Tauranga Hospitals Inquiry

A Report by the

Health and Disability Commissioner

(Case 04HDC07920)

Introduction

On 18 December 2003, following a number of complaints to my Office, I initiated an inquiry into the quality of care provided by Mr Breeze to a number of patients on whom he performed surgery.

The inquiry had two parts. The first part was an investigation into whether Mr Breeze provided services of an appropriate standard to seven individual patients who complained to my Office, and whose complaints fell within my jurisdiction and warranted investigation. Part one of the inquiry was completed in December 2004. The cases and findings are summarised in Appendix One.

The second part was an investigation into whether Mr Breeze's employers took adequate steps to respond to concerns about his practice and ensure that he was competent to practise surgery. The second part of the inquiry was initiated to recognise the important obligation of a surgeon's employing authority[1] to maintain and monitor the competence of the surgeons it employs, to protect patients.

This report addresses part two of the inquiry. The report is about whether three hospitals (one public and two private) took adequate steps to respond to concerns about the competence of a surgeon operating on their premises. The report is not about whether Mr Breeze was or is competent to practise surgery.[2] The issue this report examines is the best way for a hospital to respond to concerns about a health practitioner's competence.

The report highlights the need for hospitals to have adequate systems in place to monitor the competence of the health practitioners operating on their premises. Hospitals need to have effective processes to enable them to respond decisively to any concerns about a clinician's practice, in a co-operative and co-ordinated manner. Patient safety must be the paramount consideration. I am hopeful that this report will provide guidance to hospitals and other institutional health care providers about how to respond to similar situations.

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[1] 'Employing authority' and 'employer' are used throughout this report to denote both entities that employ surgeons on a traditional contract of service (eg, public hospitals) and entities that contract for the services of surgeons (eg, private hospitals where the surgeons are independent contractors).

[2] Mr Breeze's competence to practise surgery falls within the jurisdiction of the Medical Council of New Zealand. The Medical Council has reviewed Mr Breeze's competence (as set out in this report), and is aware of my investigations and findings in the seven individual cases. It is a matter for the Medical Council to consider all the relevant information, including my findings in part one of this inquiry, and to determine whether Mr Breeze is competent to practise surgery. The factual information in this report should be read in the context of the purpose of the report. While significant factual information regarding the reviews of Mr Breeze by external agencies is included, the purpose of its inclusion is not to draw conclusions on Mr Breeze's competence, but to analyse in detail the way the hospitals responded to the concerns about his practice.

Names (other than Mr Breeze, Tauranga Hospital, Norfolk Community Hospital, Southern Cross Hospital, the Medical Council, and the Royal Australasian College of Surgeons) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Terms of Reference

The terms of reference for the inquiry were:

1. *Did Mr Ian Breeze provide services of an appropriate standard to:*
- *a) Patient A, on whom Mr Breeze performed cholecystectomy surgery at Tauranga Hospital in late October 1999, and who developed postoperative complications.*
- *b) Patient B, on whom Mr Breeze performed bowel surgery at Tauranga Hospital in March 2000, and who developed postoperative complications.*
- *c) Patient C, on whom Mr Breeze performed cholecystectomy surgery at Tauranga Hospital in February 2000, and who developed postoperative complications.*
- *d) Patient D, on whom Mr Breeze performed a repair of hernia operation at Norfolk Hospital in August 2000, and who developed subsequent complications.*
- *e) Patient E, on whom Mr Breeze performed a laparoscopic cholecystectomy at Norfolk Southern Cross Hospital in April 2002, and who developed postoperative complications.*
- *f) Patient F, on whom Mr Breeze performed laparoscopic surgery at Southern Cross Hospital in September 1998, and who developed subsequent complications.*
- *g) Patient G, on whom Mr Breeze performed a left hemicolectomy at Tauranga Hospital in February 1999, and who developed postoperative complications.*

2. *Did Tauranga Hospital, Norfolk Community Hospital and Norfolk Southern Cross Hospital take adequate steps to respond to any concerns about Mr Breeze's practice and to ensure that Mr Breeze was competent to practise surgery?*

Summary[3]

Mr Breeze is a general surgeon, practising in Tauranga. He was appointed as a full-time general surgeon at Tauranga Hospital in April 1985. In 1989 Mr Breeze changed to a part-time position at Tauranga Hospital, and also commenced operating at two private hospitals in Tauranga – Southern Cross Hospital and Norfolk Community Hospital. Mr Breeze is described by his colleagues as a hard-working surgeon who has a great theoretical knowledge of surgery and is caring of his patients.

In June 1994 Tauranga Hospital staff raised concerns about Mr Breeze's competence with the Medical Advisor at Tauranga Hospital. The concerns were about the number of Mr Breeze's surgical patients who had postoperative complications, and his overall

[3] The matters discussed in the "summary" section are considered in more detail in the "Information gathered during investigation" section of this report.

Names (other than Mr Breeze, Tauranga Hospital, Norfolk Community Hospital, Southern Cross Hospital, the Medical Council, and the Royal Australasian College of Surgeons) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

management of those complications. A review took place, and Mr Breeze agreed to an educational programme to upskill his practice. No concerns were documented at either of the private hospitals.

In July 1995 further concerns about Mr Breeze's competence were raised with the Medical Advisor by Tauranga Hospital clinical staff. Mr Breeze's practice was restricted at Tauranga Hospital while a further review took place. Following consultation with the Royal Australasian College of Surgeons, the restrictions on Mr Breeze's practice were lifted, and a number of recommendations were made. At that time, Southern Cross Hospital was informally advised of Tauranga Hospital's actions in regards to Mr Breeze's competence. In 1996 Southern Cross Hospital commenced some preliminary investigations, but was unable to obtain any further information and the matter did not progress.

No further concerns about Mr Breeze's competence were documented until his patient, Mr A, died following bowel surgery at Southern Cross Hospital in December 1999. Following Mr A's death, a number of actions took place at Tauranga Hospital, Southern Cross Hospital, and Norfolk Hospital to address concerns about Mr Breeze's competence, and a competence review was undertaken by the Medical Council of New Zealand.

Layout of this report

This report is divided into three sections: Information gathered during investigation; Opinion; Other matters; and Appendices.

The "Information gathered during investigation" section of my report is divided into subsections corresponding to the three significant periods in which concerns about Mr Breeze's competence were raised, and the way those concerns were addressed by his employers. In particular:

1. the management of concerns about Mr Breeze's competence at Tauranga Hospital between June and October 1994;

2. the management of concerns about Mr Breeze's competence at Tauranga Hospital between July 1995 and January 1996;

3. the management of concerns about Mr Breeze's competence between 1999 and 2003, including:

   (a) actions taken by Tauranga Hospital and the Medical Council of New Zealand;

   (b) actions taken by Southern Cross Hospital;

Names (other than Mr Breeze, Tauranga Hospital, Norfolk Community Hospital, Southern Cross Hospital, the Medical Council, and the Royal Australasian College of Surgeons) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

(c) actions taken by Norfolk Community Hospital;

4. communication between the public and private hospitals.

Appendices 1 to 7 set out the relevant background information to this report. In particular:

1. a summary of the Commissioner's findings in part one of the inquiry;
2. the parties involved;
3. the investigation process;
4. Mr Breeze's submission on the audit review findings;
5. relevant background information about Tauranga Hospital;
6. relevant background information about Norfolk Community Hospital and Southern Cross Hospital;
7. the Medical Council's competence review process.

Information gathered during investigation

1. June to October 1994

1.1 *Concerns raised*
In June 1994 the Director of Nursing Practice Surgery and the Department of Radiology raised concerns with Mr B, senior surgeon and Clinical Director of Surgery at Tauranga Hospital, and Dr C, Medical Advisor, about Mr Breeze's clinical performance. It was noted that Mr Breeze had a higher rate of complications than his general surgeon colleagues. Eight to ten cases were brought to Dr C's attention, mainly cases involving anterior resections of the rectum or lower colon, which the Radiology Department had seen for investigation of complications during the previous six months. Dr C and Mr B discussed the concerns with Mr D, Chief Executive Officer of Western Bay Health, who authorised them to investigate the matter. Dr C and Mr B reviewed the case notes, and made a summary of the complications and outcomes to present to Mr D.

1.2 *Meeting and agreed action plan*
On 23 June 1994 Dr C and Mr B met with Mr Breeze to discuss the concerns. On 23 June Dr C wrote to Mr D and advised him that Mr Breeze acknowledged the problem during the meeting and that several agreements to address the issue had been made. In particular, Mr Breeze agreed to:

- contact senior surgeons in the Department of Surgery at the first public hospital, to arrange a period of review, discussion, contact and teaching with them;

- endeavour to make a similar arrangement in a city in Australia while he was on leave there during the following month;

- contact colleagues for joint consultation in future cases of abdominal surgery complications; and

- undergo an independent audit of his surgical practice in abdominal surgery over the previous 12 months, and a prospective audit for six months.

Mr Breeze's agreement to the recommendations was on a voluntary basis.

On 20 July 1994 Dr C confirmed the above arrangements with Mr D. It was agreed that the proposed steps should be sufficient to manage the situation and that it was not necessary to restrict his practice. However, it was noted by Dr C that it was a matter for continuing consideration whether additional steps should be taken.

1.3 *Audit – Mr F*

Mr F, a consultant general surgeon with an interest in colorectal surgery, practising at the second public hospital, agreed to conduct the audit into Mr Breeze's practice. On 19 August Mr F completed a retrospective review of 150 of Mr Breeze's public cases over the previous 18 months. Mr F reported:

> "In essence, the upper abdominal surgery has been of a good standard and there are few problems associated with biliary surgery, gastric surgery and acute abdominal surgery related to appendicitis.
>
> I would comment however, that rectal surgery has produced an excessive number of problems associated with abdominal sepsis and anastomotic breakdown.
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> While some of these cases have been bad risk patients by virtue of age, diabetes, poor renal function and sometimes malnutrition, I think the major problem stems from the use of the mechanical stapler – especially low EEA stapling.
>
> I comment that there are a number of factors –
>
> 1. Sometimes bowel preparation has been incomplete
>
> 2. 'Donuts' have sometimes been incomplete and there is no comment about oversewing to control this
>
> 3. Colostomy has been more often used than would be average practice, suggesting insecurity of anastomotic closure in the surgeon's judgement

4. Where a leak has occurred in the absence of a covering stoma, it appears to have been invoked later than would be ideal

5. The presence of sepsis in the abdomen after surgery has been higher and as a result the use of antibiotics – Gentamycin, Flagyl etc. has been frequent and prolonged

6. These problems need to be addressed on an ongoing basis now that they have been identified."

Mr F made recommendations at a systemic level, rather than an individual level, to address the problems identified with Mr Breeze's practice. In particular, he commented that it is important for two senior colleagues to work together on difficult cases to provide "wise judgement", and he noted that regular audit review between teams on a monthly basis is desirable.

Dr C discussed the report with Mr F, who also recommended that a member of the Department of Surgery from the first public hospital travel to Tauranga and spend a day operating with and assisting Mr Breeze. Mr F recommended Mr E, colorectal and general surgeon, as an appropriate person to do this. On 30 November 1994 Mr F wrote to Mr C to advise him that Mr E was agreeable to the suggestion. There is no documented evidence that Tauranga Hospital pursued this matter.

1.4 *Compliance with action plan*
There is no documented evidence of who was responsible for overseeing Mr Breeze's compliance with the agreements made during the meeting on 23 June, or implementing Mr F's recommendations.

Mr Breeze contacted Dr G, a senior surgeon in a city, as agreed in the meeting on 23 June. Mr Breeze arranged to spend a day in October observing Dr G performing surgery on three or four cases of carcinoma requiring an anterior resection of the rectum.

Accordingly, Mr Breeze travelled to the city in October. Mr Breeze and Dr G discussed the cases observed, and the technicalities of the procedures undertaken. Because Dr G did not observe or review Mr Breeze's surgical performance, it was felt inappropriate for him to provide Western Bay Health with a report commenting on Mr Breeze's competence. However, Dr G advised Dr C that in his opinion there was not a major problem with Mr Breeze's technical competence, and the matter could be remedied. Dr G advised Western Bay Health that he would be happy for Mr Breeze to repeat the process at any time, if necessary. There is no documented evidence that Mr Breeze returned to the city for further review by Dr G.

Dr C recalled being concerned that Mr Breeze spent only one day observing cases with Dr G in the city. Dr C's expectation was that at some stage Mr Breeze would have performed

surgery in the company of another expert surgeon, who could observe and comment on his technique.

There is no further documentation in 1994 relating to this matter. In particular, there is no documentation of further review sessions in the city, that Mr Breeze attended any review sessions in a city in Australia, or that he sought the assistance of Mr E. However, Mr Breeze advised that in 1996 he voluntarily spent two weeks undergoing continuing medical education, which included eight days at the Colorectal Unit at an Australian hospital, and a day at the Endocrine Unit at another Australian hospital, observing the latest techniques.

The Bay of Plenty District Health Board was asked what, if any, other action was taken at this time in response to the concerns about Mr Breeze's use of the mechanical stapler, and the excessive number of postoperative complications (abdominal sepsis and anastomotic breakdown), as identified in Mr F's report. The Board responded:

> "It is understood that Mr Breeze modified his stapling anastomostic technique as a consequence of his observations/discussions [with Dr G … in a city]. Further, it is believed that Mr Breeze's complication rate for this type of surgery declined for a period of time."

There is no evidence that procedures were put in place to monitor Mr Breeze's compliance with the agreed recommendations, or that Western Bay Health sought to satisfy itself that any deficiencies in his care had been adequately addressed, and there was no ongoing risk to patient safety. It was later noted (in a document dated 12 September 1995) that a lack of funding and surgeon numbers meant it had not been logistically possible to provide the necessary two-surgeon team approach or any kind of "buddy" system in general surgery (as recommended by Mr F), and precluded regular surgical team meetings for the purposes of review, discussion and audit.

2. July 1995 to January 1996

2.1 *Concerns raised in 1995*

In April 1995 Dr C was approached by two surgical ward sisters who had general concerns about Mr Breeze's postoperative infection and complication rates. He told them he needed specific instances of doubtful practice or major complications before he could do anything in response to their concerns. He did not receive any further communications from the ward sisters.

On 10 July 1995 Dr C received a letter from Mr B, requesting a meeting to discuss concerns about Mr Breeze's practice. The meeting took place on 24 July, at which point Dr C was

advised that a senior anaesthetist and a radiologist had "deep concerns" about Mr Breeze's practice, and had been taking note of some outcomes of Mr Breeze's surgical cases.[4]

On 27 July 1995 Dr C wrote to Mr D to advise him that there were recurring concerns about Mr Breeze's surgical practice and clinical competence. Dr C advised Mr D:

> "… [T]he basis for this climate of opinion, now needs to be looked at, and is urgent and important from the point of view of the institution, for the sake of preventing any surgical disaster which might occur, and not least for the sake of patients and the surgeon himself."

2.2 *Action plan*
On 3 August Mr D wrote to Mr Breeze and advised him of the concerns that had been raised about his surgical competence. Mr D proposed a more thorough investigation by an external agent, and restricted Mr Breeze from performing abdominal surgery except with the assistance of a colleague. Mr I, then a senior general surgeon at the third public hospital in a city, was asked to undertake a thorough audit of Mr Breeze's private and public abdominal surgery cases over a 12-month period.

2.3 *Audit – Mr I*
On 17 August Mr I completed a review of all abdominal surgery performed by Mr Breeze between 1 July 1994 and 30 June 1995 in both the public and private sector. Mr I concluded that there was a continuing problem with Mr Breeze's surgical management of acute colorectal cases. In some cases there were errors of judgement in the choice of operative procedure, and Mr I also questioned some of the technical aspects of the surgery performed. Mr I was concerned that Mr Breeze was not working with another surgeon as a member of the surgical team by doing combined ward rounds, operating at the same time, and sharing problems, and also noted that successful surgical management of acute colorectal cases requires input and often consensus from the team and related disciplines. Mr I also noted that despite the previous review by Mr F, the suggestion of re-training in colorectal surgery, and reorganisation of the surgical department had not occurred. Mr I concluded that "a dangerous situation" had arisen, and recommended that Tauranga Hospital seek advice from the appropriate medical people as to how the matter should be handled.

Mr Breeze strongly disputed Mr I's findings. In particular, he disputed the validity of the mortality and morbidity figures in Mr I's report.[5] His concern about the process of the audit

[4] Mr Breeze does not accept that a senior anaesthetist or a radiologist are able to reach valid conclusions about his complication rates without knowing his total work output. Mr Breeze advised that his output was high, and colorectal surgery is a high risk specialty. Mr Breeze also commented that his colleagues considered he was referred a disproportionate number of high risk elderly cases. He notes, "A peripheral observer would be unaware of the large number of patients treated by me who made uneventful recoveries."

[5] Mr Breeze advised that, whereas Mr I claimed he had had eight deaths following colorectal surgery, the records reflected three deaths, each involving poor risk patients with advanced pathology and severe

and the accuracy of the findings in the report was the subject of significant correspondence. Although the audit reviewed Mr Breeze's private cases, there is no evidence to indicate that the report was provided to Southern Cross Hospital or Norfolk Community Hospital.

2.4 *Request for assistance from the Royal Australasian College of Surgeons*
On 24 August, Dr C wrote to the Royal Australasian College of Surgeons (RACS) to request its assistance. The reason for approaching RACS was the uncertain outcome of the two reviews, the perception of ongoing problems, the need for greater experience and expertise, and Mr Breeze's unhappiness with Mr I's review and report. Dr C advised me that Western Bay Health felt that a more authoritative and independent opinion could be obtained through RACS. Dr C requested that RACS "be involved in reviewing the situation in an impartial and authoritative manner for the benefit of all parties concerned".

Discussions took place between Mr H, Chairman of the New Zealand Committee of RACS, and Western Bay Health about the options for resolution. Western Bay Health was advised that RACS could conduct a review, but that prior to doing so RACS would need to ascertain that:

(a) there was a "case to answer" of sufficient gravity to warrant a full external review;

(b) the problem was better handled externally than by an in-house review; and

(c) RACS was the best agency to conduct the review (for example, as opposed to the Medical Council, which had limited mechanisms for dealing with concerns about a doctor's performance).[6]

Western Bay Health was advised that a formal peer review would take between six weeks and three months to complete, from the time the decision to review was made.

An arrangement was made for Mr H and Mr J, a general surgeon and member of RACS, to visit Tauranga on 17 September 1995 to meet the key people to discuss the matter further, and advise Western Bay Health how RACS considered the problem would be best handled. Mr H and Mr J met with Mr B, Dr C, Dr K, deputy medical advisor, and Mr D, and met separately with Mr Breeze later in the day. At the meeting, general concerns about Mr Breeze's practice were raised, including his response to stressful situations, and his communication with colleagues about difficult cases. Mr Breeze expressed concerns about Mr I's report, and denied that there was a problem. The need for a detailed breakdown of

comorbidity. In addition, two patients Mr I claimed had died following colorectal surgery were actually still alive, and had made an uneventful recovery from surgery. A further three patients had not died following surgery. Mr Breeze described the review report as "grossly inaccurate" and the results "plainly unreliable".

[6] It is important to note that at this time the Medical Council was governed by the Medical Practitioners Act 1968, which did not make provision for competence reviews and had limited mechanisms for dealing with concerns about a doctor's general competence.

Mr Breeze's 1994 and 1995 abdominal cases was identified, but both parties agreed that they wanted to avoid a formal review.

