HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

A Decision by the Deputy Health and Disability Commissioner

(Case 21HDC02404)

Introduction

1. This report is the opinion of Rose Wall, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

2. Mrs A complained to the Health and Disability Commissioner (HDC) about the care provided to her at the local public hospital in November 2020. The complaint related to two painful and traumatic suture removal procedures, intended to relieve her pain after pelvic floor reconstruction surgery. The procedures were performed by Dr B, a senior registrar, and Dr C, obstetrician and gynaecologist.

3. The following issue was identified for investigation:

   - *Whether Dr B provided Mrs A with an appropriate standard of care between 14 November and 16 November 2020.*

4. The following parties are referred to in the report:

Mrs A	Consumer
Dr B	Provider/senior registrar
Dr C	Provider/consultant obstetrician and gynaecologist
Public hospital	Provider

5. Independent advice was received from Dr Richard Dover, obstetrician and gynaecologist (Appendix A).

Background

6. Mrs A (then aged 36 years) required reconstructive surgery for symptoms of prolapse and urinary incontinence. Mrs A also had a significant history of chronic pelvic pain.

7. On 11 November 2020, Dr C performed Mrs A's surgery, which included anterior and posterior vaginal repairs, a perineal reconstruction, laparoscopic sterilisation (at Mrs A's request), and vaginal vault (the upper part of the vagina) support using an absorbable sacrospinous fixation (SSF) suture. Examination under anaesthesia had identified that a right SSF would correct the vaginal prolapse.

Names have been removed (except Health New Zealand | Te Whatu Ora (Health NZ) and the clinical advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

8. A vaginal marking stitch was also placed at the beginning of the surgery to indicate which area of the prolapse to support against the sacrospinous ligament.[1]

9. Following the reconstructive surgery, Mrs A did not recover as quickly as expected.

Postoperative pain — 11–14 November 2020

10. Mrs A told HDC that when she woke up from the anaesthetic she was in severe pain. She was given patient-controlled analgesia, tramadol and paracetamol. The records state that her pain score was 7–9/10.

11. The public hospital said that Mrs A's pain became increasingly unusual and difficult to manage, and she was not discharged as expected on postoperative day two.

12. During the postoperative round on 13 November 2020, it was noted that Mrs A had increasing back pain. Dr C conducted a vaginal examination and excluded a vaginal haematoma (blood clot) or a right pudendal nerve entrapment.[2] The vaginal wound discomfort was consistent with expectations following surgery and was equivalent on both sides of Mrs A's pelvis.

13. The plan included increased pain relief and use of a heat pack or transcutaneous electrical nerve stimulation (TENS) machine for postoperative pain management. Dr C also requested physiotherapy input. However, the physiotherapist could not attend, and no TENS machine was available on that day (Friday) or over the weekend.

14. Dr B reviewed Mrs A on Saturday 14 November 2020. Mrs A had difficulty weight-bearing on her right leg, particularly after sitting for periods of time. At worst, she graded the pain in her right groin and tailbone as 7/10, with no pain while she was at rest in bed.

15. Dr B thought the cause of Mrs A's inability to weight-bear was likely the pain she was experiencing, which was most likely caused by nerve impingement from the SSF suture.

16. Dr B said that she telephoned Dr C, who was not on call that weekend. She recorded that Dr C recommended a right-sided pudendal nerve block with local anaesthetic to assess whether numbing that area improved Mrs A's pain and mobilisation.

17. Dr B inserted the nerve block at 12.50pm while Mrs A was in her ward bed and planned to see her an hour later to assess whether the pudendal block improved her symptoms.

18. Dr B stated that, when she returned, Mrs A was mobilising much better and she had felt relief from the local anaesthetic block. This indicated that most of the residual postoperative pain was directly attributable to increasing swelling near the SSF stitch causing undue tension/pulling on the sacrospinous ligament.

[1] The ligament in the pelvis that connects the sacrum and coccyx to the spine of the ischium.

[2] The primary nerve responsible for movement and sensation in the pelvic area.

First attempt to remove suture — 14 November 2020

19. Dr B told HDC that she spoke with Dr C about the effect of the pudendal block, and it was decided to remove the SSF suture to relieve Mrs A's ongoing pain.

20. In her response to the provisional opinion, Dr B said that Dr C was aware that she had not done this specific procedure before, and she was led to believe it would be straightforward. Dr B said she was not specifically advised that a certain examination room, examination bed, or equipment should be used or that she could consider performing it under general anaesthetic. Dr B said she did not have a detailed knowledge of Mrs A's chronic pain history and acknowledges in retrospect that she did not have the experience in 2020 to know that removal of the suture in the bedspace was the wrong decision.

21. Dr B stated that she returned to see Mrs A between 2.20pm and 6.50pm; however, the exact time is unknown as the assessment was not recorded. Dr B said that Mrs A accepted and consented to the recommended removal of the suture under local anaesthetic. However, Dr B did not record the assessment or the consent. There is also no documentation of Dr B's phone conversations with Dr C nor any notes by Dr B about the suture removal.[3]

22. A nursing note at 2.20pm states that Mrs A was to be nil by mouth in case she returned to theatre. Dr B said that she had not given this direction and did not anticipate that Mrs A would have a general anaesthetic (GA), as no theatre had been booked.

