

Complaints to the Health and Disability Commissioner involving Doctors

**Report and Analysis for
1 January 2009 to 31 December 2015**

Feedback

We welcome your feedback on this report. Please contact Natasha Davidson at hdc@hdc.org.nz

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COMMISSIONER'S FOREWORD

I am pleased to present this analysis of all complaints HDC has received about doctors over the past seven years.

The consumer's voice for bringing change is a powerful one. Complaints have an ability to shine a light on areas where improvements can be made. As you will see, 22% of practising doctors in New Zealand will receive a complaint with HDC in a seven-year period. Complaints are inevitable and complaints matter. They can change things. Handled well, they enable providers to restore trust with their patients and enhance these relationships.

While those providers who are the subject of such complaints learn and change in response to the issues raised, it is also important that these learnings are shared among the wider sector. Publication of my investigation opinions allow those providers who offer similar services to reflect on aspects of the care they provide. However, there is also much to be learned from the trends and patterns that emerge from the analysis of complaint data. We, at HDC, are committed to ensuring that these learnings are not lost, but are reported back to the sector and to consumers in a way that supports quality improvement. That is the aim of this report.

New Zealand's health and disability sector has an impressive workforce that delivers services with exceptional skill and passion. The vast majority of the time, the care provided by doctors is outstanding, and I am frequently impressed by their dedication to the provision of quality care. However, as with any workforce, there is always room for improvement. The 3844 complaints that are the subject of this report range from the comparatively minor to the profoundly tragic. Although these complaints represent a fraction of the performance of the system as a whole, they can have vast significance for those whose lives are affected.

The trends reported throughout this report, such as the importance of communication, coordination of care, and the provision of information to the consumer, reflect the importance of putting consumers at the centre of services. A consumer-centred system means engagement, seamless service, transparency, and a culture that focuses on the consumer. It is about doing the basics well. Read the notes, ask the questions, talk with the consumer.

I trust you will find this report of interest. To those of you who provide care around this country every day, and to all of the consumers who have shared your stories with us, I thank you for making the learning contained within this report possible.

Anthony Hill
Health and Disability Commissioner

EXECUTIVE SUMMARY

Between 2009 and 2015, 3047 individual doctors were complained about. As some doctors were complained about multiple times, this equated to a total of 4565 Doctor Complaints. The number of complaints received about doctors has increased over the last seven years, in line with the overall increase in complaints received by HDC over this time period.

Complaints about doctors to HDC tend to cluster around a set of identifiable demographics. Male, vocationally registered doctors who had been practising for between 20 and 40 years are the most likely to receive complaints. This is consistent with what has been found in international research.

General practitioners are the most commonly complained about specialty, accounting for half of all Doctor Complaints. This is consistent with international research, and may be a function of the fact that GPs have the most interactions with patients. Other commonly complained about specialties include: psychiatrists, orthopaedic surgeons, general surgeons, internal medicine specialists and obstetrician/gynaecologists.

Twenty-two per cent of all doctors practising in New Zealand received a complaint within this seven-year period. Of those doctors complained about, the majority only received one complaint within this time-frame.

Missed, incorrect or delayed diagnosis was the primary issue of concern raised by the complainant in 24% of Doctor Complaints. When all issues raised in Doctor Complaints were considered, concerns about inadequate/inappropriate treatment emerged as the most prevalent issue, followed by a missed, incorrect or delayed diagnosis, inadequate or inappropriate examination/assessment, and a disrespectful manner/attitude. It should be noted that these complaint issues are what was articulated by the complainant to HDC. While not all issues raised are subsequently factually and/or clinically substantiated, those issues provide a valuable insight into the consumer's experience of the services provided and the issues they care most about.

The issues raised in Doctor Complaints varied by the specialty of the doctor being complained about. For example, specialties with high diagnostic workloads, such as internal medicine specialists and general practitioners, commonly received more complaints regarding missed, incorrect or delayed diagnoses.

The annual number of complaints closed about doctors has generally increased over the last five years, consistent with an overall increase in the number of complaints closed by HDC over that time. Each complaint that is received by HDC is subject to careful assessment, and HDC has a number of resolution options available to it following this assessment. HDC recommended some kind of follow-up action or made educational comments designed to facilitate improvement in services in relation to around 20% of Doctor Complaints. Around 6% of doctors complained about each year are investigated, with around 3% being found in breach of the Code.

BACKGROUND

1. The Health and Disability Commissioner

The Health and Disability Commissioner (HDC) is an independent crown entity established under the Health and Disability Commissioner Act 1994 to promote and protect the rights of health and disability services consumers. The rights of consumers are set out in the Code of Health and Disability Services Consumers' Rights (the Code). The Code places corresponding obligations on all providers of health and disability services, including individual providers and organisational providers such as district health boards.

HDC promotes and protects the rights of consumers of health and disability services by:

- resolving complaints;
- improving quality and safety within the sector; and
- appropriately holding providers to account.

As such, HDC fulfils the critical role of independent watchdog for consumer rights within the sector.

Rights under the Code

1. The right to be treated with respect.
2. The right to freedom from discrimination, coercion, harassment and exploitation.
3. The right to dignity and independence.
4. The right to services of an appropriate standard.
5. The right to effective communication.
6. The right to be fully informed.
7. The right to make an informed choice and give informed consent.
8. The right to support.
9. Rights in respect of teaching or research.
10. The right to complain.

Anyone in New Zealand may make a complaint to HDC about a health or disability service that has been provided to a consumer. It is not uncommon for HDC to receive complaints from third parties, such as family members, friends, or other providers involved in the consumer's care. The Commissioner may also commence an investigation at his own initiative, even without having received a complaint, if he considers it appropriate to do so.

For HDC to have jurisdiction to assess and/or investigate a complaint, there must have been the provision of a health or disability service to a consumer by a provider, and a possible infringement of the consumer's rights under the Code.

2. International research on complaints about doctors

International research has found that the distribution of complaints about doctors tends to cluster around a set of identifiable characteristics, with studies finding that gender, specialty, years in practice, and country of training can all have an impact on a doctor's risk of receiving a complaint.¹⁻⁶

Research from New Zealand, Australia and the United Kingdom has found that male doctors are at an increased risk of disciplinary action and having a complaint made about them.^{1,2,3,4,7,10} A recent meta-analysis found that male doctors were nearly two and a half times more likely to be subject to medico-legal action than female doctors.⁶ Researchers have hypothesised that this difference may be due to differences in communication styles between the sexes.⁹

General practitioners, surgeons, psychiatrists and obstetrician/gynaecologists are the specialties that tend to receive the most complaints,^{1,3,4,9} with general practitioners often being found to receive around half of all doctor complaints.^{3,4,10} This is generally attributed to the fact that general practitioners have the most patient contacts, contributing to the argument that a doctor's risk for complaint increases with their number of patient encounters.^{7,6} It has also been argued that distinctive aspects of the clinical activities that specialties perform, and the patient populations they serve, can contribute to their risk of complaint.^{1,9}

Years in practice has also been found to have an impact on a doctor's risk of complaint.^{3,10} An Australian study found that doctors with multiple complaints are more likely to have been in practice for 30 years or more.³ Doctors who have been practising for longer may be at greater risk of complaint, as the risk of receiving a complaint increases with a greater number of patient encounters.^{7,6} It also may be that more experienced doctors are seen by patients and complaint bodies as responsible for the patient's care.

Research around how a doctor's risk of receiving a complaint is affected by their country of training is mixed, with some studies finding that international medical graduates are at a lower risk of complaint than doctors trained in the country in which they practice,⁹ while others have found no difference.^{10,11} However, recent studies have found that a doctor's risk of a complaint may be affected by the specific country in which he or she trained, rather than the doctor's overall international medical graduate status.²

Recent Australian studies have also found that a doctor's complaint history can affect his or her risk of receiving future complaints. A study of complaints filed with the health service Commissions in Australia found that a doctor's number of previous complaints, and the amount of time that had elapsed since the doctor's last complaint, were predictors of the doctor's risk of receiving subsequent complaints.^{3,4}

The issues complained about in relation to doctors are consistent internationally, with issues relating to treatment and communication being found to account for the vast majority of complaints about doctors.^{12,13} However, few studies have looked at what it is about treatment and communication that consumers are complaining about. This report undertakes a more granular analysis of what is complained about in relation to doctors.

3. This report

It is important to note that the number of complaints received is not necessarily a good proxy for quality of health services. It may be that on further assessment, the issues raised in these complaints were not factually and/or clinically substantiated. The value of complaints data lies in its ability to provide insights into consumers' experiences of health services, the aspects of care that consumers care most about, and aspects of care that are not caught by other systems of healthcare monitoring (such as dignity and respect). Additionally, the analysis of aggregated complaint data strengthens our ability to identify systemic issues in care and provides trend data that is useful for quality improvement.

The data analysed in this report comes from HDC's current complaints database. We extracted from that database information about all doctors complained about between 1 January 2009 and 31 December 2015 (the HDC complaints data). Complaints to HDC often involve more than one provider, and multiple doctors are sometimes involved in a single complaint. Additionally, some doctors received more than one complaint in the time period. For each complaint received we conducted an analysis of the issues raised for each doctor complained about, calling each of these analyses a "Doctor Complaint". Some of the doctors within the HDC complaints data were the subject of multiple complaints, and, consequently, while the HDC complaints data includes only 3047 individual doctors, it is made up of 4565 Doctor Complaints. Analyses found that doctors who were the subject of a large number of complaints did not skew the data for any of the reported variables.

It should be noted that this is a descriptive report. Statistical tests have not been applied to the data, and the effect of confounders has not been taken into account. It is proposed that follow-up reports will look at specific variables described within this report, and their inter-relationships, in more detail.

For each of the demographic variables reported, the characteristics of Doctor Complaints was compared to the characteristics of doctors on the New Zealand Medical Council register (registered doctors) and doctors with practising certificates (practising doctors). Specifically, registration data and relevant medical workforce reports¹⁴⁻¹⁹ were used to calculate the average distribution of each of the demographic variables across all doctors between 2009 and 2015.

Doctor Complaints are described both in terms of overall numbers and characteristics, as well as by reference to case studies. Case studies are included to encourage readers to consider their own service provision and to ask, "Could that happen at my place," and, if so, what changes can be made to prevent it.

DOCTORS COMPLAINED ABOUT

1. How many doctors were complained about?

1.1 Number of Doctor Complaints

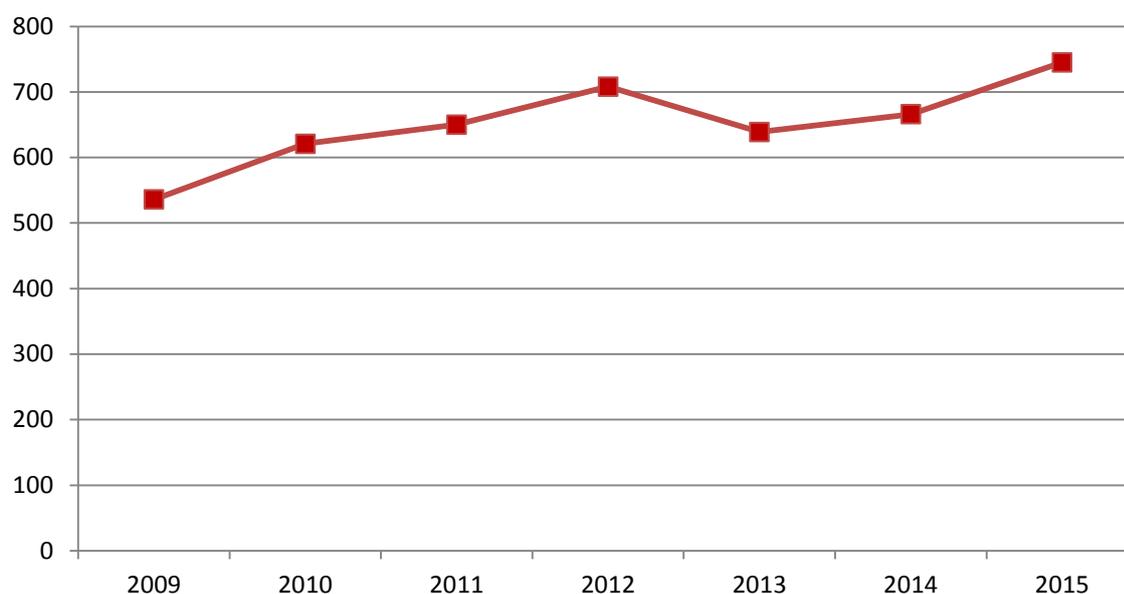
Between 2009 and 2015, 4565 Doctor Complaints were received. There were 3047 individual doctors who received at least one complaint in that time period.

An average of 652 Doctor Complaints were received each year. As can be seen below in Table 1 and Figure 1, the number of Doctor Complaints each year has increased over the last seven years from 536 in 2009 to 745 in 2015 — an increase of 39%.

Table 1. Number of Doctor Complaints received each year

2009	2010	2011	2012	2013	2014	2015
536	621	650	708	639	666	745

Figure 1. Number of Doctor Complaints received each year



Despite the fact that the number of Doctor Complaints has increased over the last seven years, as can be seen in Table 2 below, the number of Doctor Complaints as a proportion of the total number of practising doctors has remained relatively static at around 4% each financial year.

Table 2. Number of Doctor Complaints received each financial year, as a proportion of total number of doctors practising in New Zealandⁱ

	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015
Number of Doctor Complaints	582	656	706	641	657	704
Number of practising doctors	14,502	14,976	15,499	15,738	16,017	16,110
Proportion	4.0%	4.4%	4.6%	4.1%	4.1%	4.4%

1.2 Number of complaints received

Between 2009 and 2015, HDC received a total of 3844 complaints that raised issues about care provided by doctors. As noted earlier in this report, some of these complaints involved more than one doctor, and, therefore, the number of complaints received about doctors will not correspond with the number of Doctor Complaints received.

Table 3 below shows the number of complaints received about doctors each year as a proportion of the total number of complaints received by HDC each year. Although numbers of complaints about doctors have increased over the last seven years, this is in line with the overall increase in complaints received by HDC over this time period, with complaints raising issues about doctors consistently making up around 30–39% of all complaints received each year.