Following the visit from Mr H and Mr J, it was agreed that a more exhaustive review should be undertaken of Mr Breeze's work from 1 July 1994 to 30 June 1995. There is a lack of documentation relating to that decision. I understand that the review was carried out by an "in-house hospital committee of inquiry" comprising Mr D, Mr B, Dr K, and Dr C, and was overseen by RACS. The College recommended that Mr Breeze be allowed to access patient records and be given a reasonable opportunity to respond to any findings made.

2.5 *In-house review*
The review was completed by mid-October 1995, and consisted of analysing the cases identified as problematic in Mr I's report. The audit process used was the Otago Audit, which examines postoperative outcomes within the first 28 days. Mr B advised me that there are a lot of older people in Tauranga with major health problems and comorbidities, and it appears that the level of mortality and morbidity may be higher than in other centres. The review revealed that many of Mr Breeze's patients had morbidities that extended beyond 28 days, and the reviewers were particularly concerned about those cases. However, those cases were not captured within the audit findings.

There was significant correspondence between RACS, Western Bay Health, Mr Breeze and Mr Breeze's lawyer about the process of the in-house review, and the conclusions reached. There appears to have been a "stalemate" on the outcome of the review. Mr Breeze forwarded his response to the review to RACS.

Mr B advised that it was very difficult to know where to go from that point. He stated, "Frankly, none of us as individuals knew how to handle the situation other than to try to be as responsible as we could."

In early November 1995, in light of the stalemate, RACS advised Western Bay Health that the "obvious" next step was for Mr Breeze to work directly with Western Bay Health to resolve the matter. Beyond that point, RACS advised that, if requested by Western Bay Health, the College would be happy to facilitate a resolution to the problem. The College suggested that it could facilitate resolution by either a full-scale clinical review, or negotiation/mediation.

2.6 *Concerns 'resolved' directly between Western Bay Health and Mr Breeze*
On 4 December 1995 Mr Breeze met with Dr C. Dr C recorded that Mr Breeze did not accept the results of the inquiries into his surgical practice. He accepted that he had technical problems prior to July 1994, but stated that these had been corrected following his visit to Dr G in October 1994 (evidenced by the subsequent improvement in his results for anterior resections of the rectum). Mr Breeze again expressed discontent with Mr I's report, in particular the accuracy of the information relied on to form his conclusions, and the subsequent internal investigation. Mr Breeze requested a review by RACS.

A further meeting took place on 15 December 1995. Present were Mr Breeze, his support person, Mr B, and Dr K. The hospital's in-house review was discussed and a number of clinical points relating to the cases clarified by Mr Breeze. Mr B advised Mr D that there were problems, but the best way to address them would be to move forward, and permit Mr Breeze to return to abdominal surgery subject to some provisos. On 17 January 1996, following consultation with Mr B and Mr H, Mr D wrote to Mr Breeze with a proposed action plan. Mr Breeze was advised that he could resume surgical duties at Western Bay Health with the following provisos:

- all abdominal surgical lists performed by the Western Bay Health Surgical team to be audited by RACS for the following 12 months;
- one half-day per month to be devoted to audit and CME matters within the Division of Surgery;
- Mr Breeze to be required to discuss problems and contentious cases with his colleagues;
- a surgical mentor for Mr Breeze to be arranged in relation to abdominal surgery and colorectal surgery;[7] and
- Mr Breeze to be required to attend surgical technical workshops, as necessary.

On 30 January 1996 Mr Breeze accepted the proposed plan.

2.7 *Implementation of recommendations*

The only documented evidence of action taken by Western Bay Health to implement the above recommendations is a letter from Mr B to the Chairman of the Colorectal Division in an Australian city, dated 12 January 1996, requesting information about future vascular workshops intended as revision for senior surgeons. There is no record of a response to this letter, or that any further action was taken.

It is not clear who was responsible for overseeing Mr Breeze's compliance with the agreed action plan. There is no record of how it was envisaged that the recommendations would be implemented, or who would be responsible for implementing and overseeing the wider recommendations. There is no record of any specific ongoing monitoring, review, or reassessment of Mr Breeze's clinical competence from this time until concerns re-surfaced in late 1999.

The general consensus from my interviews with Mr B, Dr C, and Dr K, is that it was envisaged that the matter would be managed within the Surgical Department, under the

[7] The Bay of Plenty District Health Board advised me that a surgical mentor is usually a senior experienced surgeon, who is available to provide advice to a younger or less experienced surgeon in respect to problems, difficulties, and issues on a one-to-one basis. The relationship is private, and may vary from an 'as needs basis' to regular meetings.

oversight of the Clinical Director of Surgery, and with the collegial assistance of other members of the surgical team. I understand that in usual circumstances it would be the role of a Clinical Director to ensure the implementation of such recommendations within a clinical team. However, the oversight of the matter and the implementation of the recommendations appears to have been hindered in this case by two things:

1. Mr B advised me that the position of Clinical Director of Surgery at Tauranga Hospital was not an established clinical director's role that allowed time for a role in the oversight and management of such matters – Mr B was a busy clinician with a high surgical load; he was expected to fulfil the role in a part-time capacity, which did not allow time to adequately fulfil a wider oversight role. Mr B advised, "We tried our best to implement them to the extent that we could" and, "There needs to be at the coalface a Clinical Director who sees that this is all brought about."

2. Dr C advised me that one of the major reasons why recommendations were not implemented was "logistics, funding, numbers of personnel. There just weren't the surgeons on the ground. So to a very major extent there is a structural and quantitative problem in terms of numbers of surgeons available for it to be able to happen."

Mr B advised me that there were times when, in accordance with the recommendation that he discuss problem cases and those of a contentious nature with his colleagues, Mr Breeze immediately asked for help, but there were also times when he would not see that he was getting into trouble and call for help. Mr B advised, "This worried us greatly. We didn't quite know how to cope with it … when a colleague seems to just withdraw from seeking that help when necessary, I don't know how to train that into a person."

On 17 June 1996 Mr B, Mr C and two other surgeons met to discuss further concerns that had been raised about Mr Breeze's surgical practice. Two cases were discussed, although no specific patient complaints had been received. There was no documented outcome to the meeting or indication that the matter was taken any further.

Dr K advised me that from 1 January 1997, when he became Medical Advisor, until the end of 1999, no concern about Mr Breeze was brought to his attention. There were no ongoing reviews or reassessments of the situation between 1997 and 2000.

2.8 *Surgical audit*

An important recommendation of the January 1996 action plan was that time be set aside for audit within the surgical department, which would assist in ongoing monitoring of Mr Breeze's (and all other surgeons') clinical outcomes. There is no documentary evidence that Mr Breeze's practice was monitored from this time through an audit process. Mr Breeze advised that since the early 1990s his surgical results, together with those of all other members of the Tauranga Hospital surgical department, were monitored by total practice audit. He advised that the results were evaluated by monthly departmental meetings, which he attended, and his results in all areas of surgery were within acceptable parameters. He attended a separate weekly departmental meeting also attended by radiologists and

pathologists, which provided a forum for discussion of difficult cases with colleagues. Mr Breeze advised that the audit was supervised by Mr B. He further noted:

> "Prospective audit was carried out of every operation that I performed or supervised, and any complications were evaluated at a monthly morbidity and mortality meeting. My results were completely transparent to all members of the surgical department, and my complication rates did not reach a threshold whereby concerns were raised about the outcomes."

Mr B advised me that to the extent that prospective audit was feasible at that time, Mr Breeze's statement is correct and audits were routinely performed between 1996 and 1999. However, there were obstructions to the proper implementation of audit as a standard of excellence at Tauranga Hospital. In particular, managerial decisions impeded the standards achievable by audit being fully realised. Mr B explained that the Otago Audit started in July 1992, and he visited Dunedin to determine how the audit programme should be set up at Tauranga. He advised that the system "fell down" at Tauranga for several reasons, including demands from the records department and restrictions on audit sessions. The lack of secretarial support was also unhelpful. Mr B advised:

> "Proper audit is an in-depth prospective study of the whole range of surgical practice. To achieve this, we must have a knowledgeable audit person, capable of downloading all information of significance from the computer and preparation of all materials for the monthly M and M (morbidity/mortality) meeting."

2.9 *Communication with private hospitals*

The manager of Southern Cross Hospital was informed by Tauranga Hospital in 1996 that Mr Breeze was required to undertake further training in colorectal surgery at Tauranga Hospital. The manager referred the matter to the Hospital Clinical Management Committee, but there is no record of the Committee considering the matter at the time, or taking any further action. There is no evidence of similar notification to Norfolk Community Hospital. However, Norfolk Southern Cross Ltd advised me that at the time Mr Breeze was under review at Tauranga Hospital, he voluntarily restricted his practice at Southern Cross and Norfolk Community Hospital to exclude colorectal surgery. There are no records indicating exactly when Mr Breeze recommenced colorectal surgery at the private hospitals, although he clearly did recommence colorectal surgery not long afterwards, and before 1999.

3. 1999 to 2003

On 16 December 1999 Mr Breeze performed bowel surgery on Mr A at Southern Cross Hospital in Tauranga. Postoperatively, Mr A's condition deteriorated, and he died at

Tauranga Hospital on 21 December 1999. Concern was raised about Mr Breeze's skill and judgement in Mr A's case.[8]

Following the death of Mr A, action was taken by both Tauranga Hospital and the two private hospitals – Norfolk Community Hospital and Southern Cross Hospital – to address concerns about Mr Breeze's competence to practise surgery. The actions taken by each hospital are discussed separately, below.

3.1 Tauranga Hospital

3.1.1 *Meetings, discussions and key decisions*
Between late December 1999 and November 2000 there were a number of meetings at Tauranga Hospital to discuss the circumstances surrounding the death of Mr A, and concerns about Mr Breeze's practice. Dr K advised me that during that time, he was asked to fulfil a pastoral support role in relation to Mr Breeze, and the management of the situation and concerns about Mr Breeze's competence was in the hands of the Chief Executive Officer, Bay of Plenty District Health Board, Mr M, and "non-medical management". He advised that most of the liaison was between the surgeons and the CEO.

From December 1999 there is a significant amount of documentation relating to Tauranga Hospital's response to the concerns about Mr Breeze's competence. In summary, the following key decisions were made to address the situation between December 1999 and November 2000:

(a) On 14 February 2000, the Clinical Directors (The Surgical Services Manager, Mr B, another surgeon, and Mr M) agreed to ask Mr Breeze to step down from low colorectal procedures for six to eight weeks, or until the Coroner's Inquest into Mr A's death. It is unclear whether that decision was actioned and whether Mr Breeze was formally asked to step down from colorectal surgery at that stage. Mr Breeze advised that he was not suspended from undertaking low colorectal procedures on 14 February 2000, but continued to undertake his normal range of surgery, including bowel surgery, until 1 September 2001.

(b) On 21 March 2000, following a meeting with Mr B, Mr K, and Mr M, Mr Breeze agreed to the following recommendations:

- that he commit to acting as a member of the surgical team and asking for immediate advice from another consultant surgeon if he experienced difficulty;

- that, whenever possible, he enlist the assistance of a surgical registrar or consultant surgeon during large bowel resection procedures; and

[8] The Commissioner investigated the standard of care Mr Breeze provided to Mr A. The Commissioner's opinion 00HDC03311 is available on the Commissioner's website: www.hdc.org.nz.

- that Mr B would send a note to the consultant surgeons to remind them of the importance of backup and being available to their colleagues, and to all anaesthetists stating that a second surgical opinion is always immediately available.

Mr K envisaged that the recommendations would be managed and monitored within the Surgical Department.

(c) On 14 July 2000 Mr M decided to ask Mr Breeze to suspend colorectal surgery until the Southern Cross investigation into the case of Mr A and the Coroner's Inquest were completed. It is unclear if, and when, that decision was communicated to Mr Breeze. As noted above, Mr Breeze advised that he continued to undertake his normal range of surgery, including bowel surgery, until 1 September 2001.

(d) During a meeting on 18 August 2000 between Mr M, Mr B, and the Surgical Services Manager, the suggestion was made that the Medical Council of New Zealand (the Medical Council) review Mr Breeze's practice.

(e) On 29 August 2000 the previous Health and Disability Commissioner notified Pacific Health of her intention to investigate the care and treatment of Mr A.[9] There is documentation suggesting that Mr Breeze agreed not to perform colorectal surgery pending the determination of the Coroner's Inquest and the Commissioner's investigation, and until Pacific Health was satisfied that his colorectal surgery and ability to clinically manage patients was of a standard appropriate for a surgeon of his level.

(f) On 2 November 2000 Mr Breeze met with Mr B and Mr M, and indicated that he would be willing to undertake a competence review by the Medical Council in respect of his skills in general surgery and, more specifically, colorectal surgery.

(g) On 9 November 2000 Mr Breeze was advised of Pacific Health's intention to ask the Medical Council to formally review his surgical competence.

(h) On 14 November 2000 Mr M met with key members of the clinical staff at Tauranga Hospital to determine whether there was enough concern about Mr Breeze's competence to initiate a competence review by the Medical Council. At the meeting a decision was made that there were sufficient concerns to justify a competence review. The concerns related to Mr Breeze's technical ability in colorectal surgery, and his level of awareness of the need to intervene when the clinical outcome is compromised.

[9] The case of Mr A was the first complaint received by the Health and Disability Commissioner about Mr Breeze.

(i) On 17 November 2000 Mr M wrote to the Medical Council to request a formal review of Mr Breeze's competence.

The Bay of Plenty District Health Board (the DHB) advised me that many of the above decisions were made under difficult circumstances. It submitted that it is important in summarising the actions taken not to lose sight of the context, including the behind-the-scenes stresses at the time, and the fact that Mr Breeze denied that there was a problem and vigorously defended his position.

The Medical Council corresponded with Mr B about the request for a review of Mr Breeze's competence. In late November 2000 Mr B wrote to the Council and summarised the situation, and Pacific Health's particular concerns about Mr Breeze's practice. Mr B advised the Council that Mr Breeze's privileges had been withdrawn in the interim, and requested guidance on a way forward.

On 26 January 2001 Mr Breeze wrote to the Council and advised that it was incorrect that his colorectal privileges had been withdrawn in the interim. He advised, "I continue to carry out colorectal resection but have agreed to discuss each case with a colleague first, and to have a low threshold for seeking a colleague's collaboration at any hint of a problem." Following a meeting on 9 May 2001, Mr M noted in a file note: "Mr B confirmed meanwhile that Mr Breeze continues to consult with a senior before considering colorectal surgery and the procedure is overseen. [The Surgical Services Manager] confirmed that a process is in place to divert referrals to surgeons other than Mr Breeze."

From this point, two independent processes took place: the Medical Council's independent reviews of Mr Breeze's competence (the first review in 2001, and the second review in 2002), and an internal DHB inquiry (July 2001).

3.1.2 *Medical Council – competence review 2001*
On 16 January 2001, in response to concerns about the quality of care Mr Breeze provided to Mr A, raised during the course of my investigation into the matter, I wrote to the Medical Council and asked it to consider reviewing Mr Breeze's competence.

The requests from my Office and the DHB for a review of Mr Breeze's competence were first considered by the Council's Professional Standards Committee at a meeting on 30 January 2001. A decision was made to review Mr Breeze's competence, and Mr Breeze was notified of that decision on 13 February 2001.

The Medical Council requested two specialist general surgeons, one of whom worked in a similar practice setting to Mr Breeze, to conduct the review. The reviewers were selected and appointed as the Competence Review Committee, and review packs were sent to them on 9 May 2001.

The DHB was concerned about the length of time taken to progress the Medical Council review of Mr Breeze's competence, and raised and documented its concerns on several

occasions between February and June 2001. The CEO regularly contacted the Medical Council ("on an almost daily basis at times", according to the DHB) to insist it progress its investigation. At a meeting on 9 May 2001 the CEO noted that if the Medical Council was not prepared to start the review within "the next few days", "alternative reviewers" would be sought. Following the meeting the CEO contacted the Medical Council, and made the following note of the conversation: "They will start their review within the next few days. They expect the review to be completed within three weeks." On 5 June 2001 the DHB was advised that the review would begin within one month.

The Medical Council advised me that there was a delay in the process of selecting reviewers and setting review dates suitable for the Competence Review Committee and Mr Breeze. The Council experiences difficulties in locating appropriately qualified and available doctors for competence review committees. It is important that one of the doctors on the committee is from a similar practice setting to ensure that the process is a "real" assessment by peers. The Council stated:

> "In situations where the process goes smoothly the expected time frame from the date of the decision to do the review until the actual review can take up to six months. Council must ensure that due process is followed to ensure all parties are treated fairly while ensuring safety is not compromised."

The terms of reference for the review were agreed upon by Mr Breeze, the reviewers and the Medical Council. In mid-June the Competence Review Committee informed the Council that the review would take place on 28 and 29 June 2001.

The reviewers visited Tauranga Hospital on 28 and 29 June 2001 to conduct the review. The review included a limited audit of Mr Breeze's management of biliary tract and colorectal surgery. The notes of 40 patients who underwent colorectal surgery and 19 patients who underwent a cholecystectomy for biliary disease between July 1999 and June 2001 were reviewed. The number of notes retrieved amounted to approximately 25% of the biliary tract caseload and 50% of the colorectal workload for the period July 1999 to June 2001.

On 3 July the CEO wrote to the Medical Council stating, "As you are aware, I have some concern over the length of time taken to reach this stage, and wondered if you could advise when we may expect to receive the reviewers' report."

The report of the review was completed and forwarded to the Medical Council on 9 July 2001. The report found no evidence of a problem with Mr Breeze's management of biliary tract disease, but identified a worrying trend in the number and severity of the complications in Mr Breeze's management of colorectal disease, which suggested Mr Breeze would benefit from upskilling in colorectal surgery. The reviewers were concerned, however, that because they examined only a small number of cases in the review, definitive conclusions were not possible.

On 24 July 2001 the Medical Council notified Mr Breeze of the Competence Review Committee's report, and he was given an opportunity to comment before the report was finalised and considered by its Professional Standards Committee. On 24 July the Council also wrote to the CEO to inform him that it had received the reviewers' report but, in accordance with due process, the employer would not be notified at that stage. The Medical Council advised Mr M, "With Dr Breeze's permission Council could provide you with a copy of the report once finalised. Council does have a policy to alert employers if the Council believes there is a serious public health and safety risk following a review."

On 23 August 2001, Mr Breeze wrote to the Medical Council and expressed concern about the review report. In particular, he expressed concern about the sample size, and advised that he would prefer a more comprehensive audit.

The Professional Standards Committee considered the reviewers' report and Mr Breeze's response during a meeting on 11 September 2001.

On 19 September 2001 Mr Breeze was notified that the Professional Standards Committee had considered his response to the review report, and had resolved that a more detailed audit of his competence in colorectal surgery be undertaken. The basis for the decision was the recognition that the number of cases examined by the Competence Review Committee was small, and therefore making definitive conclusions was not possible.

On 28 September 2001 the CEO was advised that the Medical Council had determined to undertake an in-depth review of Mr Breeze's colorectal surgery.

3.1.3 *Internal inquiry*

The DHB advised me that on 11 July 2001 it commenced an internal inquiry into Mr Breeze's psychological well-being, evidence of CME (continuing medical education) and surgical audit, the outcome of the Medical Council competence review, documentation relating to competence, and the withdrawal of Mr Breeze's privileges from Southern Cross Hospital. The purpose of the inquiry was to take appropriate steps to address Mr Breeze's well-being, patient safety, and the organisation's fulfilment of its responsibilities to the public and other professional staff. The inquiry was led by the Chief Medical Director, given his and the CEO's "significant concerns in regard to issues that related to Mr Breeze and his surgical practice". The review included meetings with key clinical and management staff to discuss the concerns and how to resolve them, and meetings with Mr Breeze.

There is significant correspondence between Mr Breeze's lawyer and the DHB's legal advisors about the review and the ongoing management of the situation and Mr Breeze's employment status.

