Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Deputy Health and Disability Commissioner

(Case 20HDC02087)

Introduction

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

2. Mrs A complained on behalf her son, Master A (aged 15 years at the time of events). The report discusses the care provided to Master A in October and November 2020 by Dr B,[1] a general practitioner (GP) at a medical centre, when Master A underwent circumcision for cultural reasons.[2]

3. The following issues were identified for investigation:

- *Whether the medical centre provided Master A with an appropriate standard of care in October and November 2020.*
- *Whether Dr B provided Master A with an appropriate standard of care in October and November 2020.*

[1] Dr B works as a GP (independent contractor) at the medical centre and also provides circumcision services under a separate business. Dr B told HDC that he has been performing circumcision operations for over 30 years and has operated on over 10,000 patients.
[2] Circumcision is the surgical removal of foreskin or the skin covering the tip of the penis.

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

4. The parties directly involved in the investigation were:

Master A	Consumer
Mrs A	Complainant
Dr B	GP
Medical Centre	Group provider

5. Registered Nurse (RN) C is also mentioned in the report.

Events leading to complaint

Consultation

6. On 15 October 2020 Master A attended a consultation with Dr B at the medical centre to discuss circumcision for cultural reasons. Master A was accompanied by his father and his grandmother. Dr B told HDC that they confirmed that Master A was healthy and had no significant medical history or drug allergies.

7. Master A was asked to remove his underwear and lie on the table, at which point Dr B proceeded to demonstrate to Master A and his whānau how the procedure would occur. Dr B told HDC that this involved handling Master A's genitals to show which part of the foreskin would be cut and removed. Dr B stated that he indicated the two areas where Master A would receive his local anaesthetic injections, and advised Master A that stitches would be required.

8. After demonstrating the surgical process, Dr B advised Master A to lose weight, as the procedure is more difficult in overweight children, and advised him to shave his pubic hair before the procedure. Dr B then asked Master A and his whānau to listen to a short piece of audio on his phone, which emphasised that the most serious risk of the surgery is postoperative bleeding, which may necessitate admission to hospital. An appointment was made for 1 November 2020 for Master A to undergo the circumcision procedure, and the whānau were provided with an information sheet/consent form for signing. The form outlined a brief description of the procedure to be undertaken, the complications, and the postoperative care required.

Circumcision procedure

9. On 1 November 2020, Master A arrived with his parents and his grandmother for his surgery. The consent form was signed and returned to Dr B. Dr B then asked Master A to lie on the table to administer the local anaesthetic on his penis. At this point, Master A's grandmother and his parents heard Dr B remark that Master A had not shaved as requested and enquire whether Master A had managed to lose any weight, to which Master A said that he had forgotten to shave and that he thought he had lost some weight. Mrs A told HDC that she was troubled by Dr B's comment about weight loss.

10. Mrs A stated that Master A is very shy, and he felt nervous about exposing his genitals to Dr B. She said that Master A also felt sad after being told to lose weight. Mrs A felt that Dr B's overall manner and communication was disrespectful, and that Dr B was inconsiderate

towards the sensitivity of the procedure and their whānau's cultural values. Dr B apologised if his comments about Master A's weight and shaving were insensitive and stated that they were not intended to be.

11. In a further response to HDC dated 11 August 2022, Dr B reiterated that often circumcision is more difficult in overweight children, and that to 'expose' the penis to perform circumcision, often the nurse needs to place pressure on the patient's suprapubic and lower abdominal areas. Dr B noted that overweight children are more at risk of postoperative complications, and generally take a longer time to heal fully.

12. After administration of the local anaesthetic, Master A and his whānau were asked to return to the main reception area to wait for 40 minutes until the anaesthetic became effective. When Master A was called back into the treatment room, RN C asked Master A to lie on the bed and trimmed his pubic hair, with consent from Master A's father. Dr B confirmed to HDC that he asked Master A's whānau to leave the room before he started the procedure. Dr B told HDC that he does not permit parents to be in the operating room for safety reasons due to two recent episodes of fathers fainting, and because this affects his and the nurse's ability to concentrate on the task in hand. Mrs A said that Dr B did not tell them this until after the procedure had been completed.

