told HDC that Ms A's complaint, and the investigation process and findings have resulted in some useful learning and changes to his practice, particularly around complaints management. Dr B stated that he agreed with my comments on the importance of ascertaining a patient's views (as part of the patient assessment and informed consent process) and working in partnership with patients and respecting their right to reach decisions about their treatment and care. Further comments made by Dr B have been incorporated into this report where relevant.

Decision

Complaints management — breach

21. In my view, Dr B breached Right 10(6) of the Code of Health and Disability Services Consumers' Rights (the Code) as he did not provide Ms A with a written acknowledgement of her complaint (on 13 August 2020) within five working days.[25] As outlined in this report, there were several instances when Ms A sought further information and clarification from Dr B.

22. I consider that there was a missed opportunity to resolve this complaint. Dr B could have communicated with Ms A clearly in writing, outlining the reasons why he did not accept the complaint as justified,[26] any proposed actions he intended to take (such as referral back to her GP), and any appeal procedure that Dr B (or the clinic) had in place.[27]

Ending the doctor–patient relationship — adverse comment

23. I am critical of Dr B's reasoning in ending the doctor–patient relationship, namely 'to avoid argument'. As Dr B was unaware of Ms A's recording,[28] I consider that this was not sufficient reason for terminating the doctor–patient relationship at the time of events. I also consider that Ms A raising concerns about her nasal collapse or making a written complaint (on 13

[25] Right 10(6)(a) of the Code states: 'Every provider, unless an employee of a provider, must have a complaints procedure that ensures that the complaint is acknowledged in writing within 5 working days of receipt, unless it has been resolved to the satisfaction of the consumer within that period.'

[26] Right 10(7).

[27] Right 10(8).

[28] Dr B queried whether Ms A recorded the appointment on 27 April 2021. On 7 May 2021, Ms A confirmed that she had recorded the appointment but had deleted it accidently.

August 2020) was not a sufficient reason to end the relationship, as consumers are entitled to ask further questions about the outcome of surgery and to make complaints under the Code.

24. I acknowledge that Dr B was concerned about Ms A's non-compliance with advice post-surgery[29] and his view that Ms A was not willing to listen to him. However, even if the relationship was deemed 'irretrievable', as Dr B submits, this should have been managed in a professional manner. I note that Dr B did not document any concerns about the relationship during the first two follow-up appointments, and he could have taken steps to address Ms A's concerns.[30] However, I accept that Dr B followed up with Ms A's care to ensure that the area of concern was rechecked.

25. Nevertheless, I remind Dr B of his obligation to communicate his reasons clearly if he is ending a doctor–patient relationship with a consumer. I encourage Dr B to ensure that his practice is compliant with professional standards, including following a 'process for discontinuation of care'.[31]

Informed consent — educational comment

26. I am concerned that Dr B did not provide further information or clarification to Ms A, and I consider that the exchange of appropriate information is critical in obtaining informed consent from a consumer.

27. First, as noted by my advisor, Dr Thomson, the lack of information provided to Ms A of the risk of alar collapse in the context of her previous nose surgery constitutes a mild departure from accepted practice. Accordingly, I remind Dr B that doctors should consider risks specific to a consumer's medical history as part of their duty to provide informed consent.

28. Secondly, as evidenced in this complaint, Dr B did not explain to Ms A why repeated nasoendoscopies were necessary (as part of Dr B's clinical decision-making process), despite Ms A raising concern about this in October 2019.

29. Lastly, while I am unable to make a finding of fact on the findings of the CBCT scan (and the diagnosis of chronic sinusitis) due to the difference of clinical opinion, I acknowledge Ms A's comments that she 'trusted' Dr B's judgement as the 'expert'. In my view, this illustrates an imbalance of power within the doctor–patient relationship, where consumers may feel unable to challenge a doctor's recommendation or make decisions based on trust (as opposed to an informed choice based on knowledge about their health status and alternative treatment options).

