Dr C

A Public Hospital

A Report by the

Health and Disability Commissioner

(Case 03HDC13605)

HDC

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

Parties involved

Mr A	Consumer
Mr B	Complainant
Dr C	Provider / General Surgeon
Public Hospital	Provider
Dr D	General Practitioner

Complaint

On 9 September 2003 the Commissioner received a complaint from Mr B about the services provided to his partner, Mr A, by Dr C and a Public Hospital. The following issues from the complaint were identified for investigation:

- *The circumstances and appropriateness of Mr A's consultation with Dr C at the Public Hospital on 20 January 2003.*
- *The appropriateness of Dr C's follow-up actions.*

An investigation was commenced on 25 November 2003.

Information reviewed

- Relevant medical records
- Information from Dr D, general practitioner
- Response from Dr C
- Response from the Public Hospital
- Information from Mr A

Independent expert advice was obtained from Dr Kenneth Menzies, general surgeon.

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Information gathered during investigation

Background

On 31 October 2002 Mr A was referred by his general practitioner to the Public Hospital for a colonoscopy. The referral letter noted Mr A's HIV-positive status.

On 20 January 2003 Mr A consulted Dr C, general surgeon, at the Public Hospital. During the consultation Dr C questioned Mr A about where he lived, and discussed the risks that Mr A's HIV status potentially posed to staff and equipment. Dr C then refused to perform a colonoscopy on Mr A. Mr A was obliged to return to his general practitioner so that another referral could be made to a different specialist. Mr A died of an unrelated heart condition in another Public Hospital some months later.

Consultation with general practitioner

On 31 October 2002 Mr A, a man in his fifties, consulted his regular general practitioner, Dr D, in a city. He was accompanied by his partner, Mr B. Mr A presented with a six-month history of an altered bowel habit, bloating, colicky pain, and constipation, for which he was taking prune juice. Dr D noted that Mr A had a family history of bowel cancer, his father having died at the age of 61. Dr D recorded that Mr A's abdomen was difficult to examine because of his habitus, there was tenderness at the left iliac fossa, and a rectal examination was normal. Dr D referred Mr A for a colonoscopy (an endoscopic examination of the colon) at the Public Hospital in the region in which he lived.

Dr D's referral letter to the booking clerk at the colonoscopy clinic, dated 31 October, outlined Mr A's relevant medical history, including his past medical history of being diagnosed HIV-positive on 1 August 1989. His medications included didanosine and azidothymidine (anti-viral agents used in anti-HIV treatment).

Consultation with Dr C

On 20 January 2003 Mr A, accompanied by Mr B, attended his booked appointment at the colonoscopy clinic at the Public Hospital, and was seen by general surgeon Dr C. During the consultation Dr C questioned Mr A's need for a support person and queried whether Mr A was a resident of the region.

Mr A introduced Mr B as being "a support person who will ensure I remember the things I have to". Dr C questioned what was wrong with him if he could not remember. Mr A replied that his partner could help him remember. Dr C advised me that when Mr A asked whether Mr B could be present during the consultation, he indicated no objection, as is his usual practice. He stated that very often another "set of ears" is beneficial for the patient.

Dr C then asked where Mr A resided; a doctor from a city had made the referral, and Dr C does not receive many referrals outside of the region. Mr A's address on the referral letter was a city address, but it had been amended to the regional address. Mr A explained to Dr C that he had lived in the region for eight years.

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Dr C explained that his usual practice is to allocate patients a clinic appointment within the week of receiving a referral, and he does not recall seeing Mr A's referral letter. Dr C's practice is for the clinic clerk to check addresses, particularly if they are not in the area served by the Public Hospital. If Dr C had considered that Mr A required an urgent assessment and colonoscopy, he would have referred him to Surgical Services at a larger Public Hospital in the region.

On 5 February the Surgical Services Manager advised Mr A that "[i]t is usual that inquiries are made on the residential address of the person referred if the details provided to hospital indicated an out of region referral. This inquiry is generally made at the time the referral is received with the referrer and unless otherwise indicated by a change of address by the patient, not discussed during the course of an outpatient appointment."