13. While the circumcision procedure was being undertaken, Master A's whānau waited in the corridor area. Mrs A told HDC that she could hear Master A grunting and Dr B and RN C telling Master A to 'relax'. Mrs A said that twice she had to call out to reassure Master A. She stated that she asked Mr A whether he had been present during their elder son's circumcision procedure. She said that Mr A confirmed to her that he had been in the room during their elder son's circumcision and was surprised that they were asked to leave the room during Master A's procedure.

14. Mrs A told HDC that both Dr B and RN C seemed to be amused, and there was laughter, while she and her husband remained concerned that Master A was not settling. Mrs A felt that it would have been beneficial for a whānau member to be present during the procedure to comfort and support Master A. Dr B told HDC that he had attempted to use humour to settle Master A, who was very anxious and unsettled. Dr B acknowledged that on reflection, a better course of action would have been to invite one or both of Master A's parents in to help to settle him.

15. Mrs A told HDC that after the procedure had been completed, she asked Dr B why it had taken so long, and Dr B replied: '[B]ecause [Master A's] thighs are so big, and [Master A] kept "freezing up" it took longer than usual, which is why I had advised him to lose weight.' Dr B told HDC that the procedure took a little longer than usual due to technical challenges and the additional time spent trying to settle Master A.

16. At some stage, Master A's whānau re-joined Master A as he recovered from his surgery. Mrs A told HDC that approximately 20–30 minutes after the procedure, Dr B reached out and opened Master A's sarong without any explanation or asking for consent to examine Master A's penis. Dr B told HDC that he did this to check that there was no significant postoperative

bleeding. He apologised for not formally obtaining consent from Master A or his parents to examine the operation site.

17. Mrs A told HDC that Dr B then played an audio clip from his phone and used hand motions, pointing to Master A's penis and showcasing the use of an antiseptic solution. Dr B explained that the recording set out the postoperative instructions for Master A and advised how to care for him, what the operation site would look like, and when to return for follow-up. Mrs A was concerned by this and said she asked Dr B why he could not convey the information directly rather than playing an audio recording. Mrs A said that Dr B told her that this was to avoid him having to repeat himself. Dr B acknowledged that it would have been more appropriate for him to speak directly to Master A and his parents to explain this, and he apologised for not doing so.

18. Dr B also apologised for having appeared abrupt or rude following the procedure. In addition, Dr B apologised to Master A for any hurt or disrespect he felt because of his conduct, and Dr B apologised to Mr and Mrs A for care that fell below the standards he usually sets for himself.

Responses to provisional opinion

Whānau

19. Mr and Mrs A and Master A were given an opportunity to respond to the provisional report. A hui ā-whānau was held to discuss the report. They accepted the findings and thanked the Office for this investigation. Mrs A said she hoped that this would not happen to any other child, and also that she now feels that her whānau have finally received closure.

Dr B

20. Dr B was given an opportunity to respond to the provisional opinion. He said that he unreservedly accepted the findings and recommendations made by Dr Caldwell. Dr B also thanked this Office for a fair and thorough assessment.

Medical centre

21. The medical centre was given an opportunity to respond to the provisional opinion. It stated that it had no further comments.

Opinion: Dr B — breach

Introduction

22. Master A presented to Dr B on two occasions — in October for a consultation and in November 2020 to undergo circumcision for cultural reasons. Master A was 15 years old at the time of these consultations.

23. Mrs A said that Dr B denied Master A's right to a support person, that he told Master A to lose weight, that he used pre-recorded audio clips to communicate with Master A and his whānau, and that after the procedure, Dr B opened Master A's sarong to examine his penis without consent or an explanation of why he needed to do so. Mrs A felt that the procedure was not carried out in a way that was respectful of Master A and was culturally insensitive.

Mrs A told HDC that Master A is very shy and had never exposed his genitals to anyone previously, and this incident affected his confidence.

24. Dr B apologised for any hurt or disrespect Master A suffered. Dr B stated that there was no intention to hurt Master A and accepted that this was 'clearly a substandard episode of care which fell far below the standards [Dr B] normally set for [himself]'.

25. As a GP and a healthcare provider, Dr B has a responsibility to ensure that his services are provided in accordance with the Code of Health and Disability Services Consumers' Rights (the Code) and the applicable standards. After carefully reviewing all the information on file, including the responses provided by Mrs A and Dr B, I have found that Dr B breached Rights 6 and 7 of the Code. I set out my reasoning for this decision below.