23. The suture removal procedure was undertaken in Mrs A's bedspace with a nurse chaperone present. Mrs A told HDC:

> '[Dr B] began by unceremoniously inserting a speculum into my vagina. Given I had just had major surgery to the area 3 days prior and was tenderly swollen, this was incredibly painful and not handled delicately in any way. After a couple of minutes of her working, she announces her scissors aren't long enough for the task, says she needs to get different ones, and asks if she wants me to remove the speculum or leave it. Not being able to bear the thought of her re-inserting it, I told her to leave it. After several minutes of [me] lying there in pain, she came back and resumed work. The pain was incredible, and I started moaning and crying during the procedure. Several minutes after, she finally finished.'

24. Dr B stated that after she inserted the speculum, it became apparent that the scissors she had were too short, and longer ones were not available on the gynaecology ward. She agreed that she asked Mrs A whether she wanted her to take out the speculum and re-insert it or leave it in place while she went to get new scissors from the birthing suite. Dr B said that she knew where the scissors were and the nurse did not, so she thought it would be quicker for her to get them. She stated that once she returned, she moved the speculum to find the suture, and once she had cut the suture the procedure was over very quickly.

[3] The first record is house officer Dr D's documentation at 6.50pm, which stated: 'Dr B removed sacrospinous stitch earlier in day under pudendal block — good relief [with] pudendal block initially …'

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HDC

25. Dr B stated:

> 'I remember the procedure being uncomfortable for Mrs A, but not extremely painful. She was very keen to do something to improve her pain, and I believed I had full consent to remove the suture. I do not remember her asking me to stop or moaning or crying in pain.'

26. House officer Dr D reviewed Mrs A at 6.50pm as Dr B was in theatre. Dr D felt that Mrs A was clinically stable but in pain. Dr D discussed Mrs A's ongoing pain with Dr B, who thought it best to give Mrs A analgesia, not to repeat an examination that night, and to review the effect of the suture removal in the morning.

Second attempt to remove suture — 15 November 2020

27. On Sunday 15 November 2020, Mrs A was still unable to weight-bear on her right leg. Dr B saw Mrs A during the registrar ward round at 9.35am. Dr B stated: 'Mrs A was still in pain. I realised that I had removed the stay suture (marking suture) next to the SSF, and a repeat procedure was offered to remove the SSF stitch.'

28. Mrs A said that Dr B told her that there were actually two stitches placed in the nerve bundle and that she had removed only one, so Mrs A would need to have the second one removed. Mrs A said that she asked whether she would have to go through the same procedure as the previous day and was told 'yes'. She stated: 'I explicitly[4] told the doctor that I could *not* go through that again. [Dr B] said she would consult Dr C.'

29. Dr B documented that she telephoned Dr C and that Dr C would come in to assist with the stitch removal. However, Dr B did not document the details of her telephone conversation with Dr C.

30. Dr B told HDC:

> 'I don't remember talking to Mrs A about a general anaesthetic or her "explicitly telling me she could not go through that again." I truly believe that if she had told me that the procedure the day prior was unbearable, I would never have suggested that she have a repeat procedure under local anaesthetic.'

31. The public hospital told HDC there is no record of Mrs A saying she did not think she could cope with a repeat procedure, nor do any staff recall her saying that.

32. Dr C came to assess Mrs A and asked the team to take Mrs A to the colposcopy room for better positioning to make the procedure easier. Mrs A stated that, when they wheeled her out of the room, she assumed it was to go to theatre, but she was taken to a small room where Dr C examined her. Mrs A said that she was then taken to another clinical room where Dr C performed a further suture removal procedure.

33. The clinical records state that Mrs A gave verbal consent. Dr C, Dr B, and a nurse were in the room. Dr B stated that she positioned Mrs A in the lithotomy/colposcopy chair, which allows

[4] Emphasis in original.

positioning for optimal examination and patient comfort. Dr B cannot recall Mrs A finding the positioning uncomfortable. However, the public hospital told HDC that staff can remember acknowledging Mrs A's disquiet and apprehension when being helped into the lithotomy/colposcopy chair. Dr B said that Dr C gave Mrs A local anaesthetic by way of a pudendal block, and she assisted Dr C.

34. Mrs A told HDC that she was placed in a chair with her legs opened wide in stirrups. Dr C gave her some more local anaesthetic into the tissues near the stitch, but the nerve bundle remained fully functional. Mrs A said she felt everything as Dr C worked inside her to remove the suture, and it was agonising. She said that one to two minutes into the procedure she began to moan and cry. Dr C told the nurse to 'go and provide [her] comfort', so the nurse came up to her shoulder and rubbed it while talking to her. Mrs A stated:

> 'I was able to concentrate on the sensation of the nurse rubbing the same spot repeatedly until I started screaming from the pain of what Dr C was doing to me. At no point did she stop or ask me if I was okay. I was not asked if I wanted to proceed despite that I was screaming in pain.'

