Orthopaedic Surgeon, Dr B

A Report by the

Health and Disability Commissioner

(Case 04HDC00031)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties to the complaint

Mr A	Consumer
Ms A	Mr A's partner
Dr B	Provider/Orthopaedic Surgeon

Parties involved

Dr C	Mr A's General Practitioner
Dr D	Orthopaedic Surgeon
Dr E	Orthopaedic Surgeon
Dr F	Orthopaedic Registrar for Dr B
Dr G	Gastroenterologist

Complaint

On 5 January 2004 the Commissioner received a complaint from Mr A about the services provided to him by Dr B. The issues identified for investigation were summarised as follows:

1. *the adequacy of the information about treatment options for bone cancer that Dr B provided to Mr A;*
2. *the appropriateness of Dr B's referral of Mr A to a second Public Hospital for a titanium implant.*

Information reviewed

Information from:

- Mr A
- Dr B
- Dr C
- another doctor
- Dr D
- the first Public Hospital
- the third Public Hospital
- the Accident Compensation Corporation
- a Medical Centre

Information gathered during investigation

On 7 January 2003 Mr A, then aged 44, presented to the surgery of his general practitioner of the time, Dr C, in relation to ongoing pain in his left hip. Dr C noted that Mr A had a two-and-a-half-year history of left hip pain, and on examination observed that rotations of his hip were restricted. Dr C also noted that Mr A had previously had numerous consultations with, and investigations by, other providers in relation to his hip. In particular Dr C noted that Mr A had had a CT scan some months earlier at the first Public Hospital. Accordingly, he followed up the results of that scan.

The non-contrast CT scan of Mr A's abdomen and pelvis had been undertaken on 4 October 2002, having been ordered to exclude the possibility of renal stones as the cause of Mr A's pain. The CT report (which was received by Dr C on or about 8 January 2003) stated: "No left ureteric stone. Increased thickness of the left internal oblique muscle, of unknown cause. A haematoma or, less likely, an abscess should be considered. I recommend a repeat pelvic study with IV contrast to better appreciate the texture of the left internal oblique muscle."

X-rays had also been taken of Mr A's pelvis and lumbar spine at a Private Hospital on 23 December 2002. Those X-rays showed a possible abnormality, and a bone scan was recommended.

Following receipt of the results of these investigations Dr C, in a letter dated 8 January 2003, referred Mr A to the outpatient orthopaedic department of the first Public Hospital for a bone scan and repeat CT scan. Mr A underwent a non-ionic contrast CT scan of his pelvis on 19 February. The scan revealed a large soft tissue mass in Mr A's pelvis. The report recommended a chest X-ray, bone scan, and biopsy of the lesion.

Dr C received the CT report on 20 February 2003. He then requested Dr G, gastroenterologist, to review the films of Mr A's CT scan at a combined conference on 28 February. However, prior to that meeting – on 27 February – Dr G referred Mr A to Dr B, orthopaedic surgeon.

Mr A was assessed by Dr B at the orthopaedic clinic of the first Public Hospital on 3 March 2003. Dr B obtained a full history from Mr A. On examination, Dr B assessed Mr A's left hip for flexion and range of movement. He also elicited lower left abdominal tenderness on palpation. A rectal examination revealed a large mass on Mr A's left side, which was consistent with the CT report of 19 February. Dr B organised Mr A's immediate admission to the orthopaedic ward of the first Public Hospital, and arranged for him to have blood tests and an MRI scan.

The MRI scan of Mr A's pelvis was undertaken on 4 March. The report reads: "Destructive bony lesion on the roof of the acetabulum and lateral aspect of the superior pubic ramus … In a patient of this age, a primary chondrosarcoma would head the differential diagnosis." Chondrosarcoma is a malignant tumour, related to bones, composed of atypical cartilage cells.

Dr B discussed the results of the MRI scan with Mr A, advising him that he had a large tumour, which was likely a chondrosarcoma of the inner left pelvic aspect. Dr B further informed Mr A that a CT guided biopsy would be required to confirm the diagnosis. Mr A was scheduled to undergo the biopsy on 5 March. However, notes received from the first Public Hospital indicate that the biopsy was cancelled. On 10 March, Mr A attended the first Public Hospital for the re-scheduled CT guided biopsy. However, the pain Mr A experienced was such that, even after the administration of analgesics, he was unable to lie supine for the biopsy, and it had to be re-scheduled to 20 March under general anaesthetic. Once again the biopsy, was unable to be performed on 20 March as the CT scanner was unavailable. The procedure was re-scheduled and eventually took place on 24 March 2003.

Cytological and histological examinations of the biopsy samples were unable to confirm the diagnosis, although both reports stated that the samples were consistent with chondrosarcoma. This was confirmed by a further report by way of second opinion.

