Plastic Surgeon, Dr B

A Report by the

Health and Disability Commissioner

(Case 11HDC01438)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

Background

1. On 29 October 2010, Mrs A consulted a plastic surgeon, Dr B, at his clinic, to discuss breast reduction surgery. Mrs A told Dr B of her concerns about postoperative infection, but Dr B allayed all her fears and gave her confidence that she would have nothing to worry about.

2. Mrs A consented to the surgery, and it was performed on 7 February 2011.

3. Mrs A developed postoperative infections in her wounds. She telephoned the clinic and advised a nurse that she was nauseous and feeling hot and cold. Dr B instructed Mrs A to discontinue her antibiotics. Mrs A continued to feel ill and became increasingly concerned. She presented at the clinic and consulted with either Dr B and/or his nurse on 14, 16, 21, 23 and 28 February, and she also called the clinic on 24 February. During that time, Mrs A was prescribed an oral antibiotic and an antibiotic ointment, and swabs of her wounds were taken.

4. The swabs cultured methicillin-resistant *Staphylococcus aureus* (MRSA) and *Staphylococcus aureus*. There is no evidence that Mrs A was informed that she had an MRSA infection, or that her general practitioner was informed. Mrs A presented at the clinic again on 7, 25 and 30 March, and she was referred to the District Nurse. The District Nurse was also not advised that Mrs A had an MRSA infection.

Findings

5. The evidence suggests that it is more likely than not that Mrs A and Dr B discussed the risk of infection at the consultation on 29 October 2010. However, in attempting to allay Mrs A's concerns about the procedure, it appears that Dr B may have understated the risk. Dr B did not take sufficient care to ensure that Mrs A's expectations in that regard were appropriately managed, particularly given her experience and expressed concerns in relation to infection. It was recommended that Dr B review his practice and take greater care in the future when discussing the risks of surgery with patients.

6. Dr B should have reviewed Mrs A more closely after 28 February 2011, when it was known that her wound swab had cultured MRSA. Dr B did not provide postoperative services to Mrs A with reasonable care and skill, and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[1]

7. Dr B breached Right 6(1)(f)[2] of the Code for failing to inform Mrs A of the results of the swabs, and that she had an MRSA infection. Dr B also breached Right 4(5)[3] of the Code for failing to inform Mrs A's general practitioner and the District Nurse that Mrs A had an MRSA infection, which was information they required to ensure that her ongoing care was co-ordinated.

[1] Right 4(1) of the Code states: "Every consumer has the right to have services provided with care and skill."
[2] Right 6(1) of the Code states: "Every consumer has the right to the information that a consumer, in that consumer's circumstances, would expect to receive, including — (f) the results of tests…".
[3] Right 4(5) of the Code states: "Every consumer has the right to co-operation among providers to ensure quality and continuity of services."

8. Dr B's record-keeping in this case was incomplete and inadequate, and a breach of Right 4(2) of the Code.[4]

Complaint and investigation

9. The Commissioner received a complaint from Mrs A about the services she received from plastic surgeon Dr B. An investigation was commenced on 25 September 2012, and the following issue was identified for investigation:

Whether Dr B provided Mrs A with an appropriate standard of care between October 2010 and March 2011.

10. The parties directly involved in the investigation were:

Mrs A	Consumer
Mr A	Consumer's husband
Dr B	Provider, plastic surgeon
Dr C	Provider, general practitioner
Dr D	Provider, plastic surgeon

Also mentioned in this report:

RN E	Registered nurse

11. Information was also reviewed from the District Health Board and ACC.

12. Independent expert advice was obtained from a plastic surgeon, Dr David Glasson, and is attached as **Appendix A**.

Information gathered during investigation

13. Dr B is the sole director of the clinic. He has been vocationally registered as a plastic surgeon since 1989.

Preoperative consultations

14. Mrs A told HDC that she was keen to have breast reduction surgery to improve her quality of life, as the weight of her large breasts was causing shoulder pain and some back ache. Mrs A advised HDC that she had some fears about the surgery because she had seen a television programme about a woman in Melbourne who experienced severe postoperative infections and "horrific scarring", and because Mrs A had

[4] Right 4(2) of the Code states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

previously experienced an infection following the removal of a benign lump from her left breast.

15. Mrs A advised that she "finally … got the courage" to pursue surgery and she consulted Dr B on 29 October 2010 to discuss her options for breast reduction. Mrs A's husband, Mr A, attended the appointment with her.

16. Mrs A recalled that, at the consultation, she discussed her concerns about postoperative problems including infection and scarring, and she specifically mentioned the experience of infection following the removal of the benign lump on her left breast, and the case of the woman in Melbourne. Mrs A recalled that Dr B said that the woman in the programme had undergone too many procedures at once, and this had led to her issues with infection. Mrs A recalled that Dr B "reassured [her] that this would not happen to [her]", and that he told her she was a "good case for the procedure" as her bra straps had caused deep ruts in her shoulders. Mrs A said she was made to feel that she was an ideal candidate for the surgery. She stated: "[Dr B] allayed all of my fears and stated I would have absolutely nothing to worry about." Accordingly, Mrs A decided to proceed with the surgery.

17. Dr B recalled that Mrs A was concerned that she could have similar problems to the woman on the programme. Dr B stated:

> "I explained to her to the best of my knowledge why this may have happened and what we would do to try and prevent it, and that I felt there was a low likelihood of her developing this problem."

18. Dr B told HDC that he discussed with Mrs A the major risks of breast reduction, including bleeding, infection, numbness, scarring and slow healing. Mrs A stated that the risks of surgery were not explained to her during the consultation, although she recalled that Dr B said she might experience loss of feeling and more sensitivity. Mr A confirmed Mrs A's account of the consultation, and stated: "[Dr B] did his best to allay any fears whatsoever."

19. Dr B gave Mrs A a copy of *A Consumer Guide to Cosmetic Plastic Surgery in New Zealand*,[5] suggesting that she read the chapter on breast reduction. Mrs A told HDC that Dr B drew on the book showing where he would make the cuts and where the stitches would be. The chapter on breast reduction includes a section on "complications", which includes infection, and states:

> "This is also uncommon following breast reduction. The use of intravenous antibiotics helps prevent infection, as does a careful surgical technique. An infection will delay wound healing, but will not usually affect the long-term result."

[5] The New Zealand Foundation for Cosmetic Plastic Surgery with Lyn Barnes, *A Consumer Guide to Cosmetic Plastic Surgery In New Zealand* (Auckland: The New Zealand Foundation for Cosmetic Plastic Surgery, 1997).

20. Mrs A said that Dr B did not give her any other written information. In contrast, Dr B provided HDC with a number of documents about breast reduction, and said that he gave Mrs A copies of these, underlining the complications. These documents specifically address risks such as wound infection.[6]

21. The handwritten notes of the consultation state:

> "34ff. Shoulder ache. L>R … chest/under hurt. Bra too tight. L>R. Rashes. [Irritation]. FF. > C."

22. Dr B advised HDC that a form entitled "Informed Consent" (the Informed Consent Form) was sent to Mrs A. Mrs A and Dr B signed the Informed Consent Form for breast reduction surgery on 10 November 2010. The Informed Consent Form notes:

> "I understand that there are risks and hazards related to the performance of the surgical procedures planned for me. I realise that common to surgical procedures is the potential for infection, swelling, bruising, bleeding, blood clots in veins and lungs (extremely rare), and allergic reactions. I also realise that the following risks and hazards may occur in connection with this procedure: unsatisfactory appearance, poor healing, skin loss, nerve damage with associated sensory changes or prolonged pain and discomfort, or unattractive scarring."

