General Practitioner – Dr B

A Medical Centre

A Report by the

Health and Disability Commissioner

(Case 03HDC15569)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Consumer/Complainant
Dr B	General Practitioner/Provider
Dr C	General Practitioner
A Medical Centre	Provider

Complaint

On 17 October 2003 the Commissioner received a complaint from Mrs A about the services provided to her by Dr B at a Medical Centre in September 2003 when she had an intrauterine contraceptive device (IUCD) inserted. The following issues were identified for investigation:

1. *The circumstances and adequacy of the information Dr B provided to Mrs A:*

    - *about the IUCD procedure, including any risks or possible complications*
    - *during the IUCD procedure*
    - *after the IUCD procedure was completed.*

2. *The circumstances and adequacy of the treatment that Dr B provided to Mrs A in relation to the insertion of the IUCD.*

3. *The appropriateness of the medication that Dr B gave to Mrs A following insertion of the IUCD.*

4. *The circumstances and appropriateness of Dr B referring Mrs A for a scan following insertion of the IUCD.*

5. *The adequacy and accuracy of Dr B's clinical records.*

An investigation was commenced on 28 November 2003.

Information reviewed

Information was obtained from the following sources:

- Mrs A
- Dr B
- Dr C, the Medical Centre
- ACC
- A Public Hospital

Independent expert advice was obtained from Dr Wendy Isbell, a general practitioner.

Information gathered during investigation

Background
This complaint concerns Dr B, a general practitioner whom Mrs A consulted regarding the insertion of an IUCD in late August/early September 2003. The complaint centres on the circumstances surrounding the IUCD insertion on 2 September 2003, when Mrs A's uterus was perforated.

Counselling appointment
On 29 August 2003 Mrs A attended the Medical Centre (the Centre) as a new patient, having recently arrived from England. She consulted Dr B for a counselling assessment regarding the fitting of an IUCD. Mrs A had not previously used this form of contraception, and had specifically requested that a female doctor counsel her and insert the device.

Dr B was a locum employed for three weeks to provide cover for the only female practitioner at the Centre. She had learnt to insert IUCDs at a Family Planning Association Clinic and as a GP registrar, and her training included observing a number of insertions and being supervised when performing insertions herself. She informed me that over the past 12 years she has inserted 71 IUCDs in her own general practice. Dr B said this was the first IUCD procedure she had performed as a locum.

Mrs A asked Dr B to explain the IUCD fitting procedure. Mrs A recalls Dr B giving her a pamphlet for a new type of IUCD (which contains a slow-release drug). However, Mrs A wanted the old type of IUCD without the drug component. Dr B told her that the insertion procedure described in the pamphlet was the same for the older IUCD.

Dr B recalled that she spent 40 minutes in a pre-IUCD interview with Mrs A, whose two daughters were present (Mrs A says that this interview was much shorter – she could never have kept her children quiet for a 40-minute consultation). The interview was based on Family Planning protocols, and the Family Planning leaflets 'The IUD = Intra Uterine Device' and 'IUD Instructions for Use'.

Dr B stated:

> "This protocol includes full disclosure of the procedure, risks and complications, and provision of leaflets. Because patients invariably do not retain all the information provided in such consultations, the leaflets provide readily accessible information that the patient can refer to later on. [I] followed this protocol fully with [Mrs A], and in fact spent longer with her than usual."

Dr B stated that both the Mirena and Multiload Copper IUCDs were explained and shown to Mrs A. The pros and cons of both devices were explained. The Mirena offers superior contraception but is expensive. Although the insertion procedure is similar, particularly from the patient's point of view, it is not the same for the two devices, and this was explained to Mrs A.

Dr B recalled that she described the procedure to Mrs A as being "quite simple, taking approximately 20 minutes, and that Mrs A may suffer from slight discomfort". Dr B outlined the discussion (with "extensive" provision of oral and written information) that took place with Mrs A at the first consultation on 29 August 2003. She stated:

> "It included explaining the procedure and ensuring there were no contraindications to the IUCD in [Mrs A's] history … I explained how it works, its effectiveness, how it is inserted and how it feels. I discussed how one can self check the strings, its duration of action and removal."

Dr B explained the type of pain experienced during insertion as well as other complications, such as changes to periods and early checking if pregnancy does occur. She advised that a smear and swabs would be taken before the insertion. Dr B also mentioned other contraceptive options. She did not discuss perforation of the uterus as the risk is 1:1000, which in her view is not a significant or probable risk. However, Dr B said that she did discuss the symptoms of perforation and the need to seek immediate medical assistance. Perforation is mentioned in one of the two Family Planning leaflets, which describes, as one of the disadvantages of an IUCD, that "a few women experience damage or perforation of the uterus when the IUCD is put in".

Mrs A stated that the leaflet she was given contained no mention of perforation. The first time she knew that perforation was a possibility was when she had an X-ray after the insertion.

An appointment was made for Mrs A to return for the fitting of the device on 2 September 2003. Dr B recalled that as Mrs A was concerned about the expense and did not want to pay for two appointments (one for counselling, and one for the insertion of the IUCD), she did not charge for the first appointment. Dr B fitted the appointment in between other appointments as she had a quiet afternoon. Mrs A advised me that she was concerned about the cost only because she was accustomed to free GP consultations in the National Health Service in England. She had no idea that Dr B's initial consultation was being provided free of charge.

The copy of the relevant page in the appointment book for the Centre shows no record of Mrs A's appointment on 29 August. Dr C stated on behalf of the Centre that patient registration is usually entered by the receptionist, but for some unexplained reason Mrs A's details were not entered on 29 August 2003. Dr C said that the notes for the consultation were entered retrospectively (sometime between 10 and 12 September), after Mrs A's details had been entered in the database. The clinical notes state:

> "29/08/2003 Hx: Note entered retrospectively: [Mrs A] presented as a new patient to reception asking for a lady doctor who could fit an IUCD. [Dr B], locum (myself), was able to offer this service. [Mrs A] had her 2 girls with her. She was concerned about the cost of a consultation and then the fitting. I saw her for IUCD counselling assessment and counselling without charging her as I had a quiet afternoon. We arranged for her to come back for the fitting. Notes were not entered at that time as [Mrs A] had not been registered onto the computer."

Dr B explained what happened as follows:

> "[I] made handwritten notes at the time of [the] consultation with [Mrs A] on 29 August 2003. These were handwritten on an A5 piece of paper. This paper was headed with [Mrs A's] name, her date of birth and the consult date. Paper was used as [Mrs A] was not registered on 29 August and did not have a computer file. Patients are entered on the computer by reception staff. [Mrs A] was not registered by the reception staff because she was not charged for the consultation on 29 August 2003.
>
> The details from this paper note were transferred onto the computer when [Mrs A] was seen for the insertion on the 2 September 2003 and further on 10 September 2003. [I] did not retain the paper notes as they had been fully captured on the computer notes."