Dr B advised me of his subsequent actions on learning the biopsy results. "Because of the relative rarity of this tumour, and, in part, because of its extremely large size, and the length of time that had elapsed from the commencement of symptoms until referral to me, I recommended that the case be reviewed by [Dr D] [orthopaedic surgeon] at [the third Public Hospital]. To that end I forwarded to [Dr D] the appropriate X-rays and pathology slides." Dr B further advised me that while he was awaiting Dr D's opinion, he discussed with Mr A the possibility of having Dr E in [the second Public Hospital] give an opinion on the management. Information received from the first Public Hospital suggests that Dr B met with Mr A on 26 March for the purpose of discussing treatment/management options. Mr A advised me that the meeting with Dr B occurred on 31 March.

Dr B was unable to clarify the date of his consultation with Mr A. He observed that he had been unable to find notes in relation to this consultation, and considered that there were unlikely to be any because the options for treating Mr A's chondrosarcoma were "in evolution" at the time.

In response to my provisional opinion, Mr A noted: "I am very concerned that [Dr B] does not provide the notes of such an important meeting … I would also like to state that the meeting was very short, we were given a one-sentence description of each option, and definitely no proper information about what exactly is done in each option, [and] what are the benefits, risks, recovery processes etc."

Mr A subsequently had a telephone conversation with Dr B on 9 April, in which treatment options were discussed. Records from the first Public Hospital indicate that he was scheduled to attend a consultation with Dr B on 9 April, but that he did not attend that consultation. Mr A has said that he was advised by Dr B that there was no need to attend this consultation, as they had already spoken over the phone.

Irrespective of the specific date, I am satisfied that a consultation occurred between Mr A and Dr B in late March 2003, in which the options for treating Mr A's chondrosarcoma

were discussed. I am also satisfied, based on Dr B's assurances, that no documentation exists in relation to this consultation.

In respect of the discussion with Dr B, Mr A stated: "He told us that he discussed the scans with colleagues and that he wanted to advise a treatment plan. He said originally there were 3 options. He said in the old days they would do hindquarter amputation, but technically they are much more advanced than that now and it is not done anymore … Then there was the possibility to take out part of the hip bone and leave the leg dangling under the body, which he did not recommend … And then there was a new development in [the second Public Hospital], unique in the world, a Titanium implant that has only been done 3 or 4 times so far. It would be very suitable for me. He did mention that there was a specialist in [the third city], who wanted to be heard about his option but it was not necessary. We told him that we did want to know about that option as well, but never found out."

Mr A also advised me in relation to his discussion with Dr B: "… I was in fact never told by [Dr B] that there [was] urgency for my treatment … when he offered the option of [a] pelvic plate implant [in the second Public Hospital], and said that it will take at least 6 weeks to do, we asked him about the urgency, and the fact that it is a tumour that is growing. He reassured us that there [was] no urgency."

Records received from the third Public Hospital indicate that the films sent to Dr D, by Dr B, were reviewed by the New Zealand Bone Tumour Registry review group on 3 and 10 April 2003. Dr D, who was present at the review, described the findings of the group as follows: "The radiology demonstrated a large tumour consistent with chondrosarcoma involving all three regions of the left hemipelvis with a large soft tissue mass medially. At that time the scan suggested that the sciatic nerve and the iliac and femoral vessels were clear of the tumour. The tumour did not extend past the sacroiliac joint but did extend down to within 3cms of the ischial tuberosity … The histology from [the first Public Hospital] was reviewed by our pathologists and they confirmed a diagnosis of chondrosarcoma grade II … I then phoned [Dr B] with the group's opinion recommending that the lesion was in fact resectable and that the patient could be offered an internal hemipelvectomy with a possible femorosacral arthodesis [bone fusion] as a reconstruction … Subsequent to that telephone discussion [Dr B] mentioned to me that he would review the patient and put those options to him."

In the course of my investigation, Dr B was asked whether Dr D's recommendation was put and explained to Mr A. Dr B stated: "I did not mention bone fusion to [Mr A], as I thought it unlikely that the lesion was indeed resectable at a level that would allow femorosacral arthrodesis to be a viable option."

Subsequent to the meeting in late March, Mr A wrote to Dr B about the treatment options discussed with him. Mr A's letter, dated 11 April 2003, reads: "We would like to continue as discussed with the [second Public Hospital] surgery option that you were organizing for me. If possible I would like to know the name of the specialist there … While waiting I would like to receive second opinions re the diagnosis and the treatment." To this end, Mr A requested that Dr B forward information to two overseas countries for the purposes of

obtaining international opinions on the treatment of his chondrosarcoma. Dr B, in advice to the Accident Compensation Corporation, stated that "these efforts on [Mr A's] part significantly delayed the ultimate treatment". Mr A rejected this statement, and observed that he and his partner only wished to make use of the time available while awaiting Dr B's referral.