Table 3. Number of complaints about doctors received each year, as a proportion of total number of complaints received by HDC

	2009	2010	2011	2012	2013	2014	2015
Number of complaints received about doctors	453	507	552	583	556	565	628
Number of complaints received	1510	1407	1423	1622	1708	1793	1917
Proportion	30%	36%	39%	36%	33%	32%	33%

ⁱ Please note that, in any one year, a few doctors will have received multiple complaints, despite being represented only once in the denominator (doctors practising).

Why are complaint numbers increasing?

The increasing number of complaints being received by HDC about doctors is reflective of an overall trend of sustained growth in complaint numbers to HDC. Over the last four years, the number of complaints to HDC has increased by 33%.

This increase must be interpreted with caution. HDC has no evidence to suggest that the increase in complaints relates to a decrease in the quality of services, by providers generally, or by doctors in particular.

The growth in complaint numbers is more likely to be due to the increasing profile of HDC, the improved accessibility of complaints processes owing to advancing technology, and an increasing public knowledge of consumer rights. It may also reflect an increased willingness among consumers to complain about services received.

HDC's increasing complaint load is not unique, but is consistent with a trend being observed in complaints agencies internationally. For example, in 2014/15 complaints to both the New South Wales Health Care Complaints Commission and the Office of the Health Services Commissioner in Victoria rose by around 10%.

2. Doctor demographics

2.1 Specialty

Table 4 outlines the number of Doctor Complaints received for each specialty, as compared to the proportion of doctors registered in that specialty in New Zealand.ⁱⁱ

Table 4. Specialties represented in the HDC complaints data as a proportion of doctors registered with the Medical Council of New Zealand

	Number of Doctor Complaints	Proportion of all Doctor Complaints	Proportion of all doctors
Anaesthetist	52	1.1%	3.8%
Cardiothoracic surgeon	16	0.4%	0.1%
Dermatologist	46	1.0%	0.3%
Diagnostic and interventional radiologist	15	0.3%	2.3%
Emergency medicine specialist	53	1.2%	1.1%
General practitioner ⁱⁱⁱ	2263	49.6%	17.1%
General surgeon	270	5.9%	1.6%
House officer	17	0.4%	
Internal medicine specialist	262	5.7%	5.2%
Medical officer	22	0.5%	
Musculoskeletal medicine specialist	13	0.3%	0.1%
Neurosurgeon	28	0.6%	0.1%
Obstetrician and gynaecologist	225	4.9%	1.7%
Occupational medicine specialist	76	1.7%	0.3%
Ophthalmologist	77	1.7%	0.8%
Orthopaedic surgeon	314	6.9%	1.4%
Otolaryngologist	43	0.9%	0.6%
Paediatric surgeon	13	0.3%	0.1%
Paediatrician	61	1.3%	1.9%
Plastic and reconstructive surgeon	56	1.2%	0.3%
Psychiatrist	340	7.4%	3.3%
Radiation oncologist	13	0.3%	0.4%
Registrar	74	1.6%	
Rehabilitation medicine specialist	13	0.3%	0.1%
Rural medicine specialist	12	0.3%	0.3%
Sports medicine specialist	13	0.3%	0.1%
Urgent care specialist	45	1.0%	0.7%
Urologist	73	1.6%	0.3%
Vascular surgeon	13	0.3%	0.2%
Unknown/other ^{iv}	160	3.5%	51.8%
TOTAL	4565		

ⁱⁱ This has been calculated by averaging the number of doctors registered in each specialty, as reported in the Medical Council of New Zealand's Annual Reports for 2009/2010, 2011/2012 and 2014/2015.

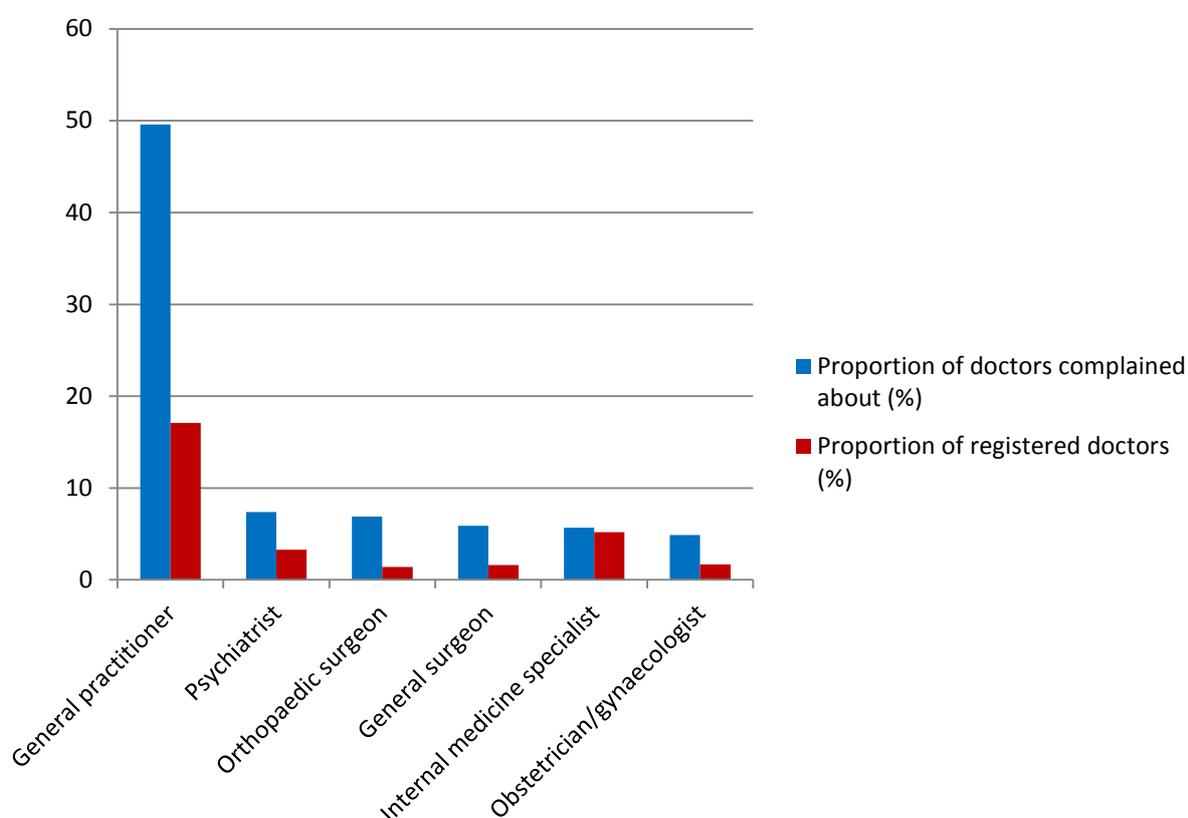
ⁱⁱⁱ A Doctor Complaint about a general practitioner is any doctor working as a general practitioner. It includes doctors holding the FRNZGP qualification and a vocational scope of practice, and those doctors training towards that qualification. However, the proportion of all doctors column refers only to general practitioners registered with the Medical Council of New Zealand in the vocational scope of practice. Therefore, the proportion of general practitioners registered may not be a good comparison for the number of Doctor Complaints about general practitioners.

^{iv} Includes house officers, registrars and medical officers

The most commonly complained about specialty was general practice, accounting for 50% of all Doctor Complaints over the last seven years. This is consistent with the international literature, which has found that GP care is at issue in around half of all complaints about doctors.^{3,4,10} This may be a function of the fact that GPs have the most interactions with patients — New Zealand GPs held around 13 million consultations in 2015/2016.

Other specialties prevalent in the HDC complaints data include: psychiatrists (7.4%), orthopaedic surgeons (6.9%), general surgeons (5.9%), internal medicine specialists (5.7%) and obstetrician/gynaecologists (4.9%). This is also consistent with what is reported in the international literature, which has found that these specialties tend to be at a greater risk for complaints.^{1,3,4,9}

Figure 2. Proportion of specialties among the HDC complaints data and among all registered doctors for the most commonly complained about specialties



As can be seen from Figure 2, the proportion of complaints about the most commonly complained about specialties is often higher than the proportion of doctors on the medical registrar who are registered in that specialty. Therefore, the number of complaints about these specialties cannot be explained by the number of doctors registered in these specialties. There are a number of other factors, however, that may account for the number of complaints about these specialties, such as the amount of patient contact that each specialty has, the clinical activities each specialty performs, and the characteristics of the population that each specialty serves.^{1,7,6,9}

There were relatively few house officers and registrars in the HDC complaints data. This may be because often more senior doctors are seen as principally responsible for the care provided.

As can be seen from Table 5 below, GPs, psychiatrists, general surgeons, orthopaedic surgeons, internal medicine specialists and obstetrician/gynaecologists have consistently been among the most commonly complained about specialties each year.

Table 5. Most common specialties complained about each year

2009	2010	2011	2012	2013	2014	2015
General practitioner (50%)	General practitioner (51%)	General practitioner (48%)	General practitioner (49%)	General practitioner (49%)	General practitioner (53%)	General practitioner (48%)
Psychiatrist (8%)	Psychiatrist (8%)	Orthopaedic surgeon (8%)	Psychiatrist (8%)	Internal medicine specialist (7%)	Psychiatrist (8%)	Orthopaedic surgeon (8%)
General surgeon (7%)	Orthopaedic surgeon (7%)	General surgeon (8%)	Orthopaedic surgeon (7%)	General surgeon (7%)	Orthopaedic surgeon (6%)	Psychiatrist (8%)
Orthopaedic surgeon (7%)	Internal medicine specialist (6%)	Psychiatrist (6%)	General surgeon (6%)	Psychiatrist (6%)	General surgeon (5%)	Internal medicine specialist (8%)
Obstetrician Gynae (5%)	Obstetrician Gynae (4%)	Obstetrician Gynae (5%)	Internal medicine specialist (6%)	Orthopaedic surgeon (5%)	Internal medicine specialist (5%)	Obstetrician Gynae (6%)

Case study: General practitioner (14HDC00368)

Mr A, a 21-year-old generally healthy man, saw his GP (Dr C) with a 10-day history of flu-like symptoms, achy bones, and a headache. Dr C undertook a physical examination and queried whether he had a viral infection. Dr C prescribed pain relief and referred Mr A for blood tests, which were undertaken that day.

Dr C reviewed the blood test results the next morning. The results were abnormal and, in particular, C-reactive protein (a non-specific inflammatory marker) was markedly elevated. Dr C intended to ask a practice nurse to contact Mr A to advise him of the results and to ascertain his current condition, but he forgot to do this.

Mr A remained unwell and, two days later, he found that he could not walk. Mr A's father took him to the local accident and medical clinic. Mr A was assessed by a doctor, who accessed his recent blood test results, noted the abnormalities, and referred him to the medical registrar at the local public hospital, where he was admitted to the intensive care unit. Mr A was reviewed by a number of specialties, and a variety of causes of his illness were considered. Eventually, Mr A was diagnosed with severe acute demyelinating encephalomyelitis (a post-infectious inflammatory disease that damages the protective myelin layer around the nerve fibres in the brain), following a systemic viral illness of undetermined nature. Mr A is now a tetraplegic and lives at a residential care facility.

The Commissioner commented that doctors owe patients a duty of care in handling patient test results, including advising patients of, and following up on, results. To ensure patient safety, GPs and practices must be especially vigilant when managing abnormal test results. The primary responsibility for following up abnormal results rests with the clinician who

ordered the tests, in this case Dr C. The Commissioner noted that the failure by Dr C to notify Mr A of his abnormal results and ensure they were followed up in a clinically appropriate manner was human error. However, the Commissioner did not consider it adequate for Dr C to rely on his memory alone to ensure that all results were actioned — Dr C should have had in place a more robust system. The Commissioner found Dr C in breach of the Code for failing to fully inform Mr A of his results, and for failing to follow up these results appropriately.

The Commissioner was critical that, at the time of these events, the medical centre did not have in place a formal process for the tracking of urgent results.

The Commissioner recommended that the Medical Council undertake a preliminary competence inquiry of Dr C's practice. This inquiry identified no concerns regarding Dr C's practice. Following a recommendation by the Commissioner, the medical centre implemented a formal tracking system for significant results/referrals.

2.2 Gender

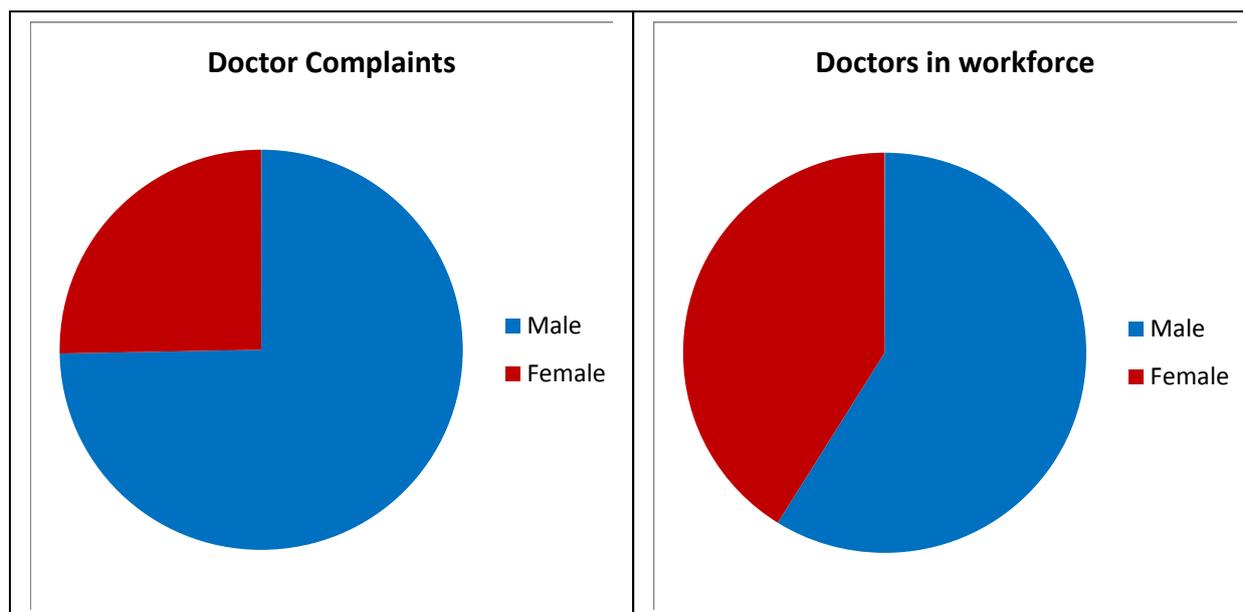
Table 6 and Figure 3 compare the gender distribution of the HDC complaints data with the gender distribution of doctors in the medical workforce.