On 15 August 2001 the CEO wrote to the Chief Medical Advisor at the Ministry of Health and stated, "… [T]here has been concern regarding this surgeon for some time and the present inordinately protracted process places ongoing patient safety at risk. I would

appreciate your advice." The Chief Medical Advisor responded on 29 August 2001. He noted:

> "It is always difficult to know how to deal with an investigation into a potential competency issue, but I believe that there is an obligation to ensure that the risks to the public are managed appropriately."

The Chief Medical Advisor noted the importance of the DHB providing Mr Breeze with appropriate support, and recommended:

> "If and when you receive the response from the Medical Council on this surgeon's competency and if you are not satisfied with its conclusions, it is your decision as Chief Executive Officer to decide whether you would like to pursue the competency issue further. If you were to do so, you should appoint two external surgeons with a set of terms of reference to prepare a report on this to you."

In September 2001 the DHB obtained legal advice about how to proceed. The legal advice was that there were insufficient grounds to terminate Mr Breeze's employment, but recommended "a formal process to review [Mr Breeze's] performance, and out of that may arise either the opportunity to address the issues and rectify any concerns, or alternatively terminate the employment of Mr Breeze". On the basis of the advice, the DHB decided to conduct a performance review of Mr Breeze in accordance with the provisions in his contract. On 18 September Mr Breeze was advised that until the performance review was completed, it was not appropriate or reasonable for him to undertake abdominal surgery or acute on-call roster work, and his duties were restricted to day surgery only.[10]

Both the internal inquiry and the performance review were unable to be completed without the result of the Medical Council's forthcoming in-depth competence review. However, in October 2001, pending the completion of the competence review, the DHB decided that sufficient information existed to support an ongoing restriction on Mr Breeze's practice to day surgery only. Mr Breeze continued to challenge the DHB's decision to restrict his practice beyond colorectal surgery, and the decision was regularly reviewed by management at the DHB. The documentation indicates that the DHB remained frustrated by the time taken to resolve the matter, and concerned about the stress of the situation on Mr Breeze, the implications for patient safety, and the Board's wider responsibilities to the general public.

[10] Mr Breeze advised that he was informed of the restriction on his practice on 18 September 2001 by letter, and the rationale for the decision was not discussed with him.

Names (other than Mr Breeze, Tauranga Hospital, Norfolk Community Hospital, Southern Cross Hospital, the Medical Council, and the Royal Australasian College of Surgeons) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

3.1.4 *Medical Council – competence review 2002*
In December 2001 it was agreed between the Medical Council and Mr Breeze that the in-depth audit would be conducted by Mr H and Mr N, Clinical Director of General Surgery at the fourth public hospital in a city.[11]

On 21 December 2001 the Medical Council requested the DHB's cooperation and support in respect of the audit. On 8 January 2002 the DHB responded, stating:

> "The Bay of Plenty District Health Board will be pleased to cooperate and provide administrative support in respect to the proposed audit. The DHB would appreciate that this audit is actioned as soon as possible, and the competency review is concluded without further delay."

The audit focused on major colorectal surgery performed by Mr Breeze from 1 January 1997 to 31 December 2001. Both public and private hospital surgery was included. The audit of clinical records took place during the week commencing 4 February 2002, and the reviewers met with Mr Breeze in March for a five-hour interview. The draft report was not available until May 2002, when it was sent to Mr Breeze for his comment.

The Medical Council received the reviewers' final audit report in June 2002, and the report was considered by the Professional Standards Committee on 17 July. The report concluded that there was no direct evidence of a major safety issue with Mr Breeze's surgical skills and technique or his knowledge of contemporary colorectal surgery. The reviewers did, however, have concerns about Mr Breeze's management of surgical complications. Although the reviewers concluded that the complications in themselves were not at a frequency that required him to be withdrawn from colorectal surgery (ie, his complication rate was within internationally accepted parameters), their severity and Mr Breeze's handling of some of them might indicate suboptimal practice. The reviewers recommended that Mr Breeze undergo a period of upskilling and mentoring but found no basis for his practice to be restricted other than in colorectal surgery. Mr Breeze does not accept the reviewers' conclusion that he experienced excessively severe complications or that his handling of them was suboptimal.[12]

The Medical Council considered Mr Breeze's case at a meeting on 17 July. The Council accepted the reviewers' conclusion that the severity of some of the complications and Mr Breeze's handling of them might indicate suboptimal practice. It also felt that Mr Breeze's time away from frontline colorectal surgery required that a return to full surgical practice be managed in a safe way. Accordingly, the Council resolved that Mr Breeze's practice was deficient in the area of colorectal surgery and that he should undertake an educational

[11] Mr Breeze submitted that the review provides the "most powerful evidence" about the results of his colorectal surgery. The review was one of the most comprehensive reviews ever undertaken by the Medical Council.
[12] Mr Breeze's response to the reviewers' findings is set out in Appendix 3.

programme to enable him to return to unrestricted practice, while ensuring patient safety was not compromised. Mr Breeze was informed of the Council's decision on 24 July 2002.

Between July and October the Medical Council corresponded with Mr Breeze and his lawyer about the exact requirements of the educational programme. Further advice was also obtained from Mr H and Mr N during this time.[13] The Medical Council advised the DHB that it was unable to release any information about the review until those details had been finalised. The DHB was not involved in the negotiations about Mr Breeze's re-training programme.

The requirements of the educational programme were agreed by November 2002.

On 6 November 2002 the DHB was officially advised by the Medical Council of the outcome of Mr Breeze's competence review. The DHB was advised that the Council had resolved that Mr Breeze's practice was deficient in the area of colorectal surgery, and that he was required to undertake an educational programme in order to return to unrestricted practice. The Medical Council advised:

> "Council is firmly of the view that Dr Breeze requires a period of upskilling, and that that period of upskilling must include hands on involvement for a suitable length of time so improvement may be achieved.
>
> [I]t has been agreed that Dr Breeze will undertake a four week attachment to the colorectal unit [in a city] where he will be actively involved in the clinical work undertaken. Council has approved Mr O as Dr Breeze's educational supervisor [there] During this attachment, Dr Breeze must keep a log book of work done and Mr O will be required to provide Council with a detailed assessment of his performance.
>
> Immediately following the four week attachment, Dr Breeze will be required to do one–two (preferably two) days a week in [another city] for a period of time. This period of time would be for at least three months dependent on factors such as the extent of procedures observed and performed by Dr Breeze in [the first city], whether it is one or two days each week and the recommendation of Dr Breeze's clinical supervisor, who may decide the exact duration. Council has approved Mr P to be Dr Breeze's clinical supervisor in [the second city].
>
> I enclose a copy of the proposed competence programme as it stands. As Dr Breeze's employer you will necessarily be involved in implementing the programme, assisting with supervision and resources. Therefore, I understand that you will wish

[13] Mr H advised the Medical Council that, in his view, Mr Breeze required hands-on involvement for a suitable length of time, for improvement to be achieved.

> to spend some time discussing Council's requirements with Dr Breeze and may have further suggestions."

The competence programme enclosed with the Medical Council's letter of 6 November 2002 allowed Mr Breeze to return to supervised duties in Tauranga, under the guidance of a vocationally registered colorectal surgeon, immediately following the completion of Mr Breeze's placement with Mr P in the city. The total duration of the competence programme was to be one year.

It was envisaged that the Tauranga-based supervisor would report to Mr P, who would continue to meet with Mr Breeze once a month and provide the Medical Council with bi-monthly reports on Mr Breeze's progress. The Medical Council noted that on-site supervision was necessary because of concerns that Mr Breeze's postoperative decision-making and care required close supervision. The Council expected the DHB to assist in this last part of Mr Breeze's re-training. The DHB did not respond to the Council's invitation to make suggestions about the implementation of the competence programme.

The Medical Council did not provide the DHB with a copy of the reviewers' report. However, the Council was aware from correspondence between Mr Breeze and his lawyer, dated 10 December 2001, that the DHB had received a copy of the report. The Medical Council confirmed, in a telephone conversation with Mr Breeze on 16 December 2002, that Norfolk Southern Cross would also be given a copy of the report.

3.1.5 *Completion of internal inquiry and performance review, and implementation of Council's educational programme*

Between 11 November and 6 December 2002 Mr Breeze worked in the unit of Mr O undertaking consultations and operations (elective and acute cases). Mr O reported to the Medical Council in February 2003 that Mr Breeze's technical skills were very accurate.

Immediately following his attachment in the first city with Mr O, Mr Breeze attended the Colorectal Unit in the second city for one to two days per week for the three-month period between January and March 2003, and was supervised by Mr P. Satisfactory reports to the Medical Council were provided by Mr O and Mr P. Mr P advised the Medical Council that Mr Breeze needed to move on to the next phase of his re-training – supervision of hands-on care and, in particular, postoperative decision-making.

In April 2003 it was agreed that Mr Breeze could resume his duties at Tauranga Hospital subject to appropriate supervision. Tauranga Hospital then expressed concern about its ability to provide Mr Breeze with supervision by a vocationally registered colorectal surgeon in compliance with the Medical Council's competence programme.

The Chief Executive Officer and the Registrar of the Medical Council met with the DHB's CEO on 7 April 2003 to discuss the concerns. Following that meeting Mr P advised the Medical Council that Mr Breeze had informed him that the DHB believed that the requirement for supervision by an experienced senior colorectal surgeon at Tauranga was

not practical or viable for Tauranga Hospital and meant that Mr Breeze could not perform the duties for which he was employed. Mr Breeze was concerned that the DHB's actions were in direct contravention to its undertaking on 7 November 2000 to assist him in resolving any issues that became apparent through the formal audit.

There was significant correspondence with the Medical Council about the DHB's ability to assist Mr Breeze to complete the final step of his re-training programme at Tauranga Hospital. The DHB was concerned about its ability to provide on-site supervision to the extent the Medical Council required, given the staffing arrangements at Tauranga Hospital, and that it did not have a suitable vocationally registered colorectal surgeon to supervise Mr Breeze's work. There was also concern about the total cost to the organisation and loss in productivity.

The Medical Council took the view that it was necessary for the DHB and Mr Breeze to resolve the employment issues before the competence programme could proceed. The Council therefore delayed finalising the competence programme, requesting information from the DHB in May and June 2003 but otherwise taking no action. In June 2003 the DHB advised the Medical Council that it would not provide the level of supervision to Mr Breeze that the Council required.

There was also a significant amount of correspondence between Mr Breeze and his lawyer, and the DHB and its lawyers, about the completion of Mr Breeze's performance review and his employment status.

The Medical Council attempted to facilitate a resolution of the DHB's concerns by arranging for Mr P to travel to Tauranga to provide assistance and support as a supervisor to review cases and discuss patient management with Mr Breeze. I understand that negotiations about Mr Breeze's re-training programme remained in progress at the time I commenced my inquiry in December 2003. Following the announcement of my inquiry, the DHB undertook with the Medical Council to arrange and oversee a re-training programme for Mr Breeze.

3.2 Southern Cross Hospital

3.2.1 *Concerns about Mr Breeze's practice identified*
In January 2000, following the death of Mr A, Mr Breeze agreed with Mr Q, the manager of Southern Cross Hospital, to refrain from performing bowel surgery at Southern Cross pending the result of a Southern Cross review of the case of Mr A.

On 9 February 2000, the case of Mr A was considered at a meeting of the Hospital Clinical Management Committee (HCMC).[14] Several members of the Hospital Clinical Management

[14] See Appendix 6 for an explanation on the clinical governance of Southern Cross Hospital, and the role of the two governance committees – HCMC and HARC.

Committee (HCMC) were aware that concerns had been raised about Mr Breeze's bowel surgery four years earlier, and that he had been subject to a formal review and his operating privileges had been restricted for a time. HCMC decided to refer the matter to the Hospital Audit Review Committee (HARC) for consideration, because of concerns that the complications in Mr A's case resulted from poor technique.

3.2.2 *Referral to the national body – HARC*
Mr Q referred the matter to HARC on 8 March 2000.

On 22 March 2000, concerns were raised with Mr Q by nursing staff at Southern Cross Hospital about another case involving Mr Breeze.

On 24 March 2000 HARC met. The case of Mr A was discussed, and two other cases of concern were noted. HARC recorded that it had serious concerns about the "present" situation, "against the background of Mr Breeze having had apparently a high incidence of patient complications leading to re-training and supervision and limitations to his practice some 3-4 years ago". HARC agreed to ask Mr Breeze to refrain from performing any surgery at Southern Cross Hospital Tauranga until the completion of a full review of the situation. It was noted that if Mr Breeze did not agree to restrict his practice, HARC would order a suspension of his visiting privileges. HARC considered whether RACS should be invited to conduct a full and formal investigation into the situation, and advise HARC of its "expert medical/surgical" findings and recommendations. It appears that no request was made to RACS.

3.2.3 *Independent review*
Mr Breeze met with Mr R, the Chairman of HARC, on 7 April 2000. Mr R advised Mr Breeze of HARC's concerns about the death of Mr A, and its intention to investigate the case. Mr Breeze was advised that the results of the investigation would not be handed on to Tauranga Hospital or Norfolk Hospital. Mr Breeze was asked to voluntarily stand down from surgery at Southern Cross Hospital pending the outcome of the investigation.

On 10 April Mr Breeze agreed to stand down from surgery at Southern Cross Hospital until the end of April 2000. Mr Breeze also agreed to a review of the case by Mr R and Mr E, general and colorectal surgeon. A process for the case review was agreed, whereby Mr R and Mr E would review the care provided to Mr A (including postoperative care) – the reviewers would review the relevant clinical records and interview staff, including Mr Breeze. The review was limited because the reviewers were denied access to records from Tauranga Hospital, and were unable to interview Tauranga Hospital staff.

The matter was investigated by Mr R and Mr E, and a provisional investigation report was given to Mr Breeze for comment in May 2000. Mr Breeze requested an extension of time to respond to the provisional report.

On 1 June 2000, HARC met. Mr R advised HARC that he had received telephone calls from practitioners in Tauranga who expressed their concerns about Mr Breeze's clinical

outcomes, and conveyed their support for the Southern Cross investigation. HARC decided to wait for the final investigation report before proceeding with the matter.

3.2.4 *Report considered and action taken*
Mr Breeze's response to the draft report was provided on 18 June 2000, and HARC considered the final investigation report during a meeting on 11 August. HARC also considered a request from Mr Breeze that it delay making a decision until the Coroner's Inquest was completed. HARC agreed to delay making a formal decision until such time as the Coroner's Inquest was completed and Mr Breeze had an opportunity to comment on the Coroner's findings. However, HARC requested comments from Mr Breeze prior to 1 September 2000 so that it could conclude the matter.

HARC met again on 8 September 2000. HARC had available to it some briefs of evidence from the Coroner's Inquest, the Coroner's findings, and the notice of my investigation into the case of Mr A. HARC decided that until all of the information from the Coroner's Inquest and the Commissioner's investigation was available, it was only "fair and proper" to withhold making any decision. On 19 September Mr Breeze was advised that his visiting privileges at Southern Cross Hospital remained on temporary suspension until such time as these investigations were complete.

Mr Breeze and his lawyer expressed concern about HARC's decision, given the length of time that the Commissioner's investigation could take. Accordingly, in October a decision was made, with the support of Mr Breeze and his lawyer, that HARC would conclude the matter without waiting for the Commissioner's report into the care of Mr A.

On 6 November 2000, HARC met and discussed in detail the case of Mr A. HARC was concerned that there had been a series of errors of judgement by Mr Breeze, which had implications for continuing his visiting privileges at Southern Cross Hospital, Tauranga. The Committee decided to terminate Mr Breeze's registration at Southern Cross Tauranga.

It does not appear that Southern Cross Hospital formally advised Tauranga Hospital or Norfolk Community Hospital of its decision to terminate Mr Breeze's operating privileges.

3.3 Norfolk Community Hospital

3.3.1 *Concerns at Norfolk about Mr Breeze's practice*
Norfolk Community Hospital was not involved in the case of Mr A. Accordingly, no action to address any concerns about Mr Breeze's competence following the case of Mr A was undertaken by the Medical Advisory Committee (MAC).[15] Mr Breeze continued to practise at Norfolk Community Hospital.

[15] See Appendix 6 for an explanation on the clinical governance of Norfolk Community Hospital, and the role of the MAC.

In December 2000 Mr Breeze operated on Mr S at Norfolk Community Hospital. Mr S's condition deteriorated postoperatively. He was transferred to Tauranga Hospital on 11 December, and died on 31 December.[16]

In January 2001 Mr Q, the Manager of Southern Cross Hospital, was appointed as Acting Manager of Norfolk Community Hospital, with a view to a future merger of the two hospitals. Mr Q was aware of concerns about Mr Breeze's practice in his role as Manager at Southern Cross Hospital, and raised his concerns with the Clinical Board of Norfolk Community Hospital. The Board concluded that the action taken by Southern Cross did not, in itself, constitute grounds for suspension of Mr Breeze's visiting privileges at Norfolk Community Hospital, although it did warrant close monitoring of his cases. In early 2001 the Board noted that the only Norfolk Community Hospital case of Mr Breeze's that raised potential concern was that of Mr S.

3.3.2 *Ongoing monitoring of Mr Breeze*
Throughout 2001 Mr Q continued to monitor Mr Breeze's cases, but no concerns were noted.

On 18 September 2001 I notified Norfolk Community Hospital of my investigation into the case of Mr S.

I understand that Norfolk Hospital unsuccessfully sought information from the Bay of Plenty District Health Board about the action being taken in response to concerns about Mr Breeze's practice at Tauranga Hospital, through a number of informal and confidential discussions. On 2 October 2001 Norfolk Hospital wrote to the DHB requesting confirmation regarding investigations into Mr Breeze's competence. On 5 October 2001 the DHB's solicitors advised:

> "We appreciate your concern regarding the need to ensure patient safety at Norfolk Hospital. However we suggest that in the first instance it would be more appropriate for you to direct your inquiry as to the existence or otherwise of such investigations to Mr Breeze personally. In the event that you are not satisfied with the response you receive from Mr Breeze please revert back to us."

Mr Breeze advised Norfolk Hospital that he was undergoing a Medical Council review process. There is no documentation to suggest that Norfolk sought to obtain further information directly from the DHB at that time.

Norfolk Hospital advised that in October 2001 it was approached by Mr H, appointed as competence reviewer by the Medical Council, and informally advised that Council was

[16] Mr S's family complained to my Office about the care Mr S received from Mr Breeze. An investigation was commenced on 18 September 2001. On 17 September 2002 I concluded that Mr Breeze did not breach the Code of Health and Disability Services Consumers' Rights in that case.

undertaking a review of Mr Breeze's bowel surgery. Norfolk Hospital was advised that the review would include bowel surgery undertaken in private, and Norfolk Hospital would be asked formally to cooperate with the review. Norfolk Hospital asked Mr H whether it should take any action to limit Mr Breeze's operating privileges. Mr H indicated that action to limit Mr Breeze's operating privileges would not be required and Norfolk Hospital should await the review outcome.

In December 2001, the Medical Council informed Mr Q that it was undertaking a full review of Mr Breeze's bowel surgery. Also in December 2001, Norfolk Community Hospital merged with Southern Cross Hospital. The agent company acting on behalf of the partnership is Norfolk Southern Cross Ltd. During the merger process, a decision was made to leave the existing clinical governance processes in place at each hospital until mid-2002 when a joint governance body would be established (ie, Norfolk Community Hospital procedures in place at Norfolk Hospital and Southern Cross procedures at Southern Cross Hospital). I understand this meant that while Mr Breeze's privileges at Southern Cross remained terminated, he was still able to practise at Norfolk Hospital.