Dr C then questioned Mr A about his presenting symptoms. Mr A explained that he had had abdominal pains of varying severity for the last 12 months, but that this was a new problem. Dr C recorded that Mr A had had a change in bowel habit with a tendency to constipation. There was no history of bleeding per rectum. Dr C considered that it was not unreasonable for Mr A to have a colonoscopy (or barium enema) to look further into his symptoms.

Dr C then began discussing Mr A's HIV-positive status and the issues involved in performing an endoscopy in such circumstances. According to Mr A, Dr C explained that he did not want to perform the procedure on him as it would pose a risk to himself and the staff. Mr A asked if he would use safety equipment during the procedure. Dr C replied that he would have to wear two pairs of gloves, which would make the procedure difficult, and would be at risk from the needle injection for sedation, as well as from other risks during the procedure.

Mr A then asked whether Dr C was saying he did not want to perform the procedure. Dr C replied that he did not want to, as it posed a risk to himself and the staff. He then suggested that Mr A have the procedure performed in the city. Mr A said that if Dr C did not want to carry out the procedure then he would have no choice but to find some other doctor to do it. Mr A found Dr C's behaviour confrontational, intimidating, predetermined and unacceptable.

Dr C does not recall noting that Mr A was HIV-positive until he saw the letter on the day Mr A arrived at the clinic on 20 January. Dr C had been on leave during November/December and on annual leave for part of January 2003. The referral letter was stamped as being received by the outpatient booking clerk on 4 November 2002.

Dr C submitted that there is only one colonoscope at the Public Hospital and that stricter cleaning and disinfecting criteria would mean that it would take at least 40 minutes to ensure that each instrument was ready for the next patient. This would restrict the number of endoscopies performed each session and put a strain on the waiting list for the procedure at the Public Hospital.

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Dr C stated that he "certainly mentioned [to Mr A] that being made aware of this [Mr A's HIV status] (the same as being made aware of a patient being serum Hepatitis B positive) meant that a few extra precautions should be taken, particularly double gloving, extra care with needle insertion and disposing and endoscopic insertion and manipulation". Dr C also informed me that he indicated to Mr A and Mr B that he would first like to check with the nursing staff who dealt with instrument cleaning, to ensure that there were not any extra steps that should be taken, because the hospital had recently converted to the Steris (peroxidase) system of disinfecting. Mr B stated that Dr C did not explain to either Mr A or himself that he wanted to check with the nursing staff who dealt with instrument cleaning.

Dr C has since been reassured that there is full confidence in the normal cycle of the Steris system and no need to give it an extended period of cleaning and checking. Following the incident, the Infection Control Nurse advised the Public Hospital that there was no infection control reason for the colonoscopy not to have been performed in the Public Hospital.

Dr C recalls that Mr A put it to him that if he was reluctant to do the examination he would go elsewhere. Dr C acknowledged his right to do so. Mr B informed me that he told Dr C that it was unfair to deny Mr A the procedure, and that the Public Hospital should be able to do such a procedure safely. He stated that Dr C denied that the hospital could perform the procedure; it posed too much of a risk, and the Public Hospital could not perform all the types of procedures that other hospitals can. Dr C remembers Mr A rapidly becoming aggressive and abusive. Mr A moved to the door to go out to the waiting area but returned to the consultation room threatening Dr C with his fist, physically pushing him against the clinic examination couch, and raising one of the clinic chairs, threatening to throw it against Dr C's face. Mr A then left the hospital with Mr B; both were feeling upset and disappointed with the situation.

Subsequent events

After Mr A left the clinic, Dr C documented the consultation, reported the events to the Public Hospital Site Co-ordinator and wrote to Dr D. In his letter to Dr D dated 21 January, Dr C stated that there were difficulties with a small hospital like theirs where there was only one colonoscope. He explained that to perform a colonoscopy on Mr A would mean that the colonoscope would be out of circulation for a longer period than usual. He also stated that there would be a slight increase in risk both to himself and to staff. Dr C informed Dr D that Mr A had not been put on the waiting list to have the colonoscopy performed at the Public Hospital and that he would be willing to refer him to another Public Hospital in the region for advice as to whether they wished to perform the examination.