Table 6. Gender distribution in the HDC complaints data, as compared to gender distribution among practising doctors

	Number of doctor complaints	Proportion of doctor complaints	Proportion of practising doctors ^v
Male	3410	74.7%	58.9%
Female	1155	25.3%	41.1%

^v This has been calculated by averaging the gender distribution of the medical workforce, as reported in the Medical Council of New Zealand's Workforce Survey for 2010, 2012 and 2014.

Figure 3. Gender distribution in the HDC complaints data, as compared to gender distribution of doctors in the medical workforce



A much higher proportion of male doctors were complained about as compared to female doctors, with male doctors making up 75% of all Doctor Complaints. This is in contrast to doctors in the medical workforce, where males account for around 59% of all practising doctors. This finding is in line with international research, which has found that male doctors are more than twice as likely than their female colleagues to be subject to medico-legal action.⁶

2.3 Scopes of practice

Table 7 and Figure 4 compare the distribution of scopes of practice for doctors represented in the HDC complaints data with the distribution of scopes of practice among registered doctors.^{vi}

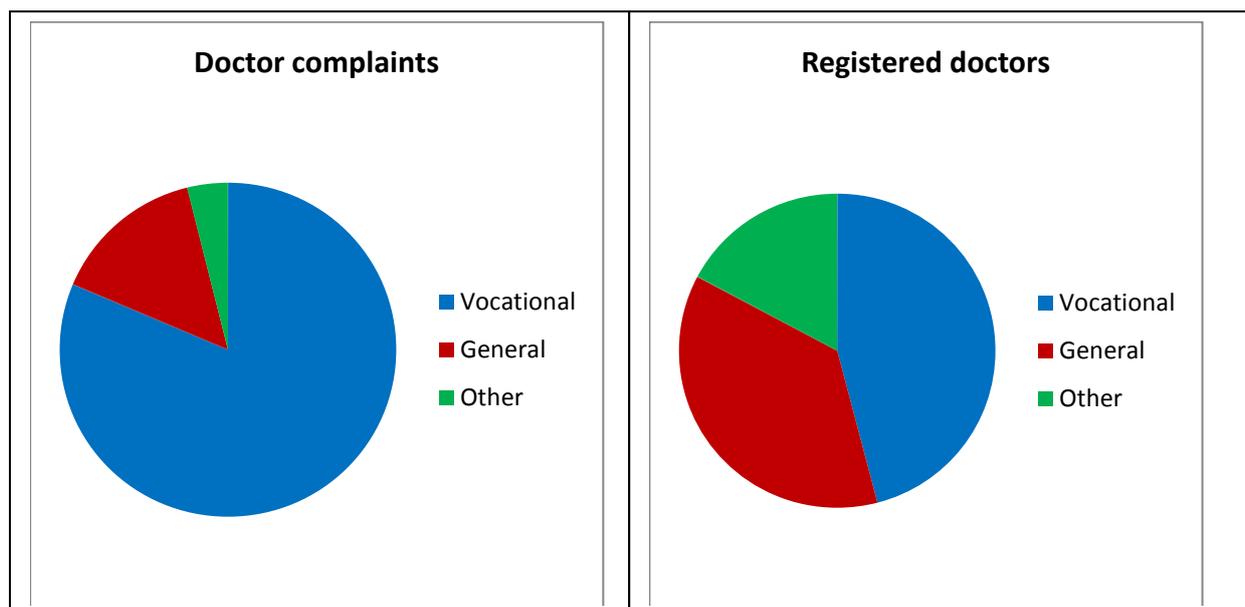
Table 7. Scopes of practice in the HDC complaints data, as compared to scopes of practice among registered doctors

	Number of Doctor Complaints	Proportion of Doctor Complaints	Proportion of registered doctors
Vocational^{vii}	3717	81.4%	45.9%
General	672	14.7%	36.9%
Provisional vocational	20	0.4%	1.0%
Provisional general	55	1.2%	15.1%
Unknown	101	2.2%	NA

^{vi} This has been calculated by averaging the number of doctors registered in each scope, as reported in the Medical Council of New Zealand's Annual Reports for 2009/2010, 2011/2012 and 2014/2015.

^{vii} Doctors registered in a vocational scope of practice have completed an approved or equivalent postgraduate training programme leading to the award of an approved or equivalent postgraduate qualification.

Figure 4. Scopes of practice of doctors in the HDC complaints data, as compared to scopes of practice among registered doctors



A much higher proportion of vocationally registered doctors are complained about as compared to other scopes of practice, with vocationally registered doctors making up 81% of doctor complaints in the HDC complaints data, but only 46% of registered doctors. This finding may be due to doctors who are vocationally registered tending to be seen as principally responsible for the care that is being complained about.

2.4 Years in practice

Table 8 and Figure 5 outline the distribution of years in practice for doctors represented in the HDC complaints data. “Years in practice” has been defined as the number of years between the year in which the doctor completed his or her primary medical degree, and the year in which the complaint about the doctor was received.

The majority of doctors in the HDC complaints data had been practising for 21–30 years (35.3%), closely followed by doctors who had been practising for 31–40 years (29.6%). Relatively few doctors who attracted complaints had been practising for fewer than 11 years or more than 41 years. The average number of years in practice was 26 years. This is slightly less than the average number of years in practice among practising doctors, which was calculated to be around 21 years.^{viii}

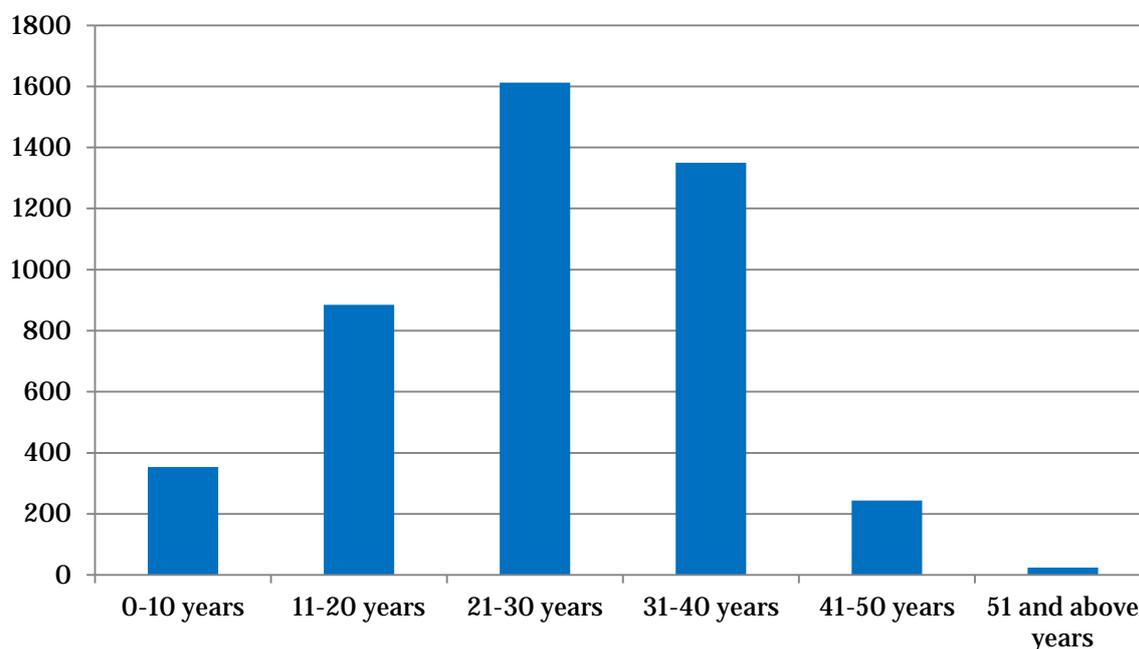
This result is consistent with the international literature, which has posited that doctors who have been practising for longer are at a greater risk of complaint due to having had a greater number of patients in their career to date.^{3,7,6} As noted earlier, more experienced doctors may also be seen as primarily responsible for the care provided.

^{viii} This has been calculated by averaging the mean age of the medical workforce, as reported in the Medical Council of New Zealand’s Workforce Survey for 2010, 2012 and 2014, minus 24 years. This is the same methodology as has been used in the international literature.¹

Table 8. Distribution of years in practice for doctors in the HDC complaints data

	Number of Doctor Complaints	Proportion of Doctor Complaints
0–10 years	353	7.7%
11–20 years	885	19.4%
21–30 years	1612	35.3%
31–40 years	1350	29.6%
41–50 years	244	5.3%
51 and above years	24	0.5%
Unknown	97	2.1%

Figure 5. Distribution of years in practice for doctors in the HDC complaints data



2.5 International Medical Graduates

Table 9 and Figure 6 show the number of Doctor Complaints for doctors who obtained their primary medical qualification in a country other than New Zealand (international medical graduate or IMG).

The proportion of IMGs in HDC’s complaints data (45%) is very similar to the proportion of IMGs practising (43%).^{ix}

^{ix} This has been calculated by averaging the number of IMGs in the workforce as reported in the Medical Council of New Zealand’s Annual Reports for 2009/2010, 2011/2012 and 2014/2015.

Table 9. Doctor Complaints, by IMG status

	Number of Doctor Complaints	Proportion of Doctor Complaints	Proportion of practising doctors
IMG	2036	44.6%	43.0%
Non-IMG	2459	53.9%	57.0%
Unknown	70	1.5%	NA

Figure 6. Doctor Complaints by IMG status, as compared to proportion of IMGs among practising doctors

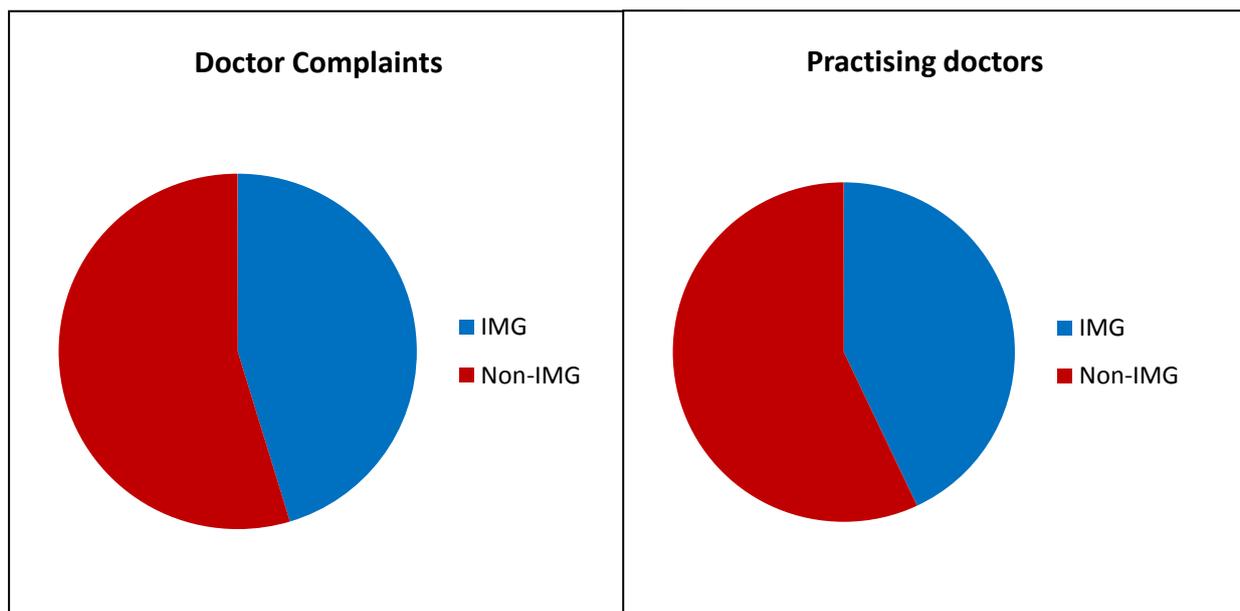


Table 10 provides a greater level of detail as to the distribution of region of training^x for doctors in the HDC complaints data, as compared to practising doctors. In this table, IMGs have been categorised based on the region where they gained their primary medical qualification.

^x Region of training has been categorised according to the United Nations Geoscheme, although some regions have been combined and others split in order to make the data more clear.

Table 10. Doctor Complaints by region of training, as compared to region of training for practising doctors

	Proportion of Doctor Complaints	Proportion of practising doctors^{xi}
New Zealand	54%	57%
Australia & Pacific	3%	3%
United Kingdom	14%	17%
Europe	5%	5%
Americas	3%	3%
Asia	10%	7%
Africa and the Middle East	9%	6%
Other	1%	1%
Unknown	1%	NA

The distribution of Doctor Complaints by region of training is largely similar to that of practising doctors. However, doctors who trained in Asia, Africa and the Middle East were slightly overrepresented in the HDC complaints data, while doctors who trained in the United Kingdom were slightly underrepresented. As noted above, possible confounders that may affect the relationship between region of training and risk of complaint, such as gender and specialty, have not been taken into account in this descriptive analysis.

^{xi} This has been calculated by averaging the number of doctors who trained in each country as reported in the Medical Council of New Zealand's Annual Reports for 2009/2010, 2011/2012 and 2014/2015.

3. Complaint history

Table 11 and Figure 7 outline the complaint history for all doctors in the seven-year period.