Norfolk Hospital submitted that it had very limited information on which to take any action in response to concerns about Mr Breeze's competence. While Norfolk Hospital was aware that Mr Breeze had voluntarily restricted his practice in the mid-1990s, the exact nature of the issues was not known. Norfolk Hospital submitted that it could not have acted on the basis of Southern Cross Hospital's decision to suspend Mr Breeze's operating privileges alone, and the fact that Mr Breeze was under a competence review was not a sufficient reason to suspend his operating privileges. Norfolk Hospital advised that at no stage throughout the Medical Council review did it receive any indication from the Council or the reviewers that Mr Breeze should not continue with bowel surgery. Furthermore, it submitted that it is not feasible to suspend every doctor under investigation or review unless there is a clear risk to be avoided in the meantime which cannot be managed by a less drastic form of intervention. Without accurate information about what had occurred at other organisations, Norfolk Hospital believed that it could only monitor Mr Breeze closely, and measures were put in place to do that at both a management and clinical level. Those measures included advising senior nursing staff and anaesthetists who worked with Mr Breeze to promptly report any concerns.

Throughout 2002 informal and confidential discussions between Norfolk Hospital and the DHB continued.

Mr Breeze's status was discussed at the Norfolk Southern Cross Board meeting in February 2002. It was agreed to seek a legal opinion on how to respond to the matter; in particular, whether steps could be taken to inquire into Mr Breeze's practice (to decide whether his privileges should continue) and, if so, under which clinical governance procedure Mr Breeze's practice could be reviewed, in light of the recent merger. Following receipt of the advice, it was determined that inquiries should be made into Mr Breeze's practice, and the fairest method for doing so was under the system employed by Norfolk Hospital.

On 18 March 2002 Mr Breeze applied for a renewal of his practising rights at Norfolk Hospital. In his application he disclosed that his clinical practice was under investigation.

On 17 April 2002 patient E (in the terms of reference to my inquiry) was operated on by Mr Breeze at Norfolk Hospital, and suffered complications resulting in her transfer to Tauranga Public Hospital. On 1 May 2002 Mr Breeze operated on another patient (patient Y, who is not covered by my inquiry's terms of reference) who also suffered postoperative complications. The two cases led to concerns being raised by management about Mr Breeze's practice.

On 2 May 2002 the Theatre Manager wrote to Mr Q voicing concerns on behalf of all nursing staff at Norfolk Hospital regarding the number of Mr Breeze's cases that became complex during the procedure and required additional nursing care. Specifically, the cases of patient E and patient Y were mentioned.

3.3.3 *Response to concerns*
Norfolk Southern Cross submitted that on 1 May 2002 it had clear evidence to suggest that Mr Breeze might not be competent in the area of colorectal surgery, at which point it immediately acted to restrict Mr Breeze's operating activities at Norfolk Hospital.

The Norfolk Southern Cross Board met on 2 May 2002, and considered Mr Breeze's application for renewal of operating privileges. As well as the two cases of concern, the Board was aware of the review of Mr Breeze's competence by the Medical Council. The Board was concerned about patient safety, and resolved that it would ask Mr Breeze not to undertake any intra-abdominal surgery until after the Medical Council's report was received and an independent report on his laparoscopic surgery was completed.

On 7 May 2002 the Chairman of the MAC, wrote to Mr Breeze and asked him to voluntarily restrict his practice to exclude intra-abdominal surgery while the Board further inquired into concerns regarding patient E and patient Y, and awaited the outcome of the Medical Council's competence review. The Chairman advised Mr Breeze:

> "These events raise concerns for patient safety. In the interests of patient safety, the MAC requests that, while we complete our enquiries, you restrict your surgical practice to exclude any intra-abdominal surgery."

The Board met on 14 May 2002, at which time there was further discussion about Mr Breeze. It was agreed that if Mr Breeze did not voluntarily restrict his activity, he would need to be suspended. At the meeting, Mr Q tabled a brief review of Mr Breeze's last two years of intra-abdominal cases at the hospital. It was noted that there had been 15 gallbladder cases, five of which had to be transferred (to Tauranga Public Hospital) and, of five bowel cases, two had to be transferred, and one patient subsequently died (Mr S).

Mr Breeze declined to restrict his practice voluntarily. He was concerned that he had not been given an opportunity to respond to the Board's concerns about particular cases, or an

opportunity to raise his concerns about the impact of systemic problems at Norfolk Hospital on the cases identified.

On 31 May the MAC Chairman again asked Mr Breeze to voluntarily restrict his practice while the Board investigated the matter. He was advised that his concerns would be addressed during the course of the investigation. The MAC Chairman recommended a meeting to agree to a procedure on how to move forward.

In May 2002, following the Medical Council's in-depth competence review and the resulting restrictions placed on his practice, Mr Breeze stopped performing bowel surgery at Norfolk Hospital.

A reconstituted Medical Advisory Committee (MAC) replaced the existing committees of Norfolk Hospital and Southern Cross Hospital in June 2002. On 26 June 2002 the MAC summarily suspended Mr Breeze's privileges to perform intra-abdominal surgery at Norfolk Hospital until such time as all issues about his intra-abdominal surgical practice were investigated in full. The MAC felt that it would be "unreasonably risky to patients", Mr Breeze, and Norfolk Southern Cross if Mr Breeze were allowed to continue practising intra-abdominal surgery at that time. The reasons for the suspension were noted as:

(a) "The fact that there is a Medical Council competence review, the result of which is as yet unknown".[17]

(b) The circumstances of the case of Mr A – the merger of the two hospitals meant that the information held by Southern Cross about that case became the property of the new company, and therefore the MAC was aware of the circumstances surrounding Southern Cross's termination of Mr Breeze's visiting privileges. The MAC was also aware of my breach finding in the case of Mr A.

(c) The two cases referred to the MAC for consideration – patient E and patient Y.

(d) The Health and Disability Commissioner had commenced an investigation into the care Mr Breeze provided to Mr S.[18]

(e) The Bay of Plenty District Health Board's restriction on Mr Breeze's scope of practice to exclude intra-abdominal and other major surgery.

[17] Letter to Mr Breeze from the Chairman of the MAC of Norfolk Southern Cross Hospital, dated 26 June 2002. The Medical Council advised that its records show that on 17 January 2002 Norfolk Hospital was advised that a more detailed review was being undertaken. The Council noted that while it is correct that formal notification of the outcome of the review occurred on 17 December 2002, it was unable to locate any written requests for a copy of the review findings, except in a letter dated 5 November 2002.

[18] On 17 September 2002 I found that Mr Breeze did not breach the Code in respect of the care he provided to Mr S. The file was closed.

(f) Mr Breeze's unwillingness to reach an informal agreement in the interim.

The MAC advised Mr Breeze that it was doubtful that low patient numbers and working in isolation (Mr Breeze's practice was restricted at the two other Tauranga hospitals where he had performed surgery in the past) presented a safe option for patients. Mr Breeze was advised that the total picture led the MAC to advise the Norfolk Southern Cross Board to offer Mr Breeze restricted privileges only, specifically excluding intra-abdominal surgery and laparoscopic surgery. The restriction was to remain in place pending a full review of the situation.

In its response to my investigation, Norfolk Southern Cross Ltd advised me that it considered the "major factor" that prevented an earlier restriction or suspension of Mr Breeze was the lack of information received from other organisations. Norfolk Southern Cross Ltd submitted that it would be inconsistent to find it liable for "not acting on very poor information" when other organisations are not liable for failing to pass on important information that would have helped it make its decision. Norfolk Southern Cross Ltd stated, "If any party held information about the competence of a surgeon and withheld that information from other parties where the same surgeon was operating, then that party would be placing privacy issues above issues of patient safety."[19]

Following the MAC's decision, there was significant correspondence between Mr Breeze's lawyer and Norfolk Southern Cross relating to the decision to suspend Mr Breeze's privileges, and Mr Breeze's intention to appeal the decision.

The result of the correspondence was that Mr Breeze withdrew his appeal in September 2002, and a meeting was held between the MAC and Mr Breeze on 17 October 2002. The reasons for the decision to restrict his practice were discussed, and Mr Breeze was advised that the intra-abdominal restrictions would remain in place pending:

(a) his completion of the requirements of the Medical Council's re-training programme, and the Council's lifting of the colorectal restriction on his practice; and

[19] Norfolk Southern Cross Ltd also expressed concern that the Health Practitioners Competence Assurance Act 2003 (HPCA) limits the substantive information available to private hospitals about the competence of doctors. Section 35(1) of the HPCA requires a responsible authority (in this case, the Medical Council) that has reason to believe that the practice of a health practitioner may pose a risk of harm to the public to give written notice to "any person who, to the knowledge of the authority, is the employer of the health practitioner". A private hospital is not an "employer" of a health practitioner, and therefore the responsible authority is not legally bound to provide written notice that it believes a health practitioner practising on its premises may pose a risk of harm to the public. I note that although s 35(1) does not "require" the Medical Council to inform a private hospital, s 35(2) gives the Medical Council the authority to do so. Norfolk Southern Cross Ltd submitted that the Medical Council and the Health and Disability Commissioner should inform each provider where the practitioner works, irrespective of the nature of the relationship, of any concerns about a practitioner's competence. Norfolk Southern Cross Ltd also noted that similarly, a private hospital is not required under s 34(3) of the HPCA to notify the Medical Council if a medical practitioner ceases to practise at a private hospital for reasons relating to competence.

(b) an independent review of his laparoscopic surgery by Mr T, a general surgeon from another city.

On 17 December 2002 the Medical Council formally advised Mr Q in writing of the outcome of Mr Breeze's competence review, and the proposed re-training programme.

3.3.4 *Independent review of laparoscopic surgery*
Mr T's review of Mr Breeze's laparoscopic surgery took place in January 2003. The review covered a substantial number of cases[20] over the previous five years of Mr Breeze's private laparoscopic surgery. In the course of his investigation, Mr T interviewed two anaesthetists who worked closely with Mr Breeze, and two theatre charge nurses.

The final report, dated 17 April 2003, concluded:

(a) There were minor concerns. In particular, Mr T advised, "Over the last year there were more incidental or small glitches than I would normally expect." However, he concluded that Mr Breeze's laparoscopic surgery did not pose a heightened risk to patient safety.

(b) The overall complication rate was comparable to published data.

In light of the period of suspension, Mr T recommended that Mr Breeze's first four surgical cases be supervised: "If there were technical issues they would be readily apparent and should be addressed at this time."

3.3.5 *Consideration of the review report and action taken*
The MAC considered the report in April 2003 and lifted the restriction on Mr Breeze undertaking laparoscopic surgery, conditional on the requirement that he have a surgical colleague in theatre with him to mentor him and provide support. It was agreed that Mr L would be Mr Breeze's mentor, and Mr Breeze would require monitoring for his first four cases.

On 12 February 2004 Mr L provided Norfolk Southern Cross Ltd with a report on his observations during his supervision of Mr Breeze's four cases. Mr L noted:

> "My presence was throughout the operating time, and I have found Mr Breeze's technique satisfactory, and his techniques would be used by most of the surgeons doing laparoscopic cholecystectomy. There were no untoward events during these procedures."

In December 2003, following the public concerns raised about Mr Breeze's competence subsequent to the Medical Practitioners Disciplinary Tribunal's finding of 'professional

[20] Sixty-six cholecystectomies, nine appendicectomies, eight Nissen fundoplications, six divisions of adhesions, and two laparoscopies.

misconduct' in the case of Mr A,[21] the MAC resolved to suspend all Mr Breeze's visiting privileges at Norfolk and Southern Cross Hospitals, pending my review of the matter and the final decision of the Medical Council. Mr Breeze was advised of that decision on 4 December 2003. It was noted that while public concern in itself was insufficient to limit a practitioner's visiting privileges, it did indicate a level of discomfort and concern that could not be ignored by the MAC.

4. Communication between the public and private hospitals – co-ordination of the response to concerns about Mr Breeze's competence

It appears that there was no formal consultation or communication between Tauranga Hospital, Norfolk Community Hospital, and Southern Cross Hospital, in relation to the early concerns about Mr Breeze's practice (1994 to 1996), and the management of those concerns. Southern Cross Hospital was informally advised of the concerns, but because of a lack of information was unable to take any further action on them. As noted by Norfolk Southern Cross, it was aware that Mr Breeze had voluntarily restricted his practice in the mid-1990s, but the exact nature of the issues was not known.

After Mr A's death in December 1999, all three hospitals became aware of concerns, and independent processes were instigated at each hospital to manage the concerns. Although there was some correspondence between the three hospitals about the matter, there appears to have been no formal communication or consultation between the hospitals about the review processes and status of Mr Breeze's practice and practising rights. While each hospital was clearly interested in what the other was doing in response to the concerns, to assist with their own processes, they felt constrained from disclosing information to each other because of privacy issues. Accordingly, each hospital worked in isolation to address the concerns about Mr Breeze's practice, which resulted in duplicate processes, inconsistency in decision-making, and lengthy resolution. The information gathered relating to formal communications includes:

- A letter dated 2 October 2001 from the Chairman of the Board of Directors at Norfolk Hospital requesting information from the DHB; in particular, requesting confirmation whether the DHB was investigating Mr Breeze and if it had placed any restrictions on his practice. The letter stated:

> "It has been brought to the attention of the Board of Directors of Norfolk Hospital that Ian Breeze is under investigation by various external authorities as well as the DHB with regard to his competence in certain areas of clinical practice.
>
> As the governing body of Norfolk Hospital, we are concerned to maintain standards and ensure ongoing patient safety and to this end we would be grateful if you would

[21] The Medical Practitioners Disciplinary Tribunal's decision is available at: www.mpdt.org.nz.

confirm or otherwise that such an investigation is underway and also indicate whether any restrictions have been placed on Mr Breeze's clinical practice.

On receiving confirmation from the District Health Board we feel we would have sufficient grounds to approach Mr Breeze and discuss the nature of his ongoing practice at Norfolk Hospital until the issue is resolved.

I know this is a difficult matter, but in the end patient safety is paramount."

- On 5 October 2001, the DHB's lawyers responded to the Chairman's letter of 2 October. The responses stated:

  "We appreciate your concern regarding the need to ensure patient safety at Norfolk Hospital. However we suggest that in the first instance it would be more appropriate for you to direct your inquiry as to the existence or otherwise of such investigations to Mr Breeze personally. In the event that you are not satisfied with the response you receive from Mr Breeze please revert back to us."

- At a Norfolk Southern Cross Board meeting at Norfolk Hospital on 14 May 2002, concern was noted about "the lack of direction from [the DHB] on the flow/reciprocation of information on the Breeze and other issues".

- On 24 May 2002 the Chairman of the MAC of Norfolk Southern Cross Ltd wrote to the Chief Medical Director at the DHB. The letter stated:

  "I mentioned to you recently that the Medical Advisory Committee at the Grace Road Hospital of Norfolk Southern Cross Limited ('NSX') had been talking to Ian Breeze concerning his operations there. You indicated that NSX must keep you informed of developments.

  With respect, we are constrained by Privacy legislation at present from sharing any specifics with you. Your senior management appears to have been similarly constrained when our Chairman made enquiries regarding their treatment of the same practitioner last year. They had their Solicitors respond in a guarded and uninformative manner.

  As stated to you previously, the NSX [Norfolk Southern Cross] Board is very willing to consider joining any BOPDHB-wide initiative to review the practising rights of health professionals so long as there are suitable statutory indemnities available to our directors for sharing information about the personal and private business of those practitioners."

In response to my investigation, Norfolk Southern Cross Ltd submitted that this case highlights the need for one body to take a lead role in the assessment and certification of medical practitioners' competence. In this case there were five entities considering Mr

Breeze's practice (the DHB, Southern Cross Hospital, Norfolk Hospital, the Medical Council and my Office). Norfolk Southern Cross Ltd submitted that the events may have been different if one agency had had overall responsibility in assessing competence and had shared the information with all organisations dealing with the matter.

Norfolk Southern Cross Ltd advised me that, following discussions with the DHB throughout 2002, both parties recognised the need to have a formalised mechanism for sharing information, and a "memorandum of understanding" was drafted. The process took some time as issues around confidentiality and the different employment relationships with public and private hospitals were explored. Accordingly, since 2002, the DHB and Norfolk Southern Cross Ltd have developed better information sharing processes, particularly in relation to credentialling.

Relevant law

A hospital employing surgeons has an obligation to maintain and monitor their competence, to protect patients. This duty is recognised by statute and the common law.

Section 11(3) of the Health and Disability Services Act 1993 provided that it was an objective of every hospital and health service to exhibit a sense of social responsibility by having regard to the interests of the community in which it operates (section 11(3)(a)), and to uphold the ethical and quality standards generally expected of providers of health or disability services (section 11(3)(b)). The Health and Disability Services Act 1993 was repealed from 1 January 2001, and replaced by the New Zealand Public Health and Disability Act 2000 (the NZPHDA), which established District Health Boards. Section 23(1)(i) of the NZPHDA provides that for the purpose of pursuing its objectives, each District Health Board must, as one of its functions, monitor the delivery and performance of services by it and by persons engaged by it to provide or arrange for the provision of services. The NZPHDA also provides that it is an objective of every District Health Board to improve, promote, and protect the health of people and communities (section 22(1)(a)), to exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of, services (section 22(1)(g)), and to uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations (section 22(1)(i)).

Both public and private hospitals are also subject to the duties imposed on health care providers by the Code of Health and Disability Services Consumers' Rights, in particular, the duty to provide services with "reasonable care and skill" (Right 4(1)). The organisational duty of care and skill of a public hospital has been considered in several major Health and Disability Commissioner reports, including *Southland District Health Board*

Mental Health Services February–March 2001,[22] *Canterbury Health Ltd 1998*,[23] and in case 03HDC05563.[24]

The duty on hospitals to ensure practitioners are competent to practise and to protect patients is also recognised in common law (see *Roylance v General Medical Council* [1999] 3 WLR 541). As stated by the Privy Council in the *Roylance* decision, "The care, treatment and safety of the patient must be the principal concern of everyone engaged in the hospital service."[25]

Similar comments were made in *The Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984–1995*:[26]

> "Placing the safety of patients at the centre of the hospital's agenda is *the* crucial first step towards creating and fostering a culture of safety. This means that safety must be *everyone's* concern, not just that of the consultant, or the nurse in charge. …The safety of patients, the safety of their clinical care, is a matter for everyone, from the trust boardroom to the ward assistants. Safety requires leadership from the highest level of management. It requires constant vigilance. It should be considered in everything that the organization does. It is not a short term project but a commitment for 365 days a year. A culture of safety can only really be created when a concern for patients' safety is embedded at every level of the organization."

The Australian Capital Territory's Community and Health Services Complaints Commissioner *Final Report of the Investigation into Adverse Patient Outcomes of Neurosurgical Services Provided by the Canberra Hospital* (February 2003) considered the responsibilities of hospital management to ensure that an appropriate standard of practice is maintained by health professionals practising in the hospital. The report emphasizes the need to monitor and maintain information, standards, policy, practices, procedures and to have systems in operation to identify adverse outcomes. Reporting systems should be in place to ensure that:

- health professionals with concerns about the standard of a colleague's practice or clinical competence are able to report their concerns; and

- concerns are acted on in a timely fashion.

The report also identifies the need for routine collection of information that is sufficiently comprehensive to allow effective peer review of clinical standards.