23. On 17 January 2011, Mrs A attended a further preoperative consultation. Dr B advised HDC that he was present at that consultation, and that "there was discussion of her admission to Hospital, what was involved in the procedure; she had photographs taken, measurements were taken for her post operative surgical garment, and any queries she had, answered". Dr B said that the Informed Consent Form was returned to him on this date and was discussed with Mrs A. Mrs A does not recall Dr B being present at the consultation, nor does she recall a conversation about the surgery that day.

Breast reduction surgery

24. On 7 February 2011, Mrs A underwent breast reduction surgery at a private hospital.

25. Dr B told HDC that the anaesthetist gave Mrs A intravenous antibiotics, and this was continued while she was in hospital. The surgery was uneventful. Dr B's operation note records:

> "Bilateral breast reduction. Removal of 500gm from left and 260gm from right. Inferior/breast mound technique. 3/0PDS, 4/0 vicryl, 4/0 monocryl [sutures]. See one week."

26. Dr B prescribed four days of the antibiotic Ceclor.

27. Mrs A remained in hospital for two days, and "no concerns" is recorded in her clinical notes on both days.

[6] One of the brochures, called "Breast Lift and Breast Reduction, A guide for women", published by the Australian Society of Plastic Surgeons Inc., states that wound infection is not common.

Postoperative care

28. Mrs A said that she started feeling very unwell when she returned home.

29. On 11 February 2011, Mrs A telephoned the clinic and spoke with a registered nurse (RN), RN E. RN E documented that Mrs A was "nauseous, hot + cold. Afebrile." The nurse spoke with Dr B, and subsequently told Mrs A to stop taking the antibiotics.

30. Mrs A told HDC that she was told she was experiencing an allergic reaction to the antibiotics and she should stop them. Dr B told HDC that "it was felt safe to stop the antibiotics as this is often the commonest cause of post [operative] nausea". Dr B also stated:

> "I consider it was appropriate to suggest she stop the prophylactic antibiotics that she was on because of severe nausea, and because she had already received intravenous antibiotics intraoperatively and in hospital, and oral antibiotics since discharge."

31. Mrs A advised HDC that she continued to feel ill and that she became increasingly concerned. She also said that her wounds were "awful" and "hurting continuously". Mrs A further advised: "I really regret the very bad decision to stop the antibiotics."

32. Mrs A consulted Dr B again on 14 and 16 February. There are no clinical notes for the consultations on these days; however, Dr B recalled that on 14 February Mrs A was "still experiencing problems with nausea with some redness of the wounds but not excessive".

33. On 21 February 2011, Mrs A again consulted Dr B at the clinic. The only clinical note, which is unsigned, records: "Pt (S)." Dr B told HDC that the notes indicate that co-trimoxazole, an oral antibiotic, was prescribed. He said that the wounds were "redder and there was some minor dehiscence[7] at the T junction[8]" and that his nurse took a swab of the wounds.

34. On 23 February 2011, Mrs A attended the clinic and was seen by a nurse. The nurse documented that Mrs A was "feeling nauseated ++. Unable to eat." The nurse discussed this with Dr B, who suggested that Mrs A shower, then apply Bactroban[9] and a non-stick dressing. The documented plan was for Mrs A to return in one week. Mrs A said that she received no instructions on how to apply the Bactroban.

35. The results of the swabs taken on 21 February 2011 were reported on 23 February 2011, and received by Dr B on 24 February 2011. The results showed a "heavy growth of Staphylococcus aureus (MRSA[10])" on the left breast, and a "heavy growth Staphylococcus aureus" on the right breast. Dr B said that, in light of the laboratory report, it was appropriate for Mrs A to continue taking co-trimoxazole.

[7] Wound dehiscence is the separation of the layers of a surgical wound.
[8] Where the horizontal and vertical scars meet at the bottom of the breast.
[9] Bactroban is an antibiotic ointment.
[10] Methicillin-resistant *Staphylococcus aureus*.

36. Dr B told HDC that "[Mrs A] was informed that there was an infection, and that she needed further antibiotics". He does not recall when she was advised of this. Mrs A said that Dr B told her she had a "bad wound infection" during "the appointment following the one where he swabbed the breasts", but did not mention MRSA.

37. On 24 February 2011, Mrs A telephoned the clinic. She reported feeling less nauseated but having very painful breasts, despite taking Nurofen. The nurse spoke with Dr B, who prescribed amitriptyline,[11] ondansetron wafers (an anti-nausea medication), and tramadol, and advised her to complete the course of co-trimoxazole. Mrs A was also advised to continue with daily showers and to apply Bactroban.

38. Mrs A told HDC that between 25 February and 25 March, the pain and redness of the wounds increased.

39. On 28 February, the nurse re-dressed the wounds and recorded that Mrs A's wounds were looking "slightly less red", and that they would see her again in one week. Dr B told HDC that he saw Mrs A on this occasion.

40. Mrs A telephoned her general practitioner, Dr C, on 1 March 2013. Dr C's notes of the telephone conversation record that Mrs A was "3 [weeks] post op", had an infection and had been having a "dreadful time". The record also noted that Mrs A regretted the surgery and would attend for a review with Dr C "when well".

41. On 7 March, a nurse at the clinic documented a telephone call from Mrs A: "Concerned about wound care." There is no further documentation about the phone call.

42. Dr B told HDC that he saw Mrs A on 7 March 2011. There are no clinical notes for a consultation on that day, but HDC was provided with a copy of a letter Dr B wrote to Dr C on 7 March, noting that Mrs A had a small area of necrosis[12] in the T junction of both breasts, but that this was "settling down very well". Dr B also told Dr C that Mrs A was having ongoing problems with feeling "quite unwell". Dr B said that he planned to see Mrs A in three weeks' time. He advised HDC that Mrs A had been prescribed doxycycline by her GP for a possible urinary tract infection, and noted that this was also suitable treatment for the MRSA infection. Dr C's notes indicate that Mrs A consulted her on 7 March 2011 complaining of six days of "suprapubic pain — [slight] dysuria — freq", and a mid-stream urine (MSU) sample was taken. The MSU was reported the next day, and Dr C's notes state: "clear urine".

43. Dr B further stated:

> "At this point, [Mrs A] was finding it very difficult to come for regular appointments from [her home to the clinic] and it was suggested she be seen three weeks hence. In the meantime, she should continue on her antibiotics with topical antibiotic treatment and we would be available to see her if she had any concerns."

[11] A tricyclic antidepressant with sedative effects.
[12] The death of some or all of the cells in an organ or tissue, caused by disease, injury, or failure of the blood supply.

44. On 22 March 2011, Dr C took a swab of the wound on Mrs A's right breast.

45. On 25 March 2011, Mrs A telephoned the clinic wanting to see Dr B as she was "in agony", but the nurses advised that he was not available. RN E referred Mrs A to the District Nursing Service for wound care. The faxed referral noted:

> "Necrosis T Junction both breasts, discomfort and anxiety [regarding] healing process. …
>
> Recently put on anti-depressants by GP. Very concerned re healing progress, could [district nurses] please take over wound care and decide on appropriate treatment. [Mrs A] very anxious & not coping well post op."

46. The referral does not mention MRSA. Dr C told HDC that Dr B did not advise her that Mrs A had MRSA.

47. Mrs A saw the District Nurse the same day. Her clinical note reads:

> "Right — 90% sloughy/necrotic base and Left — 50% sloughy/necrotic wounds …
>
> The wounds have deteriorated since her reduction and now have heavy sloughy/necrotic tissue to the wound bed. … Wounds cleansed and debridement of sloughy/necrotic tissue as able."

48. The district nurse took photographs of the wounds, took a swab of the left breast, and dressed the wounds. Mrs A saw the district nurses daily for dressing changes.

49. Mrs A consulted Dr B on 30 March 2011 with Mr A, and she showed Dr B the wounds. Mrs A recalled asking Dr B how long it would take for the wounds to heal. Mrs A said that Dr B laughed out loud and said, "[B]efore Christmas." She felt that he made "a mockery of [her] condition". She also said that Dr B "squeezed the more impacted breast and said 'we could always re stitch it'". Mrs A advised HDC that she left the appointment "devastated".