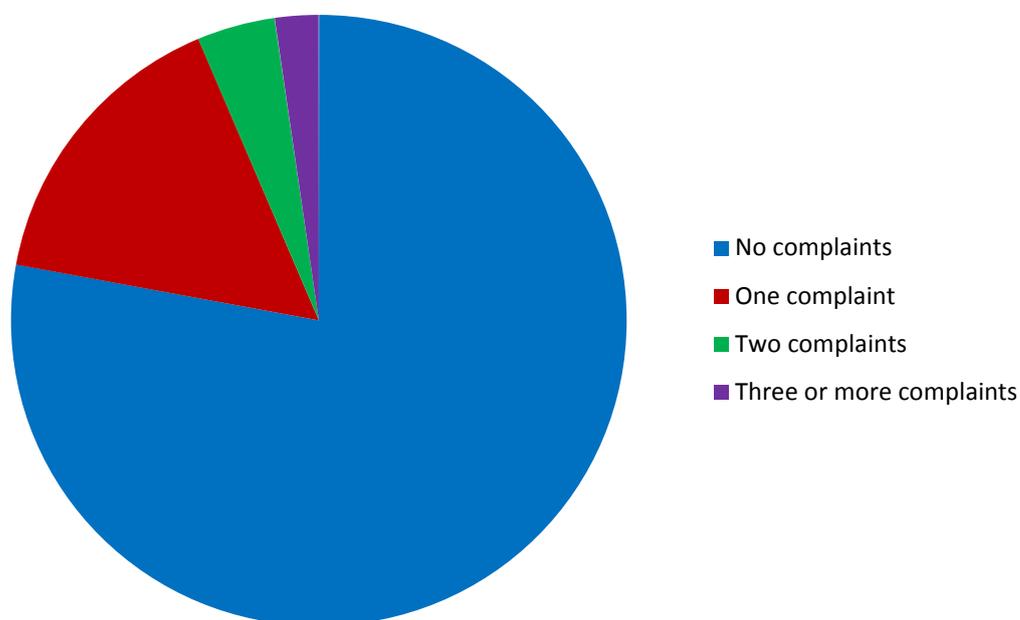
The majority (71%) of individual doctors in the HDC complaints data received only one complaint within the time period. The 30% of doctors who received more than one complaint within this period were responsible for 52% of all Doctor Complaints.

Around 78% of practising doctors received no complaints within the seven-year time period. Therefore, around 22% of practising doctors in New Zealand received at least one complaint within this time period.

Table 11. Complaint history for all doctors between 2009 and 2015

	Number of doctors complained about	Proportion of all doctors complained about	Proportion of all practising doctors ^{xii}
No complaints	0	0	78.0%
One complaint	2161	70.9%	15.7%
Two complaints	561	18.4%	4.1%
Three complaints	186	6.1%	1.3%
Four complaints	65	2.1%	0.5%
Five complaints or more	73	2.4%	0.5%

Figure 7. Distribution of complaints among practising doctors



^{xii} This has been calculated by averaging the size of the workforce as reported in the Medical Council of New Zealand's Annual Reports for 2009/2010, 2011/2012 and 2014/2015.

4. Service

4.1 Service type

Table 12 describes the service type involved in each Doctor Complaint.

Table 12. Doctor Complaints by service type

	Number of Doctor Complaints	Proportion of Doctor Complaints
Accident and emergency	171	3.7%
Aged care	99	2.2%
Anaesthetics/pain medicine	33	0.7%
Assessment for third party	282	6.2%
Diagnostics	25	0.5%
General medicine	359	7.8%
Cardiology	44	1.0%
Dermatology	50	1.1%
Endocrinology	15	0.3%
Gastroenterology	45	1.0%
Geriatric medicine	13	0.3%
Neurology	56	1.2%
Oncology	55	1.2%
Palliative care	14	0.3%
Renal/nephrology	10	0.2%
Respiratory	14	0.3%
Rheumatology	19	0.4%
Unknown/other	24	0.5%
General practice	1937	42.4%
Intensive care/critical care	6	0.1%
Maternity	129	2.8%
Mental health and addictions	322	7.1%
Occupational therapy	5	0.1%
Paediatrics	71	1.6%
Rehabilitation services	11	0.2%
Sexual health	28	0.6%
Surgery	937	20.5%
Cardiothoracic	19	0.4%
General	259	5.7%
Gynaecology	127	2.8%
Neurosurgery	23	0.5%
Ophthalmology	22	0.5%
Oral/Maxillofacial	6	0.1%
Orthopaedics	288	6.3%
Otolaryngology	40	0.9%
Paediatric	10	0.2%
Plastic and reconstructive	56	1.2%
Urology	73	1.6%
Vascular	14	0.3%
Vision/eye services	67	1.5%
Other	83	1.8%
TOTAL	4565	

The most common service types represented in the HDC complaints data are general practice (42.4%) and surgical (20.5%) services. This aligns with the earlier finding that general practice and surgery are commonly complained about specialties. The most common surgical service types complained about were orthopaedics (6.3%), general surgery (5.7%) and gynaecology (2.8%), again in line with the above findings regarding speciality.

Other common service types represented in the HDC complaints data are: general medicine services (7.8%), mental health and addiction services (7.1%), and assessment for third party (6.2%). This is, again, reflective of the fact that internal medicine specialists and psychiatrists were commonly complained about specialties. The number of doctor complaints regarding an assessment for a third party (such as ACC, the court, WINZ, etc) is also high.

Table 13 shows the most common service types in the HDC complaints data over time.

Table 13. Most common service types in the HDC complaints data each year

2009	2010	2011	2012	2013	2014	2015
General practice (39%)	General practice (41%)	General practice (38%)	General practice (42%)	General practice (44%)	General practice (48%)	General practice (44%)
Surgery (23%)	Surgery (15%)	Surgery (22%)	Surgery (20%)	Surgery (19%)	Surgery (22%)	Surgery (23%)
Mental health (9%)	Assessment for third party (8%)	Assessment for third party (8%)	General medicine (8%)	General medicine (10%)	Mental health (7%)	General medicine (9%)
General medicine (7%)	General medicine (8%)	Mental health (6%)	Mental health (8%)	Assessment for third party (7%)	General medicine (6%)	Mental health (7%)
Assessment for third party (6%)	Mental health (7%)	General medicine (6%)	Assessment for third party (6%)	Mental health (6%)	Assessment for third party (5%)	Assessment for third party and Accident & Emergency (3% each)

The common service types have remained consistent over time. Doctor Complaints in relation to an assessment for a third party have decreased in recent years, from 8% in 2010 to 3% in 2015.

4.2 Service location

Table 14 outlines the location of the services provided that were complained about in the HDC complaints data.

Unsurprisingly, given the high proportion of GPs in the HDC complaints data, the majority of services complained about were provided in general practice clinics. Just over one-third of Doctor Complaints arose from services provided in public hospitals, with almost a quarter of Doctor Complaints being in relation to treatment provided in inpatient units.

Table 14. Doctor Complaints by location of service

Service location	Number of doctor complaints	Proportion of all doctor complaints
<i>Clinic</i>	2458	53.8%
After-hours clinic	85	1.9%
General practice clinic	1988	43.5%
Other clinic	385	8.4%
<i>Public hospital</i>	1628	35.7%
Inpatient	1078	23.6%
Outpatient	486	10.6%
Emergency Department	64	1.4%
<i>Private hospital</i>	307	6.7%
Inpatient	153	3.4%
Outpatient	154	3.4%
<i>Residential aged care facility</i>	106	2.3%
<i>Prison</i>	23	0.5%
<i>Other service location</i>	43	0.9%
TOTAL	4565	

5. What was complained about?

5.1 Issues identified in complaints

Table 15 outlines the issues complained about in the HDC complaints data. Many complaints to HDC contain multiple issues of concern to the complainant. For the purposes of analysis, the primary issue being complained about, plus up to six additional complaint issues, for each Doctor Complaint were identified. A list of the possible complaint issues and definitions of these issues is provided in Appendix A.

It should be noted that the issues included in the analysis are as articulated by the complainant to HDC. While not all issues raised are subsequently factually and/or clinically substantiated, those issues can still provide valuable insight into the consumer's experience of the services provided and the issues consumers care most about.

In terms of the primary issue being complained about, issues relating to the category of care/treatment are the most common, making up over half of the primary issues complained about. When separate complaint issues are considered, missed/incorrect/delayed diagnosis (23.7%), unexpected treatment outcome (10.4%), inadequate/inappropriate clinical treatment (9.2%), disrespectful manner/attitude (7.2%), and inadequate/inappropriate examination/assessment (6.1%) emerge as the most common primary complaint issues.

On analysis of all issues complained about in the HDC complaints data, we see that issues relating to care/treatment were the most common (80.8%). Issues relating to communication (45.4%) and consent/information (28.4%) were also commonly complained about. The most common specific complaint issues were: inadequate/inappropriate treatment (35.9%), missed/incorrect/delayed diagnosis (32.4%), inadequate/inappropriate examination/assessment (27.4%), disrespectful manner/attitude (24.2%), unexpected treatment outcome (18.1%), failure to communicate effectively with the consumer (17.8%), and delayed/inadequate/inappropriate referral (15.6%).

These issues are consistent with the international literature in that issues relating to care/treatment and communication were the most common.^{12,13} However, the analysis in this report provided a more granular breakdown of what it was about these issues that complainants were concerned about than is seen in much of the literature.

The issues identified in this report are broadly similar to what is seen in HDC's complaints trends reports on complaints received about services provided by DHBs.

Table 15. Issues complained about in relation to doctors

Complaint issue	Number of doctor complaints primarily about this issue (%)	Number of doctor complaints involving this issue (%)
<i>Access/Funding</i>	<i>54 (1.2)</i>	<i>265 (5.8)</i>
ACC compensation issue	12 (0.3)	117 (2.6)
Lack of access to services	22 (0.5)	90 (2.0)
Lack of access to subsidies/funding	7 (0.2)	23 (0.5)
Waiting list/prioritisation issue	10 (0.2)	33 (0.7)
Other access/funding issue	3	12
<i>Boundary violation</i>	<i>61 (1.3)</i>	<i>77 (1.7)</i>
Financial exploitation	6 (0.1)	10 (0.2)
Inappropriate sexual communication	9 (0.2)	20 (0.4)
Inappropriate sexual physical contact	27 (0.6)	27 (0.6)
Inappropriate sexual relationship	14 (0.3)	17 (0.4)
Other boundary violation issue	10	26
<i>Care/Treatment</i>	<i>2904 (63.6)</i>	<i>3688 (80.8)</i>
Delay in treatment	91 (2.0)	390 (8.5)
Delayed/inadequate/inappropriate referral	135 (3.0)	710 (15.6)
Inadequate coordination of care or treatment	37 (0.8)	381 (8.3)
Inadequate/inappropriate clinical treatment	423 (9.2)	1641 (35.9)
Inadequate/inappropriate examination/assessment	277 (6.1)	1252 (27.4)
Inadequate/inappropriate follow-up	45 (1.0)	403 (8.8)
Inadequate/inappropriate monitoring	21 (0.5)	210 (4.6)
Inadequate/inappropriate testing	19 (0.4)	557 (12.2)
Inappropriate admission/failure to admit	6 (0.1)	25 (0.5)
Inappropriate/delayed discharge/transfer	49 (1.1)	192 (4.2)
Inappropriate withdrawal of treatment	36 (0.8)	94 (2.1)
Missed/incorrect/delayed diagnosis	1081 (23.7)	1480 (32.4)
Personal privacy not respected	6 (0.1)	43 (0.9)
Refusal to assist/attend	47 (1.0)	98 (2.1)
Refusal to treat	72 (1.6)	191 (4.1)
Rough/painful care or treatment	66 (1.4)	193 (4.2)
Unexpected treatment outcome	476 (10.4)	828 (18.1)
Unnecessary treatment/over-servicing	17 (0.4)	74 (1.6)
<i>Communication</i>	<i>412 (9.0)</i>	<i>2074 (45.4)</i>
Disrespectful manner/attitude	330 (7.2)	1103 (24.2)
Failure to communicate openly/honestly/effectively with consumer	37 (0.8)	814 (17.8)
Failure to communicate openly/honestly/effectively with family	18 (0.4)	288 (6.3)
Insensitive/inappropriate comments (not sexual)	25 (0.5)	220 (4.8)
Other communication issues	2	21
<i>Complaints process</i>	<i>19 (0.4)</i>	<i>399 (8.7)</i>
Inadequate response to complaint	13 (0.3)	363 (8.0)
Retaliation/discrimination as a result of a complaint	6 (0.1)	49 (1.1)
<i>Consent/Information</i>	<i>322 (7.1)</i>	<i>1296 (28.4)</i>
Consent not obtained/adequate	98 (2.1)	261 (5.7)
Inadequate information provided regarding adverse event	6 (0.1)	126 (2.8)

Complaint issue	Number of doctor complaints primarily about this issue (%)	Number of doctor complaints involving this issue (%)
Inadequate information provided regarding condition	17 (0.4)	168 (3.7)
Inadequate information provided regarding fees/costs	20 (0.4)	46 (1.0)
Inadequate information provided regarding options	12 (0.3)	133 (2.9)
Inadequate information regarding results	29 (0.6)	134 (2.9)
Inadequate information provided regarding treatment	47 (1.0)	495 (10.8)
Incorrect/misleading information provided	39 (0.9)	269 (5.9)
Issues regarding consent when consumer not competent	9 (0.2)	30 (0.7)
Issues with involuntary admission/treatment	41 (0.9)	53 (1.2)
Other consent/information issues	4	47
Documentation	53 (1.2)	425 (9.3)
Delay/failure to disclose documentation	5 (0.1)	59 (1.3)
Inadequate/inaccurate documentation	35 (0.8)	323 (7.1)
Intentionally misleading/altered documentation	6 (0.1)	30 (0.7)
Other documentation issues	7	54
Fees/costs	18 (0.4)	129 (2.8)
Cost of treatment	2 (0.04)	55 (1.2)
Inappropriate billing practices	14 (0.3)	95 (2.1)
Other fees/costs issue	2	4
Medication	306 (6.7)	625 (13.7)
Inappropriate administration	6 (0.1)	30 (0.7)
Inappropriate prescribing	188 (4.1)	396 (8.7)
Prescribing error	29 (0.6)	50 (1.1)
Refusal to prescribe/dispense/supply	69 (1.5)	149 (3.3)
Other medication issue	14	34
Reports/Certificates	266 (5.8)	440 (9.6)
Backdated/invalid/improper report/certificate	13 (0.3)	36 (0.8)
Inaccurate report/certificate	216 (4.7)	336 (7.4)
Refusal to complete report/certificate	31 (0.7)	74 (1.7)
Other report/certificate issue	6	21
Teamwork/supervision	8 (0.2)	67 (1.5)
Inadequate supervision/oversight	8 (0.2)	67 (1.5)
Other professional conduct issues	106 (2.3)	318 (7.0)
Disrespectful behaviour	6 (0.1)	53 (1.2)
Failure to disclose/properly manage a conflict of interest	4	30 (0.7)
Inappropriate collection/use/disclosure of information	52 (1.1)	153 (3.4)
Qualifications issue/use of title	12 (0.3)	21 (0.5)
Threatening/bullying/harassing behaviour	11 (0.2)	28 (0.6)
Other professional conduct issue	14	93
Other issues	35 (0.8)	204
TOTAL	4565	

Case study: Missed/incorrect/delayed diagnosis (12HDC00112)

Mrs A, a woman in her sixties with a history of heavy smoking, was referred by her GP to the dental unit at a public hospital for removal of her teeth. Mrs A saw a locum dental surgeon, Dr F, who requested a pre-anaesthetic assessment. Dr F's understanding was that any abnormal test findings would be reported to and acted on by the anaesthetic team.