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[22] Available on the Commissioner's website: www.hdc.org.nz.
[23] Also available on the Commissioner's website.
[24] This report is not yet on the Commissioner's website, pending completion of the Director of Proceedings' processes.
[25] [1999] 3 WLR 541, 559.
[26] Available at: http://www.bristol-inquiry.org.uk

Opinion: Breach – Tauranga Hospital

My inquiry into Tauranga Hospital[27] seeks to determine whether Tauranga Hospital took adequate steps to respond to any concerns about Mr Breeze's practice and to ensure that Mr Breeze was competent to practise surgery. As noted above, a hospital employing surgeons has an obligation to maintain and monitor their competence, to protect patients. In my view, Tauranga Hospital failed to meet that obligation and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code), for the reasons set out below.

History of concerns

Within Tauranga Hospital there is a history of concerns about Mr Breeze's surgical practice – in particular, his colorectal and abdominal cases. The documentation indicates that since 1994 the following concerns about Mr Breeze's practice have been noted:

- that Mr Breeze has a high number of postoperative complications and mortality in his surgical patients;
- about Mr Breeze's overall management of his post-surgical complications and poor decision-making; and
- that Mr Breeze does not seek appropriate and timely advice from colleagues, or routinely discuss difficult cases with colleagues.

The concerns were raised with management (the Medical Advisor, and the Chief Executive Officer) by Mr Breeze's colleagues (radiologists, intensivists, general surgeons and nurses) in 1994 and 1995, and again following the death of Mr A in December 1999. It is commendable that Mr Breeze's colleagues were prepared to voice their concerns to management – clinicians have an ethical duty to act in such situations.

Concerns were also documented by the two independent reviewers who audited Mr Breeze's practice in 1994 and 1995, Mr F and Mr I respectively, and by the reviewers who audited Mr Breeze's practice as part of his competence review by the Medical Council in 2001 and 2002.

[27] The reference to "Tauranga Hospital" is used generically throughout this opinion, and includes Western Bay Health, Pacific Health, and Bay of Plenty District Health Board, as the three bodies responsible for Tauranga Hospital over the period from 1994 to the present. The Bay of Plenty District Health Board was notified of my investigation as the current body responsible for the management of Tauranga Hospital.

Names (other than Mr Breeze, Tauranga Hospital, Norfolk Community Hospital, Southern Cross Hospital, the Medical Council, and the Royal Australasian College of Surgeons) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Corporate response

Failure to monitor Mr Breeze between 1 July 1996 and December 1999 and respond appropriately

The Commissioner's jurisdiction to investigate matters under the Health and Disability Commissioner Act 1994 (the Act) and the Code is limited to actions[28] occurring after 1 July 1996.[29] However, relevant events occurring prior to 1 July 1996 may be investigated and taken into account in deciding whether there has been a breach of the Code after 1 July 1996 (*Nicholls v Health and Disability Commissioner* [1997] NZAR 351).

The action taken by Tauranga Hospital in response to concerns about Mr Breeze's competence in 1994 and 1995 is relevant to an assessment of whether Tauranga Hospital took appropriate steps to monitor Mr Breeze's competence from 1 July 1996 to December 1999 (when Mr A died).

The evidence indicates that there was an inadequate response by Tauranga Hospital to manage and monitor the concerns about Mr Breeze's surgical practice in 1994 and 1995. In particular:

1. When concerns about Mr Breeze's surgical practice were raised with Dr C and Mr B, in June 1994, Tauranga Hospital immediately took the appropriate first step to address those concerns – a meeting was held with Mr Breeze on 23 June 1994 to discuss the concerns. It was agreed that Mr Breeze would arrange a period of review, discussion, contact and teaching with the Department of Surgery at the first public hospital and would endeavour to make a similar arrangement in Australia; that he would endeavour to consult more with his colleagues when he encountered complications; and that an independent audit would be undertaken of his abdominal surgery over the previous 12 months.

   Following an independent audit of 150 of Mr Breeze's public surgical cases, Mr F made further recommendations to Tauranga Hospital to address what he identified as an excessive number of problems associated with abdominal sepsis and anastomotic breakdown in Mr Breeze's rectal surgery cases. Mr F recommended that steps be taken at a systemic level – that two senior colleagues should work together on difficult cases to assist with skill and provide "wise judgement", and regular audit review between teams on a monthly basis was desirable.

[28] "Action" is defined in section 2 of the Health and Disability Commissioner Act 1994 to include any failure to act, and any policy or practice.

[29] The Health and Disability Commissioner Amendment Act 2003, which came into force on 18 September 2004, permits the Commissioner to investigate any action of a health practitioner that was taken at any time before 1 July 1996, if it appears that the action affected a health consumer and was, at the time that it was taken, a ground for bringing disciplinary proceedings against the health practitioner under a former health registration enactment (s 40(2)). However, as this inquiry was commenced prior to 18 September 2004 I have proceeded on the basis that events occurring prior to 1 July 1996 are simply relevant background.

There is no documented evidence of a process to oversee and monitor the implementation of the agreements made at the meeting on 23 June or the recommendations made by Mr F. This is despite the fact that both Dr C and Mr F identified that there needed to be ongoing consideration of the concerns about Mr Breeze's practice.

The outcome of the 23 June meeting and the audit review was that Mr Breeze spent one day at the first public hospital with Dr G in October 1994, where he observed Dr G performing surgery, and discussed the technicalities of the procedures undertaken. No further action was taken. Tauranga Hospital took no further steps to satisfy itself that Mr Breeze was competent to practise surgery and did not pose an ongoing risk to patients. An effective audit review system was not implemented.

2. Further concerns about Mr Breeze's practice were raised less than a year later – in April 1995 by two surgical ward sisters, and in July 1995 by Mr B (on the advice of a senior anaesthetist and a radiologist). Again, Tauranga Hospital took the appropriate first step in response to those concerns – Mr Breeze was restricted from performing abdominal surgery except with the assistance of a colleague, pending the outcome of a thorough external audit of Mr Breeze's surgical cases.

   Mr I conducted the audit and concluded that there was a continuing problem with Mr Breeze's surgical management of acute colorectal cases. Mr I noted, "These problems have now existed for two years and the suggestion as to retraining in colo-rectal surgery, and reorganisation of the surgical department have not occurred … I think a dangerous situation has arisen here."

   Mr Breeze disputed Mr I's findings and the accuracy of the information relied upon in the review. A further "in-house" review under the oversight of the Royal Australasian College of Surgeons took place in an attempt to reach a solution. A stalemate was reached – Tauranga Hospital remained concerned about Mr Breeze's surgical outcomes, and Mr Breeze denied there was a problem. In December 1995 the parties agreed that Mr Breeze could resume surgical duties at Tauranga Hospital with the following provisos: all abdominal surgical lists performed by the Tauranga Hospital surgical team were to be audited by the Royal Australasian College of Surgeons for the following 12 months; one half-day per month was to be devoted to audit and CME (continuing medical education) matters within the Division of Surgery; Mr Breeze was required to discuss problem cases and those of a contentious nature with his colleagues; a surgical mentor was to be arranged for Mr Breeze with respect to abdominal surgery and colorectal surgery; and Mr Breeze was to attend surgical technical workshops, as necessary.

   As in 1994, there is no documented evidence of a process for overseeing Mr Breeze's compliance with the agreed action plan, or monitoring that the recommendations were implemented. There is no evidence that any of the proposed actions took place.

Not only did Tauranga Hospital lack a process for implementing and overseeing the agreed action plans in 1994 and 1995, but there was also no internal clarity about who would deal with the issues.

It was suggested that it was envisaged the matter would be managed within the Surgical Department, under the oversight of the Clinical Director of Surgery with the collegial assistance of other members of the surgical team. The position of Clinical Director of Surgery at Tauranga Hospital in 1994 and 1995 was undertaken by a busy surgeon in a part-time role with a high surgical load. There was no established clinical director's role that allowed time for the oversight and monitoring of the agreed action plan. In my view, it was a responsibility of the hospital management team, and ultimately of the CEO, to ensure the proposed action plans were implemented. It was not appropriate to leave the matter in the hands of an overworked surgeon/clinical director, with no further assistance, oversight or monitoring from the hospital management team and the CEO.

The lack of corporate response in 1994 and 1995 meant that by early 1996 a serious situation had developed. Tauranga Hospital allowed a surgeon about whose competence it had concerns to continue practising without taking adequate steps to ensure that those concerns were appropriately addressed (for example, through Mr Breeze's completion of an educational/re-training programme, or appropriate and ongoing oversight). While an audit system was in place in the surgical department, it appears that there were administrative constraints to it being an effective system.

Tauranga Hospital had a responsibility to ensure there was ongoing monitoring of Mr Breeze's practice, to satisfy itself that Mr Breeze did not pose an ongoing risk to patient safety. Tauranga Hospital failed to fulfil its responsibility. There is no record of ongoing monitoring, review, or reassessment of Mr Breeze's clinical competence from December 1995. In the absence of an effective procedure for monitoring the review process from beginning to end, it was only a matter of time before concerns resurfaced – which they did in December 1999 when Mr A died following bowel surgery by Mr Breeze.

In my opinion, Tauranga Hospital breached Right 4(1) of the Code in failing to have a system in place to monitor Mr Breeze's practice effectively and respond appropriately to competence concerns between 1 July 1996 and December 1999.

When concerns about a surgeon's competence are raised, the surgeon's employer (ultimately the CEO) must ensure that patient safety is the paramount consideration, and that someone takes responsibility for addressing the concerns. As noted in the employment context by Judge Finnigan in *Air New Zealand Ltd v Samu* [1994] 1 ERNZ 93, 95, "[W]here safety is genuinely involved in the operations of an employer it is not just another ingredient in the mix, another factor to be taken into account. Safety issues have a status of

their own."[30] What is true for the safety of air travel (with which parallels are often drawn by quality experts in the medical profession) is equally true of patient safety in hospitals.

Hospitals must have in place a clear mechanism for dealing decisively with concerns about an employee's competence. Although employees are entitled to be treated fairly, hospitals cannot allow patient safety to be jeopardized while employees and their lawyers squabble about their legal rights. The situation posed by Mr Breeze was complex, and it appears that Tauranga Hospital ran out of ideas for managing the situation in the face of substantial resistance from Mr Breeze and his lawyer. As noted by Mr B, "Frankly, none of us as individuals knew how to handle the situation other than to try and be as responsible as we could."

Delay in responding to concerns about Mr Breeze's competence in December 1999
On 21 December 1999 Mr A died at Tauranga Hospital following bowel surgery performed by Mr Breeze at Southern Cross Hospital. Following Mr A's death, concerns about Mr Breeze's competence resurfaced. In late December 1999 and early 2000 there were a number of meetings at Tauranga Hospital to discuss the clinical aspects of Mr A's case.

On 14 February 2000, in response to concerns about Mr Breeze's treatment of Mr A, Tauranga Hospital considered suspending Mr Breeze from performing colorectal procedures. The documentation indicates that on 14 July 2000 Tauranga Hospital asked Mr Breeze to step down from all colorectal surgery pending the Coroner's Inquest into the death of Mr A and the Southern Cross investigation. The exact nature of the restrictions placed on Mr Breeze's practice by Tauranga Hospital is unclear. Mr Breeze advised me that he was not suspended from colorectal procedures on 14 February 2000, and continued to undertake his normal range of surgery, including bowel surgery, until September 2001.

On 18 August 2000 the CEO and the Clinical Directors discussed whether to refer Mr Breeze to the Medical Council for a competence review. However, the referral was not actioned until 17 November 2000, 11 months after the death of Mr A. It is unclear whether Mr Breeze's practice was restricted following the referral for competence review.[31]

In my view, if a hospital has (or, in light of the information available to it, should have) reason to believe that a clinician may pose a risk of harm to patients, it has a duty to respond immediately to minimise the risk. This may include placing appropriate conditions on the clinician's practice pending further enquiries. The decision to limit a clinician's practice may be based on a pattern or a single incident of substandard care. It will always be a matter of judgement when that threshold has been reached, and what action is appropriate

[30] The decision was affirmed by the Court of Appeal in *Samu v Air New Zealand Ltd* [1995] 1 ERNZ 636.
[31] In January 2001 Mr Breeze informed the Medical Council that he continued to perform colorectal surgery, but had agreed to discuss each case with a colleague first, and to have a low threshold for seeking a colleague's collaboration at any hint of a problem. On 9 May 2001 the Chief Executive Officer of the Bay of Plenty District Health Board noted that Mr Breeze continued to consult with a senior before considering colorectal surgery, and his procedures were overseen.

to protect the health and safety of the public. The interests of patients and clinicians will be better served if issues relating to competence are dealt with firmly and fairly in the workplace, before they escalate, patients (and the clinician's reputation) are harmed, and external agencies become involved.

In this case, serious concerns about Mr Breeze's competence to practise surgery were raised immediately following the death of Mr A, and arose in the context of a background of concerns about Mr Breeze's surgical competence, dating back to 1994. In my view, by late December 1999 Tauranga Hospital clearly had reason to believe that Mr Breeze posed a risk of harm to patients, and therefore had a duty to respond immediately to minimise that risk. Although Tauranga Hospital did take steps to restrict Mr Breeze's practice, restrictions were not put into place immediately. The documentation indicates that restrictions on Mr Breeze's low colorectal procedures were discussed in February 2000. However, it appears that the suspension may not have been actioned until September 2001. It is concerning that there is no clear and consistent record of the restrictions placed on Mr Breeze's practice. It was also unreasonable for Tauranga Hospital to wait 11 months before consulting and involving an outside agency (the Medical Council) in this matter. Employers have an ethical duty to report any concerns about a doctor's competence to the Medical Council.[32]

While fairness and collegial support are important factors when dealing with concerns about a surgeon's competence, patient safety must come first. The delay in taking active steps to respond to the concerns about Mr Breeze's competence put patient safety at risk. In late December 1999, Tauranga Hospital had a responsibility to the public to respond to the serious concerns about Mr Breeze's competence in a decisive and timely manner. Tauranga Hospital failed to respond appropriately, and therefore breached Right 4(1) of the Code.

I appreciate that the DHB had to grapple with a difficult and complex set of circumstances over a lengthy period in responding to the concerns about Mr Breeze's competence. The concerns were denied and challenged vigorously by Mr Breeze, and there were no clear guidelines about how to handle such a situation.

Despite the delay in its initial response, Tauranga Hospital made a number of responsible and appropriate decisions following the decision to restrict Mr Breeze's practice pending further inquiries (including the Medical Council review). For example, the restriction on Mr Breeze's practice was regularly reviewed, the DHB regularly contacted the Medical Council and expressed its concern and dissatisfaction with the time taken to resolve the matter, and the DHB also sought advice from outside agencies, including the Chief Medical Advisor at the Ministry of Health.

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[32] Medical Council of New Zealand *Employer Guidelines for Health Providers* (April 2002). In my view, although the Medical Council *Guidelines* post-date these events, the ethical duty existed prior to its affirmation by the Council. I note also that s 34(3) of the Health Practitioners Competence Assurance Act 2003 imposes a duty on employers to report resignations or dismissals of health practitioners for reasons relating to competence to the relevant registration authority.

The fact that the Medical Council is undertaking or has completed a competence review, or imposed a competence programme, does not detract from an employer's obligation to ensure that a clinician is providing services of a safe and appropriate standard to patients. The employer's obligation to assess its employee's performance under the employment contract exists independently of the Medical Council competence review process. The DHB appeared to be aware of this obligation when it commenced a concurrent internal inquiry to assess the appropriate steps to address Mr Breeze's well-being, patient safety, and the organisation's fulfilment of its responsibilities to the public. It sought legal advice regarding Mr Breeze's employment status. As a result, a formal performance review was commenced in accordance with the provisions in Mr Breeze's contract.

I also note that following these events, the DHB has taken steps to develop a clinical quality culture. In particular, in April 2002 it implemented a Senior Medical Officer credentialling programme, and has reached a verbal agreement with Norfolk Southern Cross Ltd to share credentialling information. I acknowledge and commend the DHB's efforts.

Other comment – Tauranga Hospital

Duty of employers to assist with implementation of competence programmes prescribed by Medical Council

On 6 November 2002 the Medical Council wrote to the DHB, advising it of the outcome of Mr Breeze's competence review. The DHB was advised that the Council had resolved that Mr Breeze's practice was deficient in the area of colorectal surgery, and that he was required to undertake an educational programme in order to return to unrestricted practice. The details of the educational programme were described in an enclosure to the Council's letter.

The competence programme included:

- an initial four-week attachment to the colorectal unit under the guidance of Mr O;
- a three-month period working two days a week in the city under the guidance and supervision of Mr P;
- a final period working in Tauranga under the guidance of a vocationally registered colorectal surgeon to bring the total duration of the competence programme to one year.

The Medical Council advised the DHB:

> "As Dr Breeze's employer you will necessarily be involved in implementing the programme, assisting with supervision and resources. Therefore, I understand that

> you will wish to spend some time discussing Council's requirements with Dr Breeze and may have further suggestions."

Between 11 November and 6 December 2002 Mr Breeze worked in the unit of Mr O at a city hospital. Immediately following the attachment with Mr O, Mr Breeze attended the Colorectal Unit in another city for one to two days per week for the three-month period between January and March 2003, and was supervised there by Mr P.

In April 2003 the Medical Council agreed that Mr Breeze could resume his duties at Tauranga Hospital subject to appropriate supervision. Tauranga Hospital then expressed concern about its ability to provide Mr Breeze with supervision by a vocationally registered colorectal surgeon in compliance with the Medical Council's competence programme. There followed extensive negotiations between Tauranga Hospital and the Medical Council about the ability to provide Mr Breeze with the supervision that the Council believed was necessary. Ultimately, in June 2003, the DHB advised the Council that it would not provide Mr Breeze with the supervision required.

The delay on Tauranga Hospital's part in raising concerns about its ability to provide Mr Breeze with the supervision of a vocationally registered colorectal surgeon, so that he could complete his competence programme, was unfortunate. The relevant concerns should have been raised as soon as this component of the competence programme was put forward by the Medical Council on 6 November 2002.

Tauranga Hospital's delay had significant consequences in terms of Mr Breeze's ability to complete the competence programme and return to full duties. Tauranga Hospital itself recognises that the longer a doctor's practice is restricted, the greater the potential loss of knowledge and skills and potential difficulty in re-training. The delay also left Mr Breeze professionally isolated and under considerable stress because of the uncertainty of his position.

In my view, there is an obligation for an employer such as a District Health Board to provide a reasonable level of assistance in implementing competence programmes for doctors in its employment. The successful implementation of a competence programme may depend on the willingness of the doctor's employer to provide the practical support to enable the doctor to complete the programme.

Clearly the Medical Council should consult with an employer before finalising a competence programme to ensure that the proposed programme is achievable in a practical sense, but the Council should receive cooperation from employers. If, because of resource constraints, the employer is genuinely unable to provide the necessary support, it should nevertheless cooperate with the Council and facilitate other steps (eg, leave to allow further re-training) to remedy the skill deficiencies.

In summary, while the Medical Council should work collaboratively with employers in formulating competence programmes to ensure that they are able to be implemented,

employers must make reasonable efforts to put in place the practical arrangements necessary to support competence programmes.

Credentialling
Credentialling in the New Zealand context is defined as:[33]

> "A process used to assign *specific clinical responsibilities* (scope of practice) to health professionals on the basis of their training, qualifications, experience and current practice, within an organizational context. The context includes the facilities and support services available and the service the organization is funded to provide. Credentialling is part of a wider *organizational quality and risk management* system designed primarily to protect the patient.
>
> It is an *employer responsibility with a professional focus* that commences on appointment and continues throughout the period of employment."