Fitting of IUCD

On 2 September 2003 Mrs A returned to the Centre so that the IUCD could be fitted by Dr B.

IUCD insertions at the Centre are usually performed in the treatment room, and all the necessary equipment for the procedure is stored there. Dr C stated:

> "… [The treatment room has] an appropriate adjustable plinth, adequate lighting and access to the patient on both sides. Nursing assistance is generally used. IUCD insertions are usually done on a 'booked' basis to ensure adequate instrument preparation and time. This also facilitates optimal aseptic 'no touch' technique. Doctors inserting IUCDs would usually follow normal 'informed consent' practice, with earlier consultation, discussion and clinical review. I am unaware whether any dialogue occurred between our nurses and [Dr B] concerning our usual IUCD insertion practice."

Dr B stated that she did not feel comfortable using the treatment room because of lack of privacy. The Centre was busy, and the treatment room contained a lot of essential medication and equipment which staff would come in to collect. There are three doors to the treatment room (one of which opens outside) and there is no curtain around the bed. Dr B therefore decided to use the consulting room when she inserted Mrs A's IUCD. This was not set up for such a procedure (although a light, gloves and a couch were in the room), and Dr B said that there was no room at the end of the examination couch. However, the set-up of the consulting room was one that Dr B had encountered in other practices and used to perform uneventful IUCD insertions.

Once Dr B had spoken to Mrs A and confirmed that she wanted to have the IUCD inserted, Dr B left the consulting room to obtain the equipment she required, ie, the vaginal speculum, tenaculum, sponge forceps, uterine sound (used for determining the depth of the uterus), long handled scissors, IUCD with insertion device, saline, and gauze swabs. They were all in the treatment room.

Mrs A recalled that the fitting lasted about 40 minutes, which was twice as long as she had anticipated. She said that Dr B appeared not to have all the necessary equipment in the room, and left the room on three occasions without explaining why. Dr B appeared to be having difficulty fitting the IUCD, and Mrs A experienced a high level of pain during the procedure. When Dr B said she could get dressed, Mrs A had to point out that she still had the "clamp" attached to her and the IUCD connection strings were still intact.

Dr B reported that she did not have any difficulty with the actual insertion of the device, but she did experience problems with the equipment and positioning of the couch in the consultation room, which meant the procedure took longer. For instance, the Welch Allen light did not work when she went to use it, although it had been working immediately beforehand. Dr B said she left the room to find a spare bulb, but there was not one at the practice:

> "So instead I used the equipoise light at the end of the examination couch and my diagnostic torch. This arrangement was less than optimum and did slow down the insertion. I had to be careful to make sure I had the lighting at the right angle so I could see adequately."

Dr B generally uses a Welch Allen light for this type of procedure, although she considers that using an equipoise light and a diagnostic torch is also acceptable practice.

Staff at the Centre use sterile saline during IUCD insertions, but Dr B usually uses white obstetric cream, which is useful when using the uterine sound to ascertain the length of the uterus. She had no difficulty sounding the uterus, inserting the IUCD, or resounding the uterus to check the IUCD position. Dr B felt the stem of the IUCD in the lower uterus after insertion.

Dr B realised that Mrs A experienced "discomfort or pain at the expected times during the procedure". It appeared that the pain Mrs A experienced was about average.

Dr B's lawyer elaborated on the pain issue in response to my provisional opinion:

> "At no time during or after the insertion did [Dr B] suspect that [Mrs A] had suffered a perforated uterus. [Dr B] did not suspect a perforation and therefore did not hide any such suspicion from [Mrs A].
>
> [Dr B] was not aware of the level of pain experienced by [Mrs A] as having been severe. [Mrs A] had been advised beforehand that it is common to feel some pain and/or discomfort during the procedure and immediately afterwards. At no time during or after the procedure did [Mrs A] communicate to [Dr B] that she was experiencing a high or

> unexpected level of pain. [Dr B] has now seen the later medical notes in which [Mrs A] conveyed to her husband that it was a painful procedure and that she had ongoing abdominal pain, but she did not convey this same information to [Dr B]. In retrospect it seems likely that Mrs A was stoical and perhaps reluctant to complain to the doctor."

Dr B said that when she went to cut the strings the scissors she had were not long enough and she had to exit the room to collect another instrument from the treatment room. She forgot to take the speculum out before saying to Mrs A, "Ok that's all done." When Mrs A brought it to her attention, Dr B apologised and said, "I have a bad case of locumitis."

After Mrs A had dressed, Dr B told her she wanted to send her for a scan to see if the IUCD was high enough in the uterus for contraception. Dr B said she was "anxious" to ensure this was the case, because of the awkwardness of the procedure. She was not concerned about perforation. Dr B said that in the past when she has had difficulty with IUCD insertions she has referred to mentors at Family Planning and they have usually requested a pelvic ultrasound to check the position of the IUCD. She told Mrs A that she would not have to pay for this follow-up. Mrs A assumed it was normal procedure.

Dr B recalled explaining the symptoms that Mrs A would experience over the next few days. Dr B confirmed that she gave Mrs A a sample bottle of Synflex 550mg tablets. Mrs A said Dr B gave her two bottles of Synflex 550mg and told her they were painkillers. Mrs A saw Dr B take them from a desk drawer in the consultation room.

Dr B said that she also gave Mrs A a handwritten prescription for Synflex. Dr B said that it is her usual practice to give women non-steroidal anti-inflammatory drugs (NSAIDs) for cramps and a prescription for an ongoing supply, as women usually have more period pain when fitted with an IUCD. There is no record of any medication or prescription in Mrs A's notes for 2 September 2003, and Mrs A does not recall receiving a prescription. Dr B explained that she provides free sample medication because from experience she knows that many patients forfeit this medication because of financial pressures, and Mrs A seemed anxious about money.

Subsequent events

After the consultation Mrs A was in so much pain she could barely walk to her car. She returned home and rang a radiology clinic to make an appointment to have the scan recommended by Dr B. Mrs A was told she would need to pay for the scan.

Mrs A telephoned the Centre the following day (3 September 2003) and left a message for Dr B to call her because she was in considerable pain and wanted to discuss payment for the scan. Dr B telephoned Mrs A later that day. Dr B recalls the conversation as follows:

> " … [Mrs A] described cramping lower abdominal pain. [I] asked whether [Mrs A] had taken any non-steroidal anti-inflammatory pain relief for the pain. As Mrs A said no, [I] advised her to do so and to allow 1-2 hours then to 'phone back if the pain persisted.

> [Mrs A] did not phone back. [I] therefore believed that the pain had resolved with the anti-inflammatory pain relief, as would normally be expected. [I] was therefore not aware of the pain that [Mrs A] describes between 3-5 September."