At the assessment, the anaesthetist, Dr C, examined Mrs A, recorded her history, and noted that she had a heart murmur. Dr C requested a chest X-ray and echocardiogram be done before surgery. Dr C did not document this request or Mrs A's smoking history. Dr C's signature on the X-ray request form was unclear.

Mrs A had an echocardiogram. The sonographer reported moderate aortic stenosis and recommended a re-scan in one year's time or as clinically indicated. The referrer listed on the echocardiogram report was incorrect, and the report was not copied to Mrs A's GP, Dr F or Dr C. The next day, Mrs A had a chest X-ray. The radiologist, Dr D, reported an abnormal opacity on the lung and recommended a follow-up investigation. However, the wording of Dr D's report was unclear in that it did not suggest a cause for concern, and the report was not copied to Mrs A's GP, Dr F or Dr C. Dr D did not follow the DHB's process to "red flag" abnormal results. The abnormal chest X-ray was faxed to the dental unit, but the result was not sighted by unit staff or placed in Mrs A's health record. The referrer listed on the report was a generic name, rather than a specific surgeon. There was no one clinician responsible for overseeing the dental unit.

Another anaesthetist, Dr E, who was scheduled to provide anaesthesia prior to surgery, saw Mrs A in the surgical day unit. Dr E checked Mrs A's medical history and Dr C's preoperative assessment notes, but did not review her heart murmur. Surgery went ahead and Mrs A was discharged home. A year later, following a finding of a lung mass on a chest X-ray, Mrs A was diagnosed with an inoperable carcinoma with metastasis and, sadly, died later that year.

The Commissioner considered that there was a series of missed opportunities for the identified abnormality to have been followed up. The lack of follow-up occurred because of a number of organisational and systemic failures, including the lack of clearly established and explicit processes for following up investigation test results, and poorly understood lines of responsibility, coupled with associated deficiencies on the part of a number of individual clinicians.

The Commissioner was critical of deficiencies in Dr C's documentation, which meant that clinical information and the nature of investigations ordered were not brought to the attention of the anaesthetist administering the anaesthetic on the day of surgery (Dr E). The Commissioner also considered that Dr C must accept some degree of responsibility for Mrs A's abnormal result not being followed up in a timely manner, commenting that if Dr C knew that she would not be following up the X-ray she ordered, she needed to be confident that the appropriate person had been alerted that the test had been ordered.

The Commissioner was critical that Dr D's report did not suggest a cause for concern or alarm, in that it did not make it clear that the cause of the possible abnormality could be lung cancer. Furthermore, an opportunity for Mrs A's abnormal chest X-ray result to be brought to the attention of clinicians was lost when Dr D failed to "red flag" the abnormal result on the electronic system. Accordingly, The Commissioner considered that Dr D did not provide services to Mrs A with reasonable care and skill, in breach of the Code.

The Commissioner found Dr E in breach of the Code, as his preoperative assessment did not comply fully with professional standards, in that he did not address all the elements that were identified in Dr C's pre-anaesthetic assessment, most notably Mrs A's heart murmur.

The Commissioner considered that the care provided to Mrs A by the individual clinicians was provided in the context of serious organisational and systems failures on the part of the DHB. In the Commissioner's view, if the DHB process in place at the time meant that responsibility for following up the X-ray did not lie with the clinician ordering the test, there should have been an explicit and documented process that clearly identified the clinician who would be responsible for reviewing and following up the test. An effective and formalised system was not in place for reporting test results. Accordingly, the Commissioner found that the DHB did not provide services to Mrs A with reasonable care and skill, in breach of the Code.

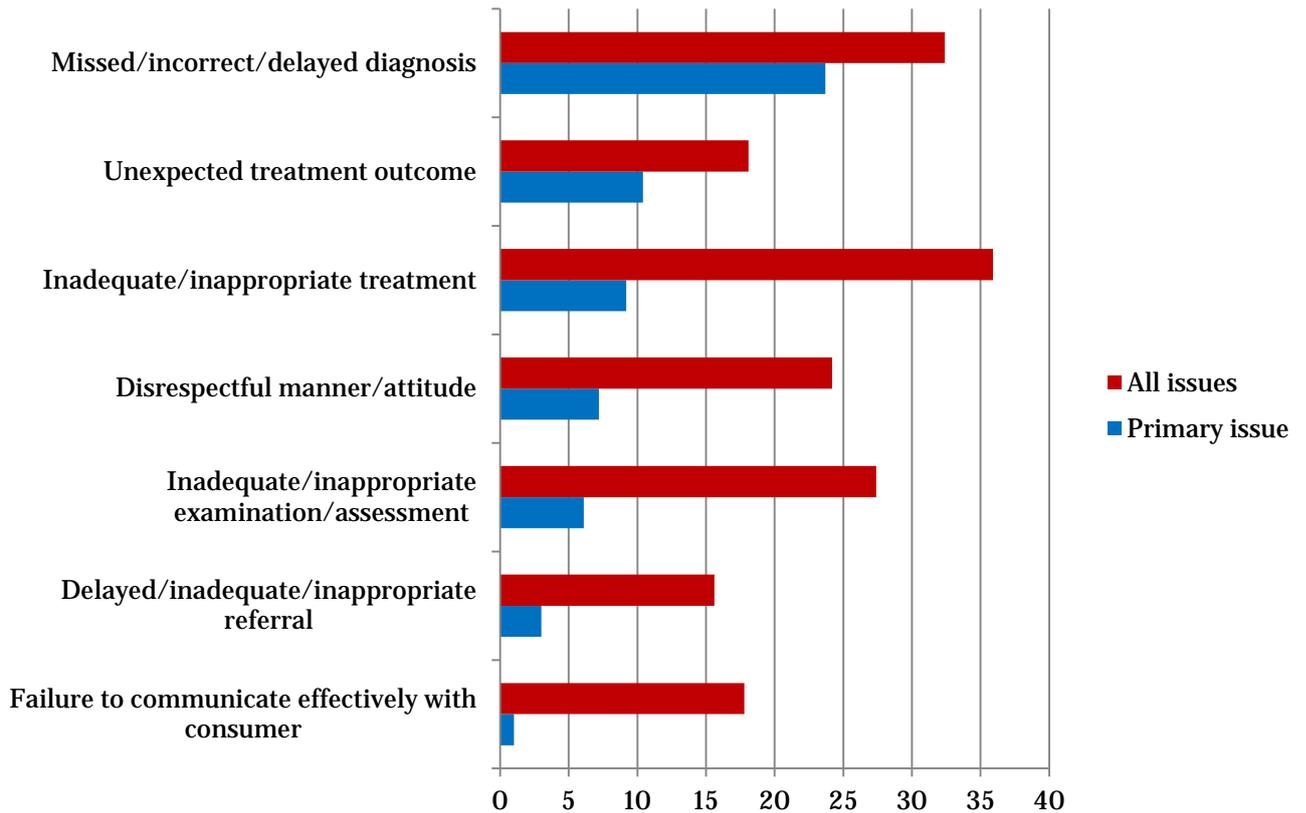
The Commissioner recommended that Dr D arrange for a clinical peer review of the standard of his radiology reporting, and that Dr E arrange for clinical peer review of the standard of his pre-surgery anaesthetic review. The Commissioner made a number of recommendations to the DHB, including that it ensure that the anaesthesia department reviews and develops a formalised process governing follow-up of all investigations ordered at the pre-anaesthesia clinic stage, and that it provide an evaluative update report to HDC on the effectiveness of all system changes implemented as a result of this case, including specific reference to:

- the radiology service's performance since these events in relation to distribution of dental X-ray reports;
- adherence to the Radiology Information System Red Flagging protocol and interpretation of the red flag criteria;
- collective feedback from pre-anaesthesia assessment clinic staff and anaesthetists performing on the day of surgery, on improvements made to their communication and new Anaesthetic Record templates;
- audit of the dental unit's compliance with the system of review and sign-off of investigation reports it receives;
- the electronic radiology system and its reporting templates; and
- the system of anaesthetic alerts sent by email to all anaesthetists with details of any expected problems a day prior to the theatre list being produced.

These recommendations have been met.

Figure 8 details the most common complaint issues raised in the HDC complaints data. The blue bars show the percentage of Doctor Complaints in which the particular complaint issue was identified as the primary complaint issue, while the red bars show the percentage of Doctor Complaints in which the particular complaint issue was raised at all. As can be seen from the large difference in the size of the blue and red bars, communication-related complaint issues (disrespectful manner/attitude and failure to communicate effectively with family or consumer) are present in a significant number of complaints, but often are not the primary issue raised. What this indicates is that although consumers may be complaining about a care/treatment issue, often they also feel as though the way they were communicated with in the context of that care/treatment issue was inadequate.

Figure 8. Most common primary and all issues in the HDC complaints data



Case study: Disrespectful manner/attitude (12HDC00846)

Ms A, a 46-year-old woman, was pregnant with her fourth child. She had an uncomplicated pregnancy. At 37+5 weeks’ gestation, Ms A experienced a spontaneous rupture of the membranes and went into hospital. A decision was made to await spontaneous onset of labour. Syntocinon (a medication used to stimulate labour) was commenced two days later because of Ms A’s failure to progress into spontaneous labour.

Ms C, the hospital midwife who was caring for Ms A, noted a series of decelerations on the cardiotocograph (CTG). Ms C called the clinical charge midwife, Ms E, after each deceleration, which initially were managed by moving Ms A into another position. A deceleration that was slow to recover was then noted and a fetal scalp electrode was attached. Following a further deceleration, the on-call obstetrician, Dr B, was called.

After assessing Ms A, Dr B decided to obtain a fetal blood sample to establish the fetal condition, but opted to await the arrival of the obstetric registrar, Dr D, to collect the sample. Ms A said that Dr B did not explain the assessment or his proposed management plan, and that the assessment was distressing owing to Dr B’s abrupt manner.

When Dr D arrived, she reviewed the CTG trace and noted that Ms A was experiencing pain between contractions. Dr D asked Dr B if she could call for an emergency Caesarean section. However, Dr B requested that fetal blood sampling be done first. The fetal blood sample showed severe acidosis, and Dr B decided to proceed with a Caesarean section. The baby was born pale and unresponsive and, sadly, resuscitation attempts were unsuccessful. A concealed placental abruption was diagnosed.

HDC's expert clinical advisor was critical of Dr B's decision to obtain a fetal blood sample, advising that the CTG was indicative of severe non-controversial fetal compromise and, therefore, fetal blood sampling was contraindicated as this would lead to a delay in delivery and potentially increase the risk of fetal problems. Furthermore, the Commissioner considered that Dr B's decision to delay obtaining the blood sample by awaiting the arrival of Dr D raised significant concerns. The Commissioner found Dr B in breach of the Code in that he failed to provide Ms A with services with reasonable care and skill by failing to respond appropriately to the abnormalities on the CTG, and by delaying the decision to perform an emergency Caesarean section.

Ms A complained that Dr B did not communicate with her, that he appeared angry and was "aggressive", and that, as a result, the experience was very distressing. Both midwives advised HDC that Dr B's communication with Ms A was minimal. The Commissioner noted that effective communication requires good interaction between the provider and the consumer, and that this is particularly important when the situation is stressful and the patient is understandably distressed and anxious. The Commissioner considered that Dr B's actions and manner were unprofessional and disrespectful, and that he failed to provide Ms A with information that a reasonable consumer in Ms A's circumstances would expect to receive, in breach of the Code. Dr B was also found in breach of the Code for not heeding the concerns raised by Dr D, and therefore failing to cooperate sufficiently with another provider to ensure the quality of services provided to Ms A.

The Commissioner referred Dr B to the Director of Proceedings for the purpose of deciding whether any proceedings should be taken. The Director of Proceedings decided to institute a proceeding.

The Commissioner recommended that Dr B undertake further training with regard to shared decision-making, fetal surveillance, and communication with patients. The Commissioner asked the Medical Council to provide a report outlining Dr B's compliance with its education programme and any further performance assessment it decided to take and/or when the restrictions on Dr B's scope of practice were reviewed. The Commissioner also recommended that the DHB where Dr B was working include in its training and induction for all staff, information that the DHB's practice is that asking of questions and reporting of concerns is expected and accepted from members of the multidisciplinary team. These recommendations have been met.

Table 16 below outlines the common primary complaint issues in the HDC complaints data each year, over the last seven years.

The common complaint issues have remained broadly similar over time, with missed/incorrect/delayed diagnosis, unexpected treatment outcome, inadequate/inappropriate clinical treatment, inadequate/inappropriate examination/assessment, disrespectful manner/attitude and inaccurate report/certificate remaining among the most commonly complained about issues each year. Missed/incorrect/delayed diagnosis is by far the most common primary issue, being at issue for around a quarter of doctor complaints each year. The fact that inaccurate report/certificate is among the most common complaint issues each year reflects the earlier finding that assessments for third parties tend to attract relatively high numbers of complaints.

Table 16. Common primary complaint issues in Doctor Complaints, by year complaint received

2009	2010	2011	2012	2013	2014	2015
Missed/delayed diagnosis (22%)	Missed/delayed diagnosis (26%)	Missed/delayed diagnosis (23%)	Missed/delayed diagnosis (22%)	Missed/delayed diagnosis (27%)	Missed/delayed diagnosis (22%)	Missed/delayed diagnosis (24%)
Unexpected treatment outcome (14%)	Unexpected treatment outcome (11%)	Unexpected treatment outcome (15%)	Unexpected treatment outcome (12%)	Unexpected treatment outcome (14%)	Inadequate treatment (17%)	Inadequate treatment (15%)
Disrespectful manner/attitude (9%)	Inadequate examination/assessment (8%)	Inadequate examination/assessment (7%)	Inadequate treatment (10%)	Disrespectful manner/attitude (8%)	Disrespectful manner/attitude (7%)	Inadequate examination/assessment (8%)
Inaccurate report/certificate (6%)	Disrespectful manner/attitude (7%)	Inaccurate report/certificate (6%)	Disrespectful manner/attitude (8%)	Inadequate treatment (7%)	Inadequate examination/assessment (6%)	Disrespectful manner/attitude (7%)
Inadequate treatment (5%)	Inaccurate report/certificate (6%)	Inadequate treatment (6%)	Inadequate examination/assessment (4%)	Inadequate examination/assessment (6%)	Inaccurate report/certificate (5%)	Unexpected treatment outcome (6%)

Case study: Inadequate treatment (13HDC01676)

Mr A, a 77-year-old man, presented to an emergency department (ED) of a regional hospital after suffering an ischaemic stroke. He was assessed by a house officer, Dr B, who, in consultation with the consultant on call, Dr C, determined that Mr A was an appropriate candidate for thrombolysis.