35. Mrs A said that she experienced six to eight minutes of the pain, was starting to black out from it, and was hyperventilating from screaming. She said that, when Dr C finally finished, she heard her tell Dr B: 'That really should have been done under GA.'

36. The public hospital said that Mrs A's description and experience of pain is undisputed. Dr C stated that Mrs A complained that it hurt as the local anaesthetic was injected, which was unavoidable. Dr C asked the nurse to help with extra comforts, checked again that Mrs A wanted to continue, and reconfirmed verbal consent. Dr C stated that Mrs A was uncomfortable and did not like being in the lithotomy position and wanted the procedure to be over. Dr C said that she double checked that the block was effective and that Mrs A was tolerating it all before the actual removal of the suture.

37. Dr C stated that Mrs A cried out unexpectedly at the critical moment of tensioning the suture to cut it free, and she had to make the difficult decision whether to abandon the procedure (which would have resulted in ongoing pain for Mrs A) or to complete the suture cutting with the expectation of quick and lasting relief. Dr C stated that, as Mrs A was keeping still despite calling out, and neither the nurse nor the registrar suggested pausing, she made a judgement call to proceed to cut the knot. Dr C said that she immediately apologised to Mrs A for the pain the procedure caused, and they all offered comfort to her.

38. Dr B stated that, during the procedure, she remembers them speaking to Mrs A constantly about whether she wanted them to proceed or to stop, and she does not remember Mrs A asking them to stop.

39. The public hospital stated that, after Mrs A was transferred back to the wheelchair and the ward, she was given an apology for her experience. The public hospital stated that regret was expressed, including reflection that, in retrospect, it may have been better in her case to wait until GA was available. However, that is not recorded. The clinical records state only that Mrs A was tearful after the procedure and was comforted by her husband.

40. Dr B reviewed Mrs A again later that day to assess how the removal of the suture had affected her pain and mobilisation. Dr B said that Mrs A was mobilising better and feeling okay. The pain had improved post-procedure but was starting to return. Dr B said she thought this was likely to have been because the local anaesthetic was wearing off, but she was encouraged by Mrs A's improved ability to mobilise. After the problematic SSF fixation suture was removed, Mrs A's symptoms improved and, ultimately, a delayed recovery began.

41. Dr B said that she reviewed Mrs A on the morning of 16 November 2020 and spoke to her about the previous day's procedure. Dr B stated that she felt Mrs A understood what had happened, and she did not voice any concerns. Her pain and mobilisation had improved, and she was keen to be discharged later that day.

42. Mrs A's GP referred Mrs A for a postoperative appointment with Dr C; in that referral, Mrs A's GP requested that Mrs A be seen by Dr C and not the junior staff because 'she requires careful debriefing re her extremely painful and distressing suture removal which is now causing her ongoing emotional distress' and 'may require ref to counselling via ACC for PTSD effects.'

43. At the follow-up appointment in the gynaecology clinic on 15 December 2020, Dr C told Mrs A that she had been unaware of the difficulties with the pudendal nerve block on the Saturday. Dr C said that Dr B had told her that the removal of the first stitch was 'an easy and normal removal' and did not mention the pain or that Mrs A had said she could not go through the procedure again. Dr C said that, in retrospect, with more information, waiting a few more days so the procedure could be performed under GA would have been preferable.

Hip pain

44. Mrs A said that when she moved back to the wheelchair after the suture removal procedure, she felt pain in her hips, but she thought that it was just sore from being in such an uncomfortable position for so long. She told HDC that she started to feel hip pain around February 2021, mostly in the evenings after a long day.

45. Mrs A saw her GP for a referral to a physiotherapist in early April 2021. Mrs A underwent an X-ray, ultrasound, and two MRIs and was diagnosed with several labral tears[5] across both hips. She stated:

> 'This is directly linked to sitting upwards in a chair with my legs in an awkward angle in stirrups, tensing and reeling from such agonising pain for a prolonged period of time. I literally tore my own hip ligaments from what was done to me.'

46. The public hospital stated that labral tears are not known to be a risk of the surgery and procedures that Mrs A underwent and are not discussed in relation to either urogynaecological or laparoscopic surgeries. The public hospital said that labral tears are

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[5] A labral tear is an injury to the tissue that holds the ball and socket parts of the hip together. Labral tears are typically caused by overuse, traumatic injuries, or abnormalities in the shape or alignment of the hip bones.

not considered to be a potential complication of placement in the lithotomy position for gynaecological surgeries or outpatient examinations. It said that a literature search failed to identify any causative association between gynaecological surgery and labral tears.

47. In response to the provisional opinion, Mrs A provided a copy of a report obtained by ACC from a musculoskeletal pain specialist. The report finds, in respect of Mrs A's hip pain, there is a 'direct causal link between [Mrs A's] symptoms and the treatment injury', stating that 'all her symptoms started following her [first surgery] and two subsequent suture removals.'

Further comment

48. Both Dr C and Dr B reiterated their sincere apologies to Mrs A for her traumatic experience, which was unintended and very much regretted.

49. Dr C said that, in retrospect, even though Dr B was an experienced registrar who she had worked closely with, it was unreasonable of her to have placed the burden of responsibility on Dr B to diagnose the cause of Mrs A's pain confidently and make the decision to proceed with SSF removal, and she is sorry that happened.