[29] Dr B told HDC that he was concerned that Ms A overused Otrivine decongestant spray (leading to bruising on the right side of her septum), was not raising her nose adequately, and did not inform him of her holiday to the South Island (which caused concern due to its very dry air and low humidity).
[30] For example, referring Ms A to 'Breathing Works' — a provider Dr B states he works 'closely with' — which teaches people how to control their breathing after nasal unblocking surgery.
[31] Medical Council of New Zealand (2020). Ending a doctor–patient relationship: www.mcnz.org.nz/assets/standards/e223e8f01b/Ending-a-doctor-patient-relationship.pdf

30. I consider that ascertaining consumer views is an important component of the patient assessment and informed consent process, especially in the context of elective surgery (which is optional and not urgent) and private health care (which is more costly). As noted by the Medical Council of New Zealand, doctors should work in partnership with consumers by 'respecting their right to reach decisions with [the doctor] about their treatment and care'.[32]

Changes made since events

31. Dr B stated that he has taken this matter 'very seriously' and has made several changes to his practice, including the following:

a) Recently he participated in a consent development forum for septorhinoplasty (AAFPS) and attended the Sydney Endoscopic Sinus Surgery course.

b) He collects outcome data from his rhinology cases (including FESS) to form part of his 'Continuing Professional Development' requirement (RACS).

c) He makes video recordings for all patients having nasal surgery, namely recording the external nasal valve stability with quiet breathing/normal quick breathing and a forced inspiration.[33]

d) He formalised the complaints process to ensure that responses to complaints are facilitated efficiently. This includes a monthly clinical governance meeting involving all members of the clinic team to discuss feedback to plan improvement.

e) He reviewed the MCNZ statement on 'Ending a doctor–patient relationship' and read relevant articles on managing challenging interactions with patients with useful insights and practical tips.

f) He increased staff, including a plastic surgeon who specialises in functional rhinoplasty.

Recommendations

32. Noting the above improvements made since these events, I recommend that Dr B:

a) Provide a written apology to Ms A for the criticisms identified in this report. The apology is to be sent to HDC, for forwarding to Ms A, within three weeks of the date of this report.

b) Undertake an audit of compliance with the complaints procedure in order to identify/ determine the degree of compliance. The summary of findings with any corrective actions to be implemented is to be provided to HDC within one month of the date of this report.

[32] Medical Council of New Zealand (2021), Good Medical Practice: www.mcnz.org.nz/assets/standards/b3ad8bfba4/Good-Medical-Practice.pdf
[33] Dr B stated that the weakest portion (alar rim, scroll 'junctional' or lateral nasal sidewall) is recorded.

Follow-up action

33. A copy of this report with details identifying the parties removed, except the advisor on this case, will be sent to the Medical Council of New Zealand, and it will be advised of Dr B's name.

Dr Vanessa Caldwell
Deputy Health and Disability Commissioner

Appendix A: Independent clinical advice to Commissioner

'19 October 2022

You have referred [Ms A's] case for an independent expert opinion and I have summarised the timeline of events as follows:

She was referred with two small lesions arising from the skin of the inside of her left nostril as excision of these cutaneous intranasal lesions was outside the expertise of the referring general practitioner. The patient's only concern at presentation were these lesions. [Ms A] did however, on specific questioning by [Dr B], have mild to moderate nasal blockage symptoms and a history of allergic nasal symptoms. She details in her HDC claim that at the time of her initial referral "I do not have any real concerns but [Dr B] believes that there are issues and says that he can improve my airways and reduce my allergies through surgery".

The patient was referred by their general practitioner, … in July 2019 and was initially seen for a consultation by [Dr B] on 29 August 2019. He noted a history of occasional crusting and bleeding in the left nostril and also a history of longstanding mild to moderate allergic rhinitis symptoms, which had been occasionally treated with nasal steroid sprays, some blockage of the nose at night and a tendency to snore at times. He also noted that she had had previous skin prick testing confirming a reaction to various allergens. He commented in his correspondence that "she also expressed a desire to have her general nasal airway improved".

This contrasts with the patient's recollection and description of this consultation as noted above, as she notes in her submission that "I had only come to the clinic to have a papilloma removed, [Dr B] convinced me I needed surgery to improve my breathing and now my breathing has been compromised".

At this consultation [Dr B] noted a history of previous rhinoplasty surgery and that there was "just a little scarring inside related to the rhinoplasty". He noted a deviated septum with a left maxillary crest spur and hypertrophic change of each inferior turbinate and a bulky right middle turbinate. He asked the patient to complete a number of questionnaires, including a SNOT 20 score (a questionnaire designed to quantify the degree of symptoms that might occur in a patient with sinonasal problems), a snoring questionnaire and an Epworth questionnaire (this is a questionnaire to evaluate the degree of sleepiness that might result from sleep disordered breathing). Videonasendoscopy was performed and [Dr B] organised a cone beam CT scan of [Ms A's] sinuses.