Mrs A recalls that Dr B told her the pain was normal, and that she should keep taking the painkillers she had been given, ie Synflex. This telephone call is recorded in the notes as "03/09/2003: Hx: Phone number corrected as it was incorrect. Cramping pains yesterday relieved by synflex 550mg bd. Improved today." Mrs A stated that the pain was relieved by the painkillers, but she started getting sharp stabbing pains in her ribs, which she thought was indigestion. She experienced severe pain over the three days following the procedure.

Dr B also told Mrs A that she would contact the radiology clinic. Subsequently, Dr B sent Mrs A a letter confirming that the ultrasound appointment had been made for the morning of 5 September 2003, and including a personal cheque to cover the cost of the scan. The letter stated, "You won't have to pay for this as I have arranged payment through the practice (envelope enclosed)."

Dr B informed me that she decided to pay for the scan out of her practice account as a "quality assurance expense". The scan was to reassure herself that the positioning of the IUCD was correct, and she believed it would be unfair for Mrs A to have to pay for it. Dr B subsequently advised me that the payment of the scan was to reassure Mrs A, as the procedure had not gone smoothly. Mrs A gave the cheque to the radiology clinic when she had the scan, but the cheque was not presented, and was returned to the Centre. A copy of the cheque was provided to my Office and is made out to the radiology clinic for $180, payable from the account of Dr B, with her signatures (her maiden name and married name) on it. No mention of the cheque appears in the notes.

On 5 September 2003 Mrs A went to the radiology clinic for the ultrasound scan. Mrs A was told the first scan did not show the IUCD. She then had an X-ray which showed that the IUCD was located in her abdominal cavity just below her ribs. The report stated: "An IUCD is seen fairly high in the right flank in the right paracolic gutter." Mrs A said the radiologist who read the scan, appeared shocked at the position of the IUCD, and this caused Mrs A to become distressed. The radiologist explained that the IUCD had perforated Mrs A's uterus and that it would have to be surgically removed.

Mr and Mrs A returned to the Centre. Mr A spoke to Dr C, one of the other doctors at the Centre, as Dr B was not there, and informed him of the X-ray findings. Mrs A stayed in the car because she was so distressed. Dr C immediately contacted a gynaecological registrar at the public hospital, and arranged for Mrs A to be admitted the same day. She underwent a diagnostic laparoscopy later that afternoon and the IUCD was removed. The operation report stated "a fundal perforation noted on the right side of the uterus, which was not actively bleeding. The IUCD was lying just above the small bowel and it was picked up and removed." Mrs A stayed overnight and was discharged the next day (6 September 2003), after the doctor on the ward round told her she could go home if she wanted.

Dr B stated that this was the first time that a perforation of the uterus had occurred during an IUCD insertion she had performed. She advised: "I have come to realise that as a locum I do not have sufficient control over how things related to the IUCD procedure are set up." Dr B no longer performs IUCD insertions as a short-term locum, and intends to arrange some time with a senior doctor from the Family Planning Association to peer review her IUCD insertion skills for her own reassurance.

Dr B commented:

> "I very much regret that the procedure did not go as expected. I am sorry for the discomfort, pain and worry [Mrs A] has gone through."

Expired medication
After she had taken seven tablets from one of the bottles provided by Dr B, Mrs A noticed that the medication had expired in August 2002. (The label on the bottle of Synflex provided to my Office by Mrs A has an expiry date of "Aug 2002".)

Dr B stated that she had previously checked the medications in the sample cupboard, and they had been current. She said it is her usual practice to check the expiry dates of all the medications she uses and dispenses. It is not her practice to use expired medication, and she believed she had taken precautions "by systematically going through the sample medication cupboard" on arrival at the practice. She therefore assumed that she had already checked that all the Synflex bottles were current, and failed to check the one she gave Mrs A.

ACC
Mrs A made a claim to ACC but withdrew it before an investigation commenced, on the basis of advice from ACC that there was nothing to be claimed.

Independent advice to Commissioner

The following expert advice was obtained from Dr Wendy Isbell, general practitioner:

> "**Agreement**
>
> I have been asked to provide a report to the Health and Disability Commissioner on case number 03/15569/WS.
>
> I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

Qualifications, Training and Experience

My **qualifications** are MB, ChB (University of Otago) 1970, MRCP (UK) 1975, FRACP 1983, and FRNZCGP 1998.

I **trained** at the University of Otago Medical School, underwent postgraduate training at Christchurch Hospital and The Princess Margaret Hospital, and undertook a Course in Advanced Medicine at the Royal Postgraduate Medical School, University of London, 1975.

I completed my Family Planning training in 1981, completed the courses in Nutrition for Health Professionals (New Zealand Nutrition Foundation) 1994-5, and have undertaken a number of courses in homeopathy.

I have had informal training from Professor Russell Scott in lipid disorders and diabetes and the Lipid and Diabetes Research Group in Christchurch 2003-4.

My **experience** has been as a junior medical doctor in Christchurch (1971-1976), and at Hammersmith Hospital in London (1977), and as a Physician in Health Care of the Elderly at The Princess Margaret Hospital (1977-1987, including maternity leave).

Since 1987 I have been in practice on my own behalf as a physician and homeopath, and later also included general practice, becoming a member of Pegasus Health and Partnership Health.

From 2003 I have also been working three-tenths as a physician at the Lipid and Diabetes Research Group, Christchurch.

Purpose

To advise the Commissioner whether the services provided to [Mrs A] by [Dr B] were of an appropriate standard.

Background

On 29 August 2003 [Mrs A] consulted [Dr B], a locum at the [the medical centre], for a counselling assessment regarding the fitting of an IUCD. She had not previously used this form of contraception.

[Mrs A] said she asked [Dr B] to explain the fitting procedure, which [Dr B] described as being quite simple, that it would take approximately 20 minutes, and that she may suffer from slight discomfort. An appointment was made for [Mrs A] to return for the fitting. The notes for this consultation were entered retrospectively after [Mrs A's] details were entered in the database.

On 2 September 2003 [Mrs A] returned and the IUCD was fitted by [Dr B]. [Mrs A] has a number of concerns about the consultations.

[Mrs A] stated that the fitting lasted about 40 minutes. [Dr B] appeared not to have all the required equipment in the room, and had to exit the room on more than one occasion to retrieve necessary items. [Mrs A] said that [Dr B] also appeared to be having difficulty fitting the IUCD, and she experienced a high level of pain during the fitting.

[Mrs A] said that when [Dr B] told her she could get dressed, she had to point out to [Dr B] that she still had the clamp attached and IUCD connection strings were still intact. [Dr B] had to exit the room to collect an instrument to cut the strings.