Thrombolysis is the breakdown of blood clots using types of drugs called tissue plasminogen activator (tPA) drugs, and can be used in patients who have suffered ischaemic stroke or a heart attack. There are a number of risks associated with thrombolysis, including intracerebral haemorrhage (bleeding in the brain).

Although it was usual practice for stroke thrombolysis to be administered in the Intensive Care Unit (ICU), Dr B decided to treat Mr A in the ED. In addition, Dr B prescribed tenecteplase rather than alteplase. Both are tPA drugs but, in New Zealand, tenecteplase is used for treatment of a myocardial infarction (heart attack) rather than ischaemic stroke. Dr B prescribed tenecteplase because she understood from nursing staff that there was no alteplase available in the hospital and was aware of studies that supported the use of tenecteplase in stroke.

Dr B followed the New Zealand Formulary guidelines for the use of tenecteplase in myocardial infarction. In doing so, she prescribed at least twice the dose of tenecteplase recommended for treatment of ischaemic stroke. In addition, Dr B did not prescribe the correct mode of administration for tenecteplase. Dr B did not discuss with Dr C her prescription of tenecteplase or the fact that the drug was administered in ED rather than ICU.

Partway through the administration of tenecteplase, Dr B was informed that alteplase was available at the hospital in the ICU. She telephoned Dr C for advice about whether or not to continue the infusion, and Dr C advised that the infusion should continue. Following the

infusion of tenecteplase, Mr A initially showed signs of improvement, but a computed tomography (CT) scan showed that he had suffered an intracerebral haemorrhage. Sadly, Mr A died a few days later.

The DHB's relevant policy titled "the Stroke Pathway" referred to alteplase in some places but did not explicitly specify alteplase as the tPA drug to be used in the case of stroke thrombolysis. In addition, "the Stroke Pathway" did not state that alteplase should be given only in ICU. There was also confusion amongst nursing staff about the correct process for administering thrombolysis, and Dr B had not been orientated to "the Stroke Pathway" adequately.

The Commissioner acknowledged that Dr B was faced with time pressure, that she had never given thrombolysis treatment previously, that she was not orientated to "the Stroke Pathway" sufficiently, and that she was the only doctor working on site in the ED that night (and one of only two doctors on site at the hospital). However, advice from a senior colleague (Dr C) was available to Dr B over the telephone, and yet she made decisions to deviate from standard practice without seeking Dr C's advice. The Commissioner considered that Dr B made significant errors of judgement in failing to transfer Mr A to ICU, in deciding to prescribe tenecteplase to Mr A at the dose and using the mode of administration that she did, and in failing to consult Dr C about the use of tenecteplase. Overall, the Commissioner found that Dr B failed to provide Mr A with reasonable care and skill, in breach of the Code.

The Commissioner was critical that Dr C did not appear to have provided Mr A or his wife with a timely and clear explanation of the error that had occurred. The Commissioner commented that open disclosure about the error and its potential consequences needed to occur, either to Mr A if he was competent, or to another appropriate person, in this case his wife.

The Commissioner held that the DHB had a responsibility to ensure that its staff had the right tools, including adequate policies and training, to provide thrombolysis safely. The DHB failed in this regard and, therefore, did not provide Mr A with services of an appropriate standard, in breach of the Code.

The Commissioner made a number of recommendations to the DHB, including that it provide HDC with the outcome of its audit regarding compliance with its updated Stroke Pathway, and review the orientation training of junior and new staff to ensure that they know how to access all medications within the DHB, and whom to contact with questions or queries. The Commissioner also recommended that the National DHB Chief Medical Officer Group take steps to ensure that all DHBs' policies/guidelines in relation to stroke thrombolysis are clear and consistent, including in relation to the appropriate medication, dose and mode of administration to use, and the level of supervision required. The majority of these recommendations have been met, and the outstanding recommendations will be met within the next six months.

5.2 Complaint issues by specialty

Table 17 outlines the most commonly complained about issues for common specialties over the seven-year period.

The issues of missed/incorrect/delayed diagnosis, inadequate/inappropriate clinical treatment, and disrespectful manner/attitude were common to all specialties. However, issues do vary according to the specialty of the doctor, and are in line with the clinical work of each specialty. For example, diagnostic issues were most common for specialties with high diagnostic workloads, with this being at issue for 37% of GPs and 38% of internal medicine specialists. Unexpected treatment outcome, on the other hand, was prevalent in surgical specialties, as this issue often related to post-surgical complications.

The specialties of general surgery and obstetrics/gynaecology had a higher proportion of complaints regarding the provision of information about treatment than was seen for other specialties or across all Doctor Complaints. In contrast, GPs had a higher proportion of complaints regarding referrals, and psychiatrists had a higher proportion of complaints about their prescribing practices, than was seen for other specialties or across all Doctor Complaints.

Table 17. Most common issues in Doctor Complaints by commonly complained about specialties

General practitioner	Psychiatrist	Orthopaedic surgeon	General surgeon	Internal medicine specialist	Obstetrician/ gynaecologist
Missed/ delayed diagnosis (37%)	Inadequate treatment (30%)	Inadequate treatment (40%)	Unexpected treatment outcome (58%)	Missed/ delayed diagnosis (38%)	Inadequate treatment (46%)
Inadequate treatment (34%)	Missed/ delayed diagnosis (25%)	Unexpected treatment outcome (40%)	Inadequate treatment (50%)	Disrespectful manner/ attitude (33%)	Unexpected treatment outcome (40%)
Inadequate examination/ assessment (32%)	Disrespectful manner/ attitude (23%)	Disrespectful manner/ attitude (32%)	Missed/ delayed diagnosis (28%)	Inadequate examination/ assessment (30%)	Failure to communicate effectively with consumer (29%)
Disrespectful manner/ attitude (32%)	Inadequate examination/ assessment (19%)	Inadequate examination/ assessment (28%)	Disrespectful manner/ attitude (26%)	Inadequate treatment (30%)	Disrespectful manner/ attitude (29%)
Delayed/ inadequate/ inappropriate referral (27%)	Inappropriate prescribing (17%)	Missed/ delayed diagnosis (28%)	Failure to communicate effectively with consumer (23%)	Failure to communicate effectively with consumer (21%)	Inadequate information provided re treatment (20%)
Failure to communicate effectively with consumer (16%)	Failure to communicate effectively with family (16%)	Failure to communicate effectively with consumer (25%)	Inadequate information provided re treatment (16%)	Inadequate testing (15%)	Missed/delayed diagnosis (20%)

Case study: Delayed/inadequate/inappropriate referral by general practitioner (13HDC00926)

Mr C, a man in his fifties, visited his GP, Dr A, complaining of weight loss and going to the toilet as much as 40 times a day with rectal bleeding. Dr A's differential diagnoses included irritable bowel syndrome and carcinoma. Dr A made a referral to the local DHB gastroenterology department and requested blood tests. Dr A recorded follow-up review "as needed". Dr A did not give Mr A information about an expected timeframe for the specialist appointment, or what to do if he had not received an appointment time or if his symptoms worsened.

Dr A's referral was not received by the DHB, and Dr A did not use his Medtech patient information system to set a reminder to follow up on the referral.

A few days later, Mr C went to the Emergency Department (ED) with groin swelling. He was referred to the general surgical team at the DHB with a suspected inguinal hernia. The DHB later sent an electronic receipt message to Dr C advising that this second referral to the surgical team (the ED referral) had been declined. Dr A, incorrectly, believed that this message related to his earlier gastroenterology referral.

Two months later, Mr C returned to the medical centre with continuing bowel symptoms. A locum GP, Dr D, established that the initial referral had not been received by the DHB and so sent a further referral. The DHB then advised Dr A that this referral had been assigned a P2 priority — to be seen within six weeks. The DHB's standard referral acknowledgement letter to patients advised only that the patient would receive an appointment "in due course".

Five weeks later, Mr C presented again to the medical centre with bowel symptoms, and the decision was made to await the gastroenterology review. No review appointment was made and, one month later, Mr C returned to the ED with blood in his urine. Tests revealed advanced metastatic cancer of the rectum. Mr C received hospice care and, sadly, he died.

The Commissioner had concerns about a number of aspects of Dr A's care of Mr C. HDC's clinical advisor was critical of Dr A's consideration of irritable bowel syndrome, given the alarm symptoms for colorectal cancer with which Mr C presented. The expert considered that Mr C would likely have fulfilled the criteria for urgent specialist referral, and was critical that Dr A did not classify his referral of Mr C as urgent. The Commissioner also considered that, in the clinical circumstances, more structured follow-up instructions and information should have been given to Mr C by Dr A. The Commissioner commented that a provider who explains to the patient the purpose of a referral and its importance not only ensures that the patient is adequately informed, but also encourages the patient to be vigilant in following up if the referral appointment is not received.

The Commissioner was critical that Dr A failed to use appropriate alert and follow-up systems to set an electronic reminder to follow up the referral. The Commissioner commented that doctors who refer patients to a specialist need to take reasonable steps, and have processes in place, to follow up the referral and check whether appropriate action has been taken. HDC's clinical advisor was also concerned not only at Dr A's misinterpretation of the referral decline message, but also that, despite the severity of Mr C's symptoms, Dr A accepted that specialists wanted Mr C to be re-referred when he showed more "significant symptoms and signs". The Commissioner was critical that Dr A also failed to advocate proactively for his patient with the DHB, did not contact the DHB and query the decline message, and did not take steps to follow up with Mr C and check on his symptoms.

Taking into account the deficiencies in the care provided to Mr C by Dr A, the Commissioner found that Dr A did not provide services to Mr C with reasonable care and skill, in breach of

the Code. The Commissioner was also critical that the processes in place at the medical centre at the time did not include a mandatory automatic reminder system.

The Commissioner considered that the DHB's turnaround time and delays in processing Dr A's referral were substandard. In addition, the DHB did not provide Mr C with clear information about an estimated timeframe for a specialist appointment, in breach of the Code.

The Commissioner recommended that Dr A have an independent GP colleague conduct a random audit of 30 referrals to specialist secondary services that he had instigated in the preceding year, to check that appropriate requests had been made and appropriate reminders put in place to follow up such referrals. The Commissioner also recommended that the medical centre provide HDC with an evaluative report of all system and policy changes implemented as a result of this case, including systems to ensure that all doctors put in place appropriate reminders to follow up referral letters, and evidence in the electronic record of confirmation that referrals have been sent and received. The Commissioner recommended that the DHB ensure that referral waiting list acknowledgement letters are copied to patients' GPs, and conduct an audit of the processing time of all referrals requesting investigative procedures received by the gastroenterology department in the last year. These recommendations have been met.

Case study: General surgeon and an unexpected treatment outcome (12HDC00779)

Mr A, a 74-year-old man with multiple co-morbidities, presented to the Emergency Department (ED) of a public hospital owing to a sudden onset of right-sided back pain. Following a renal ultrasound that showed multiple gallstones, he was referred to the surgical outpatient clinic. A general surgeon, Dr D, reviewed Mr A at the outpatient clinic and recommended he undergo an open cholecystectomy (surgical removal of the gallbladder) and incisional hernia repair. However, on the advice of an anaesthetist (Dr G), surgery was delayed for six months owing to issues with Mr A's medication. Subsequently, Mr A underwent treatment for his kidney stones, and presented at the ED with left-sided back pain.

On the day of Mr A's surgery, Dr D discussed with Mr A his recent medical history, and the decision was made to proceed with surgery. However, Dr D did not document her discussion with Mr A.

The surgery was longer and more difficult than expected, and postoperatively Mr A was transferred to the intensive care unit (ICU). During the next 24 hours, Mr A's condition deteriorated. He was in pain and had a low urine output, raised creatinine levels, electrocardiogram changes, and an increasingly distended abdomen. Mr A was treated by a number of doctors. Around midnight, a second general surgeon (Dr E) performed an exploratory laparotomy and repair of a jejunal perforation. However, Mr A continued to deteriorate and was transferred to another hospital, where, sadly, he died the following day.

The risks of surgery were elevated for Mr A given his co-morbidities. The Commissioner considered that a key aspect of Dr D's preoperative discussions with Mr A should have been about his personal risk profile. The Commissioner found that, in the absence of any documented evidence, Dr D failed to provide Mr A with adequate information about his treatment options and the risks of surgery that were specific to him. As a result, Dr D did not obtain Mr A's informed consent for surgery, in breach of the Code.

HDC's clinical advisor considered that Dr D's reasons for recommending that surgery proceed were not clinically justified. The advisor was critical of Dr D's decision to perform surgery on

Mr A seven months after her initial review of him, in circumstances where the planned surgery had been delayed, he had complex co-morbidities, and Mr A had had medical treatment relevant to his condition in the intervening period. The advisor considered that, in these circumstances, Dr D should have proceeded with more caution. The advisor was also critical of the postoperative care provided to Mr A by Dr D, stating that it was insufficiently cautionary. The Commissioner concluded that Dr D's decision to perform surgery, and her postoperative care, demonstrated a lack of reasonable care and skill, in breach of the Code. Additionally, the Commissioner found Dr D in breach of the Code as her documentation fell below professional standards.

The Commissioner also considered that there was a lack of discernible leadership, coordination and critical thinking in the clinical team treating Mr A postoperatively, and a lack of support offered by senior doctors to junior staff. This demonstrated a service level failure by the DHB to provide services with reasonable care and skill, in breach of the Code. Furthermore, there was a pattern of suboptimal documentation by clinical staff treating Mr A postoperatively, and the DHB was found in breach of the Code for failing to ensure that its staff met expected standards of documentation. The Commissioner was also critical about the DHB's preoperative process and consent to treatment process.