At this first consultation it was deemed that the lesion inside the nose was a viral papilloma and that surgery to excise this would be necessary but that other surgery might also be indicated for her other unrelated symptoms of allergic rhinitis and nasal obstruction.

A second clinic appointment was undertaken on 31 October 2019. The patient's submission states that she could not understand why this appointment was necessary as she had

already agreed to surgery with [Dr B] following his initial consultation and his ordering of a CT scan and a skin prick test for allergy.

At this follow-up visit [Dr B] details that repeat nasendoscopy was performed. [Ms A] states that "no endoscopy was performed, only the light at the end of the instrument was shone up my nose". The patient notes that she specifically complained that she was invoiced for nasendoscopy and that she corresponded by email with the clinic highlighting this but did not receive a response.

At the second appointment correspondence from [Dr B] details that the "cone beam CT scan shows significant inflammation of the paranasal sinuses and the cause for the mechanical block". However, he followed this comment with the further comment that "the paranasal sinuses were satisfactory".

At this second appointment he detailed that he once again discussed the risk and benefits of surgery and the plan to operate in the New Year. Surgery was scheduled for 24 April 2020. An unexpected upwards revision in the cost of surgery was tendered with an increase of 22% on the original estimate. [Ms A] detailed that this estimate included septoplasty surgery which was "not something [Dr B] discussed with me". I note on [Dr B's] 31 October 2019 consultation that he had detailed a plan to perform "functional endoscopic sinus surgery, septoplasty, turbinoplasties and excision papilloma left anterior nasal airway".

Surgery was then delayed because of the Covid alert. This upset [Ms A] as did the revised expected cost of surgery. The patient then had a further preoperative appointment scheduled on 15 June 2020. Her concern was that there was no requirement for this appointment as no new information was tendered nor did she seek any further detail. However, given that there was a disparity between what surgery was suggested and her understanding of what she was going to undergo, it would not have been unreasonable to schedule a further appointment to discuss this.

The patient asserts that at this 15 June 2020 appointment that endoscopy was not performed but that "*the doctor only shone a small light at my nose".* There was concern from the patient that there had been an invoice of $250 for diagnostic imaging which did not occur on the date that she attended for this further appointment (but which may have referred to the imaging performed immediately subsequent to her initial consultation).

At this appointment [Dr B] has detailed repeat rigid nasendoscopy and comments on the area where the "*papilloma occurs and the overhanging left maxillary crest deviation and commented on further deviation of the septum and the vomerine spur at the back of the nose".* He discussed the cone beam CT images and "*sinus ventilation and mucosal thickening"* changes that have been documented on the CT scan and documented that consent was completed at this appointment.

Surgery was performed on 26 June 2020, consisting of bilateral endoscopic sinus surgery, septoplasty, bilateral endoscopic inferior turbinoplasties and EUA postnasal space. The operative notes detail bilateral middle meatal antrostomies (surgery to open into the

maxillary sinuses) bilateral sphenoethmoidectomy and "frontal outflow" is also detailed on the operative note. It is uncertain from this latter comment whether or not the frontal recess region has been simply inspected or operated upon. The surgical note also details what is described as reduction of the right middle turbinate and cautery of the left middle turbinate.

On the day of surgery, the patient was concerned about the extended interval between admission to hospital and time of surgery. Within 2 days of surgery the patient had raised concern with [Dr B], corresponding with him by texting on her cell phone, that she noted inwards collapse of her left nostril when inhaling deeply. His response was to advise that she continue to rinse the nose and use ointment in the nostrils.

On 2 July 2020 she attended her first formal post-surgery review, with examination and cleaning of her nose. The patient was advised to continue with topical ointments, to continue to rinse her nose and add steroid spray into the nasal rinse as is common with this type of after-care.

The patient reattended 3 weeks later on 23 July 2020. The patient was advised that "the nose has settled down beautifully" as a result of her following her post-operative instructions clearly. There was no reference in the clinic letter from this visit of the concerns that the patient had articulated about her collapsing nostril. In response to having received this letter the patient sent [Dr B] an email further expressing her concern about her collapsing left nostril. At her third post-operative appointment on 12 August 2020 the patient outlined her ongoing concerns about collapsing of her left nostril when she inhaled deeply and asserted that "[Dr B] became defensive, he agreed that the left nostril was collapsing but stated that this was still a good outcome". His consultation letter notes at this point, for the first time, her complaint of dynamic collapse of the left alar region but only on very forced inspiration.