50. Dr B told HDC that the comment he made to Mrs A was not meant to be mocking, but was meant to indicate that it might take a long time for everything to heal satisfactorily. Dr B stated: "I am very sorry that she has interpreted what I said as being a comment of this nature." Dr B documented that Mrs A had not been sleeping and was depressed, and noted his plan to review Mrs A in two weeks' time. Following this appointment, Mrs A did not return to see Dr B. Mrs A advised HDC: "I did not want to see him again as his mocking style and aftercare to this point had been awful."

51. On 30 March, Dr B wrote to Dr C, stating: "[Mrs A] has had marginal necrosis of the skin flaps and subsequently the wounds have dehisced." There is no mention of MRSA in the letter. Dr B also stated in the letter that he had organised for the district nurses to do regular dressings for Mrs A, and that he planned to see her in "a couple of weeks' time".

52. On 31 March, Dr B wrote to Dr C, noting that Mrs A had called the clinic and expressed her disappointment with the results of her surgery. Dr B noted that Mrs A had advised that she did not want to return to the clinic.

53. On 6 April 2011, Mrs A saw Dr C, who took swabs of both breast wounds. The laboratory reports showed a light growth of MRSA.

54. Dr C's clinical notes record that, on the following day, Mrs A telephoned Dr C reporting "bad pain" in her right wound. Although the results of the swab were not yet available, Dr C prescribed further antibiotics for Mrs A.

55. Mrs A sought a second opinion from plastic surgeon Dr D on 14 April. Dr D examined Mrs A and documented his findings in a letter to Dr C:

> "On the right side there is a 6 x 6cm area of granulation tissue with slight undermining of the lateral skin edges. On the left side she has had a 4 x 3.5cm area of wound dehiscence of which 50% is now covered with granulation tissues and 50% has healed secondarily. The wounds are clean and there is no evidence of infection at present."

56. Dr D also noted in his letter to Dr C that options for Mrs A were either to continue dressings and conservative treatment, or to perform a split skin graft. He noted that although the skin graft would heal the wounds more quickly, Mrs A was reluctant to undergo further surgery. Accordingly, Dr D arranged for Mrs A to continue with district nurse dressings, and to return for a further review in two weeks' time. He stated in his letter: "I have given the District Nurses a note so that if there is any change in the condition of her wound then a culture should be sent to test for any new organisms. I have reassured her that her breast will eventually heal satisfactorily and she should have a good long term result."

57. Dr C also recorded in Mrs A's clinical records that she received a telephone call from Dr D on 14 April. Dr C's notes of the conversation state:

> "[Dr D] rang to say that he had seen [Mrs A]. [Patient] reassured that Breast reduction wounds will heal with regular dressings. Is to see [district nurse] for same. [Dr D] will see [patient] in a couple of weeks time for a [review]. Stated that there is no need for any more surgery at the moment."

58. Mrs A suffered from a number of wound infections over a period of nine months. She required dressing changes by the district nurses for seven months (Mrs A was discharged from the district nursing service on 16 November 2011), and she had regular review consultations with Dr D throughout 2011.

Complaint to Dr B

59. In April 2011, Mrs A complained to Dr B about his care and treatment of her, following which there was a series of correspondence between them. On 5 December 2011, Dr B wrote to Mrs A and stated:

> "… prior to your surgery, we spent considerable time discussing breast reduction and it's [sic] major risks, notably infection and tissue loss. … Major surgery such as breast reduction certainly carries risk that we discussed the most significant being infection, poor healing and tissue necrosis. It is not possible to give a 100% guarantee that there will not be an infection, poor healing, or tissue loss … Every effort was made by the Hospital and myself to prevent infection … Unfortunately you developed an infection."

60. Dr B advised HDC: "It is simply not correct for [Mrs A] to say that the major risks including, in particular, wound infection, were not discussed. Infection is indeed the most common of the risks of surgery of this type, coupled with poor healing and tissue necrosis."

Subsequent events

61. Due to personal circumstances, Dr B has reduced his hours to four days per week and has reduced the scope of his practice. He has stopped doing breast reduction surgery.

Opinion: Dr B

Preoperative information — Adverse comment

62. I accept the advice of my independent expert advisor, Dr David Glasson, that Mrs A was a suitable candidate for breast reduction, and I have no concerns about the clinical aspects of the preoperative care Dr B provided to Mrs A. However, Mrs A has raised concerns about the adequacy of the information she was given prior to giving her consent to breast reduction surgery.

63. Mrs A had the right to the information that a reasonable consumer, in her circumstances, would expect to receive prior to undergoing breast reduction surgery, including information about the expected risks of such surgery (Right 6(1)(b) of the Code).

64. Mrs A advised HDC that she was keen to have breast reduction surgery to improve her quality of life; however, she was also nervous about surgery because she had previously experienced an infection when a benign lump was removed from her left breast, and because she had seen a programme on television where a woman from Melbourne had experienced severe postoperative complications following such surgery, including infection and scarring.

65. Mrs A consulted Dr B on 29 October 2010 to discuss her options for breast reduction. Mrs A expressed her concerns about the surgery, including her concerns about infection. Mrs A said that Dr B "allayed all of [her] fears and stated [she] would have absolutely nothing to worry about". Mrs A decided to proceed with the surgery and, on 10 November 2010, she signed the Informed Consent Form for breast reduction surgery.

66. Dr B advised that he discussed the risk of infection with Mrs A, and that he provided her with written information pamphlets about the surgery, which also refer to the risk of infection.

67. Dr B did not document in the clinical records the discussion he had with Mrs A about the surgery, including the risks of surgery. He also did not document that he gave Mrs A written information pamphlets about the surgery. However, Mrs A accepts that she was provided with a copy of *A Consumer Guide to Cosmetic Plastic Surgery in New Zealand*, which includes a chapter on breast reduction and the risks associated with that procedure, including the risk of infection.

68. As I have previously noted, "If it isn't recorded in the notes the starting point is that it didn't happen."[13] That message is not new, as the following quote from a previous HDC opinion shows:

> "It is often stated by medical defence lawyers: 'If it isn't documented, it didn't happen.' Baragwanath J made comments to similar effect in his decision in *Patient A v Nelson Marlborough District Health Board*.[14] Justice Baragwanath noted that it is through the medical record that doctors have the power to produce definitive proof of a particular matter (in that case, that a patient had been specifically informed of a particular risk). Doctors whose evidence is based solely on their subsequent recollections (in the absence of written records offering definitive proof) may find their evidence discounted."[15]

69. Dr B did not document that he discussed with Mrs A the risks of breast reduction surgery, including the risk of infection. Furthermore, Dr B did not document that he gave Mrs A written information pamphlets that discuss the risk of infection.

70. While I am critical of Dr B's poor record-keeping (see below), I find that the evidence suggests that it is more likely than not that Dr B did discuss with Mrs A the risk of infection associated with breast reduction surgery. In particular, Dr B and Mrs A both recall that they had a discussion about Mrs A's concerns about infection. In addition, Mrs A was provided with written information about breast reduction surgery, which included information about the risk of infection, and the Informed Consent Form that Mrs A signed specifically referred to the risk of infection. In these circumstances, I accept that there was some discussion about the risk of infection during Mrs A's consultation with Dr B on 29 October 2010.