The Commissioner recommended that the Medical Council consider whether a review of Dr D's competence was warranted. The Commissioner also made a number of recommendations to the DHB, including that it: review its processes for ensuring that pre-surgical patients are assessed in an appropriate and timely manner prior to surgery, especially in cases where surgery is delayed unexpectedly; report to HDC on the actions it intends to take to ensure that all ICU patients have a senior lead clinician who takes ownership for managing the patient's care at all times; audit clinical records to ensure that documentation by medical staff is being completed with sufficient detail; and provide training to staff on the legal requirements of informed consent.

5.3 Complaint issues by service type

Table 18 below outlines the most common complaint issues in the HDC complaints data by service type.

Common complaint issues seen for predominant service types typically match the common complaint issues for the specialty working in those services. For example, the complaint issues for general medicine are generally consistent with those for internal medicine specialists, while the common complaint issues for mental health and addiction services are consistent with those for psychiatrists.

Common complaint issues across the service types were also quite consistent with one another, with missed/delayed diagnosis, inadequate treatment, disrespectful manner/attitude and inadequate/inappropriate examination/assessment being common issues for most service types. However, general practice had a higher number of complaints regarding referrals and inadequate testing than was seen for all doctors and for the other service types. Issues regarding information about treatment were higher for surgical services, and issues regarding prescribing practices were higher for mental health and addiction services.

Common issues for doctors providing an assessment for a third party were quite distinct, but not unexpected, with issues regarding an inaccurate report/certificate being complained about for 69% of these Doctor Complaints and issues around examination/assessment being higher for this service type than for others. Issues around ACC compensation and collection/use of information were also common complaint issues for doctors conducting such assessments.

Table 18. Most common complaint issues, by service type

General practice	Surgery	General medicine	Mental health and addictions	Assessment for third party
Missed/delayed diagnosis (38%)	Unexpected treatment outcome (53%)	Missed/delayed diagnosis (40%)	Inadequate treatment (34%)	Inaccurate report/certificate (69%)
Inadequate examination/assessment (34%)	Inadequate treatment (45%)	Inadequate treatment (34%)	Disrespectful manner/attitude (26%)	Inadequate examination/assessment (43%)
Disrespectful manner/attitude (34%)	Missed/delayed diagnosis (25%)	Disrespectful manner/attitude (32%)	Missed/delayed diagnosis (25%)	Disrespectful manner/attitude (37%)
Inadequate treatment (34%)	Disrespectful manner/attitude (24%)	Inadequate examination/assessment (26%)	Inappropriate prescribing (21%)	ACC compensation issue (23%)
Delayed/inadequate referral (26%)	Failure to communicate effectively with consumer (23%)	Failure to communicate effectively with consumer (21%)	Failure to communicate effectively with consumer (18%)	Missed/delayed diagnosis (15%)
Inadequate testing (17%)	Inadequate information provided re treatment (19%)	Unexpected treatment outcome (15%)	Inadequate examination/assessment (16%)	Inappropriate collection/use/disclosure of information (8%)

Case study: Mental health services and prescribing (11HDC01072)

A psychiatrist, Dr A, treated 11 patients with intramuscular injections of ketamine. Each patient had treatment-resistant depression (TRD). Dr A was employed by a university and holds a clinical position with a DHB. Ketamine is approved for use in New Zealand only as an anaesthetic. The unapproved use of an approved medicine is termed “off label” and is subject to practice guidelines.

It was alleged that the treatment was part of Dr A’s research agenda and that patients had not given consent to participate in research. The Commissioner initiated his investigation after the case was referred to him by the National Health Board. None of the patients had complained about the treatment provided. However, the Code requires informed consent in writing if the consumer is to participate in research, or if the procedure is experimental.

The Commissioner concluded that the evidence did not support a finding that research was being undertaken or that the treatment, though uncommon, was experimental. The Commissioner also found that the patients involved were provided with the information they needed, and that the decisions they made were made on an informed basis. However, the Commissioner also considered that a more explicit discussion with some of the patients about

the ketamine use being off-label, and better recording of those discussions, would have been preferable. Notwithstanding this, as the treatment was not experimental, and did not constitute research, written consent was not required.

Dr A was criticised for not taking a more formal approach, given that the particular treatment had not been used previously in New Zealand, and due to Dr A's known research interests in the area. The Commissioner observed that it is important that innovation is able to flourish in the health and disability sectors, but that "it is even more important that consumers are fully engaged in their treatment and fully informed as to their options and choices, and that they properly consent to their treatment course". The DHB was criticised for not having in place a policy regarding off-label prescribing.

Consideration was given to whether the relevant practice guidelines for off-label prescribing were complied with. In April 2010 the DHB did not have in place a policy regarding off-label prescribing, and there was no requirement that Dr A advise the DHB of his intention to prescribe this off-label medication. The Commissioner stated that it was suboptimal for the DHB to adopt a "hands off" system of oversight.

Recommendations were made to Dr A and to the DHB to improve their approach to off-label prescribing. The Commissioner recommended that Dr A ensure that consultations about off-label treatments are recorded, including any dissenting opinions expressed and details of the literature considered; develop a process he will use to ensure that all elements of the College of Psychiatrists Practice Guidelines are considered and recorded when using off-label treatments; and arrange for this process to be reviewed by a clinician approved by the Royal Australian and New Zealand College of Psychiatrists.

In recognition of the wider significance of the issues investigated in this case, it was also recommended that all DHBs ensure that they have appropriate policies in place for off-label prescribing, and that they have policies and protocols setting out what is required of staff members in relation to their clinical and research activities, particularly where these activities may overlap.

These recommendations have been met.

COMPLAINTS CLOSED

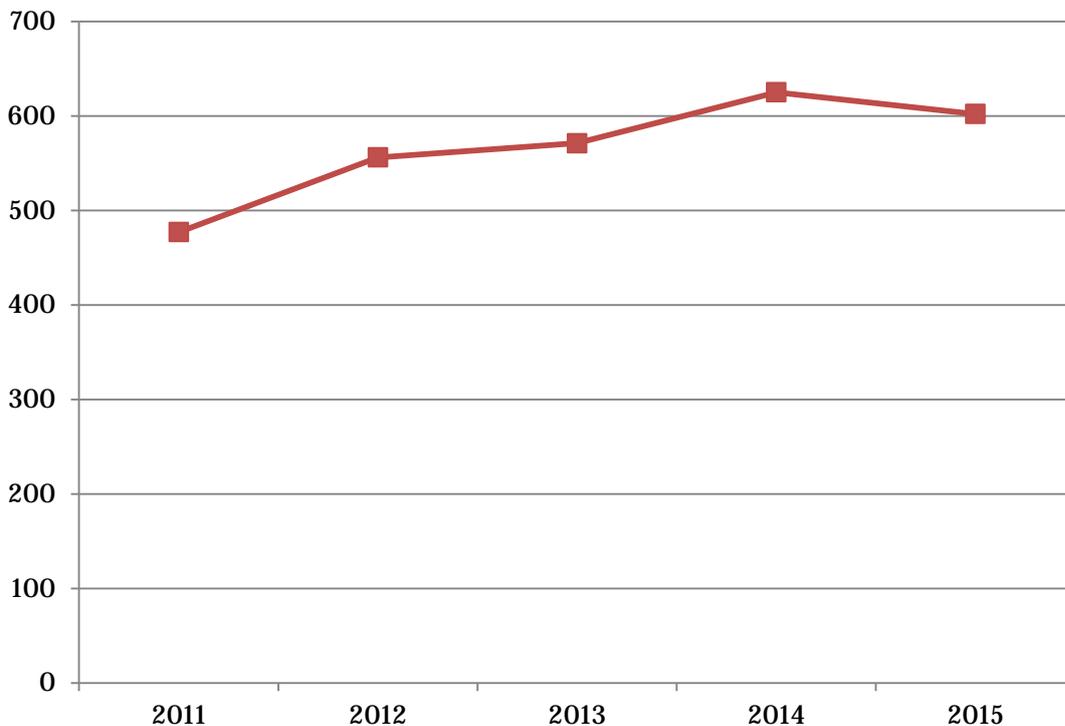
1. How many complaints were closed?

Figure 9 below shows the number of complaints closed by HDC about doctors each year, over the last five years.

The number of complaints closed about doctors has generally increased over the last five years, increasing from 477 complaints in 2011 to 602 complaints in 2015 — an increase of 26%.

This increase in complaints closed about doctors is consistent with an overall increase in the number of complaints closed by HDC over the last five years. Complaints closed by HDC increased from 1263 complaints in 2011 to 1906 in 2015 — an increase of 51%.

Figure 9. Number of complaints closed about doctors in last five years



2. What were the outcomes of the complaints closed?

2.1 Available resolution options

HDC has a number of options available for the resolution of complaints. These include referring the complaint to the Nationwide Health and Disability Advocacy Service (the Advocacy Service), to the provider's regulatory authority (such as the Medical Council), or to another agency (such as ACC, the District Inspector or the Ministry of Health).

HDC may also refer a complaint back to the provider to resolve directly. In line with their responsibilities under the Code, DHBs and general practices have increasingly developed good systems to address complaints in a timely and appropriate way. It is often appropriate for HDC to refer a complaint to the provider to resolve, with a requirement that the provider report back to HDC on the outcome of its handling of the complaint

The Commissioner also has a wide discretion to take no further action on a complaint. For example, the Commissioner may take no further action because careful assessment indicates that a provider's actions were reasonable in the circumstances, or a more appropriate outcome can be achieved in a more flexible and timely way than by means of formal investigation, or that the matters that are the subject of the complaint have been, or are being, or will be, addressed appropriately by other means. This may happen, for example, where already the provider has reviewed the case carefully, and no further value would be added by HDC investigating, or where another agency is reviewing, or has reviewed the matter carefully (for example, the Coroner, the Director-General of Health, or the District Inspector).

Assessment of a complaint prior to a decision to take no further action will usually involve obtaining and reviewing a response from the provider and, in many cases, expert clinical advice. Often a decision to take no further action will be accompanied by an educational comment or recommendations designed to assist the provider in improving future services.

Where appropriate, the Commissioner may investigate a complaint formally. Once HDC has notified the parties that a complaint is to be investigated, the complaint is classified by HDC as a formal investigation, even though subsequently an alternative manner of resolution may be adopted. Notification of formal investigation generally indicates more serious or complex issues.

In appropriate cases, the Commissioner may decide to refer a provider who has been found in breach of the Code to the Director of Proceedings. The Director of Proceedings then makes an independent decision about whether to bring proceedings against the provider in either the Health Practitioners Disciplinary Tribunal (if the provider is an individual health practitioner) or in the Human Rights Review Tribunal. Referral to the Director of Proceedings occurs only in the most serious of cases.

Case studies: Doctor found in breach of the Code

Administration of drug to consumer with known allergy (14HDC00157)

Mrs A, an 80-year-old woman who previously had experienced a severe adverse reaction to the antibiotic trimethoprim, was admitted to hospital for a period of supportive rehabilitation following surgery for a fracture. Mrs A wore a medical alert bracelet that stated: "Allergy Co-Trimoxazole & Trimethoprim Angina."

The admitting house officer, Dr I, took a full medical history and recorded in the progress notes that Mrs A had numerous drug allergies. Dr I recorded on orange adverse reaction labels, which were stuck to each page of Mrs A's drug chart: "Trimethoprim/Co-trimaxazole — toxic epidermal necrolysis."

Two days later, the registrar (Dr E) reviewed Mrs A for a suspected urinary tract infection. Dr E did not check the orange adverse reaction sticker and prescribed trimethoprim 1x 300mg tablet to be given at night for the next five days. Dr E, while accepting that she made a "grievous error", pointed to a number of systemic factors in the ward. In particular, she noted the large workload, high patient turnover, and the requirement to support and supervise junior staff, which made her vulnerable to omitting her standard check of the orange alert sticker.

That evening, a registered nurse, RN F, administered the trimethoprim 300mg. She advised that in her busyness she did not see the adverse reaction written on the adverse reaction sticker, and she placed too much reliance on the fact that Mrs A would not have been charted medications to which she was allergic. The following morning, Mrs A was reviewed by a second registrar, who identified that Mrs A had been given trimethoprim in error, stopped the prescription, and advised the nursing staff to observe Mrs A for signs suggesting an allergic reaction.

Within 24 hours, Mrs A was admitted to the intensive care unit with toxic epidermal necrolysis, a life-threatening skin condition resulting from the allergic reaction to the trimethoprim. Sadly, Mrs A died a few days later.

The Commissioner considered that both Dr E and RN F missed several opportunities to establish Mrs A's allergy status, including reading the notes, reviewing the drug chart, noting the medical alert bracelet, and asking Mrs A whether she had any allergies. The Commissioner acknowledged that the ward was busy, but stated that it was Dr E's responsibility to take the necessary steps to ensure that Mrs A was prescribed medication that was appropriate for her. Accordingly, the Commissioner found that both Dr E and RN F did not provide services to Mrs A with reasonable care and skill and, therefore, breached Right 4(1) of the Code.

The Commissioner held that the staff and the systems existing at the DHB let Mrs A down. The DHB failed to provide Mrs A with services with reasonable care and skill, and was directly responsible for those failures. Accordingly, the DHB breached Right 4(1) of the Code.

The Commissioner recommended that the Medical Council consider whether a review of Dr E's competence was warranted. The Commissioner also made comprehensive recommendations to the DHB requiring it to report on its involvement to date in the National Medication Safety Programme; develop a policy requiring the routine checking of medical alert bracelets; report back on its review of staff workloads, the measures it has instituted to identify and manage clinical risk, and its review of the working environment and clinical governance of the ward involved; develop a process by which all staff are empowered to raise concerns about issues relating to patient safety, which are responded to and acted upon; and develop a process to ensure that clinicians prescribing and administering medication are not interrupted or otherwise exposed to factors associated with increased errors. These

recommendations have been met.

Complication during eye surgery (13HDC01345)

Mrs A was seen at an ophthalmology clinic by a senior ophthalmology trainee, Dr D. Dr D was supervised by an ophthalmology consultant (Dr C) who was not present at the consultation. At the consultation, Mrs A signed an "Agreement to Treatment" form providing that the procedure was to be a right eye cataract and epiretinal membrane peel under local anaesthetic (the procedure). Shortly after the consultation, Dr D left the DHB and was replaced by Dr B, another senior ophthalmology trainee.

Six weeks later, Mrs A presented for the procedure. Mrs A understood that Dr B would be observing during the surgery, and that Dr C would be the operating surgeon. In contrast, Dr B said that he clearly recalls telling Mrs A that he would be the operating surgeon. He said that Mrs A was under local anaesthetic, and throughout the surgery was fully aware that he was operating.