50. The public hospital agreed that the first attempt to remove the SSF suture should have occurred under either general or regional anaesthetic, and, if that option were not available, then in the treatment room or colposcopy clinic setting with appropriate lighting and equipment ready and available. The public hospital noted that adjuncts such as nitrous oxide could also have been provided in that setting.

51. The public hospital stated:

> 'Fundamentally, the decision to remove the suture was taken with the patient's interests at heart, and in an effort to provide timely and effective resolution of her postoperative pain. It is sincerely regretted that the execution of this plan has fallen short of expected standards. We do not believe these events would be repeated and are not aware of any similar cases.'

Response to provisional opinion

Mrs A

52. Mrs A was given an opportunity to comment on the provisional opinion, and her comments have been incorporated into the report where relevant.

53. Mrs A emphasised that she was under the impression that she would be going to theatre under general anaesthetic for the second suture removal procedure, and it was never explained to her that local anaesthetic was being used. Mrs A said, if she had known that only local anaesthetic would be used, she would not have agreed to go through with it.

54. Mrs A said that she appreciates the findings of the report and the changes to this type of procedure, but she still finds herself with daily pain in her hips that did not exist before the procedure. She said the procedure will have a lifelong impact on her, and she does not think the hospital has done anything to address it.

Dr C

55. Dr C was given an opportunity to comment on relevant sections of the provisional opinion. Dr C advised that she thought the report was fair and she had no further comments.

Dr B

56. Dr B was given an opportunity to comment on relevant sections of the provisional opinion, and her comments have been incorporated into the report where relevant.

57. Dr B said she accepts the adverse comment made in relation to her documentation and that she is disappointed with herself in regard to her lack of documentation. She said this was contributed to by a busy shift with reduced staff, which meant she did not have the opportunity to go back and add to her documentation because of the competing clinical needs. Dr B acknowledged that she should have documented the information provided to Mrs A and the consent obtained.

58. Dr B acknowledged that, at the time, she did not appreciate how painful and distressing the procedure was for Mrs A, and if she had known this she would have stopped the procedure and would 'certainly have documented more.'

59. Dr B said she is truly sorry for the distress these procedures have caused Mrs A and that the learnings from these events continue to inform her practice.

The public hospital

60. The public hospital was given an opportunity to comment on the provisional opinion and advised it was grateful for the opportunity to do so but had no comments to make.

61. The public hospital said it would 'support Dr C and Dr B in their responses and any additional undertakings required of them.'

Opinion

62. I acknowledge that Mrs A found this experience extremely distressing and that it has had a lasting impact on her emotional wellbeing. Mrs A describes it as a horrific and traumatic experience causing ongoing psychological issues. In considering her concerns, I have been guided by independent advice from Dr Richard Dover (Appendix A). Dr Dover stated that, as Mrs A had a history of chronic pelvic pain, she needed more sensitivity and care than patients who did not have that pre-existing condition, particularly regarding her significant postoperative pain. I agree that more thought should have been given to the manner in which the procedures were undertaken

Opinion: Dr B — breach

First suture removal — breach

63. Dr Dover advised that the plan to remove the SSF suture was correct. However, Dr Dover stated in relation to the first attempt that the preparation to remove the SSF suture was inadequate, as the scissors were not suitable and a second set were needed. Furthermore, visualisation of Mrs A's vaginal area would have been inadequate. Dr Dover noted that the suture that needed to be removed would have been high up and off to one side in Mrs A's

vagina, and access to and visualisation of that area would have been expected to be challenging. He said that attempting to perform this procedure in the bedspace area with inadequate instruments, lighting, and backup was setting the procedure up to fail.

64. Dr Dover stated that, had the procedure been performed in the treatment room with adequate lighting and correct instruments, visualisation of the sutures would have been much improved, and the chances of a successful procedure at the first undertaking would have been much higher.

65. Dr Dover advised that Dr B's decision to undertake removal of the suture in Mrs A's bedspace was incorrect and fell short of accepted practice. He stated that, in the context of a patient with chronic pain, and in light of the location of the stitch, this is at least a moderate departure. I agree that Dr B showed poor judgement in her management of the suture removal.

66. Dr B did not perform the initial procedure and had not performed an SFF suture removal before and, as Dr C has reflected, it was a difficult position to have put Dr B in. However, I agree with Dr Dover that Dr B should have anticipated that visualisation of the area would have been challenging. In my view, as the responsible clinician, she was accountable for ensuring the procedure was being performed in an appropriate setting and with required equipment to hand.

67. I accept that the procedure was painful for Mrs A. However, I am unable to make factual findings on the extent to which she expressed her discomfort during this procedure because of the differing recollections of this, as outlined above. This is particularly so because Dr B made no record of the procedure. However, I agree with Dr Dover that the management of analgesia was suboptimal and that Mrs A's history of chronic pain, her recent procedures, and her significant current pain were relevant considerations. Greater care should have been taken with the use of analgesia before the procedure.

68. For the reasons outlined above, I find that Dr B did not undertake the removal of the suture with reasonable care and skill and breached Right 4(1)[6] of the Code of Health and Disability Services Consumers' Rights (the Code).