71. Nevertheless, Mrs A left the consultation with the impression that she had nothing to worry about, and that she was an ideal candidate for the surgery. I am concerned that, in attempting to allay Mrs A's concerns about the procedure, Dr B understated the risk of infection, particularly given Mrs A's experience and expressed concern about infection, and did not take sufficient care to ensure that Mrs A's expectations in that regard were appropriately managed. In this respect, I am concerned that Dr B did not

[13] Hill, A., "Systems, Patients, and Recurring Themes", *New Zealand Doctor* (9 March 2011). Available at: www.hdc.org.nz.
[14] *Patient A v Nelson-Marlborough District Health Board* (HC BLE CIV-2003-406-14, 15 March 2005).
[15] See Opinion 05HDC07699 (31 August 2006), pp 29–30.

communicate with Mrs A as effectively as he could have. Although I do not consider that Dr B breached the Code in this respect, I recommend that he review his practice and, in the future, take greater care to ensure that he does not understate the risks associated with the procedures he is recommending.

Postoperative care and treatment — Breach

72. Mrs A developed postoperative infections in her wounds. She contacted the clinic, and reported to RN E that she was nauseated and was feeling hot and cold. After speaking to Dr B, the nurse advised Mrs A to stop taking her antibiotics.

73. Mrs A is concerned about the appropriateness of Dr B's advice to discontinue the antibiotics she was taking, and she considers that Dr B should have prescribed her an alternative antibiotic. Dr B advised HDC that antibiotics are the commonest cause of postoperative nausea, and therefore he considered it appropriate to suggest she stop her antibiotics.

74. Mrs A advised HDC that she continued to feel ill and that she became increasingly concerned. She also said that her wounds were "awful" and "hurting continuously". Mrs A presented at the clinic and consulted with either Dr B and/or his nurse on 14, 16, 21, 23 and 28 February, and she also called the clinic on 24 February. During that time, Mrs A was prescribed an oral antibiotic, and an antibiotic ointment, and swabs of her wounds were taken.

75. The swabs grew a culture of MRSA and *Staphylococcus aureus*. Dr B said that he advised Mrs A that she had an infection, and Mrs A recalled that she was told she had a "bad wound infection". However, there is no evidence that Mrs A was informed that she had an MRSA infection. Mrs A had the right to be informed of the results of her tests, and there is no evidence that Dr B fulfilled his obligations to Mrs A in that regard. In addition, Dr B did not inform Mrs A's general practitioner, Dr C, that Mrs A's wound swabs had cultured MRSA. As this was important information for Mrs A's ongoing care, Dr B should have communicated it to Dr C.

76. Mrs A contacted the clinic again on 7 March and was reviewed by Dr B. Dr B noted that Mrs A was "quite unwell", and that she had a small area of necrosis in the T junction of both breasts. There are no clinical records for that consultation, and no evidence of what treatment, if any, Dr B provided to Mrs A. Dr B told HDC that he gave Mrs A advice about wound care.

77. On 25 March, Mrs A contacted the clinic again, explained that she was "in agony", and she asked to see Dr B. She was advised that Dr B was not available, and she was instead referred to the district nurse. The referral to the district nurse did not mention that Mrs A had MRSA. Again, that was important information relevant to Mrs A's ongoing care and treatment that should have been provided to the district nurse.

78. Mrs A consulted Dr B for the last time on 30 March, and reported that she had not been sleeping well and was depressed. Mrs A was concerned that when she asked Dr B how long it would take for her wounds to heal, he laughed and told her it would be "before Christmas". Again, there is no evidence of what, if any, care and treatment

was provided to Mrs A at that appointment, other than that Dr B advised Mrs A to return in two weeks' time for a further review.

79. Dr Glasson advised me that the frequency of Mrs A's postoperative consultations with Dr B was as expected until 28 February, at which time it was known that Mrs A's wound swab had cultured MRSA. After that time, closer review of Mrs A's wounds should have occurred. It was inadequate that there were periods of one and three weeks between appointments, and that the referral to the district nurse did not occur until 25 March 2011. Dr Glasson advised that the frequency of appointments for Mrs A's wound management was "not good practice when there was wound breakdown and positive MRSA culture". Dr Glasson further advised: "The need for closer supervision of the wound should have been anticipated by [Dr B]."

80. Dr B failed to support Mrs A when her condition deteriorated, and breached Right 4(1) of the Code by failing to provide postoperative services to Mrs A with reasonable care and skill.

81. I am also concerned that Dr B did not inform Mrs A that the swabs from her wound cultured MRSA. In my view, that is information that a reasonable consumer, in Mrs A's circumstances, would expect to receive. I find that Dr B breached Right 6(1)(f) of the Code for failing to inform Mrs A of the results of the swabs.

82. Mrs A was also receiving care from the district nurse and her general practitioner. Dr B did not inform either provider that Mrs A had been diagnosed with an MRSA infection. In my view, that information was crucial to Mrs A's ongoing care and was relevant to the practice of both providers. Dr B should have communicated the information to both Mrs A's general practitioner and the district nurse, to ensure that Mrs A's care was well co-ordinated. I find that Dr B breached Right 4(5) of the Code for failing to co-operate with the other providers to ensure Mrs A received quality and continuity of services.

Documentation — Breach

83. I am concerned about the poor quality of Dr B's record-keeping. Dr B did not make clinical records for some of his consultations with Mrs A, his records are incomplete and, as noted by Dr Glasson, the style of his handwritten notes is cryptic (for example, the unsigned note of his consultation with Mrs A on 21 February 2011 simply stated: "Pt (S)").

84. As I have previously noted:

> "Good clinical records are integral to providing care. They demonstrate the reasoning behind the diagnosis, set out the key information upon which decisions about ongoing care are based and can help safeguard practitioners when faced with allegations of inadequate practice. The records are also vital for enabling continuity of care and ensuring other practitioners know what decisions have

previously been made and the care that has been provided. Notes need to be comprehensive, accurate, and contemporaneous."[16]

85. The Medical Council of New Zealand publication *Good Medical Practice* (2008) sets the following standard in respect of record-keeping:

> "You must keep clear and accurate patient records that report:
>
> - Relevant clinical findings
> - Decisions made
> - Information given to patients
> - Any drugs or other treatment prescribed.
>
> Make these records at the same time as the events you are recording or as soon as possible afterwards."

86. I find that Dr B failed to comply with professional standards and, accordingly, breached Right 4(2) of the Code, as a result of his incomplete and inadequate record-keeping.

Recommendations

87. As per the recommendation in my provisional opinion, Dr B has provided a written apology, which will be forwarded to Mrs A.

88. In my provisional opinion, I also recommended that Dr B:

- review his record-keeping practice and advise HDC of the steps he has taken to improve his record-keeping processes; and
- advise HDC of the steps he has taken to improve his postoperative care of patients and communication with other providers, to prevent a similar event recurring.

89. In response to the provisional opinion, Dr B advised HDC that he has reviewed his record-keeping practice and is:

- making increased efforts to record what happens at consultations;
- dictating notes to the referring doctor;
- ensuring he documents the provision of hand-out sheets regarding procedures and complications; and
- ensuring that, where a patient is seen by a nurse, this is documented.

90. Dr B further advised HDC that he has also taken steps to improve the postoperative care and communication with other providers by increasing communication with general practitioners and writing to them at the initial consultation, after surgical

[16] Hill, A., "Systems, Patients, and Recurring Themes", *New Zealand Doctor* (9 March 2011). Available at: www.hdc.org.nz.

procedures, at postoperative visits, and at the time of discharge. He is also now ensuring that all laboratory results are always sent to the patient's general practitioner, in addition to letters noting these results. Furthermore, Dr B told HDC that he continues to ensure that he is available to see patients 24 hours a day in the postoperative period, and noted that the nurses at the clinic are available to see patients between 8.30am and 5pm.

Follow-up actions

91.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Medical Council of New Zealand with the recommendation that Dr B's competence be reviewed. The Medical Council will be advised of Dr B's name.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the New Zealand Association of Plastic Surgeons and the District Health Board, and they will be advised of Dr B's name.

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

Appendix A — Independent advice to the Commissioner

The following expert advice was obtained from a plastic surgeon, Dr David Glasson:

"1. INTRODUCTION
I have been asked to provide expert advice regarding this complaint, no 11/01438. I have read and agree to follow the Guidelines for Independent Advisors.