During the procedure, Dr B inadvertently touched an instrument onto Mrs A's retina (the adverse event). Dr C stated that the action took less than a second and occurred too quickly for him to prevent it. Dr C completed the surgery.

Mrs A said that she asked to speak to the doctor before she left theatre. Dr B told HDC that, as Mrs A was quite anxious, he provided an explanation to her when she was just outside the operating theatre. Dr C said that he insists on senior ophthalmology trainees explaining any complications to patients themselves as part of their learning, but he advises them as necessary.

Dr B recorded in the clinical notes that the membrane peel had been performed and that there were punctuate retinal haemorrhages, but he did not document the adverse event. The only reference to the adverse event is in Mrs A's discharge summary. Dr B did not record the adverse event in two letters to Mrs A's GP.

Mrs A stated that by the time she went for a follow-up appointment 10 days after the surgery, she was sure that all was not well. She said that Dr B expressed no concern and did not admit to anything being amiss. A month later, Dr C saw Mrs A privately. Mrs A said Dr C confirmed that her eye had been damaged permanently during the procedure.

The Commissioner found that Dr B did not explain to Mrs A sufficiently that he was a trainee and that he would be carrying out the surgery on her, and did not inform her of any increased risks resultant from having such delicate surgery performed by a trainee. Accordingly, Dr B breached Right 6(1)(b) of the Code. It followed that Mrs A was not in a position to give informed consent and, accordingly, Dr B breached Right 7(1) of the Code. Dr B also breached Right 4(2) for failing to record the adverse event adequately, and not disclosing the adverse event to Mrs A or her GP appropriately. The Commissioner was critical of Dr B's error during surgery.

The Commissioner held that Dr C breached Right 6(1) of the Code for failing to ensure that open disclosure occurred promptly. The Commissioner was critical that Dr C failed to ensure that details about the nature of the harm and any subsequent action, including disclosure to Mrs A, were documented in Mrs A's clinical notes. The Commissioner was also critical of the DHB's systems.

The Commissioner recommended that Dr B and Dr C undertake further training on informed consent and open disclosure. The Commissioner also made a number of recommendations to the DHB, including that it review the "Agreement to Treatment" form with a view to including the role of trainees during surgery; provide ophthalmology service staff with training on informed consent and open disclosure, in particular the role of senior members of the multidisciplinary teams during disclosure of an adverse event; and audit records in the ophthalmology service to ensure that a record

of consent to the involvement of trainees had been maintained. These recommendations have been met.

2.2 Manner of resolution of Doctor Complaints

Table 19 below outlines the outcomes of complaints of Doctor Complaints, by the year the complaint was closed.

Each year over the time period, around 6% of Doctor Complaints were formally investigated, and around 3% of the doctors investigated were subsequently found in breach of the Code. For around 42% of doctors, no further action was taken, while HDC recommended some kind of follow-up action or made educational comments designed to facilitate improvement in their services in relation to around 20% of Doctor Complaints.

Table 19. Outcome of Doctor Complaints, by year complaint closed

Outcome for doctor^{xiii}	2011	2012	2013	2014	2015
<i>Investigation</i>	14	50	62	53	44
Breach finding	9	21	24	24	19
No further action with follow-up or educational comment	3	11	18	14	4
No further action	2	18	20	14	17
No breach finding	0	0	0	1	4
<i>Other resolution following assessment</i>	505	612	599	660	634
No further action with follow-up or educational comment	80	142	140	164	180
Referred to Medical Council	31	32	20	19	13
Referred to District Inspector	8	12	5	3	0
Referred to other agency	6	7	2	0	1
Referred to provider	61	69	51	94	119
Resolved between parties	5	4	0	0	1
Referred to Advocacy Service	87	57	29	46	21
No further action	210	272	332	313	293
Withdrawn	17	17	20	21	6
<i>Outside jurisdiction</i>	35	20	18	25	22
TOTAL	554	682	679	738	700

^{xiii} It should be noted that outcomes are displayed in a descending order. If there is more than one outcome for a doctor upon resolution of a complaint, then only the outcome listed highest in the table is included.

Case studies: Recommendations made by HDC

Recommendations arising from breach relating to inappropriate prescription of narcotic medication (15HDC00100)

A woman attended an emergency department with a suspected ankle fracture. The woman completed an admission form and documented that she was allergic to “morphine, codeine, penicillin, erythromycin”. The emergency department consultant noted the woman’s history and her current medications. The consultant prescribed the woman Sevredol, which is the controlled drug morphine sulphate in tablet form, and discharged her home. The consultant did not ask the woman whether she had any allergies, nor did he explain that Sevredol is a form of morphine. The consultant also did not document his management or discharge plan.

The Commissioner found the consultant in breach of the Code for: inappropriately prescribing Sevredol to someone who has a known and well documented allergy to the drug; for failing to explain to the woman that Sevredol is a form of morphine, meaning that the woman was unable to give her informed consent for this aspect of her treatment; and failing to document his management, a discharge plan and, in particular, his prescription of Sevredol.

Following a recommendation by the Commissioner, the consultant undertook further training in relation to history taking in a clinical setting and safe prescribing practices. In accordance with the Commissioner’s recommendation, the DHB agreed to share its learnings and the actions it has taken in relation to prescribing controlled drugs and the maintenance of records, through the National DHB CMO Group.

Recommendations arising from breach relating to insertion of IUCD (13HDC01212)

A woman attended a medical centre to receive treatment for bacterial vaginosis (BV). She advised the nurse that she had in place an intrauterine contraceptive device (IUCD), which was due to be removed. The nurse recorded this in the woman’s clinical notes. The woman then saw her GP about heavy menstrual bleeding. The GP said she did not ask the woman about her contraceptive use and history, and was not aware that the woman had an IUCD in place. The woman asked the medical centre about Mirena (a different type of intrauterine system), and attended an appointment with her GP to have the Mirena inserted. The GP performed pelvic and speculum examinations, and told HDC that the results of these assessments were normal, and that no strings from an existing IUCD were visible. The GP did not remove the existing IUCD before inserting the Mirena.

The Commissioner found the GP in breach of the Code for: not assessing the woman’s contraceptive history adequately prior to inserting the Mirena; failing to read the nurse’s note stating that the woman had an IUCD in place; failing to consider alternative causes of the woman’s heavy menstrual bleeding and BV; and failing to keep adequate clinical records.

In accordance with the Commissioner’s recommendations, the GP:

- undertook an audit of her standards of clinical documentation against the Royal New Zealand College of General Practitioners’ standards;
- undertook further education on the assessment and management of menorrhagia, including a review of her technique by a gynaecologist in relation to bimanual and speculum examinations and Mirena insertions; and

- provided HDC with a report outlining her reflection on this further education.

The medical centre met the Commissioner's recommendation that it audit compliance with its *Guideline for doctors inserting contraceptive implants or intrauterine devices or systems*, including the use of the intrauterine consent form and pre-insertion screening checklist.

Recommendations arising from breach relating to monitoring of a suspicious lesion(12HDC01533)

A woman presented to her GP with an irregular shaped lesion on her lower right leg. The GP examined the lesion using dermoscopy, excised the lesion, and sent a sample for histopathology. The histopathology report stated that melanoma could not be excluded in the tissue examined. The clinical record suggests that the GP told the woman that the lesion was clinically benign. The GP felt that it was reasonable not to re-excise the lesion and to proceed with a plan to observe it closely and to re-excise it if he had any concerns, because the lesion was clinically and dermoscopically benign and there was no sign of residual lesion. Nine months later, the woman drew the GP's attention to two lesions at the surgical site. The histopathology report confirmed that the lesion was a potentially serious form of skin cancer, and so the GP performed a further re-excision with a wide clinical margin. The histopathology report confirmed that there was no residual melanoma. No review arrangements were put in place. The woman attended further GP appointments with lesions at the surgical site, and eventually the GP sent an urgent referral to a plastic surgery department, where the woman was diagnosed with invasive melanoma.

The Commissioner found the GP in breach of the Code for: his decision to observe the lesion rather than to re-excise it; the delay in referring the woman to hospital after she expressed concerns about a new lesion; failing to ensure that the woman was aware and understood that the histopathology report stated that melanoma could not be excluded; failing to discuss the option of a re-excision of the lesion, including the risks and benefits of that option; and failing to put in place a structured monitoring plan for the woman.

In accordance with the Commissioner's recommendations, the GP:

- developed a recall system for skin checks and provided HDC with a review of the application of the new system;
- reviewed how the practice follows up patients for regular reviews, and provided evidence to HDC of this review and the subsequent changes made to his practice following the complaint; and
- undertook training on the diagnosis and treatment of melanoma.

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APPENDIX A: COMPLAINT ISSUES

Access/funding

- ACC compensation issue
- Lack of access to services
- Lack of access to subsidies/funding
- Waiting list/prioritisation issue
- Other

Boundary violation

- Inappropriate communication — non-sexual
- Inappropriate communication — sexual
- Inappropriate physical contact — non-sexual
- Inappropriate physical contact — sexual
- Inappropriate relationship — non-sexual
e.g., inappropriately close friendship or co-dependence between consumer and provider
- Inappropriate relationship — sexual
- Other

Care/treatment

- Delay in treatment
- Delayed/inadequate/inappropriate referral
e.g., failure/delay by GP to refer patient for specialist investigation, failure/delay by specialist to refer patient to more appropriate service within hospital, referral lost, unnecessary referral, etc.
- Inadequate coordination of care or treatment
e.g., lack of communication/information exchange between and within teams in a hospital, between GP and specialists, between DHBs, etc. Can also include a failure to obtain appropriate consultant input.
- Inadequate/inappropriate care — non-clinical
Provision of personal cares such as feeding, washing, etc.
- Inadequate/inappropriate examination/assessment
- Inadequate/inappropriate follow-up
e.g., failure to follow up abnormal test results, failure to follow up recovery post-surgery, failure to follow up symptom resolution, etc.
- Inadequate/inappropriate monitoring
Includes on-going assessment, e.g., CTG readings, postoperative monitoring
- Inadequate/inappropriate testing
e.g., blood tests, CAT scans, X-rays, neurological assessments, psychiatric tests, etc.
- Inadequate/inappropriate treatment/procedure — clinical
Issues regarding the actual treatment or procedure provided by a provider, not medication related
- Inappropriate admission/failure to admit

- Inappropriate/delayed discharge/transfer
e.g., discharged home too early, policies/procedures for discharge/transfer not followed, delay in discharge, delay in transfer, transfer to inappropriate service, etc.
- Inappropriate withdrawal of treatment
- Missed/incorrect/delayed diagnosis
- Personal privacy not respected
e.g., curtains not pulled to protect privacy, door to room left open, etc.
- Refusal to assist/attend
- Refusal to treat
- Rough/painful care or treatment
- Unexpected treatment outcome
e.g., post-surgical complications, consumer experienced harm from treatment, unexpected side-effects, etc.
- Unnecessary treatment/over-servicing
- Other

Communication

- Disrespectful manner/attitude
- Failure to communicate openly/honestly/effectively with consumer
- Failure to communicate openly/honestly/effectively with family
- Failure to accommodate cultural/language needs
- Insensitive/inappropriate comment — non-sexual
- Other

Complaints process

- Inadequate information regarding complaints process
- Inadequate response to complaint
e.g., response not timely, disagreed with provider's response, no apology given, did not feel heard by provider, feels there was a lack of preventative action by provider, provider would not meet with them, etc.
- Retaliation/discrimination as a result of a complaint
- Other

Consent/information

- Coercion by provider to obtain consent
- Consent not obtained/adequate
- Failure to assess capacity to consent
- Inadequate information provided regarding adverse event
e.g., not told about adverse event, not provided with explanation for adverse event, etc.
- Inadequate information provided regarding condition
e.g., not provided with diagnosis, not provided with information about what to expect from condition, not told about seriousness of condition, not told how to manage condition, etc.
- Inadequate information provided regarding fees/costs

- Inadequate information provided regarding options
- Inadequate information provided regarding provider
e.g., not provided with information regarding qualifications and experience of provider, not given enough information as to which provider will be treating them, etc.
- Inadequate information provided regarding results
e.g., not told about results of tests, not told what test results mean, etc.
- Inadequate information provided regarding treatment
e.g., not told about potential side effects/possible complications of treatment, not told what will occur during surgery, not told how/when to take medication, not told why particular procedure/treatment is being performed/provided
- Incorrect/misleading information provided
- Issues regarding consent when consumer not competent
e.g., EPOA/advance directive issues
- Issues with involuntary admission/treatment
e.g., issues with admission and treatment under the Mental Health Act
- Other

Disability-specific issue

- Discrimination
- Inadequate/inappropriate equipment provided
- Inadequate physical access
- Inadequate/inappropriate support provided
- Other

Documentation

Only includes issues regarding documentation for the purposes of providing care, and between providers who are providing care, e.g., notes, care plans, records, fluid balance charts, clinical referral documents/letters, etc. Does not include issues with documentation to third parties; see 'Reports/Certificates' list.

- Delay/failure to disclose documentation
to consumer or consumer's representative
- Delay/failure to transfer documentation
to another provider
- Inadequate/inaccurate documentation
- Inappropriate maintenance/disposal of documentation
- Intentionally misleading/altered documentation
- Other

Fees/costs

- Cost of treatment
- Inappropriate billing practices
- Other

Medication

Please choose from the following options:

- Administration error
- Dispensing error
- Inadequate storage/security
- Inappropriate/unlawful administration
- Inappropriate/unlawful dispensing
- Inappropriate/unlawful prescribing
Provider meant to prescribe it but it was, e.g., contraindicated
- Inappropriate/unlawful supply
- Prescribing error
Provider did not mean to prescribe what he/she prescribed
- Refusal to prescribe/dispense/supply
- Other

Reports/certificates

To a third party, e.g., to WINZ, ACC, Court.

- Backdated/invalid/improper report/certificate
- Inaccurate report/certificate
- Refusal to complete report/certificate
- Refusal to disclose report/certificate
- Other

Teamwork/supervision

- Delayed/inadequate/inappropriate handover
- Inadequate supervision/oversight

Professional conduct issue

- Disrespectful behaviour
- Failure to disclose/properly manage a conflict of interest
- Inappropriate collection/use/disclosure of information
- Threatening/bullying/harassing behaviour
- Qualifications issue/use title(s)
- Other professional conduct issue