Documentation — adverse comment

69. Dr B did not document her telephone conversations with Dr C to discuss the plan for Mrs A on 14 November 2020 before the first suture removal or on 15 November 2020. Furthermore, Dr B did not document her assessment after the right-sided pudendal nerve block was inserted, or the procedure she performed to remove the suture on 14 November 2020. Dr Dover advised that there was a moderate departure from accepted practice regarding the documentation of the telephone calls to Dr C and that the absence of documentation of the suture removal procedure was also a moderate departure from accepted standards.

[6] Right 4(1) states: 'Every consumer has the right to have services provided with reasonable care and skill.'

70. Dr B did not document consent for the pudendal block or the suture removal procedure. As the procedures were not under GA, verbal consent was acceptable. However, Dr B should have recorded the information provided and the consent given. Dr Dover stated that failing to do so was at least a mild departure from accepted practice.

71. The importance of clear and accurate documentation to ensure continuity of care for the patient cannot be over-emphasised. I agree with Dr Dover's remarks in this respect and am critical of Dr B's deficient documentation on these occasions.

Opinion: Dr C — adverse comment

72. Dr C said that Dr B told her that the removal of the first suture was 'an easy and normal removal' and did not mention the extent of Mrs A's pain or that she had said she could not go through the procedure again.

73. Dr B said that she had thought that the first procedure had gone as well as expected and did not recall Mrs A crying or asking her to stop the procedure. Therefore, Dr B considered that there was no reason to convey a negative patient experience to Dr C during their telephone conversations. However, had Dr C been alerted to the context of the situation and discussed the events of the previous day with Mrs A, she may have realised the extent of Mrs A's distress and recognised that a further attempt to remove the suture under local anaesthetic was inappropriate. Dr C said that, in retrospect and with more information, waiting a few more days to perform the procedure under GA would have been preferable. I agree.

74. Mrs A verbally agreed to have the suture removed. Although she was under the impression that this would be performed under GA, there is no evidence that Dr C was aware of that assumption.

75. Dr C was aware that Mrs A was uncomfortable during the second procedure and rechecked her consent and asked the nurse to comfort her. Mrs A cried out when Dr C tensioned the suture to cut it free, and Dr C said that she had to decide whether to abandon the procedure, which would have meant ongoing pain for Mrs A, or to complete the suture cutting to relieve the pain. Dr C stated that as Mrs A was keeping still despite calling out, and neither the nurse nor the registrar suggested pausing, she proceeded to cut the knot. Under the circumstances, I consider that this was not unreasonable.

76. However, Dr Dover advised that the management of analgesia was clearly suboptimal. I agree with Dr Dover that Mrs A's history of chronic pain, her recent procedures, and her significant current pain were relevant considerations and that greater care should have been taken with the use of analgesia before the procedure.

77. Dr C recorded the procedure itself but not how Mrs A coped with it or her level of distress. In my view, that information should have been recorded.

Opinion: The public hospital – adverse comment

78. The public hospital recognises with hindsight that the quality of their care was somewhat suboptimal, and they deeply regret that routine postoperative support was insufficient. I consider the public hospital holds some responsibility for the events that transpired for Mrs

A and the difficulties she encountered. Dr Dover refers to the use of physiotherapy, a heat pack, or TENS machine to address problems of significant pain following a postoperative issue. They were not obtainable for Mrs A over the weekend in question, and he states that the fact that capacity was insufficient to deal with postoperative needs is an issue that the district clearly needs to consider. Dr Dover also refers to the decision-making that led to the second procedure being performed under local anaesthetic and it being influenced by the lack of access to acute theatres for 24–48 hours. I agree with Dr Dover's remarks in all respects; in my view, the lack of resources at the time had some bearing on the outcome for Mrs A.

Changes made

79. Dr C said that additional methods of self-administered local anaesthetic analgesia creams are now part of her postoperative analgesia programme and that suture removal procedures (which are rarely needed) have not been and will not ever be offered under local anaesthetic again. She has also indicated that, as a result of this experience, she now specifically requests both the nursing chaperone and the patient to signal clearly if a procedure has become distressing as she would not want to continue if that were the case, and she remains mindful of the level of supervision and support and coaching needed by resident medical staff.

80. Dr B said that, five years on, she is now a Consultant Obstetrician & Gynaecologist with much more experience in difficult examination settings and in communication. Dr B said the learnings from this case continue to inform her practice, and she has indicated she would not attempt such a procedure in a ward situation in the future.

81. The public hospital said it has undertaken the following:

- It revised its 'weekend plan' summary sheet, which on reflection it considered was not patient centred and was too narrowly focused on medical concerns.
- It now provides additional postoperative pain relief for women after pelvic floor reconstructive surgery.
- A TENS machine is now available on the Gynaecology ward. The nursing staff have received education on it and indications for use. The machine is used, with benefit, for patients who have postoperative back pain after pelvic floor reconstructive surgery.
- Local anaesthetic gel is now provided for self-administration at the bedside.
- The gynaecologists who perform SSF have all confirmed that they would release SSF sutures only in an operating theatre environment, with general or regional anaesthesia. Where possible, the surgeon who performs the operation will make themselves available if there is a need to return to theatre to remove an SSF suture.