[Dr B] noted "near full healing of the nasal septum, the turbinates and sinuses" and detailed the histology results which showed that the 2 lesions excised were fibrous papules (angiofibromas) rather than papillomas. Biopsy of the left anterior septum showed chronic inflammatory change. He noted that the histology report details that inverting papilloma cannot be ruled out but felt that this was overly cautious and documented this area as being entirely normal with no changes noted during surgery which was detailed with photography. He detailed that he had explained to the patient that the septum was now straight and that his surgery did not modify the left alar region and noted that "the two mucosal biopsies were less than 2 mm" and that there was no local scarring following this excision.

He did touch on the issue of what intervention that might be required to correct dynamic collapse of the alar cartilage, discussing surgery through an open approach using alar battens to strengthen the side wall of the nasal tip. He advised this was not surgery that he performed. At this point he acknowledged in his consultation letter that the patient had "certainly expressed dissatisfaction with a collapsing nostril with forced inspiration" and he also noted that "we have certainly addressed the bony irregularities and chronic rhinosinusitis which we felt was causing nasal crusting, bleeding and papillomas to recur which is a good outcome".

The patient details that at this point there was a heated disagreement and that she was advised by [Dr B] that he no longer wished to treat her and he asked her to leave. She was, according to her recollection, castigated by the receptionist for her apparent rudeness and she departed. In her submission she detailed repeated issues with long waits for her consultations when she attended [Dr B's] rooms. In summary, this patient presented with a specific complaint of two small intranasal cutaneous lesions lying just inside the left nostril with a referral by the GP requesting excision of these lesions. [Dr B] determined, after two consultations, that other surgery was also required for unrelated conditions that the patient did not primarily present with, namely nasal blockage and apparent sinus issues. There is a conflict between the accounts of each party. [Dr B] describes the patient's nasal obstruction complaints and her desire to undergo treatment to deal with this. The patient's assertion is that she never complained of other nasal issues nor did she suggest or seek surgery to deal with these.

As a consequence of undergoing the additional surgery the patient has developed left nasal alar collapse which she did not anticipate. She maintains that she was not warned that this surgery might lead to this problem. [Dr B] maintains that the Royal Australasian College of Surgeons guidelines do not indicate a risk of alar collapse that would normally be discussed with the patient having septoplasty or endoscopic sinus surgery with septoplasty and that this is more in the realm of rhinoplasty surgery.

There has been a subsequent breakdown in the surgeon–patient relationship and the patient has initiated a complaint to the HDC authority detailing a number of issues as follows:

1. That she did not need to undergo the extra surgery that was suggested
2. That she did not anticipate or expect that she would develop left sided nasal obstruction post operatively with alar collapse and was not warned that this might occur
3. That her insurer was billed on more than one occasion for a service that she disputes was provided (rigid nasal endoscopy)

The HDC has requested specific comment upon the following:

1. Whether the surgical treatment options recommended by [Dr B] were appropriate in the circumstances

This is considered with respect to each component part of the surgery, being: (a) intranasal skin lesion excision, (b) septoplasty and bilateral endoscopic inferior turbinoplasty surgery, (c) bilateral endoscopic sinus surgery.

(a) Skin lesion excision: This patient was referred with two very small cutaneous lesions lying just inside the lateral aspect of the left nostril. Inside the nose skin continues as a lining for a short distance but then transitions abruptly into what is called respiratory epithelium at the lower margin of what is called the lateral crus of the alar cartilage.

The shape and strength of this cartilage determines the shape of the nasal tip and the ability of the side wall of the nose to resist inwards displacement during nasal inspiration. The lesion that was excised was postulated by [Dr B] to be a papilloma but histology confirmed that it was a fibrous papule or angiofibroma. These lesions arise from skin rather than mucosa and intraoperative photography indicated that they arose from the skin immediately inside the nostril in a position that would be, for most otolaryngologists with simple equipment in their consulting rooms, easily accessible for excision under local anaesthetic.

The pathology report indicated that these lesions were very small and therefore these lesions should not be expected to have been a cause of nasal obstruction. Careful excision of these with either healing by secondary intention (leaving a wound defect to heal without surgical closure) or primary intention (direct closure of the wound at the time of lesion excision) would not, in my opinion, be expected to cause post operative nasal obstruction.