The Ministry of Health states:[34]

> "… [T]he responsibility to ensure that practitioners are competent to work in a particular setting ultimately lies with the employer. It should be noted that where practitioners are self-employed and publicly funded the employer is considered to be the funding agency. In the case of private health facilities, credentialling would form part of the access agreement made with practitioners.
>
> Putting in place a credentialling system will not eliminate the occasional medical error. It will help to manage this risk by identifying both systems errors and individual practitioners who are developing a pattern of poor performance. … The credentialling process relies largely on the ability of practitioners to engage actively in self and peer assessment. It takes a *quality improvement* approach rather than disciplinary approach, where practitioners actively participate in the process as part of professional accountability."

Credentialling supports patient safety by clearly defining and monitoring practitioner competence within a given scope of practice. A robust credentialling system may enable early identification of an emerging pattern of poor performance by a clinician. It is now a requirement that all public hospitals have processes for credentialling senior medical officers. Over time, credentialling should, in my view, be broadened to encompass all clinical staff.

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[33] Ministry of Health, *Toward Clinical Excellence – A Framework for the Credentialling of Senior Medical Officers in New Zealand*, March 2001, para 1.1.
[34] Ministry of Health, *Toward Clinical Excellence – A Framework for the Credentialling of Senior Medical Officers in New Zealand*, March 2001, para 1.1.

If a credentialling system had been in place at Tauranga Hospital when the concerns about Mr Breeze's practice first arose, it may have been in a better position to move quickly and decisively to protect the safety of its patients. I recognise that in the 1990s New Zealand public hospitals did not have such systems in place. The third public hospital led the way in introducing credentialling in New Zealand in 1995-96, and implementation nationally followed the Commissioner's recommendations in the *Canterbury Health Ltd 1998* report. In April 2002 Tauranga Hospital implemented a process for credentialling its senior medical staff and will be better placed to respond to such concerns in the future. Tauranga Hospital has also been in discussions with Norfolk Southern Cross Ltd about sharing credentialling information, and a verbal agreement has been reached for the hospitals to work together on credentialling. This is commendable precedent for other New Zealand public and private hospitals who share a pool of clinicians.

Opinion: Breach – Norfolk Community Hospital

In my opinion, Norfolk Community Hospital did not take adequate steps to respond to escalating concerns about Mr Breeze's competence, and breached Right 4(1) of the Code, for the reasons set out below.

In the mid-1990s, when Mr Breeze's practice was under review at Tauranga Hospital, Mr Breeze voluntarily restricted his practice at Norfolk Hospital.

Norfolk Community Hospital was not directly involved with the case of Mr A, and accordingly was not formally aware that concerns about Mr Breeze's competence had resurfaced in December 1999. However, in January 2001 the Manager of Southern Cross Hospital was appointed as the Acting Manager of Norfolk Community Hospital, with a view to the future merger of the two hospitals. From that time, Norfolk Hospital was on notice of concerns about Mr Breeze's practice, and could and should have been aware of the events that had transpired at Southern Cross Hospital. The Acting Manager raised his concerns about Mr Breeze's competence to practise surgery with the Board of Norfolk Community Hospital, who concluded that the action taken by Southern Cross Hospital did not, in itself, constitute grounds for suspension of Mr Breeze's visiting privileges at Norfolk Hospital. At the time Norfolk Hospital had only one documented case of concern about Mr Breeze. The Norfolk Southern Cross Board concluded that the situation did, however, warrant close monitoring of Mr Breeze's cases.

Throughout 2001 the Acting Manager of Norfolk Hospital continued to monitor Mr Breeze's cases, but no concerns were noted.

Following informal and confidential discussions with Bay of Plenty District Health Board, Norfolk Hospital unsuccessfully sought formal confirmation of the investigations being undertaken into Mr Breeze's practice at Tauranga Hospital. Mr Breeze informed Norfolk

Names (other than Mr Breeze, Tauranga Hospital, Norfolk Community Hospital, Southern Cross Hospital, the Medical Council, and the Royal Australasian College of Surgeons) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Hospital that the Medical Council was reviewing his competence, and in October 2001 the review was informally confirmed by the Medical Council. Norfolk Hospital advised that it asked Mr H, one of the Medical Council reviewers, whether it should take any action to limit Mr Breeze's operating privileges at that time, but was advised that it should await the outcome of the review.

In December 2001 the Medical Council informed Norfolk Hospital that it was undertaking a full review of Mr Breeze's bowel surgery. Norfolk Hospital formally merged with Southern Cross Hospital in December 2001. Following the merger, Norfolk Hospital was formally on notice of the concerns at Southern Cross Hospital about Mr Breeze's competence.

In February 2002 the Board decided to seek a legal opinion on how it should respond to the matter. Following receipt of the legal opinion, the Norfolk Southern Cross Board decided that it would make enquiries into Mr Breeze's practice, in accordance with Norfolk Hospital's clinical governance processes. Meanwhile, Mr Breeze's practice remained unrestricted at Norfolk Hospital.

On 17 April 2002 Mr Breeze operated on Patient E. Patient E suffered postoperative complications resulting in her transfer to Tauranga Hospital. On 1 May 2002 Mr Breeze operated on patient Y at Norfolk Hospital. Patient Y also suffered postoperative complications. It was only after these two cases that Norfolk Hospital took positive steps to respond to concerns about Mr Breeze's competence.

On 7 May 2002 Mr Breeze was asked to voluntarily restrict his practice to exclude intra-abdominal surgery while the Board conducted an inquiry and awaited the outcome of the Medical Council competence review. Mr Breeze declined to voluntarily restrict his practice. However, he stopped performing bowel surgery at Norfolk Hospital in May 2002 following completion of the Medical Council's competence review. On 26 June 2002 Norfolk Hospital summarily suspended Mr Breeze's privileges to perform intra-abdominal surgery at Norfolk Hospital pending a full investigation of his intra-abdominal surgical practice.

An independent review of Mr Breeze's laparoscopic surgery was commissioned by Norfolk Hospital, and took place in January 2003. There is no written documentation to explain the delay in commencing the review. The final review report was completed on 17 April 2003, and noted minor concerns but no heightened risk to patient safety from Mr Breeze's practice. Mr Breeze was allowed to re-commence intra-abdominal surgery at Norfolk Hospital with a supervisor for his first four operations. However, in December 2003, following notice of my investigation, Norfolk Hospital suspended Mr Breeze's visiting privileges.

The question for determination is whether Norfolk Hospital responded appropriately to escalating concerns about Mr Breeze's competence between December 1999 and December 2003. It involves consideration of the threshold for initiating conditions on practice (supervision, restrictions, or suspension).

As a private hospital, Norfolk Hospital did not at any stage employ Mr Breeze. Rather, Norfolk Hospital granted Mr Breeze the right to operate in its facilities. In granting clinicians the right to operate in their facilities, private hospitals owe a duty to patients to ensure that those clinicians are carefully selected, reviewed and monitored. Accordingly, if a private hospital has (or, in light of the information available to it, should have) reason to believe that a clinician may pose a risk of harm to patients, it has a duty to respond immediately to minimise the risk. At the point when the concerns become serious, supervision, restrictions or suspension must be considered.

Norfolk Southern Cross Ltd submitted that on 1 May 2002 it had clear evidence to suggest that Mr Breeze may not be competent in the area of colorectal surgery, at which point it took immediate action to restrict Mr Breeze's operating activities at Norfolk Hospital. Norfolk Southern Cross Ltd argued that any information Norfolk Hospital held about Mr Breeze's competence prior to May 2002 was "poor" and insufficient to support a restriction on his practice. The "clear evidence" to support the suspension of Mr Breeze's operating privileges at Norfolk Hospital in June 2002 was recorded by Norfolk Hospital as:

1. "The fact that there is a Medical Council competence review, the result of which is as yet unknown".[35]

2. The circumstances of the Mr A's case – the merger of the two hospitals meant that the information held by Southern Cross about that case became the property of the new company, and therefore the MAC was aware of the circumstances surrounding Southern Cross's termination of his visiting privileges. The MAC was also aware of my breach finding in the case of Mr A.

3. The two cases referred to the MAC for consideration – patient E and patient Y.

4. The Health and Disability Commissioner had commenced an investigation into the care Mr Breeze provided to Mr S.

5. The Bay of Plenty District Health Board's restriction on Mr Breeze's scope of practice to exclude intra-abdominal and other major surgery.

Apart from the two cases referred to the MAC for consideration, the information justifying the suspension of Mr Breeze's operating privileges at Norfolk Hospital in June 2002 was available to Norfolk Hospital prior to June 2002. In particular:

1. Norfolk Southern Cross Ltd was informed in December 2001 that the Medical Council was undertaking a full review of Mr Breeze's bowel surgery.

[35] Letter to Mr Breeze from the Chairman of the MAC of Norfolk Southern Cross Hospital, dated 26 June 2002.

2. In January 2001 the Manager of Southern Cross Hospital was appointed Acting Manager of Norfolk Hospital, with a view to the future merger of the two hospitals. The Acting Manager had been directly involved in the management of concerns about Mr Breeze's practice at Southern Cross Hospital, which led to the termination of his privileges there in late 2000. The Acting Manager advised the Board of Norfolk Hospital of Southern Cross's concerns about Mr Breeze's practice. Accordingly, from January 2001 Norfolk Hospital was on notice of Southern Cross Hospital's concerns about Mr Breeze's practice. Southern Cross Hospital and Norfolk Hospital merged in December 2001. At that time, the information held by Southern Cross about Mr Breeze became the property of the new company. Therefore, in December 2001 Norfolk Hospital was formally aware of the circumstances surrounding the termination of Mr Breeze's visiting privileges at Southern Cross Hospital.

3. In September 2001 Norfolk Hospital was notified of my investigation into the case of Mr S.

4. Norfolk Hospital was informally aware that the Bay of Plenty District Health Board was investigating Mr Breeze's practice, and in October 2001 wrote to the DHB requesting further information about their investigations. The DHB requested Norfolk Hospital to direct any questions to Mr Breeze in the first instance. When Norfolk Hospital directed its questions to Mr Breeze, Mr Breeze informed Norfolk Hospital of the Medical Council review. There is no evidence that Norfolk Hospital approached the DHB for further information at that time.

In my view, the decision of Norfolk Hospital (after Mr Q's appointment as Acting Manager in January 2001) that the suspension of Mr Breeze's operating privileges by Southern Cross Hospital did not, in itself, constitute grounds for suspending his privileges at Norfolk Hospital was unfortunate. The concerns that caused Norfolk Hospital to decide to monitor Mr Breeze's cases closely from January 2001 could equally have been the basis of a decision to take more positive action to ensure that the rights of patients at Norfolk Hospital were protected. Such action could have included the suspension or restriction of Mr Breeze's operating privileges pending further inquiries. At the least, Norfolk Hospital should have sought legal advice as to how it should respond to the matter. It is notable that when Norfolk Hospital did seek legal advice in February 2002, the hospital's legal advisors promptly recommended an investigation into Mr Breeze's practice. I do not accept that monitoring was the only course of action available to Norfolk Hospital at that time. Norfolk Hospital could have approached Mr Breeze directly for information, and could have sought his consent to Tauranga Hospital and Southern Cross disclosing the details of their inquiries.

Determining the exact point when conditions should have been imposed on Mr Breeze's practice is difficult. Throughout 2001 Norfolk closely monitored Mr Breeze's practice, sought to obtain further information from the DHB, and obtained guidance from one of the reviewers appointed by the Medical Council. These were positive actions. The Medical

Council reviewer advised Norfolk Hospital in October 2001 that it should await the outcome of Council's review before considering any action to limit Mr Breeze's operating privileges. Accordingly, at that time Norfolk Hospital felt that the continued monitoring of Mr Breeze's cases and the impending Medical Council review was appropriate and all that was required.

While in October 2001 the issue may have been grey, in my view, by December 2001 Norfolk Hospital was aware of serious concerns about Mr Breeze's practice. At that stage Norfolk Hospital had a duty to impose conditions on his practice to minimise the risk to patients. By that time Norfolk Hospital was formally aware of the information held by Southern Cross, that the Medical Council was undertaking a full review of Mr Breeze's competence, that the DHB was investigating Mr Breeze (albeit informally and without details of the exact parameters of the review), and that my Office was investigating the care Mr Breeze provided to Mr S.

Norfolk Southern Cross Ltd submitted that neither Southern Cross's actions nor the Medical Council's review were sufficient reasons to restrict Mr Breeze's operating activities at Norfolk Hospital. Yet they were considered key factors supporting the eventual suspension of Mr Breeze's operating rights in June 2002. Furthermore, while I agree that the commencement of a competence review should not warrant suspension of a practitioner, in this case the competence review was not the only relevant factor for Norfolk's consideration. It was one of a number of factors that, when considered together, suggested a pattern of concern that needed to be addressed by placing conditions on Mr Breeze's practice. A hospital cannot simply wait for the responsible authority to resolve all issues of competence. Competence reviews may take months to complete, and hospitals must consider the need to take additional steps in the interim to protect patients pending the outcome of a review. Such steps may include supervision, practice restrictions or suspension. All the relevant factors must be considered. By December 2001 Norfolk Hospital was aware of additional factors, which required it to reassess the situation.

Mr Breeze's practice was restricted at the two other Tauranga hospitals where he had performed surgery in the past and, as recognised by Norfolk Hospital, low patient numbers and the fact that he was working in isolation did not present a safe option for patients. While I acknowledge the difficulty presented by the lack of information shared by the DHB, Norfolk Hospital could have sought the information directly from Mr Breeze. If a practitioner refuses to disclose relevant information about his or her employment status at other institutions where he or she works, and there is an apparent risk of harm to patients, the employer requesting the information is entitled to take appropriate disciplinary or other action. Challenges to the legality of action taken by a hospital in accordance with employment contracts or clinical governance procedures, and threats of legal action, should not dissuade employers from acting decisively in the face of serious and broad-ranging concerns about a clinician's practice.

It appears that Norfolk Community Hospital felt restrained by its own rules – clinical governance procedures – and Mr Breeze's rights as a visiting practitioner at Norfolk Hospital. While I acknowledge that Norfolk Hospital had certain obligations to Mr Breeze in terms of the conditions of registration at Norfolk Hospital, as a health care provider it also had a clear legal obligation to its patients.[36] Norfolk Hospital did not meet its legal obligation to its patients. The decision only to monitor Mr Breeze's practice – in effect, to wait for a patient to be harmed before taking any action – did not place patient safety as the paramount consideration.

In summary, Norfolk Hospital had a duty to patients to ensure that its visiting practitioners were competent, and a responsibility to respond to concerns about a practitioner's competence in a decisive, timely and appropriate manner. Norfolk Hospital took steps to restrict Mr Breeze's practice in May 2002. However, in my view, there was sufficient information to justify it taking earlier action. By failing to do so, Norfolk Hospital did not take adequate steps to protect patient safety and breached Right 4(1) of the Code.

Opinion: No breach – Southern Cross Hospital

In my opinion Southern Cross Hospital responded in an appropriate and timely manner to the concerns about Mr Breeze's competence following the death of Mr A at Southern Cross Hospital, and did not breach Right 4(1) of the Code.

Mr Breeze operated on Mr A at Southern Cross Hospital on 16 December 1999. Mr A suffered postoperative complications and was transferred to Tauranga Hospital, where he died on 21 December 1999. Southern Cross Hospital quickly responded by asking Mr Breeze, in January 2000, to refrain from performing bowel surgery at Southern Cross pending the results of a review of Mr A's case.

The case was considered by the local hospital committee at a meeting on 9 February. The committee was concerned that the complications arising from Mr A's case were the result of poor technique, and the matter was therefore referred to the national body, HARC.

HARC met on 24 March, and recorded that it had serious concerns about the situation "against the background of Mr Breeze having had apparently a high incidence of patient complications leading to re-training and supervision and limitations to his practice some 3-4 years ago". Accordingly, HARC requested that Mr Breeze refrain from performing any

[36] Norfolk Community Hospital is subject to the duties specified in the Code and is required to take all reasonable steps to ensure that its visiting surgical practitioners are competent and fit to practise.

surgery at Southern Cross Hospital Tauranga until completion of a full review of the situation.

Mr A's case was reviewed by the Chairman of HARC and an independent reviewer. A draft report was given to Mr Breeze to comment on in May 2000. The final reviewer's report was considered by HARC on 11 August 2000. Between 11 August and October 2000 Mr Breeze (and his lawyer) corresponded with HARC about whether HARC would proceed with making a decision on Mr Breeze's operating privileges with or without information from the Coroner's Inquest and the Health and Disability Commissioner investigation. Because of Mr Breeze's concern about the length of time the Coroner's Inquest and the Commissioner's investigation might take, HARC was asked to proceed with its decision. HARC met on 6 November, when the case of Mr A was discussed in detail. The Committee decided to terminate Mr Breeze's registration at Southern Cross Hospital, Tauranga.

I am satisfied that Southern Cross responded promptly and appropriately to the concerns about Mr Breeze's competence following the death of Mr A. Southern Cross did not consider the case in isolation, but looked at the wider picture raised by the case of Mr A, in the context of the historical concerns about Mr Breeze's surgical competence. Less than a month after Mr A's death, Mr Breeze's operating privileges in bowel surgery were suspended. A review was commenced quickly, and the reviewer's report was available for comment by Mr Breeze within two months. There was a small delay between the time when the final investigation report was considered by HARC on 11 August, and the decision to terminate Mr Breeze's operating privileges. However, that delay was the result of negotiation with Mr Breeze about whether to proceed or wait for the outcome of investigations by my Office and the Coroner.

In my opinion, Southern Cross Hospital acted responsibly to ensure the matter was dealt with promptly and effectively, and any risk to patients was minimised. Accordingly, Southern Cross Hospital did not breach Right 4(1) of the Code.

Other matters

Sharing information re concerns about a practitioner's competence

My investigation revealed that there was a significant lack of communication between Tauranga Hospital, Southern Cross Hospital, and Norfolk Community Hospital regarding concerns about Mr Breeze's competence and the action taken by each hospital in response to those concerns.

The failure of the hospitals to share information, and the lack of a co-ordinated response to the concerns about Mr Breeze's competence, had a significant impact on the consistency and effectiveness of action taken by each hospital. For example, failure to share information

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with Norfolk Hospital meant that Mr Breeze continued to practise there at a time when both Tauranga Hospital and Southern Cross Hospital deemed that his practice posed a significant risk to patient safety.

It is clear that the hospitals felt restrained from sharing information because of privacy obligations owed to Mr Breeze. The Privacy Act 1993 seeks to promote and protect individual privacy by establishing principles with respect to the collection, use, and disclosure of information relating to individuals by public and private sector agencies (section 6). The Health Information Privacy Code 1994 (made under the Privacy Act) governs the handling of health information by health agencies (which includes health care providers). Privacy principle 11 places limits on the disclosure of personal information by providing that an agency that holds personal information shall not disclose the information to a person, body or agency except in limited circumstances. While one of the exceptions to principle 11 includes where the disclosure of the information is necessary to prevent or lessen a serious and imminent threat to public health or public safety, it is unlikely that the information the hospitals sought to share in this case would reach that high threshold for disclosure.[37] It appears that, at the time, the hospitals had reasonable grounds for believing that any disclosure of information to each other about Mr Breeze could have implications for his right to privacy.

Privacy restraints on appropriate bodies and organisations sharing critical information when there are concerns about a practitioner's competence are a key barrier to resolving those concerns in a decisive and timely manner to protect patient safety. Where a practitioner works in three hospitals, each of which has concerns about his or her practice, it is in the interests of the practitioner, the hospitals, and patient safety to have a single co-ordinated response to those concerns, rather than three separate internal inquiries. The inefficiency of a number of agencies working in isolation to resolve wide-ranging concerns about a clinician's competence is clearly highlighted in this case.