Informed consent — breach

26. According to Right 6(2) of the Code, before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent. Right 7(1) of the Code states that every consumer has the right to receive services only if that consumer makes an informed choice and gives informed consent.

27. Mrs A told HDC that after the procedure, Dr B opened Master A's sarong without consent from Master A or any forewarning, in the presence of Master A's whānau. Dr B acknowledged that he did not 'formally' seek consent from Master A prior to opening his sarong and explained that he did this to check for postoperative bleeding. Dr B apologised for this and for any hurt or disrespect Master A suffered.

28. In my view, although Master A had consented to undergo circumcision, this did not mean that Dr B could continue further physical examinations without explicitly gaining Master A's consent for each examination. Master A had the right to be informed about Dr B's intention to examine his postoperative site, and the reasons for that examination, and he had the right to give or withhold his consent.

29. Consenting is an ongoing process, and care must be taken to protect the privacy and dignity of consumers. Given Master A's vulnerability as a young person, the intimate nature of the examination, and the presence of Master A's whānau in the room at the time, I find Dr B's action of opening Master A's sarong unacceptable.

30. Whilst it was clinically appropriate to ensure that the surgical site was not bleeding, Dr B did not explain to Master A his intention and his reason for doing so, prior to the examination. This is information that a reasonable consumer in Master A's circumstances needed to receive to give informed consent to the examination. I therefore find that Dr B breached Right 6(2) of the Code. It follows that without being adequately informed of the postoperative examination to be undertaken, Master A was not in a position to give his informed consent to the examination, and Dr B has acknowledged that he did not obtain Master A's consent prior to the examination. I therefore find that Dr B breached Right 7(1) of the Code.

31. Had Dr B given Master A the information he was entitled to receive, and obtained his consent to the examination, not only would Dr B have upheld Master A's rights as a healthcare consumer, but also would have preserved his dignity and sense of safety. As such, I ask that Dr B reflect carefully on these events, and I address this further under the recommendations section.

32. Mrs A also told HDC that in their culture, it is not usual to show your 'private parts', and she wishes Dr B had been more sensitive to that. Whilst I acknowledge Mrs A's concerns, I note that it is not appropriate in any circumstance to undertake a sensitive examination without first obtaining the consumer's informed consent.

Right to a support person — no breach

33. The Medical Council of New Zealand's policy statement, 'When another person is present during a consultation' (referred to in Appendix A) states that patients have a right to have a support person present except when safety is compromised. In addition, Right 8 of the Code states that every consumer (including adolescents) has the right to one or more support persons of their choice present, again except where safety may be compromised.

34. Mrs A told HDC that her husband and her mother had been present in the procedure room when their elder son had undergone a circumcision procedure seven years previously, and, as such, they expected to be present during Master A's procedure. Mrs A said that during the procedure she could hear Master A grunting heavily, and she regrets not being there for her son. She said that she could hear Dr B's and RN C's attempts to settle Master A. Mrs A said that after the procedure, Master A was emotional and glad that it was over.

35. Dr B told HDC that he declined Master A's parents request to be present in the room because of previous incidents that had compromised the safety of his patients. However, Dr B did not state whether he communicated this reasoning to Master A's parents before the procedure. Dr B acknowledged that in hindsight, it would have been useful to have had one of Master A's parents present during the procedure. Dr B apologised and stated that he regrets not having done this.

36. I acknowledge Mrs A's distress at not being able to support her son, and I can understand why, as acknowledged by Dr B, Master A may have benefited from having his parents present during the procedure. However, I accept Dr B's reasoning for not allowing Master A's parents to be in the procedure room. Patient safety is paramount during any medical procedure, and this superseded Master A's right to have a support person present, as reflected in the Code and the Medical Council's policy statement.

37. Whilst I acknowledge that Master A's brother benefited from having a support person present, it is entirely appropriate for Dr B to implement any changes needed to protect his patients' safety. It would also have been acceptable for Dr B to re-evaluate the safety of the procedure when Master A continued to be unsettled. Dr B considers that it may have been more beneficial to have had a parent present as the balance of safety had shifted. Dr B stated that he now explains this to parents during the first consultation, and he has updated

the information sheet/consent form, which gives parents and/or the adolescent sufficient opportunity to switch to another provider if they are dissatisfied with the conditions.