On 20 January 2003 Dr D referred Mr A to the colonoscopy clinic at a city public hospital. Mr A was assessed at the outpatient clinic on 31 March and placed on the non-urgent list. An appointment was scheduled for June 2003. However, on 20 May Mr A collapsed and was taken to the Public Hospital. He was subsequently transferred to the Intensive Care Unit at another regional hospital but, sadly, died some months later from a myocardial infarction.

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Mr B advised me that Mr A was concerned that his symptoms may have been cardiac-related but did not convey this to Dr D or Dr C. Dr D confirmed that Mr A had not complained of having any cardiac symptoms.

On 20 January 2003 Mr A made a complaint to the Public Hospital. On 5 February the Surgical Services Manager explained that Dr C agreed that it was inappropriate for him to raise his concerns about infection control directly with Mr A, and that the accepted universal precautions for all blood-borne disease could be practised to minimise the risk of cross-infection. The Public Hospital apologised to Mr A for the suffering and unhappiness the situation had caused him. It concluded that Dr C's knowledge of universal precautions for infection control required updating, and directed him to update his knowledge on infection control. The Medical Director at the Public Hospital advised me that he offered Dr C access to counselling designed to address issues about the care of patients with HIV infection, and they discussed the Royal Australasian College of Surgeons' guidelines on the issue. Dr C indicated that the guidelines were adequate for his needs.

Dr C advised me that he has made the following changes to his practice since the incident:

- He is more vigilant in scrutinising clinic referral letters.
- He is more conscious of getting a chaperone/witness in the consultation room to assist him.
- He continues to take additional precautions in performing surgery or endoscopy on patients thought to be at risk of being serum positive for infectious diseases, such as hepatitis and HIV, but does not withhold treatment or investigations.

He does not discuss a patient's HIV or hepatitis status prior to the procedure, but deems it prudent to make other affected staff aware of the situation. He accepts that with good standard precautions the risk to staff is minimal.

Responses to Provisional Opinion

In response to my provisional opinion, Mr B stated that the stress caused by Dr C's actions "had a disastrous effect on both our lives: Dr [C's] actions shook [Mr A] to his core and he lost faith in the essential fairness of the health system. He laid this complaint to ensure no one else would be exposed to this sort of treatment from this doctor or [the Public] Hospital in the future."

In response to my provisional opinion, Dr C stated:

> "I wish to stress again that as I had been on extended leave prior to this clinic date and in fact this was my first day back at work I was not able to be in this position [of having a planned approach by checking queries prior to the consultation] with this particular

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> patient at that time and it was only reasonable to advise him of my desire to get further advice.
>
> This set of events needs to be set in its proper context of a sole practitioner (endoscopist) functioning in a very small peripheral hospital with minimal specialist staff (at present just two – a physician and myself) and with minimal equipment.
>
> The consultation was terminated prematurely in my opinion by the aggressive behaviour of the patient.
>
> At no point did I prevent the patient having a support person in the room for the consultation. This is a direct misrepresentation of what happened.
>
> …
>
> At no time in the consultation was I able to offer the patient a further visit or discuss alternative approaches."

Dr C confirmed that he has reviewed his practice in light of the complaint and my report.

The Public Hospital submitted that Dr C's usual practice is to fully prepare prior to his consultations or clinics. The lack of preparation before this particular consultation was out of the ordinary and the Public Hospital intends to discuss this matter with Dr C. It further stated that Dr C has collegial support and professional oversight from the Head of Department; he is fully supported in an administrative and nursing sense at the Public Hospital.

The Public Hospital extends its apology to Mr A's partner, Mr B.

Independent advice to Commissioner

On 30 March 2004 Dr Kenneth Menzies, general surgeon, provided verbal advice in relation to this investigation.