An initial report was provided on 26/6/12.

2. QUALIFICATIONS
MB ChB Otago 1978, and FRACS (Plastic) 1987.

I have practiced as a registered specialist Plastic Surgeon in Wellington since 1988. I worked as a part time consultant at the Wellington Regional Plastic Surgery Unit from 1988–2005. I have had a private practice since 1988, and have been in full time private practice since 2005. I have a broad experience in Plastic and Reconstructive Surgery, and I am familiar with many cosmetic procedures including breast reduction.

My Continuing Professional Development Program in Plastic and Reconstructive Surgery with the RACS is current.

3. SUPPORTING INFORMATION
My preliminary report was dated 26/6/12. For this supplementary report, there is supporting information — 21 items. **Some of these were available for the preliminary report. There is a significant amount of new information, including the response from [Dr B]. All new items are highlighted.**

Supporting Information

1. Complaint from [Mrs A] including photographs;
2. Notification of investigation letter to [Dr B], dated 25 September 2012;
3. GP clinical record;
4. File note of phone call with [Dr C], 12 February 2013;
5. Letter from ([the] DHB) dated 30 March 2012, including clinical records;
6. Clinical record from [Dr D], received 13 April 2012;
7. File note of phone call with [Mrs A], 20 September 2012;
8. Summary of interview with [Mrs A], 5 December 2012;
9. Copies of the letters the [couple] sent [Dr B];
10. File note of phone call with [Mrs A], 12 February 2013;
11. [Dr B's] response to complaint, including clinical records;
12. File notes of phone calls with [Dr B's] surgery, 18 and 21 May 2012;
13. [Dr B's] handwritten clinical notes;
14. Letter from [Dr B's lawyer], 11 October 2012;
15. Letter responding to notification of investigation, dated 15 November 2012, including enclosures;
16. Letter from [Dr B], dated 28 November 2012;
17. Letter to [Dr B], dated 18 December 2012;

18. Letter from [Dr B], dated 9 January 2013;
19. Letter to [Dr B], dated 13 February 2013 and
20. Letter from [Dr B], dated 25 February 2013.
21. ACC treatment injury claim form and hospital clinical notes.

HDC INVESTIGATOR: "I have not included a copy of the ACC treatment injury report which states that ACC has approved cover for 'Bilateral wound infection and subsequent dehiscence following a bilateral reduction mammoplasty'.

4. PURPOSE
To provide independent expert advice about whether [Dr B] provided an appropriate standard of care to [Mrs A].

5. BACKGROUND (from HDC)
On 7 February 2011, [Mrs A] underwent breast reduction surgery. [Mrs A] started feeling unwell two days after surgery.

On 24 February 2011, [Dr B] received results for the swabs he had done of her wounds, and these showed MRSA growth.

Her wounds worsened and she experienced intermittent infections.

On 25 March 2011, [Mrs A] was referred for care by the district nurses.

[Mrs A] sought a second opinion from [Dr D] and did not return to [Dr B].

6. COMPLAINT (from HDC)
[Mrs A] complained that [Dr B]:

- did not inform her of the risks involved
- stopped antibiotics and did not start her on an alternative
- reviewed her infrequently
- did not inform her about the nature of her infection
- did not tell her how to treat the infection
- made a mockery of her condition

7. REVIEW OF NEW INFORMATION

1) HDC Notification of investigation letter to [Dr B]. Requested:

a) Further response
b) Detailed description of the care provided
   i) When did [Dr B] see [Mrs A] himself
   ii) When did he advise her of the MRSA infection
   iii) Description of wounds
   iv) Were arrangements made for wound care between 7/3/11 and the next appointment 3 weeks later
   v) Was there discussion with an infectious disease specialist
   vi) How frequently was she reviewed once complications had arisen
c) Response to issues raised by David Glasson report
d) Copies of medical records from
   i) 2nd post op consultation (Comment: presumably **PRE** op consultation)
   ii) Consultation 16/2/11
   iii) Does the consent form constitute the 2nd pre operative consultation

iv) Any other correspondence with GP
v) Documentation re discussion with [Mrs A] about risks of infection
e) College membership
f) Changes to practice
g) Other information

2) File note of phone call with [Dr C], 12 February 2013, to HDC
a) [Dr C] advised **[Dr B] had not informed her of the MRSA infection**
b) [Dr C] was first aware of the MRSA infection when a swab was reported on 22/3/11
c) The MRSA infection was diagnosed 24/2/11 by [Dr B], 1 month earlier.

3) File note of phone call from HDC with [Mrs A], 20 September 2012
a) Pre op consultations
i) She decided to proceed with surgery 'because he assured me there would be no problem'
ii) 2nd consultation: does not recall seeing [Dr B]; nurses took photos
b) Does not recall being given Consent form provided by [Dr B]
c) Started feeling unwell after discharge after 2 nights in hospital
i) [Dr B] said the antibiotics were making her feel unwell, and he did not tell her about the MRSA (Comment: MRSA unlikely to be the cause at this stage)
ii) If MRSA was a possibility she would not have had surgery
d) Post op
i) Saw [Dr B] several times
ii) Was told it was 'bad infection'
iii) At 1 month asked to see [Dr B] and told he was not available, and she was referred to District Nurses by [Dr B's] nurse (Comment: actually it was Day 46 after surgery)
iv) At her last appointment [Dr B] had said the wounds could be stitched; but [Dr D] had explained that the infection had to be treated first
v) [Dr B] had paid for appointments with [Dr D] and for gel sheets
vi) ACC: [Dr B] had mentioned applying, but GP had completed the forms

4) Summary of HDC interview with [Mrs A], 5 December 2012
a) Pre op consultations
i) [Mrs A] unsure whether 2 or 3 pre op consultations
b) 1st pre operative consultation:
i) she mentioned the Melbourne case (of infection after surgery), and [Dr B] said that patient had too much surgery. He gave her a book and drew on it what would happen. Drawings showed the technique. He advised about loss of sensation. He did not discuss infection. 'He did his best to allay any fears …'.
c) Re [Dr B's] letter of 5/12/11 stating he discussed risks including infection
i) [Mrs A] states there was never any mention of risk
d) Written information
i) Pamphlets provided by [Dr B] to HDC were not received by [Mrs A]. She had read the book with the relevant section marked.

e) 2nd pre operative consultation
   i) [Mrs A] states she did not see [Dr B]
   ii) Did not discuss surgery
   iii) Saw only the nurses
f) Consent form:
   i) She does not recall signing the consent form
   ii) [Mr A] said [Mrs A] would have read it but they do not recall being 'walked through' the form
g) Seeing [Dr B]
   i) Mainly saw the Nurses. [Dr B] walked in and out
h) Who was present at consultations
   i) [Mr A] at some and her father at others
   ii) Nurse would see first, and then [Dr B] would examine and assess.
   iii) Sometimes she was seen only by the nurse for a dressing change
   iv) Stopping the antibiotic (after surgery, due to nausea)
      (1) She feels [Dr B] could have given an alternative antibiotic
         (a) Comment: this may have not changed the course of the complication (see first report of June 12, section 9.3.b, p 10)

i) When was she told about 'a bad wound infection'?

   i) 24/2/11 (Day 17) first positive swab received by [Dr B]
      (1) Comment: he did not inform her that there was MRSA
   ii) [Dr B] gave her Bactroban cream to use for 3 weeks, then return to see him.
      (1) Comment: he also advised her to complete the antibiotic (CTM) course. She was seen again 4 days later

j) When was she informed re MRSA
   i) by the District Nurse
k) Re payments made to [Dr D] and counselling
   i) This was without any condition

5) Copies of letters from [Mr and Mrs A] to [Dr B]

a) These do not raise any new issues not addressed elsewhere

6) File note of HDC phone call with [Mrs A], 12 February 2013

a) Re diary entries: she no longer has these
b) When was she told about MRSA: at 2nd appointment with District Nurses
   i) Comment: [Mrs A] was first seen by DN on 25/3/11
      DN notes first record MRSA on 11/4/11, the 21st appointment
c) [Dr B] had told her of the 'bad wound infection' following the appointment when swabs were taken i.e. 24/2/11 presumably.