Communication and respect — educational comment

38. Mrs A told HDC that on two occasions, Dr B played pre-recorded audio clips to Master A and his whānau — once before the procedure to explain the risks associated with circumcision, and again following the procedure to explain postoperative bleeding. She raised concerns about Dr B's manner of communication.

39. Communication represents a fundamental clinical skill that involves the establishment of a therapeutic relationship, understanding of the patient's perspective, and exploring thoughts and emotions. It is well documented that the communication process can have a profound effect on a consumer's health status and functioning. The Medical Council's statement on cultural safety (referred to in Appendix A) states that doctors should include the patient's whānau in their health care when appropriate. Doctors should communicate effectively with all patients and recognise that the verbal and non-verbal communication styles of patients may differ from their own, and they may need to adapt as required.

40. Whilst I acknowledge that Dr B's practice of playing pre-recorded audio clips was not compatible with the whānau's preferred form of communication, audio recordings can be a valuable tool for educating patients, and, in my view, it is acceptable to use these. However, physicians must ensure that patients and their whānau have sufficient opportunities to discuss their concerns before and after such use, to encourage active participation from consumers. When looking at the overall situation, Dr B used several techniques to communicate with Master A and his whānau. An information sheet provided at the initial consultation, one month prior to the procedure, outlined the nature of the procedure and the risks associated with it. This gave the whānau a reasonable opportunity to consider the information and to follow up and ask further questions if needed. I also acknowledge that Dr B has now updated the information sheet/consent form to include further information, which otherwise would have been relayed through the pre-recorded audio clips. Accordingly, I am satisfied that Dr B's communication with Master A and his whānau in this respect was adequate.

41. Mrs A also told HDC that during the procedure, she heard laughter from Dr B, whilst Master A appeared to be in pain. This left Mrs A and her husband feeling anxious and distressed. Dr B stated that he attempted to use humour to calm Master A, who was distressed. In hindsight, Dr B acknowledged that this was not appropriate and apologised for his conduct.

42. Master A was in a vulnerable position, and it must be acknowledged that a procedure involving intimate areas is an uncomfortable situation for most people, particularly for adolescents. However, I acknowledge that Dr B's use of humour was well intentioned and that it was done to attempt to relieve Master A's discomfort. It is well documented that humour can decrease stress and relieve tension. Nevertheless, I encourage Dr B to be cautious about how his use of humour may be interpreted by others.

43. Mrs A told HDC that she was left feeling troubled by Dr B's comments on weight loss and said that Master A felt sad about this. Dr B told HDC that circumcision can be challenging in overweight children, and this is why he advised Master A to lose weight.

44. I acknowledge that talking about weight loss can be an uncomfortable situation for adolescents. Care should be taken to tailor the discussion to the individual patient, taking into account the sensitive nature of the topic and the discrimination faced by many overweight people. As Master A's healthcare provider, it was appropriate for Dr B to advise Master A to lose weight if necessary, and such advice was relevant to the circumcision procedure. From the information provided, I am unable to determine whether this was done respectfully. However, Dr B's tone and manner of communication clearly had an adverse impact on Master A and his whānau. I encourage Dr B to ensure that he uses sympathetic and thoughtful language in the future when advising his patients on weight loss, and I make further recommendations on this below.

Information sheet/consent form — other comment

45. Master A presented to the medical centre for his circumcision. In the consent form provided to Master A and his whānau, the address listed for the service is that of the medical centre. The contact details also state Dr B's email address as including the name of the medical centre.

46. The medical centre told HDC that it did not employ or engage Dr B for the circumcision services provided to Master A. However, the medical centre does lease rooms to Dr B and provide reception services for his separate circumcision services, under the name of Dr B's business. This is a personal business that is run and operated separately by Dr B outside the ordinary working hours of the medical centre's primary business.

47. The medical centre stated that it does have a separate agreement with Dr B to provide GP services as an independent contractor. However, this does not include circumcision services. I remind Dr B that patients have a right to know the complete identity of the business that is providing them with services. I address this further under the 'recommendations' section below.