82. The public hospital stated that there is more awareness within the Women's Health Service regarding 'trauma-informed care.' Specific staff education sessions were provided by Psychiatry and Pain Medicine in December 2020 and August 2024 at its monthly clinical forum. It stated that Mrs A's experience will be discussed at an upcoming education session, and the importance of clear documentation and heightened awareness of the patient

experience during outpatient procedures would be emphasised. It stated that undertaking sensitive procedures in the outpatient setting requires an excellent rapport between clinician and patient. Patients must feel empowered to withdraw consent, to ask for a procedure to be paused or ceased, and to know that all options, with respect to analgesia or anaesthesia, have been considered and administered if requested or clinically appropriate.

Recommendations

83. I recommend that Dr B and Dr C provide formal written apologies to Mrs A for the criticisms in this opinion. The apologies are to be sent to HDC for forwarding within three weeks of the date of this report.

84. I recommend that Dr B undertake HDC's e-learning module on informed consent and provide HDC with evidence of having completed the module within three months of the date of this report.

85. In light of the changes already made, I have no further recommendations regarding Dr C and the public hospital.

Follow-up actions

86. A copy of the sections of this report that relate to Dr B will be sent to the Medical Council of New Zealand.

87. A copy of this report with details identifying the parties removed, except the advisor, will be sent to the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and the Medical Council of New Zealand and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from Dr Richard Dover, obstetrician and gynaecologist:

'**Re: Complaint C22HDC02404**

Thank you for your letter of instruction dated 4 August 2023 in which you have requested that I provide my opinion on the care provided by [Dr C] and [Dr B].

My qualifications and experience

I can confirm I am registered with the Medical Council of New Zealand in the vocational scope of practice of obstetrics and gynaecology. I am a Fellow of the Royal College of Obstetricians and Gynaecologists and a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG).

I am a full-time practising private gynaecologist working out of Oxford Women's Health based in the Forte Hospital complex in Christchurch.

I have been based in New Zealand for over 20 years, initially working in private practice and through the CDHB. I have been employed solely on a private basis for the last 14 years.

In the past I have served two terms on the RANZCOG New Zealand committee and have been an examiner for the RANZCOG final exam for over 12 years.

I have been involved in practice visits for both the Medical Council and the Royal College.

The Complaint

The complaint relates to postoperative complications following a pelvic floor reconstruction, sacrospinous fixation (SSF) and laparoscopic sterilisation at [the public] hospital on 11 November 2020.

Background

The report has been based on the letter from the patient herself detailing her experiences.

There is also a full response from […], Chief Executive of the [hospital] concerned and some of the hospital notes that were attached.

Reference has also been made to some of the clinical correspondence and hospital records.

For the purposes of the chronology of the admission, I have based this on the report written by Dr [B], which lays matters out in a linear sequence.

The testimony from patient [Mrs A] describes her experiences of these events, but it does not necessarily alter the timeline.

There is, as far as I can see, no dispute about the procedure that was undertaken or the fact that following this [Mrs A] did not recover as quickly as had been expected. It is recognised that there was a postoperative complication and that the cause for this was the PDS suture that had been used as part of the SSF. This was responsible for the pain and the inability to mobilise and following removal of this the symptoms improved. There also seems to be no dispute about the fact that on the first occasion the marking stitch was removed rather than the problematic PDS fixation stitch. This resulted in the removal procedure having to be repeated a second time.

What does differ are the perceptions of both sides, particularly on behalf of patient [Mrs A] who describes a horrific and traumatic experience with ongoing psychological issues.

Sequence of Events

From [Dr B]'s account, she first met [Mrs A] on Saturday 14. It was noted [Mrs A] had difficulty weight bearing and on mobilisation. It was recognised in her report that the pain was most likely due to nerve impingement from the SSF. Following this [Dr B] called [Dr C], the operating surgeon. Although not on call this weekend she suggested that a right-sided pudendal nerve block was inserted. This was performed at 12.50 pm in the ward bed. This is documented in the clinical notes.

Review later by [Dr B] confirms that [Mrs A] had improved and she spoke again to [Dr C] with regard to the effect of the pudendal nerve block. It was suggested that removal of the suture should be expected to bring relief and this was undertaken. As will be discussed later, there were issues with this procedure.

[Dr B]'s report (pg 2: para 10) describes that she went back to see [Mrs A] between 1420 and 1850. The notes that have been supplied to me show no evidence of any documentation with regard to that nor to any of the phone conversations with [Dr C]. There is no documentation at all in the notes that I have been sent that relates to the procedure being performed to remove the suture. At 1850, [Dr D] clearly writes that "[Dr B] removed the sacrospinous stitch early in day under pudendal block."

Following this, it seems that there was some improvement in the pain, which was short lived. The following day, [Dr B] reviewed the patient at 0935 and has written "in retrospect I think stay suture was removed rather than SSF stitch as I removed a Vicryl not a PDS." She then called [Dr C], who agreed to come in and assist removal of the stitch. At 11.00am there is a written note, presumably by [Dr C] describing the procedure itself. It gives a clinical picture of what had happened but provides no comment at all about how this was tolerated by the patient or the level of distress that she experienced. I can see no written consent for this.