7) Letter from [Dr B's lawyer], 11 October 2012

a) Intention to obtain independent opinion

8) Letter from [Dr B] responding to notification of investigation, dated 15 November 2012, including enclosures: KEY POINTS

a) 1st consultation 29/10/10

i) He advised re normal post operative period, and risks including bleeding, infection, numbness, scarring and slow healing.
ii) He gave written information, and a book including a chapter on breast reduction. The technique and scars were explained.

b) 2nd consultation: 17/1/11
i) Comment: there is no contemporaneous record nor record of discussing the Consent form
ii) He recollects a discussion, photos and measurements for her surgical garment

c) Post operative events
i) 11/2/11 — explains reason to stop antibiotic
ii) Seen 14/2/11 — he recalls problems with nausea and some redness of the wounds
(1) Comment: there is no record of this appointment
iii) Seen 16/2/11 — he recalls that the wounds were checked and the dressings were changed
(1) Comment: no entry in the notes for that date
iv) Seen 21/2/11 — red wounds, swab taken, minor dehiscence (separation) of wound, cotrimoxazole was prescribed
v) Seen 23/2/11 — apply Bactroban ointment after shower
vi) Seen 28/2/11 — change of dressing
vii) Seen 7/3/11 — on Doxycycline from GP for UTI. Also appropriate for MRSA infection. To review in 3 weeks, as [Mrs A] finding it difficult to attend
(1) District Nurse referral made. (actually, this was not until 25/3/11)
viii) Seen 30/3/11 — discussed poor healing
(1) Advised re 2nd opinion

IN RESPONSE TO SPECIFIC QUESTIONS IN NOTIFICATION LETTER FROM HDC 22/9/12: see section 7, item 1 above

d) Detailed description of the care provided
i) When did [Dr B] see [Mrs A] himself
(1) 29/10/10, 17/1/11 (no record), 7/2/11, 14/2/11 (no record), 16/2/11(no entry, just date stamp), 21/2/11, 23/2/11, 28/2/11, 7/3/11, 30/3/11
ii) When did he advise her of the MRSA infection
(1) He does not recall when she was told the results of the swab
iii) Description of wounds
(1) Not responded to
iv) Were arrangements made for wound care between 7/3/11 and the next appointment 3 weeks later
(1) Instructions were given to take antibiotics and use topical antibiotic
(2) She could phone if concerned
v) Was there discussion with an infectious disease specialist
(1) no
vi) How frequently was she reviewed once complications had arisen
(1) Once or twice a week in February and then twice in March

e) Response to issues raised by David Glasson report

i) Risks were discussed particularly infection, poor healing and wound dehiscence

ii) There was a low likelihood of [Mrs A] having the complications seen in a recent TV program

iii) He wrote a letter to the GP

(1) Comment: No copy provided

iv) Information supplied to [Mrs A] at the first consultation

(1) ASAPS pamphlet

(2) Book with chapter on breast reduction

(3) Complications discussed and given in writing

v) Antibiotic prescribing explained

(1) This has been covered in the initial report

(2) The use of cotrimoxazole and tetracycline was suitable

vi) Follow up

(1) He reports he saw [Mrs A] more frequently than his normal practice

vii) Departures from normal treatment as reported

(1) There was extensive pre operative discussion

(2) Information was given verbally and in writing

(3) He and his staff were available at all times

(4) Wound swabs were taken and antibiotics given

(5) Surgery was suggested to shorten recovery

(6) He treated her to the best of his ability and with respect

f) Copies of medical records requested from [Dr B] for

i) 2nd pre op consultation 17/1/11

(1) Comment: there is no contemporaneous record of this consultation

(2) Documents enclosed — pamphlets from American Society Plastic Surgery, ASAPS, NZ FOUNDATION FOR COSMETIC PLASTIC SURGERY, Australian Society of Plastic Surgeons, [Dr B's] profile, book chapter from 'A Consumer Guide to Cosmetic Plastic Surgery in NZ'.

ii) Correspondence with GP 28 October (either not enclosed by [Dr B], or not provided to me by HDC)

iii) Consultation 16/2/11 (either not enclosed by [Dr B], or not provided to me by HDC)

iv) Does the consent form constitute the 2nd pre operative consultation?

(1) Yes

(2) There is no other documentation

v) Any other correspondence with GP

(1) Already answered

vi) Documentation re discussion with [Mrs A] about risks of infection

(1) Already answered

g) College membership

i) RACS

h) Changes to practice

i) Scope of practice has been reduced following the death of his wife, and his own ill health

ii) These changes are not related to [Mrs A's] surgery

i) Other information

i) [Dr B] expresses his deep sorrow for the problems [Mrs A] had

ii) He has assisted with the additional cost incurred

iii) There was never any condition attached to the financial support

9) Letter from [Dr B], dated 28 November 2012

a) Requests questions in writing

10) Letter to [Dr B], dated 18 December 2012

a) Further questions from HDC

11) Letter from [Dr B], dated 9 January 2013

a) He explains that he has provided 2 detailed analyses or responses regarding 4 specific issues raised by HDC

b) He is willing to address further questions in writing

12) Letter to [Dr B], dated 13 February 2013

a) 10 questions

13) Letter from [Dr B], dated 25 February 2013, responding to HDC letter of 13/2/13

a) Which documents were given to [Mrs A]: there were 3 copied in the letter of 15/11/11?

i) Copies enclosed. They are **not** included in this section provided by HDC. Presumably he means that all of the documents were supplied?

(1) It is still not clear which of these, or all, were provided.

b) How was the consent form (10/11/10) completed?

i) It was sent from his office, and discussed with her at the 2nd consultation on 17/1/11

(1) Comment: there is no contemporaneous record of this 2nd consultation

c) Where are the complications detailed in writing?

i) On 29/10/10, after discussion, including wound infection and dehiscence (as seen on TV), written information was given which included complications

d) On 17/1/11, 2nd consultation, what discussion was held, and who was involved?

i) [Mrs A] and [Dr B], and his nurse

ii) Information re admission to the Surgical Centre

e) Pre operative antibiotic?

i) IV Rocephin given at the beginning of the operation and continued while in hospital.

ii) Oral Cefaclor given after discharge

f) Anti-nausea medication on 11/2/11. Is this documented?

i) Ondansetron

g) What is meant by 'arrangements for … wound care on 7 March and on the 30th, were on an as needed basis'? What care was provided between these dates?
   i) Showering, drying and application of Bactroban
   ii) He could see anytime if she was concerned

h) When was cotrimoxazole commenced?
   i) On 21/2/11

i) What does the handwritten note of 21/2/11 mean?
   i) It indicates that cotrimoxazole was prescribed

j) Phone call from [Mrs A] 7/3/11 — who received and documented it?
   i) [Dr B's] nurse received and documented the call

k) Requested copies of all letters to [Mr and Mrs A]
   i) provided

14) ACC treatment injury claim form and hospital clinical notes.

8. ADVICE REQUESTED FROM HDC – 15/3/13
Please review your preliminary advice (dated 26 June 2012) and amend as necessary**, in light of the further information provided.**

1) Please comment generally on the standard and appropriateness of the care that [Dr B] provided to [Mrs A].

If not covered above, please answer the following questions, with reasons for your views.