[Mrs A] said that after getting dressed [Dr B] said she wanted to send her for a scan to see if the IUCD was high enough. [Mrs A] said she assumed this was normal and asked if she had to pay for it. She said [Dr B] informed her that she would not be charged for the scan.

[Mrs A] stated that [Dr B] gave her 2 bottles of Synflex 500 and said they were painkillers. [Mrs A] said that she noticed later that this medication had expired in August 2002. (The label on the bottle of Synflex provided by [Mrs A] has an expiry date of Aug 2002.)

After the fitting [Mrs A] returned home and rang [the radiology clinic], to make an appointment to have the scan. She said they told her she would need to pay for it. [Mrs A] contacted [Dr B] about this. [Dr B] decided to pay for the scan from her practice account and sent a cheque.

[Mrs A] stated that over the next three days she experienced extreme pain. On 3 September 2003 [Mrs A] contacted [Dr B] who told her that this was normal, and she should take the painkillers she had been given.

On 5 September 2003 [Mrs A] went to [the radiology clinic] for an abdominal ultrasound. [Mrs A] said the first scan did not show the IUCD. She then had a further X-ray which showed the IUCD was located in her abdominal cavity just below her ribs. The report stated that: 'An IUCD is seen fairly high in the right flank in the right paracolic gutter' (document number 35 in the supporting information). [Mrs A] said that the radiologist who read the scan, appeared shocked at the position of the IUCD, and this caused her to become distressed. [Mrs A] said the radiologist explained that the IUCD had perforated [Mrs A's] uterus and that it would have to be surgically removed.

[Mr and Mrs A] returned to the [the medical centre] and [Mr A] spoke to [Dr C], as [Dr B] was not there. [Dr C] immediately contacted a gynaecological registrar at [the public hospital] and arranged for [Mrs A] to be admitted immediately.

[Mrs A] was admitted to [the public hospital] that afternoon and underwent a diagnostic laparoscopy later the same day to remove the IUCD. The operation report recorded 'a fundal perforation noted on the right side of the uterus, which was not actively bleeding. The IUCD was lying just above the small bowel and it was picked up and removed.' [Mrs A] stayed overnight and discharged herself the next day.

Complaint

1. *The circumstances and adequacy of the information [Dr B] provided to [Mrs A]:*
   - *about the IUCD procedure, including any risks or possible complications*
   - *during the IUCD procedure*
   - *after the IUCD procedure was completed.*

2. *The circumstances and adequacy of the treatment that [Dr B] provided to [Mrs A] in relation to the insertion of the IUCD.*

3. *The appropriateness of the medication that [Dr B] gave to [Mrs A] following insertion of the IUCD.*

4. *The circumstances and appropriateness of [Dr B] referring [Mrs A] for a scan following insertion of the IUCD.*

5. *The adequacy and accuracy of [Dr B's] clinical records.*

Supporting Information

I have reviewed the supporting information sent by the Commissioner.

These include:
- Letter from [Mrs A] to the Commissioner dated 28 September 2003, marked 'A' (numbered 1-5).
- Investigation letter to [Dr B] dated 17 December 2003, marked 'B' (numbered 6-8).
- Medical notes received from [the public hospital] on 5 January 2004, marked 'C' (numbered 9-35).
- Letter from [the medical centre] to the Commissioner, dated 16 January 2004, marked 'D' (numbered 36-37).
- Letter dated 3 February 2004 and enclosures from [Dr B], marked 'E' (numbered 38-75).
- Letter dated 2 March 2004 from ACC, marked 'F' (numbered 76).
- Further documentation received from [Mrs A] on 29 April 2004, marked 'G' (numbered 77-81).
- X-rays received from [Mrs A] on 21 April 2004, marked 'H' (3 scans).

Expert Advice Required

To advise the Commissioner whether, in your professional opinion, the standard of care [Mrs A] received from [Dr B] was of an appropriate standard. In particular:

- What information and advice should [Dr B] have given [Mrs A] about the IUCD, the fitting procedure, and any possible risks?
- Is perforation of the uterus one of the risks that should be explained for this kind of procedure?

- What is the likelihood of a uterus perforating during an IUCD insertion?
- What information should be given during the procedure?
- What equipment should have been in the room before the procedure is started?
- What is your opinion of the set-up for this procedure, including the room and equipment used during the procedure?
- Is it usual to have assistance when fitting an IUCD?
- What level of pain would you expect a patient to experience during insertion of an IUCD? In your opinion, what level of pain did [Mrs A] experience?
- In your opinion, how did the IUCD get into [Mrs A's] abdominal cavity?
- What, if any, indication would there be that the IUCD had perforated [Mrs A's] uterus?
- What actions should [Dr B] have taken if she was unsure about the position of the IUCD after it had been fitted?
- What should Dr B have told [Mrs A]?
- Is it usual for a pelvic scan to be requested after an IUCD is fitted?
- Was [Dr B's] explanation for ordering the scan reasonable?
- Was it appropriate for [Dr B] to offer to pay for the scan out of her practice account? Is this usual practice?
- Was the action taken by [Dr B] after the procedure appropriate? Please comment.
- Is [Dr B's] record keeping appropriate and accurate?
- Is [Dr B's] training on the insertion of IUCDs adequate?
- Should [Dr B] have checked the medication she gave to [Mrs A], particularly the expiry date?
- Are there any other matters which you believe to be relevant to this complaint?

Advice Given

To advise the Commissioner whether, in your professional opinion, the standard of care [Mrs A] received from [Dr B] was of an appropriate standard. In particular:

- ***What information and advice should [Dr B] have given [Mrs A] about the IUCD, the fitting procedure, and any possible risks?***

It is only recorded after the consultation what advice [Dr B] did give [Mrs A].

I think the pamphlet and instruction sheets put out by the Family Planning Association (pages 61-64 in the supporting information) would be appropriate for the doctor to cover with the patient before inserting an IUCD. It would be quite appropriate for the doctor to go through this written material with the patient.

The Family Planning Association pamphlet (page 63 of supporting information) specifically mentions 'a few women experience damage or perforation of the uterus when IUD is put in'.

I think it would be appropriate to mention this as a rare complication before the procedure is performed.

- ***Is perforation of the uterus one of the risks that should be explained for this kind of procedure?***

I think it should be mentioned as a very rare risk.

- ***What is the likelihood of a uterus perforating during an IUCD insertion?***

The risk is about 1 in 1000.

- ***What information should be given during the procedure?***

During the procedure, the doctor should tell the patient what is being done next, and how it will feel. Then the doctor should check that the patient is comfortable before continuing with the next step of the procedure.

After the procedure is finished, the doctor should check that everything is completed, and the patient is comfortable, before asking the patient to get up from the table.

I think [Dr B] may have underestimated the severity of [Mrs A's] pain.