Dr Menzies was asked whether he was familiar with the sterilisation methods required for performing a colonoscopy on an HIV-positive patient. Dr Menzies explained that the sterilisation requirements are the same for all patients – you can never be sure that a patient does not have an infectious disease, so you should err on the side of caution. Sterilisation procedures are the same irrespective of whether the patient is known to be HIV-positive. Dr Menzies explained that the sterilisation of equipment is handled by nurses. However, if he has a query (as Dr C did), he checks it out prior to the consultation with the patient, as he always reviews his referrals before seeing the patient so he can plan (if necessary) how he is going to approach things with them.

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Dr Menzies commented that it appeared that Dr C had been "thrown" by having an HIV-positive patient. However, his approach was not appropriate.

Dr Menzies thought Dr C's referral back to the general practitioner for management was reasonable in circumstances. He felt that the colonoscopy referral and response was timely and appropriate in view of Mr A's age and his father's death from bowel cancer.

Dr Menzies was informed that Mr A's partner had expressed concern about whether Mr A's death could have been prevented if he had had a colonoscopy sooner, in light of his concern that his symptoms could be cardiac-related and his intention to get this checked if the colonoscopy did not reveal anything. (Mr A had not told his general practitioner, or any doctor, about any cardiac symptoms or concerns.) Dr Menzies advised that there was no connection between Mr A's death from a myocardial infarction and the delay in having a colonoscopy.

Code of Health and Disability Services Consumers' Rights

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

RIGHT 2
Right to Freedom from Discrimination, Coercion, Harassment, and Exploitation

Every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial, or other exploitation.

RIGHT 4
Right to Services of An Appropriate Standard

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

RIGHT 5
Right to Effective Communication

(2) Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively.

RIGHT 8
Right to Support

Every consumer has the right to have one or more support persons of his or her choice present, except where safety may be compromised or another consumer's rights may be unreasonably infringed.

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Opinion: Breach – Dr C

The consultation

Dr D referred Mr A to Dr C's clinic for consideration of a colonoscopy in view of his gastrointestinal symptoms. The referral letter noted that Mr A was HIV-positive. On 20 January 2003 Mr A, accompanied by his partner, Mr B, was seen by Dr C. The referral letter contained a city address, and Dr C questioned whether Mr C lived in the region. Mr A confirmed that he lived in the region. Dr C also queried Mr A's need for a support person at the consultation, and asked why Mr A could not remember what he was told.

Dr C does not recall specifically seeing Dr D's referral letter until the day Mr A arrived at the clinic on 20 January. Dr C had been on extended leave prior to 20 January and, as it was his first day back at work, he had not planned his approach to Mr A's care. He told Mr A that he wanted to obtain further advice. Dr C's lack of preparation was apparently out of the ordinary in terms of his usual practice at the Public Hospital.

During the consultation Dr C discussed Mr A's HIV-positive status and the requirements for performing a colonoscopy in the circumstances. In particular, Dr C indicated that a few extra precautions would have to be taken, such as double gloving. Dr C advised Mr A that he did not want to perform the procedure on him as it would pose a risk to himself and staff. Mr A put it to Dr C that if he was reluctant to do the colonoscopy he would go elsewhere, and Dr C acknowledged his right to do so. Mr A found Dr C's behaviour confrontational and intimidating throughout the consultation. Mr A became aggressive and threatened Dr C. Accordingly, the consultation was terminated and Dr C referred Mr A back to his general practitioner.

Dr C wanted to check with the nursing staff that no extra steps were required for sterilising the equipment, as they had recently changed the system for disinfecting. Following the incident the Infection Control Nurse at the Public Hospital advised that there was no infection-control reason not to have performed the colonoscopy at the hospital. Dr C informed me that he has been reassured that there is full confidence in the normal cycle of the Steris system, and no need for an extended period of cleaning and checking.

Expert advice

My expert surgical advisor, Dr Menzies, commented that sterilisation procedures for colonoscopy are the same irrespective of whether a patient's HIV status is known. Dr Menzies also informed me that good clinical practice should involve reviewing patients' referral letters before seeing patients in clinic. If there are any queries, for example about sterilisation, they can then be investigated and resolved before the consultation with the patient. Dr C's approach was not appropriate.