2) Please comment on the adequacy and appropriateness of the information provided to [Mrs A] prior to her operation. You will note that [Mrs A] and [Dr B] have differing recollections of this. **We would appreciate receiving advice in the alternative (ie. adequacy and appropriateness if [Mrs A's] recollection is accepted; adequacy and appropriateness if [Dr B's] recollection is accepted.)**

3) Was [Dr B's] postoperative management of [Mrs A] appropriate?
4) Were [Dr B's] actions adequate in light of [Mrs A's] swab results, in particular, those which showed MRSA growth?
5) Please comment on the adequacy of [Dr B's] communication with other relevant health providers regarding the care of [Mrs A].
6) Please comment on [Dr B's] record-keeping.

If, in answering any of the above questions, you believe that [Dr B] did not provide an appropriate standard of care, please indicate the severity of his departure from that standard.

To assist you on this last point, I note that some experts approach the question by considering whether the providers' peers would view the conduct with mild, moderate, or severe disapproval.

Are there any aspects of the care provided by [Dr B] that you consider warrant additional comment?

9. COMMENTS and OPINION

1) Please comment generally on the standard and appropriateness of the care that [Dr B] provided to [Mrs A].

a) [Dr B] and [Mrs A] have a different recollection of events and of the information given at consultations:

i) Pre operative consultations

(1) 1st consultation

(a) [Mrs A] was a suitable candidate for breast reduction. The operation was appropriate for her. [Dr B] and [Mrs A] must have agreed on that.

(b) [Dr B] recalls

(i) He advised about the normal post operative period, and risks including bleeding, infection, numbness, scarring and slow healing.

(ii) He gave written information, and a book including a chapter on breast reduction. The technique and scars were explained.

(iii)He describes a satisfactory consultation for this surgery

(c) [Mrs A] states there was never any mention of risk

(2) 2nd consultation

(a) [Mrs A] does not recall seeing [Dr B] at the 2nd preoperative consultation (17/1/11)

(b) [Dr B] recalls a discussion including about the Consent form, and the taking of photos and measurements for her surgical garment

(3) [Mrs A] states she was assured there would be no problem with her surgery

(4) [Dr B] states he advised her about risks including wound infection and dehiscence.

(5) [Mrs A] is unsure whether there were 2 or 3 pre operative consultations.

ii) The Consent form

(1) [Mrs A] does not recall signing it

(2) The signed consent form has been sighted by me for the first report, and is a good document

(3) [Dr B] states that he discussed it at the 2nd consultation on 17/1/11

(4) [Mrs A] does not recall seeing [Dr B] that day, and Mr A states that the form was not 'walked through'.

iii) Post operative consultations

(1) Record keeping is poor

(2) Supervision of the wounds was not adequate (see below)

iv) When was [Mrs A] advised about MRSA in the wound?

(1) [Dr B] did not advise her about the MRSA positive wound swab.

(a) Such information should be given to patients.

(2) The District Nurse advised her of MRSA infection at a later date

v) **[Mrs A]** will rely on memory, and diary records. Diary records were alluded to in a phone interview with HDC (12/2/13), but are no longer available

vi) **[Dr B]** should be able to rely on accurate contemporaneous notes.

2) Please comment on the adequacy and appropriateness of the **information** provided to [Mrs A] prior to her operation. You will note that [Mrs A] and [Dr B] have differing recollections of this. **We would appreciate receiving advice in the alternative (ie. adequacy and appropriateness if [Mrs A's] recollection is accepted; adequacy and appropriateness if [Dr B's] recollection is accepted.)**

a) [Mrs A's] recollection

i) If her recollection is correct there was no discussion of risk, and she was reassured there would be no problem. She does not recall receiving the Consent form.

ii) She states she was given a book by [Dr B] and he drew on it. She had read the book and the relevant section marked.

iii) She states the pamphlets [Dr B] provided to the HDC were not provided to her.

iv) The Consent was signed, and sighted for the first report, and is a good document. She does not recall it being discussed with [Dr B].

v) If her view is correct, then the consultation process was inadequate

b) [Dr B] recalls

i) giving information about complications, in particular about infection and wound dehiscence. He recalls giving her written information. He did give her the Consent form which was signed. He recalls discussing it with her on 17/1/11.

ii) [Dr B] is let down by his inadequate record keeping. There is no written record of his discussion about complications, nor a record of the written information he supplied, nor a record of the second pre operative consultation.

iii) Accepting his recollection, the information was sufficient.

c) On the balance of probabilities

i) I expect that there **was** discussion of the possible complications, and it is unlikely that assurances of low risk were given as 'no risk'.

ii) Patients can misinterpret low risk events as a promise they will not happen to them.

iii) Again, thorough record keeping, and a letter to the GP, would have provided evidence of the consultation and what transpired.

3) Was [Dr B's] postoperative management of [Mrs A] appropriate?

a) Stopping the antibiotic (after surgery, due to nausea)

i) [Mrs A] feels [Dr B] could have given an alternative antibiotic

ii) At this stage of events, changing the antibiotic may not have changed the course of the complication (see report June 2012, 9.3.b, p 10)

b) At appointments, his Nurse would see [Mrs A] first, and then [Dr B] would examine and assess. Sometimes she was seen only by the nurse for a dressing change.

i) This is normal and acceptable practice.

c) The frequency of appointments for post op management was as expected until 28/2/11 (Day 21)
   i) By then the MRSA result was known
   ii) There was then a gap of 1 week until she was seen next on 7/3/11
   iii) Then she was advised to return in 3 weeks time
   iv) Referral to the District Nurse did not occur until 25/3/11

d) Closer supervision should have occurred in the presence of wound dehiscence and MRSA infection.

e) The assistance of an infectious disease specialist was not sought. However, [Dr B] may feel confident to manage this complication without such input.

f) [Dr B] **did not inform** [Mrs A] about the positive MRSA swab result.
   i) This is relevant, as this complication was a specific fear she expressed before surgery.

g) [Dr B] supported the assistance of [Dr D].

h) The possible surgical repair of the wounds was discussed at Day 51, 30/3/11. This intervention is hard to assess without photos of the wound, wound culture status etc. Generally the wounds need to be free of infection, and have good vascularity, and the wound size must be small to allow repair under local anaesthetic. If there is a need for a generous wound debridement and sutured repair, general anaesthetic would be required. Skin grafts onto a healing large wound might shorten the healing period and can be done under local or general. I detect this issue was explained by [Dr D]. [Mrs A] wished to avoid any further surgery.

i) Overall, I find the post operative management not appropriate.

4) Were [Dr B's] actions adequate in light of [Mrs A's] swab results, in particular, those which showed MRSA growth? I have considered this under 2 headings.

a) Therapeutic
   i) The positive swab result was known on 24/2/11
   ii) [Mrs A] was seen for a dressing change on 28/2/11
   iii) She was seen again on 7/3/11 for a dressing change. She was advised to return in 3 weeks.
   iv) The District Nurses were not contacted until 25/3/11, 18 days after the appointment on 7/3/11
   v) The frequency of appointments for wound management is not sufficient in my opinion. There was an MRSA infection, and periods of 1 week, and 3 weeks, occurred between appointments. Referral to the District Nurses was delayed.

vi) This is not good practice when there was wound breakdown and positive MRSA culture. The need for closer supervision of the wound should have been anticipated by [Dr B].

b) Communication with [Mrs A]

i) He did not advise her of the positive MRSA result received on 24/2/11.

ii) [Dr B] saw [Mrs A] on 7/3/11, advised on care and arranged review in 3 weeks. He did not tell [Mrs A] of the MRSA result.

iii) She was first informed [of MRSA] by the District Nurses about 11/4/11

5) Please comment on the adequacy of [Dr B's] communication with other relevant health providers regarding the care of [Mrs A].

a) District Nurses

i) He did not advise them of the MRSA culture when he referred her to their care

b) GP

i) No letter was provided by [Dr B] after the initial consultation. If it was written, [Dr B] has not supplied a copy, nor does it appear in the GP notes.

ii) [Dr C] reports that **[Dr B] had not informed her of the MRSA infection**

iii) [Dr C] was first aware of the MRSA infection when a swab was reported on 22/3/11

iv) The MRSA infection was diagnosed on 24/2/11 by [Dr B], 1 month earlier

v) The post operative letter to the GP, 30/3/11, after the diagnosis of MRSA, did not mention MRSA.

c) [Dr D]

i) I cannot find a referral letter to [Dr D] in the documents provided.

d) The level of communication is poor

6) Please comment on [Dr B's] record-keeping.

a) His record keeping is poor.

b) He has hand written notes and the style is cryptic

c) His records fail to document events sufficiently. This makes it difficult to defend a complaint when a third party is called upon to analyse the sequence of events, and standard of care. [Dr B] must rely on his recollections.

d) For example,

i) the 2nd pre operative consultation on 17/1/11 was not recorded. He states that the signed Consent form serves as a record of that consultation.