- ***What equipment should have been in the room before the procedure is started?***

I agree with the list of equipment that [Dr B] gave, namely examination couch, pillow and sheeting, vaginal speculum, lighting, tenaculum, sponge forceps, uterine sound, long handled scissors, IUCD with insertion device, Hibitane Cream or saline, gauze swabs and gloves.

The doctor should make sure that all the equipment is functional before using it, for example that the light is working, and is suitable for the procedure.

[Dr B] stated that there was no space at the end of the examining bed. In that case the bed should have not been used.

[Dr B] wrote that she was aware at the time of a number of difficulties. If that was so, maybe she shouldn't have continued with the procedure.

- ***What is your opinion of the set-up for this procedure, including the room and equipment used during the procedure?***

The treatment room was already set up for this procedure, and the insertion of the IUCD should have been done there, where all the equipment and lighting was available, and also presumably other equipment in case of medical emergency.

The fact that the treatment room opened outside cannot have been a problem, as this had presumably been successfully solved by the staff who regularly used the treatment room, and the door must have had a lock.

One assumes that the consulting room would not be as well set up as the treatment room, as proved to be the case. Using makeshift equipment in the examining room, such as a torch for a light source, is inexcusable, especially when a properly set up system was available.

- ***Is it usual to have assistance when fitting an IUCD?***

Yes, it is usual to have assistance when fitting an IUCD, and was routine practice and definitely advisable in that medical practice, especially as [Dr B] was a locum and may not be fully aware of placement of equipment.

There are some circumstances when a very senior person might do the procedure on their own, provided all the equipment was present, and the room was appropriately set up. But in most situations a nurse is available to assist, and there definitely was in this case.

Having assistance is also a safeguard both for the procedure, and for any questions that may arise afterwards.

[Dr B] said that as a locum she did not have sufficient control over how 'things related to procedures' were set up. She can always ask for guidance about the arrangements already in place, and can then use her training and professional experience to do her part of the procedure safely and accurately.

- ***What level of pain would you expect a patient to experience during insertion of an IUCD? In your opinion, what level of pain did [Mrs A] experience?***

There is usually a sharp, short-lasting pain when the tenaculum takes hold of the cervix.

There may be some pain as the uterine probe is passed through the cervix, as it tends to dilate the cervix a little.

There may be some cramping uterine pains after the IUCD has been inserted.

[Mrs A] described 'a high level of pain during the fitting of the IUCD'. This is more than would be expected, as was the 'extreme pain' she experienced in the 3 days after the fitting of the IUCD.

- ***In your opinion, how did the IUCD get into [Mrs A's] abdominal cavity?***

I think that one of two things may have happened:

Firstly the uterus may have been perforated by the uterine sound before the IUCD was introduced. This would then provide a conduit through which the IUCD could pass later.

Secondly, when the IUCD was inserted into the uterus, the insertion device may have been pushed in too far, so that when it extruded the IUCD the uterine wall was penetrated.

- ***What, if any, indication would there be that the IUCD had perforated [Mrs A's] uterus?***

There would be pain, of more degree than usually felt. There would also be pelvic and/or abdominal pain.

On examination the abdomen may be tender, and on bimanual examination of the uterus there would be tenderness of the uterus, and in the pelvis.

- ***What actions should [Dr B] have taken if she was unsure about the position of the IUCD after it had been fitted?***

The IUCD should have been in the uterus. Bimanual examination would have shown no tenderness. The strings would be palpable in the vagina, and visible coming through the cervix, when viewed with a speculum in situ.

If the IUCD was still in the cervical canal there would be pain in the cervix area, the device may be visible on speculum examination, and the lower part of the device would be palpable at the cervix.

If the uterus had been perforated, an abdominal examination may show tenderness or other findings. A bimanual examination may show a tender uterus, or pelvic tenderness.

- ***What should [Dr B] have told [Mrs A]?***

The truth, in a kindly and competent manner. She should have promised to follow her up until any problems had settled.

- ***Is it usual for a pelvic scan to be requested after an IUCD is fitted?***

No. It would only be ordered if some gynaecological abnormality was found on examination (in which case the procedure would be postponed or cancelled).

If there was a suspicion of a perforation of the uterus, it would certainly be appropriate.

- ***Was [Dr B's] explanation for ordering the scan reasonable?***

[Dr B] said she ordered the scan to check if the IUCD was high enough in the uterus. I have never heard of this being an issue. Normally, once the IUCD is beyond the cervical canal, it is considered to be in place in the uterus.

No, I do not think [Dr B's] explanation for ordering the scan was reasonable.

[Dr B] also stated that in the past when she had had difficulty inserting IUCDs, she had turned to a mentor who had recommended a pelvic scan. If there had been a number of problems previously, then the question should be asked as to whether she was safe to continue with unsupervised insertions of IUCDs.

- ***Was it appropriate for [Dr B] to offer to pay for the scan out of her practice account? Is this usual practice?***

This is not usual practice, and I don't think it was appropriate.

I think [Dr B] should take good care to prevent any complications arising from her actions.

Then if complications do arise, she will know she has done all in her power to practise safely and competently. If she has aborted an attempt at a procedure for safety reasons, she can know that she has practised wisely, in the best interests of the patient.

If a complication has occurred, or is thought to have occurred, she should sit down and calmly discuss this with the patient, and arrange for appropriate follow-up.

She should also immediately obtain peer or mentoring advice.

I think to some extent [Dr B] was using her belief that the patient was hard up to provide less than perfect service (not booking her in for an appointment, not charging her, etc). The service should always be excellent, no matter what the circumstances.

If Dr B was paying for the scan because she felt responsible for [Mrs A's] clinical state, then she should have been open about it. I have never heard of doctors paying for scans, and justifying it as 'a quality assurance expense' (page 45 of supporting information).

It seems that it was probably a personal cheque that [Dr B] wrote, because it had both her surnames on it.

There is a good case for limiting the cost to patients of medical misadventure, and this is properly arranged through ACC.

- ***Was the action taken by [Dr B] after the procedure appropriate? Please comment.***

I have already commented on the ordering of the scan, and the payment for it.

[Mrs A] was in considerable pain, and this should have been taken seriously by [Dr B]. It would be wise to have examined her, as mentioned above.

The Family Planning Association pamphlets recommend using paracetamol for pain after insertion of IUCDs, but an NSAID such as Synflex would also be appropriate.

The IUCD instructions (enclosure number 60) state 'It is normal to have some cramp-like pain in your lower abdomen....for a few days after your IUD is put in.....If the pain is severe, ask your health professional for advice.'

[Mrs A] said she experienced severe pain for three days after the insertion of the IUCD, and rang [Dr B], who told her to continue with the pain relief. [Dr B] should have seen [Mrs A] if she was complaining about severe pain, especially as the question of complications had already arisen, or should have arisen.