Following removal of the suture, the symptoms improved and ultimately a delayed recovery began.

Other Issues to Consider

There are a number of other points that do need addressing, particularly some of those drawn from the response of the CEO. There seems to be some recognition, with hindsight, that the quality of care was somewhat suboptimal, and the letter certainly says "deeply regretted that routine post-operative support was insufficient."

It is clear from that letter and the medical notes that the patient, [Mrs A], had a significant past history of chronic pelvic pain. This is recorded in several areas within the report and should suggest that slightly more sensitivity and care would have been needed compared with patients who did not have this pre-existing condition. I think this would be true of all aspects of care on the ward but particularly due to problems of significant pain following a postoperative issue.

There is certainly recognition in the report that in an ideal world the use of physiotherapy or a heat pack or TENS machine would have been available, but these were not obtainable over a weekend. The fact there was insufficient capacity to deal with postoperative needs is an issue that the DHB clearly needs to consider.

There is also the comment that the decision-making that led to the second procedure being performed under local anaesthetic was influenced by "little likelihood of being able to get to acute theatres for 24–48 hours." Again, this is something that the DHB need to consider.

On the sixth page of the CEO's report, it states "*[Dr C] informed [Mrs A] that she had been unaware of the difficulties with the pudendal nerve block on the Saturday and in retrospect, with more information, waiting a few more days when the procedure could have been performed under GA would have been preferable. The emotional trauma of the event was acknowledged as PTSD."*

The fact that [Dr C] was unaware does not necessarily fit with [Dr B]'s report, who details a number of telephone consultations through to [Dr C]. I would have expected that at the time of these there would have been a discussion about the case itself and some feedback as to whether it had been successful and what the next step in management would be. I find it difficult to accept that that conversation would not describe the patient's experience. I would have thought this was something that would have been expected to be volunteered by the person performing the procedure or be specifically enquired about by the specialist on the phone.

The last issue relates to the clinic letter dated 15 December, in which [Dr C] described the first postoperative follow-up. At that point, [Dr C] recognises that "*I also found it traumatic and expressed regret at the time."* It does go on to mention that [Mrs A] felt that [Dr C] was uninformed as to how traumatic the first procedure had been but, again, I would have thought that this should have been communicated at the time of the telephone consultations between [Dr B] and [Dr C].

PARTICULAR ISSUES RAISED:

I don't think there is a need to particularly comment on the surgery performed by [Dr C]. It is certainly an appropriate choice for the symptoms, and this aspect of the management does not seem to be in dispute. I think that identifying the portion of the vagina that you wish to elevate, with a marking stay stitch, can often make life easier as the anatomy can sometimes appear to shift a little once the dissection has begun. The use of a stay stitch makes it more likely that the permanent suture is placed in the correct position. The issue of course is that once the suture has been placed in the correct position there is no need for the supporting/pilot suture. This plays no function in the apical support, and removing it at the end of the procedure would not cause any problems with ongoing recovery. Clearly, there is no downside to removing the stay suture and there is the potential benefit that in the accepted small number of cases (1% according to the accompanying literature) that the suture needs to be removed then the presence of a secondary suture can only add to the confusion, as was the case here.

I feel comfortable that this aspect of the case meets the standard of care/accepted practice and would be viewed positively by our peers.

It does seem from the notes that [Mrs A] had a slightly slower than anticipated recovery following her surgical procedure. Having said that, it probably still falls within the realms of what would be perceived to be normal, and I think the management and monitoring of this was within the standard of care.

Once it became apparent that there was some weakness and difficulty mobilising, a plan was put into place within a reasonable timeframe, and the injection of local anaesthetic in the form of a pudendal block was undertaken. This relieved the symptoms and, in some ways, acted as a diagnostic aid and confirmed the impression that the discomfort was due to a suboptimal placing of the SSF suture.

The plan to remove the SSF suture was clearly the correct one, and that decision does not seem to be disputed.

The initial attempt was performed in [Mrs A]'s bedspace. As mentioned before in the notes, there was no written note of this and preparation about this is uncertain. It is certainly clear that the preparation was inadequate in that the scissors were incorrect and a second set needed to be obtained.

There are considerations relating to this procedure that do need to be seen in the context of the clinical situation. [Mrs A] was a patient with documented chronic pelvic pain prior to the procedure. She had significant pain following a misplaced suture. In addition to this, there would have been the general tenderness and discomfort from the repair procedures that had been undertaken a few days beforehand.

The stitch that would need to be removed would be high up in the vagina off to one side, and access and visualisation of this would have been expected to be challenging right from the outset. Attempting to perform this in the bedspace area with inadequate instruments, lighting and backup was, I think, setting the procedure up to fail right from

the outset. The procedure was ultimately completed, but it became apparent that the wrong stitch had been removed.