I believe that there was a reasonable indication for her to undergo excision biopsy of the left nostril lesions. Given the small nature and relatively easy accessibility of these many surgeons would recommend excision under local anaesthetic to reduce down time for the patient, the cost of surgery and the potential morbidity of general anaesthetic. However, some surgeons are not well set up for local anaesthetic procedures in their rooms and it is not unreasonable for this to have been performed as a day case under general anaesthetic.

My opinion is that there was a reasonable indication for surgery to excise the nostril lesions either under local or general anaesthesia.

(b) Septoplasty and bilateral endoscopic inferior turbinoplasty: Both the advisability and necessity of this surgery in this patient's case is arguable.

It is well recognised that any nasal surgery that increases nasal airflow and decreases nasal airway resistance, including septoplasty and endoscopic inferior turbinoplasty surgery, can paradoxically lead to worsening of nasal obstruction where there is weakness or pinching of the nasal tip side wall. This is a particular risk in patients who have undergone previous rhinoplasty surgery where reduction of the nasal tip cartilage's size has been performed. These patients are at risk of developing alar collapse following septal and turbinate surgery.

[Ms A] had recorded a history of previous rhinoplasty surgery in her patient questionnaire. This was detailed by [Dr B] as a previous diagnosis in his 29 August 2019 consultation but there is no further reference to this in the body of the letter. Subsequent correspondence to the HDC by [Dr B] on 16 February 2021 details presenting complaints of bleeding from the left side of the nose, symptoms of rhinosinusitis, nasal obstruction and complaints regarding a narrow nose, snoring and nasal blockage since her rhinoplasty surgery 25 years ago. It also details that the nose appeared collapsed at the junction of the upper and lower lateral cartilages at the site of a previous inter cartilaginous incision.

This was not commented upon at her 29 August 2019, 31 October 2019 and 15 June 2020 preoperative consultations. Instead, these consultations focused on the fact that this

patient snored and had a moderate degree of nasal obstruction and that she should undergo surgery to straighten her septum, reduce her turbinates and open up her sinuses.

If the patient had presented specifically complaining of nasal obstruction, then I feel that it would have been reasonable for the surgeon to have considered and recommended septal and turbinate surgery as an option to improve her nasal airway. However, [Ms A] should have been warned preoperatively of the risk of developing alar collapse in the context of her having been noted to have history of previous rhinoplasty surgery.

The patient asserts that she did not have any other concerns about her nose other than the lumps inside her nostril and that the decision surgery to the septum, turbinates and sinuses appears to have been driven by [Dr B] rather than [Ms A].

My opinion is that, if the patient's detailed lack of concern about her nasal airway is factual, there was no indication for her to undergo septoplasty and bilateral endoscopic inferior turbinoplasty surgery. This surgery appears not to have been sought by the patient. The presence of a deviated septum in itself is not an indication for surgery unless a patient complains specifically of nasal obstruction, the obstruction is deemed to related to the septal deviation and the patient seeks a treatment for this complaint. In my opinion the decision to recommend septal and turbinate surgery to [Ms A] represents a moderate departure from the accepted standards of practice. This practice would be viewed moderately unfavourably by surgical peers.

c) Bilateral endoscopic sinus surgery: Other than having moderate nasal discharge, consistent with the patient's history of allergic rhinitis, [Ms A] did not detail any symptoms consistent with chronic sinusitis on her patient questionnaire. There was a delay in completion of this report due to my not being able to view the original CT scanning films in the correct coronal format. I have now reviewed these directly. The CT scan only demonstrated minor mucosal thickening in the floor of the right maxillary sinus. There was no obstruction to the outflow of either maxillary sinus and there was no evidence of ethmoid, sphenoid or frontal sinus disease. In contrast, [Dr B's] consultation letter of 31 October 2019 details that the cone beam CT scan showed "significant inflammation of the paranasal sinuses".

Minor mucosal thickening in the floor of the maxillary sinus is a common incidental CT scan finding in asymptomatic patients. It is clear that this patient had no symptoms of chronic sinusitis nor any supportive radiologic evidence of sinus disease. There was no indication for this patient to undergo endoscopic sinus surgery and in particular there was no indication for the extensive nature of the sinus surgery that was performed. There are no alternative versions of the events provided. The CT findings are incontrovertible and have been falsely described by [Dr B] in both his correspondence to the GP and in his discussions with the patient.