In relation to infection control measures, in its "Policies – Infection Control in Surgery" (1998), the Royal Australasian College of Surgeons states:

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> "Since all patients infected with HIV or other blood borne pathogens cannot be reliably identified, surgeons must regard the blood and body fluids of all patients as potentially infective."

Dr Menzies considered that following the consultation it was appropriate for Dr C to write back to the referring general practitioner who, in the circumstances, organised another referral. Dr D's referral for a colonoscopy was appropriate and timely in the circumstances, given Mr A's age, family history, and symptoms. The delay in Mr A having the colonoscopy did not in any way contribute to his death – Mr A did not complain of any symptoms that would have prompted either Dr D or Dr C to consider an alternative (cardiac) diagnosis.

Communication and discrimination

Dr C's communication at the consultation was insensitive, and his behaviour discriminatory. On the most favourable interpretation, he was flustered ("thrown", as my advisor suggested) by his late realisation that Mr A was HIV-positive. That does not excuse his behaviour.

Dr C began the consultation by querying whether Mr A was a resident of the region, since the referral had come from a city general practitioner. It was a legitimate question to ask, but in light of what followed I am left with the suspicion that Dr C was determined to put Mr A on the back foot right from the start.

Patients are entitled, under Right 8 of the Code, to bring a support person to a consultation, and doctors are required to "enable" patients to exercise their rights (clause 1(3)(b) of the Code). A support person is often helpful as someone who can later remind the patient about information conveyed at the consultation. Even though Dr C did not prevent Mr A having a support person during the consultation, his initial querying of Mr A's need for a support person, followed by his asking what was wrong with Mr A if he could not remember things, was hostile and unprofessional. It set the scene for the complete breakdown in communication that followed.

Dr C then raised the issue of Mr A's HIV-positive status and, in a manner described as "confrontational, intimidating and predetermined", made it clear that he was not prepared to expose himself or staff to the risk of infection. Whether through ignorance or as an excuse, Dr C claimed that the necessary sterilisation procedures would restrict the number of endoscopies performed each session and put a strain on the waiting list at the Public Hospital.

Had Dr C resolved the issue about sterilisation before seeing Mr A in clinic, it is likely that the communication breakdown during the consultation could have been prevented. Likewise, any query about the appropriateness of the referral – in terms of the area served by the Public Hospital – could and should have been dealt with prior to seeing Mr A, which is apparently Dr C's usual practice. Even though the date of the consultation fell on Dr C's first day back at work from extended leave, in the circumstances it would have been appropriate for him to make enquiries before the actual consultation took place.

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From a clinical perspective, I am advised that Dr C's actions did not adversely affect Mr A's care (or contribute to his death). However, I consider that Dr C's communication during the consultation process was inappropriate and insensitive. It caused Mr A unnecessary distress and humiliation. Understandably, under such provocation Mr A became angry – although his aggressive response was regrettable. I note that Dr C did not apologise to Mr A or his partner for his insensitivity.

In my opinion Dr C's behaviour was discriminatory and his behaviour led to a complete breakdown in communication during the consultation. In these circumstances, Dr C breached Rights 2 and 5(2) of the Code.

Unethical behaviour
The New Zealand Medical Association's *Code of Ethics* (March 2002) is relevant to this case. Principle 1 states:

> "1. Consider the health and wellbeing of the patient to be your first priority."

The Medical Association has made recommendations designed to promote professional behaviour consistent with the principles set out in the Code of Ethics. Paragraph 8 states:

> "When a patient is accepted for care, doctors will render medical service to that person without discrimination (as defined by Human Rights Act)."