Opinion: Medical centre — no breach

48. I have concluded above that Dr B breached Rights 6(2) and 7(1) of the Code.

49. Dr B is contracted to provide GP services at the medical centre. However, although Master A's procedure took place within the rooms at the medical centre, Dr B was not employed or contracted by the medical centre to provide circumcision services. He provides these services under a separate business. I have discussed this above and will recommend that Dr B make this arrangement clearer for consumers.

50. As a healthcare provider, the medical centre is responsible for providing services in accordance with the Code. Even if I considered that the circumcision services provided by Dr B were sufficiently linked to the services provided by the medical centre, such that it

could be held responsible for Dr B's failings, I note that individual providers are responsible for obtaining informed consent for the procedures they perform. In addition, it would be reasonable for the medical centre to expect Dr B to obtain consumers' informed consent appropriately for the examinations he performs.

51. I am satisfied that the deficiencies identified in this investigation relate to the care provided by an individual clinician, rather than any systemic issues. As such, I consider that the medical centre did not breach the Code.

Changes made since events

52. Dr B advised that he is now more mindful of how he communicates, and he tries to communicate in a more sensitive manner.

53. Dr B said that he has abandoned the postoperative audio advice that previously he asked patients and their families to listen to, and now he communicates this information directly.

54. Dr B told HDC that he has added more information to his initial consultation regarding the potential pain or discomfort a child may feel during the procedure, and has added this information to the consent form, as well as the offer of referral to another provider if the patient prefers a general anaesthetic.

55. Dr B has also added more information on the circumcision consent form, which states that parents are not permitted in the operating room, and that if this does not suit them, Dr B can refer them to another doctor. Dr B also explains this during the initial consultation with families. However, Dr B stated that he does make exceptions for young and particularly nervous or anxious children.

Recommendations

56. I acknowledge the changes already made by Dr B. In addition, I recommend that Dr B:

a) Provide a formal written apology for the concerns identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Master A and Mrs A.

b) Review the Best Practice Advocacy Centre's guidelines on how to address weight issues in young people and families,[3] and confirm to HDC that this has been completed, within three months of the date of this report.

c) Complete HDC's online module on Informed Consent[4] and provide HDC with a reflection on what has been learnt, within three months of the date of this report, for forwarding to Master A and Mrs A.

[3] Best Practice Advocacy Centre New Zealand (2012). Addressing weight issues in young people and families in New Zealand. BPJ 45: Addressing weight issues in New Zealand (bpac.org.nz).
[4] Health and Disability Commissioner (2023). Online Learning: https://www.hdc.org.nz/education/online-learning/

d) Amend the consent form to clarify that circumcision services are provided under Dr B's business, which is separate from the services at the medical centre, within three weeks of the date of this report.

Follow-up actions

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

58. A copy of this report with details identifying the parties removed will be sent to the Royal New Zealand College of General Practitioners and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Relevant policies and standards

The Medical Council of New Zealand's policy statement (2004),[5] 'When another person is present during a consultation', states:

> 'For some or all consultations a doctor or patient may want another person present … The support person(s) has the right to have one or more support persons of his or her choice present, except where safety may be compromised or another consumer's rights may be unreasonably infringed.'

The Medical Council's statement on cultural safety (2019) states:

> 'Cultural safety requires [doctors] to engage in ongoing self-reflection and self-awareness. This includes a respect for patient's cultural beliefs, values, and practices …
>
> Understanding that [the] patient's cultural beliefs, values, and practices influence their perceptions of health, illness, and disease, how they respond to and manage their health, and their treatment decisions and interactions with doctors, other health professionals, and the wider health system.'

It also states:

> 'Cultural safety requires [doctors] to consider the sources and determinants of inequities and to implement reflective practice so you can:
>
> Build a relationship and provide a healthcare environment that supports the cultural safety of all patients.
>
> Self-assess and learn to recognise when your actions might not be acceptable to patients.
>
> Include the patient's whānau in their healthcare when appropriate.
>
> Communicate effectively with all patients and recognise that the verbal and non-verbal communication styles of patients may differ from your own and that you will need to adapt as required.'

[5] This policy statement was updated in 2022.