(1) That consultation is important. It is when [Mrs A] returned the signed Consent form and [Dr B] states it 'was discussed with her at that time'. ([Dr B] letter to HDC 25/2/13). What was said about infection? Were risks given?

ii) [Dr B] has not provided a copy of the letter he states he wrote to the GP after the first pre operative consultation

iii) A post operative appointment is not recorded at all, and another has only a date stamp with no entry

e) A computerized record system would more likely ensure a more accurate record, with dictated notes to be entered, prescriptions and lab results recorded, letters kept on file etc

7) If, in answering any of the above questions, you believe that [Dr B] did not provide an appropriate standard of care, please indicate the severity of his departure from that standard.
To assist you on this last point, I note that some experts approach the question by considering whether the providers' peers would view the conduct with mild, moderate, or severe disapproval.

a) CONCLUSIONS RE STANDARD OF CARE

i) Pre operative

(1) On the balance of probabilities, I believe the **pre operative standard of care was sufficient** (though poorly recorded)

ii) Post operative period

(1) The clinical supervision of [Mrs A] during the post operative period was not adequate in my opinion. When the clinical situation was deteriorating, [Dr B] failed to support her. It is not surprising that [Mrs A] lost confidence.
(2) There were long periods between appointments after the positive MRSA swab was obtained (see Section 9, 3.c, and 4.a P11,12 above)
(3) Referral to the District Nurse service was delayed.
(4) In my opinion, **the expected standard of care in the post operative period was not met, and in my view, that departure was moderate.**

iii) Communication

(1) With **[Mrs A]**
  (a) Was poor. See section 9, 4b, page 12.
  (b) He did not inform her of the MRSA swab result.
  (c) She was entitled to know this.
(2) With the **GP**
  (a) [Dr B] states he wrote a letter to the GP after the first consultation. He has not provided a copy.
  (b) Subsequent letters to the GP did not advise her of the MRSA infection
  (c) This is important information for the GP. For example, if [Mrs A] had attended her practice for a dressing change, special precautions are taken when a wound is positive for MRSA
  (d) Regular communication with GPs about their patients is important, and even more so when there are complications. Patients are distressed when complications occur, and may call upon their GP for support. [Dr B] did not maintain sufficient correspondence with [Dr C].
(3) With the **District Nurses**
  (a) When [Dr B] referred [Mrs A] to the District Nurse service, no mention was made of the positive MRSA wound swab.
  (b) This information is important.

(4) Communication with these 3 parties fell below the expected standard. **The departure from that standard is moderate,** in my opinion.

iv) Record keeping

(1) See Section 9, part 6 above.
(2) While there is nothing wrong with hand written records, they need to be full and accurate.
(3) Hand written records can be illegible.
(4) [Dr B's] records are incomplete. They are insufficient to allow for accurate assessment by a third party, as required for the preparation of this report.
(5) In my opinion, the standard of his record keeping falls below the expected standard of a surgical specialist.
(6) Given that no record was even made of some appointments, I assess **the departure from the expected standard of care to be moderate**.

7) **Are there any aspects of the care provided by [Dr B] that you consider warrant additional comment?**
   a) No additional comments.

10. FINAL COMMENT

[Dr B] provided more information in response to my preliminary report of June 2012. I have considered the additional information for this report.

In my report of June 2012, I commented that I was hampered by the absence of a record of events provided in the documents from [Dr B]. I could not be sure whether records and letters existed, or had just not been provided by him. This is still the case. For example, there is still no copy of the letter he said he wrote to the GP after the first pre operative consultation.

Yours sincerely

David Glasson MB Chb, FRACS (Plastic)
Plastic Surgeon
Bowen Hospital
Wellington 6035"

Further advice by Dr David Glasson

"I have received further documents from HDC. These have been provided after HDC received my report of 27/3/13. I have been asked whether these documents substantially alter my advice. This response is an addendum to my report of 27/3/13.

The documents received by email on 28/3/13 are:

1) Letter from [Dr B] to GP after 1st consultation, dated 29/10/10.
2) Letter from [Dr B] to [insurance company] dated 29/10/10.
3) 4 enclosures all relevant to the provision of pre-operative information.

a) Brochure on Breast Lift and Reduction (endorsed by ASPS, ASAPS, NZAPS).
b) General Information for Patients Considering Cosmetic Surgery (ASPS, ASAPS).
c) Book Chapter 11: Breast Reduction.
d) Pamphlet on Breast Reduction (ASAPS).

COMMENTS

1) Letter to GP.
   a) The provision of this copy confirms the letter was sent at the first consultation.
   b) It is brief, and does not give detail about what transpired.
   c) There is no specific comment about the discussion regarding the Australian case in the media.
   d) There is no specific comment about the discussion of risks and complications.
   e) There is no specific comment about the provision of written information.
   f) A succinct letter like this is not helpful to [Dr B] when a 3rd party must consider all aspects of care provided.

2) Letter to [insurance company]
   a) Not relevant to this complaint.

3) The enclosures
   a) Are all useful and contain good quality information.

CONCLUSIONS RE STANDARD OF CARE

1) Pre operative
   b) In my March report I concluded: 'On the balance of probabilities, I believe the **pre operative standard of care was sufficient** (though poorly recorded).'
   c) The written information provided by [Dr B] (see enclosures) is good quality and comprehensive.
   d) My advice on the pre operative care is **not altered**.

8) **Post operative**
   a) In my March report I concluded: 'In my opinion, **the expected standard of care in the post operative period was not met, and in my view, that departure was moderate.**'
   b) Having viewed these new documents, my advice is **not altered**.

9) **Communication**
   a) With [Mrs A]
      i) The problem with communication was the failure to inform her of the presence of MRSA in her wound.
   b) With the GP
      i) The copy of the letter to the GP confirms that [Dr B] did write at the first consultation.

(1) This letter is very brief and gives no detail as to what transpired, specifically how risk of complications were addressed.

ii) Post operative communication was poor, with no advice to the GP about MRSA.

c) With the District Nurses

i) Nothing in these latest documents is relevant.

d) In my March report I concluded: 'Communication with these 3 parties fell below the expected standard. **The departure from that standard is moderate,** in my opinion.'

e) My advice is **not altered**.

10) **Record keeping**

a) In my March report I concluded: "Given that no record was even made of some appointments, I assess **the departure from the expected standard of care to be moderate"**.

b) My advice is **not altered.**

11) **Final comment: see March report Section 10**

a) I wrote: '[Dr B] provided more information in response to my preliminary report of June 2012. I have considered the additional information for this report.

In my report of June 2012, I commented that I was hampered by the absence of a record of events provided in the documents from [Dr B]. I could not be sure whether records and letters existed, or had just not been provided by him. This is still the case. For example, there is still no copy of the letter he said he wrote to the GP after the first pre operative consultation.'

b) That letter to the GP of 29/10/10 has now been provided to me by HDC.

Yours sincerely

David Glasson MB Chb, FRACS (Plastic)
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Bowen Hospital
Wellington 6035"