Under section 44 of the Human Rights Act 1993 it is unlawful for any person who supplies services such as health care to the public, to refuse to provide those services, or to treat any person less favourably in connection with the provision of those services, by reason of any of the prohibited grounds of discrimination. Under section 21, "disability" is a prohibited ground of discrimination and includes "the presence in the body of organisms capable of causing illness" (section 21(1)(h)(vii)). Thus, health care providers cannot refuse a patient health care simply because he or she is HIV-positive.

The Medical Council of New Zealand's "Good Medical Practice – A guide for doctors" (December 2003), paragraph 8, is also relevant. It states:

> "You must not refuse or delay treatment because you believe that patient's actions have contributed to the condition, or because you may be putting yourself at risk. If a patient poses a risk to your health or safety you may take reasonable steps to protect yourself before investigating his or her condition or providing treatment."

The Royal Australasian College of Surgeons describes a surgeon's duty of care in its "Policies – Infection Control in Surgery" (1998) as follows:

> "… [P]atients with infectious transmissible diseases … should have the same rights to appropriate medical care as any other patient.
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> This duty of care and the provision of continuing medical treatment should be accepted by surgeons, anaesthetists and other practitioners as well as the institution. …"

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In his article entitled "Not Saints, But Healers: The Legal Duties of Health Care Professional in the AIDS Epidemic", Professor George Annas observes that "neither law nor ethics expects sainthood or martyrdom of health care professionals" but that "the law can reinforce an ethic of professionalism in face of this modern plague".[1]

I have considered the professional and ethical standards quoted above. It is clear that Dr C did not render medical services without discrimination and did not consider the health and well-being of his patient to be the first priority. He did not extend Mr A the same rights to appropriate medical care as any other patient. In my opinion, his behaviour was unethical and unbecoming of a surgeon, even one working in a provincial hospital with limited experience in treating HIV-positive patients. In these circumstances, Dr C breached Right 4(2) of the Code in failing to provide Mr A with services that complied with professional and ethical standards.

I acknowledge that since the events took place, Dr C has made changes to his practice. He states that he is more vigilant in scrutinising clinic referral letters, does not withhold treatment or investigation from patients who may be at risk of having an infectious disease, and accepts that with good standard precautions the risk to staff is minimal. I draw Dr C's attention to the Royal Australasian College of Surgeons' "Policies – Infection Control in Surgery" (1998), which notes that *all* patients are potentially infective, and recommend that he adopt universal precautions in relation to all surgical patients.

Opinion: No vicarious liability – The Public Hospital

Employers are vicariously liable under section 72(2) of the Health and Disability Commissioner Act 1994 for ensuring that employees comply with the Code of Health and Disability Services Consumers' Rights. However, under section 72(5) an employing authority has a defence if it shows that it took such steps as were reasonably practicable to prevent an employee from breaching the Code.

I acknowledge that the Public Hospital took appropriate actions following the incident – in particular, by directing Dr C to update his knowledge on infection control, and apologising to Mr A. The Public Hospital advised me that its usual practice is to make enquiries about a patient's residential address if the details provided to the hospital indicate an out-of-region referral. This is generally done at the time the referral is received.

[1] George Annas, "Not Saints, But Healers: The Legal Duties of Health Care Professionals in the AIDS Epidemic" (1988) 78(7*) American Journal of Public Health* 78(7) 844.

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It is difficult to see how the hospital could have prevented Dr C's unacceptable behaviour. Accordingly, in my opinion the Public Hospital is not vicariously liable for Dr C's breaches of the Code.

Follow-up actions

- This matter will be referred to the Director of Proceedings in accordance with section 45(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.
- A copy of this report will be sent to the Medical Council of New Zealand and the Royal Australasian College of Surgeons.
- A copy of this report, with identifying features removed, will be sent to the Human Rights Commission, the AIDS Medical and Technical Advisory Committee, the New Zealand AIDS Foundation, and the New Zealand Medical Association, and will be placed on the Health and Disability Commissioner's website, www.hdc.org.nz, for educational purposes, upon completion of the Director of Proceedings' processes.

Addendum

The Director of Proceedings considered this matter and decided not to issue proceedings before the Medical Practitioners Disciplinary Tribunal or the Human Rights Review Tribunal.