- ***Was [Dr B's] record keeping appropriate and accurate?***

It was inappropriate, and probably unethical, for [Dr B] to write retrospective notes. As she said, she had an hour spare that afternoon, so she had plenty of time to enter the patient's registration details before she consulted with [Mrs A], or preferably to make arrangements for the receptionists to do this.

I would think the usual arrangement would be for the patient to book in with the receptionist, then before the first consultation for the receptionists to enter all the details.

If for any reason (which I doubt) this was not possible, then [Dr B] should have made paper notes at the time of the consultation, referred to them when she entered the electronic notes, and also kept them as a record.

I note that on the appointment report provided (page 59 supporting information), it was not recorded that [Dr B] had seen [Mrs A]. It is necessary that all consultations be recorded on the appointment book, so that appropriate information can be forwarded to the authorities, and also for audit purposes.

- ***Is [Dr B's] training on the insertion of IUCDs adequate?***

Yes, I think that [Dr B's] training on the insertion of IUCDs was probably adequate. But if this was the first time she had inserted an IUCD as a GP locum, she should have been especially vigilant, made use of the usual assistance given in the practice, and used the full facilities.

It is important that the doctor behaves correctly at all times, without cutting corners, especially when she is not being supervised. She should at all times be aware of her professional role and responsibility.

I don't know if further training in inserting IUCDs would necessarily help. Maybe mentoring might be useful.

- ***Should Dr B have checked the medication she gave to [Mrs A], particularly the expiry date?***

Yes. It is important that medicines not be used after their expiry date. If dispensing the medicine herself, [Dr B] should have specifically checked this herself. Having checked

some of the other bottles in the cupboard previously does not exempt her from the responsibility to check each time.

Personally, I do not give drug samples to patients. I would rather write a prescription, which is then subjected to the usual checks and audits.

- ***Are there any other matters which you believe to be relevant to this complaint?***

I am concerned that [Dr B] is taking pains to justify her actions. This leads me to believe that she hasn't learnt from this unfortunate episode.

General Comments

1. *The circumstances and adequacy of the information [Dr B] provided to [Mrs A]:*
   - *about the IUCD procedure, including any risks or possible complications*

   [Dr B] recorded at a later time that she had discussed the IUCD procedure with [Mrs A]. She seems to have given an explanation that emphasised the simplicity of the procedure, and not to have properly discussed risks or possible complications.

   - *during the IUCD procedure*

   It seems that [Dr B] did describe what was going on at the time. But it seems that she was unduly distracted by (self-created) difficulties she was having with the procedure.

   - *after the IUCD procedure was completed.*

   [Dr B] seems to not have adequately assessed the degree of [Mrs A's] pain. She arranged for an ultrasound, but did not properly explain why it was being done.

   If she suspected complications from the insertion of the IUCD, she did not explain this to the patient.

2. *The circumstances and adequacy of the treatment that [Dr B] provided to [Mrs A] in relationship to the insertion of the IUCD.*

The circumstances of the treatment were inadequate. [Dr B] was using a room that was not properly equipped, and a makeshift light. She had transported some equipment into the room she was using, but did not have with her all that she needed.

I think the treatment was inadequate, because several errors were made, leading to a significant complication.

3. *The appropriateness of the medication that [Dr B] gave to [Mrs A] following insertion of the IUCD.*

Synflex, a non-steroidal anti-inflammatory agent would be appropriate for pain relief following insertion of an IUCD. But it should not be used when it is past its expiry date.

4. *The circumstances and appropriateness of [Dr B] referring [Mrs A] for a scan following insertion of the IUCD.*

As mentioned above, a scan would not usually be required. If it was ordered the patient should be told why, and not be given a spurious explanation.

If medical misadventure had occurred then this should have been discussed with the patient.

The doctor should not have given the patient a personal cheque to pay for the scan.

5. *The adequacy and accuracy of [Dr B's] clinical records.*

[Dr B's] clinical records do not seem to be adequate. She mentions an IUCD counselling assessment, but does not say what topics were covered, and whether risks and complications were discussed.

The notes to do with the IUCD insertion are adequate, but do not mention [Mrs A's] severe pain, or the fact she had dispensed Synflex.

The notes from [Mrs A's] phone call do not reflect the severe pain [Mrs A] reported.

As mentioned above, the notes from her first consultation with [Mrs A] were entered at a later time, and no contemporaneous notes seem to be available. This is inappropriate, and unsafe practice."

Response to Provisional Opinion

In response to my provisional opinion, a barrister submitted on behalf of Dr B:

"Primarily [Dr B] acknowledges that [Mrs A] suffered a perforation of her uterus resulting from the insertion of an IUCD by [Dr B] on 2nd September 2003. [Dr B] wholeheartedly regrets and apologises for this occurrence.

With respect to the provisional opinion [Dr B] wishes to address the following matters:

PERFORATION NOT SUSPECTED:

… Dr Isbell states that [Dr B] should have seen [Mrs A] if she was complaining of severe pain. Dr B agrees with this and regrets she did not realise [Mrs A] was in severe pain. …

PRACTICE NURSE ASSISTANCE:

While assisting [Dr B] in gathering equipment for the IUCD insertion the two practice nurses were fully engaged in other work at the time the IUCD insertion was booked to take place. [Dr B] has learned from this experience and will in future not agree to perform an IUCD insertion where there is no assistance available.

POSTPONING THE PROCEDURE:

Dr Isbell has criticised [Dr B] for not postponing the IUCD insertion when it was apparent that there were a number of difficulties. [Dr B] did not feel this was warranted at the time although now of course regrets this. [Mrs A] herself was anxious to get the procedure done and had difficulties arranging childcare. …

ULTRASOUND:

[Dr B] strongly denies providing 'spurious reasons' for requesting a pelvic ultrasound. [Dr B] also denies misleading [Mrs A] as to the reasons for requesting the ultrasound. Dr B did not suspect perforation when requesting the scan. Had [Dr B] suspected a perforation, she would not have referred [Mrs A] for a scan, but would have arranged for immediate admission to hospital.

An abdominal examination was performed after the insertion following removal of the vaginal speculum. There was nothing from that examination to indicate perforation or other complication arising from the procedure. A bimanual was not done following the insertion. There was no abdominal tenderness.

PAYMENT FOR THE SCAN:

Because the insertion had not gone as smoothly as usual, [Dr B] felt she owed [Mrs A] the reassurance of a scan and also wanted to reassure herself that the IUCD was well fitted. In addition, as this was the first time that [Dr B] had used saline rather than her usual obstetric cream, she wished to ensure that the IUCD was properly placed and would provide the required contraception. [Mrs A] was not expecting to pay for a scan, which would cost more than twice the cost of the IUCD insertion.

[Dr B] paid for the scan out of her business practice account … [and] paid for the ACC surcharge on the ultrasound scan [Mrs A] had on 5 September 2004.