In my opinion the decision of [Dr B] to perform bilateral endoscopic sinus surgery represents a serious departure from the accepted standards of practice. This decision would give rise

to serious concern amongst surgical peers and by the Royal Australasian College of Surgeons and would be likely to be viewed as representing serious misconduct.

2. Whether the patient had been fully informed about the procedures that she would be receiving and the risks associated with her surgery

[Ms A] appears to have had many preoperative consultations and fairly detailed consenting appears to have been undertaken. The patient had complained that she was not aware that septoplasty surgery was to be performed but it does appear that this has been documented both in writing and verbally preoperatively. She does not appear to have been adequately warned about the risk of developing nasal valve/alar collapse problems following septoplasty and turbinate surgery in the context of her previous rhinoplasty surgery.

In my opinion the failure of [Dr B] to warn [Ms A] of the risks of alar collapse following nasal surgery in the context of her previous rhinoplasty surgery represents a mild departure from the accepted standards of practice.

3. Whether the care provided on the day of surgery on 26 June 2020 was appropriate and consistent with accepted standards of practice and whether the management of [Ms A's] post-operative care and concerns regarding her collapsed left nostril were appropriate in the circumstances

In my opinion her care on the day of surgery appears to have been quite appropriate and consistent with the accepted standards of practice. There was a longer than expected wait for theatre but her perioperative management on the day of surgery appears to have been satisfactory.

The management of [Ms A's] post-operative care and concerns regarding her collapsed left nostril, and whether this was appropriate in the circumstances.

[Dr B] appears to have been dismissive of the patient's post-operative concerns and initially unresponsive to her contact with him regarding these, taking some time to both accept and document that she had developed left nasal alar collapse. He has instead sought to normalise [Ms A's] post-operative concerns and examination findings in his written correspondence with the referring GP and in his discussion with [Ms A]. He has focused on the fact that the excision of the small internal skin lesions could not have caused her symptoms and has failed to recognise that this complication is a result of the septal and turbinate surgery that has been performed.

In my opinion this represents a mild departure from the accepted practice.

4. Whether there were any other matters warranting comment

I have several further concerns regarding this patient's management by [Dr B]:

[Ms A] documented that she was repeatedly invoiced for visits in the initial post-operative period. This is not a generally accepted practice in New Zealand for insured and self-funding patients. It is usually expected that a surgeon's fee for surgery should include the cost of provision of any form of initial post operative care required during the healing phase,

typically for a 6 to 8-week period post. If a patient should require longer term post-operative surveillance then billing would be expected to resume following this initial period.

The patient appears to have had repeated preoperative visits where little extra information has been provided. The patient has simply had the original opinions restated. The exception was where there was a delay to surgery in which case it appeared reasonable that the patient was seen again for a preoperative visit. Each of these visits has incurred a significant invoice to the insurer.

At each of the preoperative visits there appears to have been repeat nasendoscopy performed and invoiced to the insurer. There is a conflict between the surgeon's description and the patient's version of events. If the patient's version is accepted as correct, subsequent endoscopies have simply involved shining the endoscope light at the nostrils without entering the nose. If the surgeon performed endoscopy correctly by inserting the endoscope into the nose then this would be reasonable practice if there was an unanswered preoperative question that the surgeon was asking himself or if the patient had proferred a new nasal symptom that required repeat endoscopy to further elucidate the cause of the new symptom. In my opinion there is no indication for repeated endoscopies unless the patient brings to light a new symptom or unless the CT scan had highlighted an unexpected finding requiring re-evaluation. I am concerned that there has been "over servicing" leading to overcharging of the insurer.

The surgical procedure also details an ""EUA postnasal space". Was the patient's insurer billed for this? If so, this would represent over-servicing and over-billing. The post nasal space is fully visible at endoscopy in a surgeon's clinic and no further information will be yielded by performing this during surgery although in passing the postnasal space is routinely viewed during endoscopic sinus surgery.

I am concerned about [Dr B's] style of practice in this case. [Ms A] presented with a simple minor problem that only required a simple solution. She did not offer any other complaints but was extensively questioned about other possible ORL symptoms. This was highlighted by [Dr B] as part of his thorough preoperative approach. I feel that this "search for symptoms" has led to unnecessary and unrequested surgery and the unfortunate sequellae that the patient has experienced in this case.