I suspect that if this procedure had been performed in the treatment room with adequate lighting and the correct instruments that visualisation of the sutures would have been much improved, and I think the chances of a successful procedure being performed at the first undertaking would have been much higher. I suspect that greater care could have been taken with the use of analgesia before the procedure, and this may have improved matters.

In my opinion, the decision of [Dr B] to undertake removal of the suture in the patient's bedspace was incorrect. I think, with hindsight, this would fall short of the standard of accepted practice. I imagine in an ideal world a number of my professional colleagues would have elected to have removed the suture under general anaesthetic as a formal procedure in an operating room. This would have led to the stitch being removed on the first occasion in a humane manner, and the problems relating to the complaint would not have eventuated.

Accepting that there were logistical issues and constraints with accessing theatre space over a busy weekend, I still feel that the plan made to remove the suture in the bedspace would fall short of expected standards. In my opinion, a significant number of my colleagues would have recognised that this would be a challenging undertaking in a patient with chronic pain and ongoing pain symptoms. Forward planning would have meant all of the potential instruments were available and consideration and thought would have been given to the location of the procedure. A treatment room with a good bed, lithotomy poles and good lighting and the requisite instruments would have meant this procedure would be undertaken with a greater chance of success. Clearly, we will never know whether the outcome would have been different, but it is certainly my opinion that it would have been much more likely that the correct stitch would have been identified.

The second procedure was performed by [Dr C] under more optimal conditions and was accomplished successfully. It is, however, worth pointing out that this was performed by a more experienced surgeon and in the absence of any potential confusion as to which suture should be removed due to the stay suture having been removed previously. It is also worth reiterating that, despite these preparations it was, however, associated with a significant degree of discomfort and as mentioned earlier, even [Dr C] found it "*traumatic*" and there seems to be a feeling that it would have been better performed under general anaesthetic.

This asks whether the SSF suture could have been removed on 14 November, and clearly this was the plan with [Dr B]'s original attempt.

I think that with hindsight it is acknowledged by the clinical team that the management of the analgesia throughout the procedures was suboptimal.

The above comments are made with hindsight in the cold light of day as a clinical opinion. It does need to be remembered that these events were happening in real time, in a busy DHB with reduced staffing levels over a weekend and competing clinical needs. This is no excuse, but it does allow us to recognise that at times a degree of expediency and pragmatism needs to be injected into the decision-making.

Summary
In my opinion there was no issue with the operation undertaken on patient [Mrs A]. It became apparent that her postoperative recovery was not going as smoothly as it should have done, and a management plan for this was undertaken.

Whilst there does seem to be some issue with documentation, the sequence of events is still reasonably clear.

The events surrounding this admission have raised some issues with regard to the provision of out-of-hours services, such as physiotherapy or TENS machines. It has also highlighted difficulties with accessing theatre space in an acute setting.

The main problem here, however, relates to the initial attempt to remove the SSF stitch and, in my opinion, the inadequate preparation and suboptimal decision-making that was associated with the first attempt.

Richard Dover
Obstetrician & Gynaecologist BM, MRCPI, FRCOG, FRANZCOG RD/dc'

Addendum

'Re: Complaint C22HDC02404

Thank you for your follow-up letter.

I agree a number of these are interlinked, and I suspect it is difficult to necessarily comment on them individually.

There was clearly a lack of available service provision, particularly with regard to physiotherapy. It is, of course, uncertain whether this would have made any difference, and I think if we are honest the level of provision on this occasion, in a busy metropolitan DHB over a weekend, is probably the same as it would be nationwide. Whilst this does fall short of what we would all like to receive, I would expect it would be punitive to single out failings in this regard, as I suspect this may well have been meeting the national standards.

I think the documentation issue is slightly different, as this does fall to basic standards of record keeping and is something we are all very familiar with. I think it also leads on to one of the later issues where the complainant felt that [Dr C] was unaware of what had happened in the past. As such, I think it there is a departure here from the expected

practice with regard to the documentation of the phone call to [Dr C]. I would have thought this would be at a moderate departure. There is clearly an absence of documentation, which would have to make it a mild departure at best. I think the context of the clinical situation makes this more imperative, and as such I think this should be classified as moderate.

There was no documentation for consent, and I suspect there may have been a feeling that this was going to proceed far more smoothly than expected. It is clearly an invasive procedure, but in some ways so is insertion of an intravenous line or a blood test, where you are not taking informed consent for those. As such, I think the absence of signed consent is perhaps acceptable, but I would have thought there should be some documentation about the discussion of the procedure. Clearly, that is at least a mild departure from normal practice.

There was a failure to remove the correct stitch, and I have discussed this in my report. I suspect that was unfortunate. As pointed out, I suspect if things had been performed differently the correct stitch may well have been identified at the outset.

The decision to undertake removal in the patient bedspace, I think, was incorrect. This is clearly a mild departure at best, but I would think in the context of a patient with chronic pain, and when one looks at the location of the stitch, I think this is at least a moderate departure. I think this decision is the crux to the whole case and if care had been taken at this stage, and the procedure had been performed with good lighting and the correct instruments (scissors), I suspect the correct suture would have been removed at the outset and the complaint would be much less likely to have been lodged.

The management of analgesia was clearly suboptimal, and I suspect this should be classified as mild.'