INTENTION TO PROVIDE THE BEST SERVICE:

[Dr B] at no time compromised her care or actions on the basis of cost or [Mrs A's] ability to pay. To do this would be in breach of a fundamental ethic of medical practice. [Dr B] emphatically and absolutely rejects this opinion.

At all times [Mrs A's] best interests were at the forefront of [Dr B's] treatment, concern and attention. …

[Dr B] does not agree that her practice [of taking contemporaneous handwritten notes that were later entered into a computerised record] was 'inappropriate and unsafe' as stated by Dr Isbell.

OTHER MATTERS:

… [Dr B] deeply regrets the outcome this procedure had for [Mrs A] and particularly the pain and distress [Mrs A] endured.

While accepting responsibility for what happened [Dr B] also hoped by her response to reassure [Mrs A] that her intention was always to provide [Mrs A] with the service she requested in a caring and competent manner.

[Dr B] will no longer offer IUCD insertion in an unfamiliar environment.

SUMMARY:

[Dr B] regrets and apologies to [Mrs A] for the difficulties which have arisen with this IUCD insertion. This occurrence has led to [Dr B] re-examining her practice and her competencies.

[Dr B] welcomes any review of her practice or any advice which may be offered. …"

Code of Health and Disability Services Consumers' Rights

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

RIGHT 4
Right to Services of an Appropriate Standard

(1) Every consumer has the right to have services provided with reasonable care and skill.

(2) Every consumer has the right to have services provided that comply with legal, professional, ethical and other relevant standards.

RIGHT 5
Right to Effective Communication

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

RIGHT 6
Right to be Fully Informed

(1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –

…

(b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; …

Relevant standards

The Medical Council publication 'Good Medical Practice – A Guide for Doctors' (2000) states that doctors must:

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

Opinion: Breach – Dr B

Explanation of procedure for IUCD insertion
Right 6(1)(a) of the Code states that a patient is entitled to an explanation of the options available, and an assessment of the expected risks, side effects, and costs of each option.

Mrs A stated that when she asked Dr B about the IUCD fitting procedure, she was told that it was quite simple, would take approximately 20 minutes, and that she might experience slight discomfort. Dr B explained about the IUCD, the pain experienced during insertion, and complications (including the symptoms of perforation and the need to seek immediate medical assistance), but did not advise of the risk of perforation of the uterus because it is only 1 in 1000.

My advisor, Dr Isbell, noted that the advice and explanation Dr B gave to Mrs A, which was recorded after the consultation, appears to have "emphasised the simplicity of the procedure, and not to have properly discussed risks or possible complications". Dr Isbell commented that it would have been appropriate for Dr B to go through the written information with Mrs A, and mention the possibility of perforation of the uterus noted in one of the pamphlets, even though it is a rare complication (1 in 1000).

Dr B appears to have spent some time discussing the pros and cons of IUCDs, although the clinical notes are insufficient to establish exactly what was discussed. The provision of information on available options and potential risks is a very important part of the service provided by health professionals, and is essential to help patients make an informed choice. In my opinion a reasonable patient in Mrs A's circumstances, who is considering insertion of an IUCD for the first time, would expect (and is entitled) to be told the specific risk of perforation of the uterus. Dr B did not give sufficient information to Mrs A, and therefore breached Right 6(1)(a) of the Code.

Standard of care and communication during insertion procedure
Under Right 4(1) of the Code, patients are entitled to services provided with reasonable care and skill, in accordance with professional, legal, ethical and other relevant standards. Under Right 5(1) of the Code, patients are entitled to effective communication.

Dr B inserted Mrs A's IUCD in the consultation room instead of the treatment room because of her understandable concerns about the privacy of the treatment room. This meant she needed to retrieve from the treatment room most of the equipment required for the procedure. The practice nurses were busy. Dr B experienced a number of problems with the equipment during the procedure. For example, the Welch Allen light was not working, so she used the equipoise light at the end of the examination couch and her diagnostic torch, and there was a lack of space at the end of the examination couch.

Dr Isbell advised that the consultation room should not have been used under these circumstances. The procedure should have been performed in the treatment room, which was set up with the appropriate medical equipment and lighting:

> "Using makeshift equipment in the examining room, such as a torch for a light source, is inexcusable, especially when a properly set up system was available."

Dr Isbell further commented:

> " … [I]t is usual to have assistance when fitting an IUCD, and was routine practice and definitely advisable in that medical practice, especially as [Dr B] was a locum and may not be fully aware of placement of equipment …"

It is clear that Dr B's decision to use the examination room instead of the treatment room, with no assistance, created a number of problems. In my view Dr B should not have proceeded in these circumstances.

Mrs A was concerned that the procedure took longer than anticipated. Dr B did not appear to have all the necessary equipment to hand, she left the room on three occasions, and she seemed to experience difficulty with the insertion. Mrs A also reported experiencing a high level of pain during the procedure, although Dr B thought that her level of pain appeared to be about average; she did not communicate any significant discomfort.

Dr Isbell advised:

> " … [T]he doctor should tell the patient what is being done next, and how it will feel. Then the doctor should check that the patient is comfortable before continuing with the next step of the procedure. After the procedure is finished, the doctor should check that everything is completed and the patient is comfortable, before asking the patient to get up from the table."

My advisor considered that the level of pain Mrs A experienced was more than is usual, and that Dr B may not have questioned her sufficiently about her pain or its severity during the insertion. Indicators that an IUCD has perforated the uterus include more pain than usual, as well as pelvic or abdominal pain, which would be evident during bimanual examination. In hindsight, it is obvious that Mrs A experienced such a level of pain because Dr B had perforated her uterus (as was subsequently shown on the X-ray).

Dr B also forgot to remove the speculum at the end of the procedure. She was disorganised, and did not make sufficient checks or take appropriate care during the procedure.

In my view, establishing the level of pain a patient is experiencing during a procedure is a basic element of good care. In this case the pain Mrs A experienced during the procedure may have been an important indicator that something was amiss. By failing to make appropriate preparations or to communicate effectively with Mrs A during the procedure, Dr B's actions fell below the appropriate standard of care. In these circumstances, Dr B breached Rights 4(1) and 5(1) of the Code.

Arrangements for scan

After the IUCD was inserted, Dr B advised Mrs A to have a scan to check the location of the IUCD, and attempted to pay for it herself with a cheque from her business practice account.

Dr B said that the scan was intended to give Mrs A reassurance, as the procedure had not gone smoothly, and was not prompted by suspicion of a perforation; yet she initially claimed that the scan was a "quality assurance" step to reassure herself that the position of the IUCD was correct. The inconsistency in her explanation is of concern.

Dr Isbell advised that it is not usual for a scan to be requested after an IUCD is fitted. One would normally "only be ordered if some gynaecological abnormality was found on examination". It would also be appropriate if perforation of the uterus was suspected.