I also have particular concern that [Dr B] has deliberately misrepresented the x-ray findings both to the referring GP and the patient in order to justify performing endoscopic sinus surgery on this patient. **In my opinion this is a serious departure from an accepted pattern of practice and is fraudulent and represents serious professional misconduct.** While septal and turbinate surgery could arguably have had the potential to improve [Ms A's] nasal obstruction symptoms there was no conceivable benefit of her undergoing endoscopic sinus surgery. One might consider whether the motivation for this surgery was financial. I recommend that an independent audit is undertaken of [Dr B's] sinus surgery practice by an Otolaryngologist, whose practice is focused on rhinology with a review of the case notes and CT scans of a number of consecutive endoscopic sinus surgery cases performed by him.

Yours sincerely

Chris Thomson'

Further advice

'12 November 2024

Thank you for contacting me again to seek further comment on the responses received from [Dr B]. You asked that I review these and determine whether this might lead to any variation in my original advice.

1. With respect to the legal response from … my only comment is that I disagree with point number 3. I agree that the films submitted are axial only. However, I have previously had the opportunity to review a coronal reconstruction of these films which indicated no obstruction of the maxillary sinus ostium on either side. This is the opening of the maxillary sinus into the nasal cavity and is typically the area where relevant pathology in the sinus starts, with secondary changes in the sinus being seen once this opening is obstructed. I agree that there was some mucosal thickening in the floor of the maxillary sinus bilaterally. However, this is quite a common incidental finding in the general population and does not in itself imply sinus disease. I have made previous relevant comment in my response to correspondence received on 2 August 2024 as follows:

   "[Ms A] scored, on my assessment, 2 out of a possible maximal 24 points on this scale. Studies show that the average Lund Mackay score for patients who undergo radiology for non-rhinologic symptoms is 4.3. This is the average expected score for a randomly selected asymptomatic patient who does not have sinusitis."

In isolation I would not consider her CT scan to be a supportive reason to consider performing endoscopic sinus surgery on a patient. The absence of any mucosal changes in all the other paranasal sinuses and the absence of symptoms that would be likely to be attributable to chronic rhinosinusitis make the decision of [Dr B] to perform comprehensive endoscopic sinus surgery questionable.

2. I have no comment to make on [the plastic surgeon's] submission.

3. [Dr B] has written an extensive response. In this response he states that "further investigation confirmed sinusitis". I assume that he is referring to [Ms A's] CT sinus scan. As noted above I dispute that this scan confirms sinusitis. He also states in his "criticism of Mr Thomson's alternative treatment plan" that she would have been left with "ethmoid pressure and hyposmia" if sinus surgery had not been performed. Based on my comments above my response is that I do not believe that this patient had sinusitis. In the absence of this diagnosis I believe that the comments regarding ethmoid pressure and hyposmia are an invalid assumption.

> With regards to the patient's perception that her air flow had altered post-surgery the logical inference is that surgery must have in some way affected airflow through the nose. She complained of a new symptom after her septal and turbinate surgery. [Dr B] was dismissive of this, describing her breathing attempts as supraphysiologic. I have previously commented that I feel her surgery has unmasked latent alar prolapse and that she was predisposed to this condition having had a previous history of reduction rhinoplasty and having had some internal scarring noted by [Dr B] at the previous sites of her intercartilaginous incisions. I have no further comments on this matter and stand by my original report.

[Dr B] comments on what he considers is the perspective of my clinical practice, inferring that it is more focused on rhinoplasty and airway. My adult ENT practice is almost solely rhinologic, with a roughly equal mixture of rhinoplasty and endoscopic sinus surgery cases, which I feel gives me a broad perspective and allows me to consider all matters in this case. Expert HDC review is to not usually directly examine patients and I acknowledge that I have not seen [Ms A] person. I do feel that direct examination of the patient by an unconflicted otolaryngologist who specialises in rhinology would be potentially very useful if there remained unanswered questions in this case.

In [Dr B's] final paragraph response he implies that her apparent previous dissatisfaction following her reduction rhinoplasty has "undoubtedly influenced her interaction with my practice and the medical profession in general". I am concerned that he is deflecting any personal responsibility and attributing much of the difficulties in [Ms A's] interaction with [Dr B] to her previous experience with another surgeon.

I do not wish to comment on any potential further responses from [Dr B] as I feel that I have nothing further to add even if he does correspond further. My only further suggestion is that it might be useful to have a brief second opinion from a Head and Neck Radiologist on [Ms A's] cone beam CT films. It would be important to reconstruct the raw films in order to generate a coronal image which would assist greatly in x-ray interpretation.

Kind regards

Chris Thomson'