The Health Practitioners Competence Assurance Act 2003 (HPCA) is a significant step forward to ensure co-ordinated inter-agency responses to concerns about a health practitioner's competence. The HPCA provides a consistent framework for the regulation of health practitioners and seeks to streamline processes for handling concerns about health practitioners, so that they can be resolved speedily and fairly with adequate communication between the various agencies involved. Under the HPCA it is the responsible authorities, such as the Medical Council, that have the specific role of setting professional standards for the protection of the public, and receiving referrals of concerns about a practitioner's competence and fitness to practise. Part 3 of the HPCA includes provisions relating to inter-

[37] See Privacy Commissioner Case Note 6998 [1997] NZPrivCmr 1 and Case Note 2049 [1996] NZPrivCmr 7 for the interpretation and application of this exception to Principle 11 of the Privacy Principles, and the equivalent rule in the Health Information Privacy Code.

agency communication and communication with employing authorities (public and private).[38]

However, as noted by Norfolk Southern Cross Ltd, there are gaps in the HPCA with regard to the sharing of information between responsible authorities and private hospitals. In addition, the HPCA does not cover employer-to-employer information sharing.

In my view, concerns about privacy should not prevent a hospital from acting responsibly in response to concerns about a clinician's practice. Hospitals can take practical steps to ensure that privacy issues do not restrain their ability to facilitate a co-ordinated and responsible approach. For example:

- Private hospitals can seek written consent from clinicians to whom they grant visiting privileges to access information about the clinician's practice held by any institution that employs the clinician and any other private hospital where the clinician has visiting privileges whenever concerns about the practitioner's competence have been raised. (I understand that Norfolk Southern Cross has developed new visiting practitioner guidelines that should enable greater information sharing.) Public hospitals can include similar provisions in their employees' contracts.

- Hospitals in the same regions can develop information sharing protocols. For example, Norfolk Southern Cross and Tauranga Hospital have taken steps to share credentialling-type information.

The failure of the HPCA to require information sharing with a private hospital where a clinician has visiting privileges is a legislative gap. In my view, if the Medical Council is aware that a doctor has operating privileges at a private hospital it should routinely consider whether notice should be given to the private hospital. I am advised that the Council shares this view. The Council has decided that if the Chairperson, CEO and Registrar agree, and it is in the interests of public health and safety, a person working in association with the doctor will be advised of the Council's order that a person undergo a competence review. Norfolk also noted that there is no requirement in the HPCA for a private hospital to notify the Medical Council if a visiting clinician ceases to practise at its hospital for reasons relating to competence, because private hospitals do not "employ" clinicians. A practical solution to this problem would be for private hospitals to require visiting clinicians (on appointment) to give written consent to the private hospital disclosing to the Medical

[38] Section 34(1) of the Health Practitioners Competence Assurance Act allows practitioners to bring any concerns they have about a colleague's practice to the attention of the responsible authority, and s 34(3) requires employers to inform the responsible authority if a health practitioner employee is dismissed for reasons relating to competence. Section 35 provides for communication between the responsible authority and the employer, or persons who work in association with the practitioner, on issues relating to competence.

Names (other than Mr Breeze, Tauranga Hospital, Norfolk Community Hospital, Southern Cross Hospital, the Medical Council, and the Royal Australasian College of Surgeons) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Council if the clinician subsequently ceases to practise at its facilities for reasons relating to competence.

I note that the difficulties in obtaining information from a third party such as another hospital do not prevent a private hospital with concerns about a clinician's practice from seeking information directly from the clinician him- or herself. The terms and conditions on which private hospitals appoint clinicians should require clinicians to provide such information upon request.

Medical Council of New Zealand

The terms of reference for this investigation did not include investigation of the Medical Council. As Health and Disability Commissioner I have jurisdiction only in respect of the actions of health care or disability services providers, as defined in section 2(1) of the Health and Disability Commissioner Act 1994. The Medical Council is not a provider.

The Medical Council played a pivotal role in assessing the concerns raised about Mr Breeze's clinical practice and determining whether a competence programme was required. In my report I have criticised Tauranga Hospital and Norfolk Hospital for not responding to the concerns about Mr Breeze's competence in a decisive and timely manner. The responses of Tauranga and Norfolk Hospitals hinged, to some extent, on the outcome of the Medical Council's competence review.

Some aspects of the Medical Council's process contributed to delays on the part of Tauranga Hospital and Norfolk Hospital in responding to and resolving the concerns about Mr Breeze's practice. Accordingly, some comment on the role of the Medical Council is necessary.

Time-frame for competence reviews
It took 21 months from the decision by Council to review Mr Breeze's competence (January 2001) until Mr Breeze's employer was notified of the requirement for Mr Breeze to undertake a competence programme (November 2002). The Medical Council advised me that it has processes in place that are designed to progress competence reviews as quickly as possible. It has a pool of reviewers who are experienced and well respected members of the profession with currency of clinical practice. Its standard timetable for competence reviews is based on the expectation that most will be complete within six months. At times there can be difficulties identifying clinicians in active clinical practice who have the requisite experience and the time to undertake a competence review and are free of conflicts of interest.

In addition, section 61(1)(c) of the Medical Practitioners Act 1995 required the Medical Council to give a doctor whose competence was to be reviewed notice of the grounds on which it had decided to carry out the review, and information held by it relevant to the doctor's competence. It also required that the doctor be given a reasonable opportunity to

comment on the matter of the competence review. The Health Practitioners Competence Assurance Act contains similar provisions (section 37(1)(c)).

The Medical Council is also bound to follow the principles of natural justice and must ensure that the process of commencing a competence review is fair.

I accept that the Medical Council was required to give Mr Breeze a reasonable opportunity to comment on the proposed review and to ensure that its processes were fair. Any failure by the Council to accord Mr Breeze these rights could have rendered its decisions open to legal challenge and potentially resulted in further delays.

However, it is important to note that those requirements may, in some circumstances, also prolong the review process. While it is important that a practitioner be given a reasonable opportunity to respond, it is concerning that prolonged response times can result in a lengthy review process. It is especially concerning if the process is prolonged by defence lawyers who seek to negotiate the scope or timing of the review, or the identity of reviewers. I note that section 61(1) of the Medical Practitioners Act was clear that the *form* of the review is at the Medical Council's discretion (also see section 37 of the Health Practitioners Competence Assurance Act).

In summary, although I appreciate the need for the Medical Council to act fairly in undertaking their processes, I am concerned at the length of time it took to complete the review of Mr Breeze's competence in this case. The responses of Tauranga Hospital and Norfolk Hospital were affected by the delays in the Council's process. Nonetheless, no matter how promptly a competence review is commenced and concluded, other than in exceptional cases,[39] there will be a period during which the practitioner may continue to practise pending the outcome of the review. In such cases, the hospitals where the practitioner practises have a responsibility to ensure their patients are not exposed to avoidable risks.

Notification of competence programme

The Medical Council's policy is to notify an employer when it orders that a doctor undertake a competence programme since the employer will be involved in implementing the programme and assisting with supervision and resources. In Mr Breeze's case there was a delay of almost four months[40] in the Medical Council advising Tauranga Hospital of its

[39] Section 39 of the Health Practitioners Competence Assurance Act provides that a responsible authority may order the interim suspension of a practitioner's practising certificate, or place conditions on the practitioner's scope of practice, pending a review of the practitioner's competence. Before doing so, the responsible authority must be satisfied that there are reasonable grounds for believing that the health practitioner poses a risk of serious harm to the public by practising below the required standard of competence. Interim suspension was not an available option under the Medical Practitioners Act 1995, the governing legislation at the time of Mr Breeze's competence review.

[40] The Medical Council decided that Mr Breeze should undergo a competence programme on 17 July 2002 but did not notify Tauranga Hospital of its decision until 6 November 2002.

decision that Mr Breeze should undertake a competence programme. The Council indicated that the delays were in part due to the request by Mr Breeze's lawyer that the Council postpone notification of the competence review until he had assessed the decision and had time to lodge an appeal, if appropriate.

Under section 116 of the Medical Practitioners Act, Mr Breeze had a right to appeal Council's decision that he undertake a competence programme. Section 116(4) provides that every appeal lodged under section 116 must be lodged within 20 working days after notice of the decision. In my view, at the latest, the Medical Council of New Zealand should have notified Mr Breeze's employer when an appeal was not lodged (ie, after expiry of the 20-day period), not four months later. It was in the interests of patient safety, Mr Breeze and his employers that they be notified of the order for a competence programme at the earliest opportunity. The process should not be delayed by defence lawyers who seek to negotiate Council's findings.

I note that section 38(3) of the Health Practitioners Competence Assurance Act now requires a registering authority to notify the employers of a practitioner (and any person who works in partnership or association with the practitioner) for whom it orders a competence programme within five working days of making the order.

Co-operation between Medical Council and employers re implementation of competence programmes

When developing the competence programme for Mr Breeze, the Medical Council did not discuss with Tauranga Hospital the feasibility of providing Mr Breeze the supervision of a vocationally registered colorectal surgeon during the final phase of the programme. However, in its letter of 6 November 2002 it invited Tauranga Hospital's suggestions with respect to the implementation of the programme, provision of supervision, and resources. Tauranga Hospital did not respond to the Medical Council's invitation to make suggestions about the implementation of the competence programme.

Tauranga Hospital did not raise concerns about any aspect of the competence programme until April 2003. At this point the Medical Council was satisfied that Mr Breeze could resume his duties at Tauranga Hospital subject to appropriate supervision. Tauranga Hospital expressed its concern and there was a meeting between the Medical Council and the DHB's CEO on 7 April 2003. Following that meeting the Medical Council was advised that Tauranga Hospital felt it was not a practical or viable proposition for Mr Breeze to be supervised by an experienced senior colorectal surgeon.

The Medical Council's failure to consult with Tauranga Hospital about the requirements of the competence programme and the feasibility of the hospital providing on-site supervision led to further significant delays in the process of resolving the concerns about Mr Breeze's competence. Mr Breeze completed parts one and two of his competence programme by early to mid-2003, but he was delayed from completing the final component of the competence programme and resuming his surgical duties. The delay was due, in part, to

ongoing communications between Tauranga Hospital and the Medical Council about the Hospital's ability to assist Mr Breeze to complete the programme, and in part to the dispute that developed between Mr Breeze and Tauranga Hospital about Mr Breeze's ability to perform his duties as an employee given the requirement that he work under the supervision of an experienced colorectal surgeon. The Medical Council felt that it was necessary for the employment issues to be resolved before the competence programme could continue, and therefore postponed action, although it did request information from Tauranga Hospital in May and June 2003.

Competence programmes seek to remedy deficiencies found in a review. Council must be satisfied that the proposed programme will sufficiently upskill a practitioner to ensure that he or she is competent to resume normal practice. The Council cannot put in place lesser requirements because of an employer's lack of resources or reluctance to assist the practitioner to meet those requirements. However, it is important that a proposed programme be discussed with the practitioner's employers at the earliest opportunity to allow opportunity for discussion and agreement, and to ensure effective and efficient transition through the competence programme by the practitioner, free from ongoing conflict between the employer and the Medical Council. In this case it was not until early 2004 that an agreement was reached and Mr Breeze was enabled to progress his programme – a delay of almost a year. The delay had significant implications for Mr Breeze and, in my view, was avoidable.

Concluding comment
Responsible authorities have a duty to protect the public by ensuring the fitness and competence of practitioners. The competence review process is the key tool available to responsible authorities to address concerns about a health professional's competence to practise. It is essential that responsible authorities have effective processes (including readily available competence reviewers) in place to act swiftly to determine whether a review is necessary; and, if so, to carry out the review and implement a competence programme, if necessary. Responsible authorities and employing authorities need to communicate effectively, to ensure a smooth and efficient process.

Conclusion – problems and solutions

The Review of the Health and Disability Commissioner Act 1994 (October 1999) by the first Commissioner, Robyn Stent, and the Report on the Review of Processes Concerning Adverse Medical Events (March 2001) by Helen Cull QC identified problems with the complaints system in place at that time. The problems included time delays, multiple investigations, poor agency interaction, and lack of information sharing. This case provides a clear example of those problems. As noted by Norfolk Southern Cross, this case illustrates the desirability of having one body with overall responsibility in the assessment and

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certification of a medical practitioner's competence, which can share the information with all organisations (as opposed to each employing authority, public and private, undertaking its own separate investigations, and different agencies investigating at the same time).

The Health Practitioners Competence Assurance Act is a significant step in the right direction towards improving inter-agency communication and co-ordination in complaints and competence issues. However, the HPCA does not provide guidance to employing authorities about how to deal with concerns about a practitioner at the ground level. This raises the question: what is the best way for an employing authority to handle this type of situation? These situations obviously need to be dealt with fairly and speedily, in a manner that co-ordinates the actions of multiple employing authorities, to avoid duplication, delays and inconsistent outcomes. Employing authorities need to take a pro-active role to deal with any concerns prior to and during any external agency involvement. The aim for any employing authority should be to recognise any potential risks to patient safety before they eventuate, and to respond in a decisive and timely manner. Patient safety should be the paramount consideration. Steps an employing authority should take include:

- having in place effective systems to identify potential concerns about a practitioner's practice at the earliest possible opportunity. Such systems include effective procedures for audit, peer review, credentialling, and for incident reporting and complaints;

- ensuring there is a clear and widely known process for practitioners to raise concerns about a colleague's practice;

- putting in place effective systems to respond to concerns. The systems should allow for early co-ordination and consultation with appropriate bodies (including other known employers, and the responsible authority, where there are risks to patient safety), to avoid duplication of process and conflicting/inconsistent outcomes;

- providing support to any practitioner whose practice is under review; and

- ensuring any recommendations arising out of investigations into a practitioner's practice are:

  (a) overseen by a responsible person who reports to the Chief Executive Officer or General Manager; and

  (b) implemented promptly;

- tackling any foreseeable problems (that may prevent the practitioner's return to safe practice) at the earliest opportunity.

Employing authorities should keep the situation under close review to ensure there are no ongoing risks to patient safety.

I conclude with an observation from the Bay of Plenty District Health Board:

> "A subsequent issue that evolved out of the 'Breeze inquiries' is a negative influence that impacts on any rehabilitation. The longer the doctor is restricted the more his knowledge/skills are lost and once the possible deficits are promulgated the greater the difficulty in obtaining re-training occurs. It may be that some situations are irretrievable? The issues, delays, and time factors rest with a number of organizations: the Medical Council, the College, the 'hospital organisation', and indeed the HDC. We can all reflect on the eventual outcomes."

Recommendation

I recommend that:

- the Bay of Plenty District Health Board and Norfolk Southern Cross Ltd review their policies and procedures for responding to concerns about a clinician's competence, and their contracts of employment/appointment arrangements with clinicians, in light of this report.

Follow-up actions

- A copy of my report will be sent to the Minister of Health, the Director-General of Health, the Medical Council of New Zealand, and the Royal Australasian College of Surgeons.
- A copy of my report with details removed identifying all parties (other than Mr Breeze, Tauranga Hospital, Norfolk Community Hospital, Southern Cross Hospital, the Medical Council, and the Royal Australasian College of Surgeons) will be sent to all District Health Boards, the New Zealand Private Hospitals Association, the New Zealand Association of General Surgeons, the Association of Salaried Medical Specialists, the New Zealand Medical Association, the *New Zealand Medical Journal*, and all responsible authorities under the Health Practitioners Competence Assurance Act 2003, for educational purposes.
- A copy of my report with details removed identifying all parties (other than Mr Breeze, Tauranga Hospital, Norfolk Community Hospital, Southern Cross Hospital, the Medical Council, and the Royal Australasian College of Surgeons) will be sent to the Privacy Commissioner with a request that the Commissioner consider the issue of communication between health care providers about a health practitioner's competence,

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and the need for guidance to employing authorities on privacy and the disclosure of competence information.

- In light of the significant public interest in my inquiry into Mr Breeze's practice, an executive summary of my report will be released to the media, and a copy of my report with details removed identifying all parties (other than Mr Breeze, Tauranga Hospital, Norfolk Community Hospital, Southern Cross Hospital, the Medical Council, and the Royal Australasian College of Surgeons) will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix 1 – Commissioner's findings in Part 1 of the inquiry

The following is a summary of the Commissioner's findings into part one of the Commissioner's inquiry – the quality of care provided to seven patients by Tauranga surgeon Mr Ian Breeze.

Patient A (03HDC18935)
In October 1999 Patient A underwent an open cholecystectomy at Tauranga Hospital, performed by Mr Breeze's registrar with Mr Breeze's assistance. Patient A developed a persistent postoperative wound infection.

The Commissioner found that while the operation was performed in accordance with professional standards, Mr Breeze did not adequately manage Patient A's postoperative wound infection, and breached Right 4(1) of the Code of Patients' Rights. The Commissioner recommended that Mr Breeze apologise to Patient A, and review his practice.

Patient B (03HDC18359)
In March 2000 Mr Breeze performed bowel surgery on Patient B at Tauranga Hospital to remove a malignant polypoidal tumour in her right colon. Patient B developed faecal peritonitis from a leak in the surgical anastomosis (which another surgeon surgically repaired), and a faecal fistula and associated wound infection.

The Commissioner found that Mr Breeze did not breach the Code. There was no indication that the anastomotic leak was caused by poor surgical technique, and Mr Breeze treated Patient B's faecal fistula and wound infection in a standard and appropriate manner.

Patient C (03HDC18925)
In February 2000 Mr Breeze performed a laparoscopic cholecystectomy and intra-operative cholangiogram on Patient C at Tauranga Hospital. Patient C's condition deteriorated postoperatively. Patient C was returned to theatre twice over the following two days, the first time by Mr Breeze (to repair a perforated duodenum) and the second time by another surgeon. Patient C was admitted to the Intensive Care Unit until her condition improved.

The Commissioner found that Mr Breeze did not breach the Code. Perforation of the duodenum is a recognised complication of the procedure undertaken, and was not the result of any lack of reasonable care and skill on Mr Breeze's part during surgery. Mr Breeze's subsequent care of Patient C was reasonable.

Patient D (03HDC18813)
Mr Breeze performed a left inguinal hernia repair on Patient D at Norfolk Hospital in August 2000. Postoperatively, Patient D suffered from swelling, bruising, pain in his groin area, and persisting impotence.

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The Commissioner found that although the operation was performed in accordance with professional standards, Mr Breeze did not adequately assess and manage Patient D's postoperative condition. In addition, Mr Breeze did not give Patient D sufficient information about his condition. Accordingly, Mr Breeze breached Rights 4(1) and 6(1)(a) and (b) of the Code. The Commissioner recommended that Mr Breeze apologise to Patient D, and review his practice.

Patient E (03HDC19128)
Mr Breeze performed a laparoscopic cholecystectomy on Patient E at Norfolk Hospital in April 2002. Mr Breeze did not inform Patient E prior to surgery that he had restrictions on his practice at two other hospitals in Tauranga. Patient E's condition deteriorated postoperatively, and she was transferred to Tauranga Hospital, where she underwent further surgery to drain a haematoma.

The Commissioner found that Mr Breeze's clinical treatment of Patient E was appropriate and in accordance with professional standards. However, Mr Breeze breached Right 6(1) of the Code by not informing Patient E of the restrictions on his practice prior to surgery. The Commissioner recommended that Mr Breeze apologise to Patient E and review his practice.

Patient F (04HDC00208)
Mr Breeze performed a laparoscopic Nissen fundoplication on Patient F in September 1998 at Southern Cross Hospital, Tauranga. Postoperatively, Patient F suffered from abdominal pain, difficulty swallowing, and regurgitation. Patient F required further surgery to loosen the wrap on the Nissen fundoplication, following which she developed a small bowel obstruction and a mild wound infection.

The Commissioner found that Mr Breeze's clinical care of Patient F was appropriate, and in accordance with professional standards. Accordingly, Mr Breeze did not breach the Code.