My expert also said that Dr B's initial explanation noted for ordering the scan – to check the positioning of the IUCD – was not reasonable. Once the IUCD is beyond the cervical canal, it is considered to be in place in the uterus. "Bimanual examination would have shown no tenderness. The strings would be palpable in the vagina, and visible coming through the cervix, when viewed with a speculum in situ." Dr B did not perform a bimanual examination. I accept Dr Isbell's advice that to order a scan in these circumstances was very unusual.

If Dr B had sufficient concerns about the placement of the device to warrant requesting a scan, she should have performed a bimanual examination, informed Mrs A of her concerns, and taken immediate action (such as a referral to hospital). In my view Dr B's actions did not demonstrate the standard of care and skill expected of a general practitioner, and amounted to breach of Right 4(1) of the Code.

I also agree with Dr Isbell's advice that it was inappropriate for Dr B to pay for the scan herself, unless she was accepting responsibility for a complication of the insertion, in which case she should have been open about it. Dr B's initial explanation that it was a "quality assurance expense" is unconvincing. I suspect that Dr B's muddled explanations reflect a lack of clarity in her own mind – worry about the course of the procedure, and a perception that cost was an issue for Mrs A. Although I do not believe Dr B's motive was sinister (to cover up her actions), her offer to pay for the scan herself was inappropriate and unethical, and amounted to a breach of Right 4(2) of the Code.

Pain relief

Mrs A said that Dr B gave her two sample bottles of Synflex from a drawer in the consultation room. Dr B stated that she gave Mrs A one sample bottle of Synflex and a handwritten prescription for Synflex for future period pain. The notes do not mention the medication or any prescription for this consultation, so I cannot resolve this discrepancy.

After Mrs A had taken seven tablets from one of the bottles, she noticed that the medication in both bottles had expired in August 2002.

My advisor stated that every bottle of sample medication should be checked before being given to a patient, even where the doctor believes (as Dr B did) that he or she has previously checked all the medication in a cupboard.

Dr Isbell also advised that Dr B should have arranged to see Mrs A after the telephone call, especially as Dr B already had concerns about the procedure, and the pain Mrs A was continuing to experience was not normal.

In my view, Dr B's failure to check the medication she gave to Mrs A, and to arrange to see her again following the telephone call complaining of severe pain, was poor practice and amounted to a breach of Right 4(1) of the Code.

Record-keeping

The notes made for the counselling session on 29 August were made retrospectively and do not adequately record what was discussed and, in particular, what risks were discussed. If,

as occurred in this case, contemporaneous handwritten notes are made, they should be entered into the patient's computerised records soon afterwards – not several days later. The paper notes should also be kept. The appointment book does not record the counselling consultation on 29 August. It is important that all appointments are recorded for auditing purposes, and to provide information for future heath care providers.

In addition, the notes do not record:

- Mrs A's severe pain during the procedure or at the time of her telephone call to Dr B on 3 September;
- Mrs A's telephone conversation with Dr B on 2 September;
- Dr B's dispensing of a sample bottle of Synflex medication to Mrs A;
- that Dr B sent Mrs A a cheque to pay for the scan.

In my view, Dr B's record-keeping was significantly below professional standards and amounted to a breach of Right 4(2) of the Code.

Summary
Dr B counselled Mrs A about the use of an IUCD for contraception at the first consultation, and inserted the device at a second consultation. Dr B provided Mrs A with information about the device and the procedure, but her notes do not accurately record what was discussed. In particular, it is unclear what specific risks of the procedure Dr B discussed with Mrs A. The risk of perforation of the uterus was not discussed. Dr B decided to perform the insertion procedure in a 'makeshift' environment, instead of the treatment room, which was set up for the procedure. This contributed to Dr B performing a substandard procedure in awkward conditions, and may also have contributed to the perforation of Mrs A's uterus. Dr B also did not make appropriate follow-up arrangements when she ordered a scan without relaying her concerns about the procedure to Mrs A, attempted to pay for the scan with a personal cheque, provided out-of-date medication for pain relief, and failed to examine Mrs A when she telephoned in severe pain the day after the procedure. Dr B's actions fell well below the standard of care expected of a general practitioner.

Opinion: No Breach – the Medical Centre

Employers are responsible under section 72(2) of the Health and Disability Commissioner Act 1994 for ensuring that employees comply with the Code. Under section 72(5) it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the employee from breaching the Code.

The Centre advised that the treatment room was available for Dr B to use, and contained the appropriate equipment required for the procedure. Nursing assistance could be requested, if necessary.

I am satisfied that at the time Mrs A consulted Dr B at the Centre for the insertion of the IUCD, there was an appropriate room, equipment and nursing support in place for the procedure. In these circumstances, the medical centre is not vicariously liable for Dr B's breaches of the Code.

Action taken

Dr B provided a written apology to Mrs A, in which she stated:

> "I write to express my sincere regret for the events which led to your complaint to the Health and Disability Commissioner regarding the IUCD insertion I performed and the circumstances arising from this.
>
> It was not my intention to cause you harm in any way, or for you to receive anything but the best care. For the pain and concern you and your family experienced I offer my full and heartfelt apologies.
>
> I acknowledge the pain that you felt during the IUCD procedure and subsequently.
>
> I apologise for any lack of information or explanation I provided to you. I recommended an ultrasound scan for reassurance at the time, and did not intend in any way to mislead or falsely reassure you. I apologise that I did not recognise that the procedure had not gone well at the time.
>
> I understand that it is important to you that I ensure that the errors which occurred with the IUCD insertion you experienced will not happen again. I assure you that this will be the case. I have reviewed my practice in light of the criticisms made by yourself and Dr Isbell and I have learnt from the errors I made."

Recommendation

I recommend that Dr B review her practice in light of this report and, in particular, undertake further training in the insertion of IUCDs with an experienced general practitioner recommended by the Royal New Zealand College of General Practitioners.

Follow-up actions

- A copy of my final report will be sent to the Medical Council with a recommendation that the Council undertake a review of Dr B's competence.

- A copy of my final report will be sent to the Royal New Zealand College of General Practitioners with a request that the College arrange for Dr B to receive further training in the insertion of IUCDs from an experienced general practitioner recommended by the College.

- A copy of my final report, with details identifying the parties removed, will be sent to the Family Planning Association of New Zealand, Women's Health Action, and the Federation of Women's Health Councils Aotearoa and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Non-referral to Director of Proceedings

A number of features of this case indicate that a referral to the Director of Proceedings may be indicated. However, having considered Mrs A's wishes (that she does not wish the case to go to a hearing; her only concern is that another patient does not suffer the same experience), Dr B's response (she has apologised and indicated her willingness to undertake further training and a competence review) and the public interest, I have decided not to refer Dr B to the Director of Proceedings.