Patient G (03HDC19273)
Mr Breeze performed a left hemicolectomy on Patient G at Tauranga Hospital in February 1999, for diverticulitis. Patient G had a prolonged and tumultuous postoperative recovery, complicated by a pre-sacral abscess.

The Commissioner found that Mr Breeze breached Right 4(4) of the Code in relation to his surgery on Patient G, and Right 4(2) of the Code in relation to his management of her postoperative pre-sacral abscess. The Commissioner recommended that Mr Breeze apologise to Patient G for his breaches of the Code, and review his practice.

Copies of individual decisions
Copies of the Commissioner's above decisions, with details removed identifying all parties other than Mr Breeze, the Commissioner's expert advisor, and the hospitals, may be viewed at www.hdc.org.nz.

Appendix 2 – Parties involved

Tauranga Hospital

- Mr D – Chief Executive Officer, Western Bay Health
- Dr C – Medical Advisor, Western Bay Health (1990-1996)
- Mr B – General Surgeon and Clinical Director of Surgery, Tauranga Hospital
- Dr K – Deputy Medical Advisor, Western Bay Health (1990-1996)
- Mr M – Chief Executive Officer, Pacific Health and Bay of Plenty District Health Board
- Dr K – Medical Advisor, Pacific Health (1997-2001)
- Chief Medical Director, Bay of Plenty District Health Board (2001-ongoing)

Norfolk Community Hospital and Southern Cross Hospital

- Mr Q – Manager Southern Cross Hospital, Acting Manager Norfolk Community Hospital (January 2001 to December 2001), General Manager Norfolk Southern Cross Ltd (December 2001 to present)
- Mr R – Chairman, Southern Cross Hospital Audit Review Committee
- Chairman, Medical Advisory Committee, Norfolk Southern Cross Ltd

Appendix 3 – The investigation process

The seven individual complaints were investigated in accordance with the standard investigation process of my Office. Complainants/consumers were interviewed, medical records and witness statements were obtained, and expert advice was sought on the relevant clinical issues. I formed a provisional opinion on each individual complaint, which was forwarded to the parties for their comment. Responses to my provisional opinion were carefully considered, and additions to my reports made where necessary before they were finalised.

My investigation into the Bay of Plenty District Health Board and Norfolk Southern Cross Ltd was conducted in a similar manner. Information and documentation was obtained and

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reviewed from the Bay of Plenty District Health Board and Norfolk Southern Cross Ltd. Interviews with key personnel from Tauranga Hospital (Dr C, Dr K, Mr B, and a senior anaesthetist) took place on 23 June 2004. Additional information was obtained from the Medical Council of New Zealand, the Royal Australasian College of Surgeons, and the New Zealand Association of Surgeons.

Appendix 4 – Mr Breeze's submission on review findings

Review conducted by Mr T into Mr Breeze's laparoscopic surgery, initiated by Norfolk Hospital[41]

Mr T reviewed a substantial number of cases (66 cholecystectomies, nine appendicectomies, eight Nissen fundoplications, six division of adhesions, and two laparoscopies over the period 1 January 1997 to 17 April 2002). Mr T found that Mr Breeze's complication rate compared with published data and that his surgery did not pose a heightened risk to patient safety. He recommended that Mr Breeze be mentored by a colleague for the first four cases. Mr Breeze was mentored by Mr L, who approved of Mr Breeze's technique.

Review conducted by Mr H and Mr N, February and March 2002 (MCNZ competence review #2)

Mr Breeze submitted that this review is "the most powerful evidence you have available about the results of my colorectal surgery and was described by the Minister of Health as *one of the most comprehensive reviews ever undertaken by the New Zealand Medical Council*". He noted that Mr N and Mr H were "very well qualified" to undertake the review – both are academic surgeons with comprehensive surgical experience and experience in conducting reviews.

Mr Breeze advised that the review was of 184 of his major colorectal surgery cases from 1997 to 2001 inclusive, and included a five-hour interview. The review found that there was no direct evidence of a major safety issue about his work, that his operative mortality and complication rates were within acceptable limits, and his knowledge of colorectal surgery was acceptable. In his response, Mr Breeze went on to explain the findings regarding his complication rates, and internationally accepted parameters. In particular, he explained:

[41] Mr Breeze submitted that the fact that Norfolk Hospital initiated the review is something that should be noted to its credit and is contrary to the opinion that its response to concerns about his practice were inadequate.

> "anastomotic leakage
>
> My rate of anastomotic leakage was 2.2%, within the acceptable parameter of (0-4%).
>
> This compares favourably with a rate of 6.5% in a recent study of 9673 patients in Western Australia, 4.5% in a recent study of 11036 patients in Victoria, Australia, 3.8% in [a New Zealand hospital], and 3.3% rural Australian hospitals.
>
> Wound infection
>
> My rate of wound infection was 3.8%, within the acceptable parameter of 0-10%.
>
> This compares favourably with an incidence of 12% [in two other New Zealand public hospitals]."

Mr Breeze noted that when he asked the reviewers to identify concerns about his complications that might indicate sub-optimal practice, eight cases were identified. Mr Breeze discussed the specific cases in question, and the basis for his dispute that the cases in question indicated sub-optimal practice. Mr Breeze advised:

> "I consider that neither the criticisms of my treatment [in those cases], nor of the severity of the complications, is valid … It has been recognised by the reviewers that my rate of complication is not excessive. I submit that neither is the severity excessive, and that my handling of these complications has been optimal. The audit has not proven that my management of post-operative complications is deficient, or that my decision making was poor. The quality of my decision making is reflected in my low rate of complications."

Mr Breeze also advised that it is important the report reflect the adverse Tauranga patient demographics when considering the outcomes of his surgery. He noted, "Despite the adverse Tauranga patient demographics … the outcomes of my colorectal surgery are unequivocally within acceptable parameters."

Review in July 2001 (MCNZ competence review #1)[42]
Mr Breeze noted that this review included 19 cholecystectomies and 40 colorectal cases. For biliary surgery Mr Breeze was categorised as 2, which equates with good to average. Mr Breeze noted that the sample sizes were too small to provide conclusive results. Mr Breeze submitted:

[42] Mr Breeze submitted that this review was initiated by Tauranga Hospital following the death of Mr A, and was conducted by the Medical Council. As such, it indicates that the hospital was responsive to any concern perceived to have arisen as a consequence of his involvement in Mr A's case.

> "It is noteworthy that initially following this review, [the Medical Council reviewer] placed results of colorectal surgery in category 3 (*adequate requires upgrading*). It then records in the appendix, that after [the reviewer] was contacted by Tauranga Hospital management, [identified by the reviewer to be the Chief Medical Director], I was downgraded to category 4 (*Below average. Should undergo a competence programme and then be reassessed*) on the basis of rumour and innuendo. Nevertheless, it is agreed by all parties that this review of my colorectal surgery was inconclusive, and that a larger review was necessary. [The] review did not identify that I presented risks to patients (category 5,6)."

Review by Mr I August 1995

Mr Breeze submitted that Mr I's report was "grossly inaccurate" and his results "plainly unreliable" (for example, Mr I's report claimed that Mr Breeze had eight deaths following colorectal surgery, when he had in fact only had three deaths, all of which were poor risk patients with advanced pathology and severe co-morbidity. In addition, two patients Mr I claimed had died following surgery were actually still alive after making an uneventful recovery from surgery). Mr Breeze advised:

> "When the MCNZ undertakes a performance assessment, it appoints a committee consisting of two appropriate medical practitioners usually of the same medical discipline, and one lay person. All three assessors undertake training for participation in this.
>
> In contrast, [Mr I's] review was carried out by one untrained medical practitioner who was … inexperienced in this process …
>
> The situation was then reviewed externally by Mr H and Mr J, who likewise were not convinced that there was a case to answer. An internal review by Mr B, Dr C and Dr K of my patient deaths of that period, was not critical of my treatment."

Mr F 1994

Mr Breeze noted that Mr F's review found that his upper abdominal surgery (gastric, biliary, appendiceal) was of a good standard, but that he was having excessive complications from rectal anastomosis.

Mr Breeze submitted that the audit undertaken by Mr F was suboptimal, in that he conducted it by himself and was untrained. However, Mr Breeze advised that he accepted that in 1994 his complication rate for stapled rectal anastomosis may have been excessive. He advised that his experiences were not isolated, and there was widespread international dissatisfaction with the technique at that time, single stapling, which was the impetus leading to the development of the current technique, double stapling. The double stapling technique was demonstrated to Mr Breeze by Dr G when he spent a day with him in a city, at which point he adopted that technique. Mr Breeze advised that the review verified this by specifically documenting his low anastomotic leakage rate.

Appendix 5 – Tauranga Hospital

The public hospital system 1993-2004
During the 1990s the health sector in New Zealand experienced a process of reform underpinned by policy developments designed to create a competitive model of health delivery. Public hospitals became corporate entities ("Crown Health Enterprises") with a specific objective of being as successful and efficient as comparable businesses not owned by the Crown.[43] A marketplace environment developed with regional health authorities purchasing services from a range of private and public providers.

The change to a competitive model of health delivery resulted in structural changes to the management of hospitals throughout New Zealand. My report raises issues about the way concerns about Mr Breeze's competence were managed within Tauranga Hospital from 1994 to 2003, and a number of key players in the course of my investigation commented that my report must be mindful of the changes that were occurring at the time. In summary, the changes were as follows.

In 1993, 14 Area Health Boards were replaced by 23 Crown Health Enterprises (CHEs), as providers of secondary and tertiary health services. The CHEs were established under a business model, and were required to compete with other health service providers for contracts from four Regional Health Authorities (RHAs). RHAs were established to plan and purchase health and disability support services. The CHE boards were appointed by central government, rather than partially elected, as occurred with Area Health Boards.

In 1997 the four RHAs were amalgamated into a single national purchaser, the Health Funding Authority. CHEs became Health and Hospital Services (HHS), in a shift towards a more co-operative model. The HHS boards were appointed by central government, as were the CHE boards, and contracting between the funder and HHS providers remained.

In 2001, following the passage of the New Zealand Public Health and Disability Act 2000, 21 District Health Boards (DHBs) were established. The Bay of Plenty District Health Board is one of New Zealand's 21 District Health Boards. Funding for health services is devolved to the Boards, which fund and provide services for geographically defined populations. DHBs are governed by boards of up to 11 members, the majority of whom (7) are elected, and the remainder (4) appointed by central government. DHBs, through their provider arms, are responsible for providing secondary/tertiary care (in public hospitals) and for funding community and primary care providers.

It was suggested that the practical implications of the competitive model of health delivery for surgery is relevant context to the failure to implement the recommendations made over time to address concerns about Mr Breeze's competence.

[43] Section 11(2)(d) of the Health and Disability Services Act 1993.

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The changes in the health system and the management of complaints at Tauranga Hospital
Before the competitive model of health delivery, hospitals were managed by a medical superintendent, who was a medical practitioner in charge of the hospital. The medical superintendent filled an important role in managing concerns within the hospital, including concerns about a clinician's practice.

With the advent of the competitive model, the position of medical superintendent was disestablished, and hospitals were run by a chief executive officer. Because there was no requirement that chief executive officers be medically trained, the position of medical advisor was created. The role of the medical advisor was, amongst other things, to be an advisor to the non-medically trained chief executive officer, to act as an intermediary between staff and management, to fulfil a pastoral role looking after the interests of colleagues and clinical staff, and to investigate complaints and concerns, including complaints from the public about health care, and competence concerns.

Prior to the changes in the health system in the early 1990s, concerns about a colleague's practice could have been brought to the attention of the medical superintendent, ideally dealt with within a collegial environment. In the new environment it appears that there was no set process or guidelines within Tauranga Hospital to raise concerns about a clinician's practice, and no set process for the management of such concerns. The concerns could either be brought to the attention of the clinical director and managed within the department, or to the attention of the medical advisor and/or management (either via the clinical director or directly by the concerned colleague) and managed at a higher level.

The Department of Surgery at Tauranga Hospital
The Department of Surgery at Tauranga Hospital is headed by the Clinical Director. Between 1993, when concerns were first formally raised about Mr Breeze's competence, to 2003, the position of Clinical Director was a part-time position, undertaken by a senior surgeon, Mr B. Mr B also carried a high surgical workload.

Mr B understandably felt that he did not have the non-clinical time to dedicate himself to the role of clinical director, and on three occasions between 1993 and 2003 he unsuccessfully advocated to management for a full-time position of clinical director to be created. Mr B envisaged that a full-time clinical director would perform only enough surgery to maintain his expertise and for the balance of his time would be engaged in general oversight and audit of the Department of Surgery. Mr B maintained the role of clinical director in addition to his surgical duties.

Appendix 6 – Norfolk Community Hospital and Southern Cross Hospital

In December 2001, Norfolk Community Hospital and Southern Cross Hospital merged, and became governed by the joint Board of Norfolk Southern Cross Ltd. Prior to the merger, both hospitals operated separately in Tauranga, and had separate systems for managing concerns about a clinician's practice.

Southern Cross Hospital
Southern Cross Hospital did not employ medical practitioners, but granted practitioners rights to practise within the hospital, on application. Applications were considered by a local hospital committee, the Hospital Clinical Management Committee (HCMC), which made recommendations to a national committee, the Southern Cross Hospital Audit Review Committee (HARC), as to whether visiting privileges should be granted. Renewals of visiting privileges occurred annually, and were the responsibility of HCMC.

HCMC was responsible for ensuring that the clinical and ethical standards within the hospital were met. HCMC met at least every three months to review clinical processes and procedures, assess applications for visiting privileges, and deal with any clinical incidents or complaints. HCMC had recourse to HARC when further advice or investigation was warranted. HARC is a sub-committee of the Board of the Southern Cross Hospital Trust, and is responsible for matters concerning hospital audit and quality systems.

Southern Cross Hospital had provision in its visiting practitioner arrangements that visiting privileges could be modified or suspended if there was a risk to patient safety.

Norfolk Community Hospital
Norfolk Community Hospital had procedures similar to Southern Cross Hospital for the governance of clinical issues. The Hospital was governed by a Medical Advisory Committee (the MAC) and a Clinician Board. Surgeons and anaesthetists applied to the MAC for visiting privileges, which were reviewed/renewed every two years. The MAC managed clinical issues, and made recommendations to the Clinician Board. The Board was the final decision-making authority, and also had the power to modify or suspend operating privileges when there was a risk to patient safety.

Norfolk Southern Cross Ltd
When the two hospitals merged in December 2001, the hospitals were managed by Norfolk Southern Cross Ltd. Following the merger, Norfolk Southern Cross Ltd sought to address the clinical governance process of the new corporate entity. Given the high number of changes at the time, a decision was made by the Norfolk Southern Cross Board to leave the existing arrangements in place at each hospital until June 2002.

In June 2002 a reconstituted Medical Advisory Committee replaced the Southern Cross Hospital and Norfolk Community Hospital committees. The MAC consisted of two clinical members of the Board, two other surgical representatives, and the general manager. In 2003, the clinical operations manager also joined the MAC. The reconstituted MAC

functioned along similar lines to the original Norfolk Community Hospital MAC, although its regulations were re-written.

Norfolk Southern Cross Ltd retained the right to modify or suspend visiting practitioner privileges if there was a risk to patient safety.

Appendix 7 – The Medical Council's competence review process

The principal purpose of the Medical Practitioners Act 1995[44] was to "protect the health and safety of members of the public by prescribing or providing for mechanisms to ensure that medical practitioners are competent to practise medicine".[45] Section 3(2)(c) stated that the Act seeks to attain its principal purpose by, among other things, providing for the review of the competence of medical practitioners to practise medicine.

Part V of the Medical Practitioners Act (sections 60 to 65) provided for competence reviews[46] and competence programmes. Section 60 specified that the Medical Council may carry out a competence review on any medical practitioner at any time.

A competence review is a process to assess whether a doctor is practising safely and has an acceptable level of knowledge, skills, attitudes and judgement. A competence review is not a disciplinary process, but is designed to be educative and rehabilitative.

When the Medical Council receives a referral for a competence review, it considers the available information and decides whether the review will be carried out. The medical practitioner concerned is notified that he or she is being considered for a competence review, and is informed of the concerns raised with the Medical Council. The medical practitioner is given an opportunity to respond to the proposal to review his/her competence.

If the Medical Council determines that a competence review should be undertaken, a Competence Review Committee (CRC) is appointed. The CRC compromises two medical practitioners, at least one of whom is practising in the same branch and practice setting as

[44] The Medical Practitioners Act 1995 was repealed as from 18 September 2004, by s 175(4) of the Health Practitioners Competence Assurance Act 2003. The HPCA provides for Council to review the competence of medical practitioners to practise medicine, using similar processes to those in the Medical Practitioners Act 1995.
[45] Section 3 of the Medical Practitioners Act 1995.
[46] A competence review is a review to determine whether a doctor has the necessary skills, judgement, attitude and knowledge to practise medicine in accordance with his or her registration and meets the reasonable standard expected of a doctor with his or her level of registration (Medical Council of New Zealand *Competence Review Policies and Procedures Manual* (January 2004) p16).

the medical practitioner under review, and one lay member. The medical practitioner whose competence is to be reviewed is given an opportunity to comment on the proposed CRC members.

The CRC conducts the competence review in accordance with terms of reference agreed with the Medical Council and the practitioner under review. The terms of reference include a summary of the background to the concern in sufficient detail to allow the reviewers to decide on the focus of the review, and the process to be used. Different assessment methods include case based oral, review of clinical records, peer rating, interview, and audit.

After the review, the CRC writes a report which is first provided to the medical practitioner for comment, prior to being referred to the Medical Council for consideration. Council considers the findings of the CRC, and determines whether the medical practitioner should undertake a competence programme.

Under the Health Practitioners Competence Assurance Act, if before or during a competence review the Medical Council has reasonable grounds for believing that the health practitioner poses a risk of serious harm to the public by practising below the required standard of competence, Council may suspend or place restrictions on the doctor's practice.[47] If, following a competence review, the Medical Council has reason to believe that a doctor fails to meet the required standard of competence, the Medical Council may develop a competence programme to help re-educate and upskill the doctor.[48]

A competence review by the Medical Council is a confidential process,[49] and the Council does not usually release information about a medical practitioner under review without his or her permission.[50] While the Medical Council notes that it is desirable that a medical practitioner's clinical director or employer is informed that a competence review is taking place, the current policy is to advise the practitioner that the Council expects his or her clinical director or employer to be informed of the review. If the Council has reasonable cause to believe that there is a risk to public health and safety, it will disclose the details of a competence review or programme to the practitioner's employer.[51]

If a competence programme is required, the doctor's employer will be notified by the Medical Council to ensure that supervision and other requirements can be fulfilled and support is provided. The extent of any ongoing liaison concerning the implementation of the

[47] Section 39(1).
[48] Further information about the New Zealand Medical Council's competence review process is available on the Council's website at www.mcnz.org.nz/information/aboutcompreview.asp.
[49] Medical Council of New Zealand *Competence Review Policies and Procedures Manual* (January 2004) p 11.
[50] Section 65 of the Medical Practitioners Act 1995 made information relating to competence reviews confidential except in certain specified situations. Section 44 of the Health Practitioners Competence Assurance Act 2003 preserves this confidentiality.
[51] Ibid.

competence programme depends on the nature of the programme, and differs from case to case.

The Medical Council provides competence review committee members with a recommended timeline, and requests the reviewers to provide it with their report within two months. Most competence reviews are completed within a six-month timeframe, inclusive of the opportunity to respond during the process.

Names (other than Mr Breeze, Tauranga Hospital, Norfolk Community Hospital, Southern Cross Hospital, the Medical Council, and the Royal Australasian College of Surgeons) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.