Dr B referred Mr A to Dr E, orthopaedic surgeon at the second Public Hospital, on 29 April 2003. By letter dated 1 May, Dr E confirmed that he had fully assessed Mr A, had reviewed all the relevant imaging, and confirmed that Mr A wished to have surgery – namely replacement of the hemi-pelvis with a hip replacement (a custom-made titanium implant). A CT scan of Mr A's pelvis was performed on 1 May for the purpose of constructing a bio-model for Mr A's titanium implant. Construction of the titanium implant was to occur over the ensuing 4 to 6 weeks.

Mr A noted: "Already then on 1 May 2003, [Dr E] and [the second Public Hospital] administrator mentioned to me that funding might be a problem. I … trusted [Dr B] that if he referred me he knew what he was doing ..."

Although the bio-model was constructed as arranged, disputes over the funding of Mr A's operation (estimated at $55,000) delayed his treatment. Surgery was not able to proceed because of the [second Public Hospital's] financial constraints and a lack of funding from outside the region. An application for high-cost treatment was made to the Ministry of Health on 22 May, and was subsequently declined on 9 June.

On 10 June 2003, Dr E contacted Dr D, orthopaedic surgeon, at the third Public Hospital. Dr E informed Dr D of the funding constraints that had prevented Mr A from receiving treatment, and asked Dr D to review Mr A. Dr D also received telephone calls and a written referral requiring him to take over Mr A's care from Dr F, orthopaedic registrar for Dr B.

On receiving Dr F's referral, Dr D scheduled an appointment for Mr A to consult him on 20 June, with a tentative operation date of 23 June, subject to Mr A's approval. Dr D requested Dr F to conduct an urgent repeat MRI scan of Mr A's pelvis, and a repeat CT scan of Mr A's chest. Dr D noted in his clinical record: "It is my opinion that these new scans are required in view of the extensive time period that has [e]lapsed since his initial imaging … The significant delays and treatment for this man are of significant concern. I have expressed this concern both to [Dr F] and directly to [Dr E]."

The CT scan of Mr A's chest and abdomen was performed on 16 June. The CT films showed no metastatic disease detected in the chest or liver (which was consistent with an earlier CT scan performed on 31 March). The MRI scan, however, showed that the tumour had grown since the previous imaging in March.

Mr A and Ms A (Mr A's partner) met with Dr D on 20 June at a clinic in the third city. Dr D observed: "It seems to me that [Mr A] was not aware of the significance of his disease. He tells me that he was informed that there was no rush for him to make a decision about this pelvic tumour." On reviewing Mr A's recent MRI scan, Dr D noted that the tumour had become significantly more extensive. The chondrosarcoma was now displacing the

prostate and bladder and extending to the sacroiliac joint and close to the symphysis pubis. A plain X-ray revealed no calcification in the soft tissues. Dr D concluded that Mr A's chondrosarcoma was now grade III.

In a letter to Dr B, dated 20 June, Dr D explained that although optimal treatment would have involved a wide resection of the tumour, this was no longer possible. The only viable way to achieve resection, in Dr D's view, was to perform a hindquarter amputation, effectively removing Mr A's left leg and the majority of his left pelvis. Dr D did not consider, in view of the tumour's increased size, that a hemipelvic reconstruction could be manufactured in reasonable time. He informed Mr A of the poor five-year survival rate of patients with grade III chondrosarcomas, even where tumours could be resected widely. Dr D also mentioned the option of palliative care, and emphasised that resection surgery might not affect Mr A's chances of long-term survival.

Dr D, in his notes, observed: "After a consultation which essentially took all afternoon with three periods where I left [Mr A] and [Ms A] to discuss things at length in their own time … [Mr A] has made a decision that he wishes to go ahead with a hindquarter amputation understanding what is involved. He understands that there is a risk that we may have to perform a cystostomy if we are unable to free this tumour from his prostate and base of [his] bladder. The other risks include incontinence and impotence as well as infection, DVT, pulmonary embolus, and the not insignificant risk of local tumour recurrence which is associated with very poor survival … [Mr A] today repeatedly expressed serious concern regarding initially his delay in diagnosis and then the significant delay since the initial referral in early April of this year and his getting surgery." Mr A noted: "It is impossible to describe what agony we went through that weekend. We decided to go ahead with the operation. Fortunately the bladder and prostate could be saved."

On 23 June 2003, Mr A underwent a left hindquarter amputation. The histopathology specimen taken subsequently indicated that the tumour removed was a chondrosarcoma, grade II (although Dr D observed that it was more aggressive than a typical grade II chondrosarcoma). Postoperatively, Mr A experienced a long period of convalescence, which was complicated by his pain relief requirements, infection, and necrosis of the skin flap formed around his wound. He has since been fitted with a hindquarter disarticulation prosthesis.

Mr A explained the impact of his surgery as follows: "There is no way to describe how a hindquarter amputation affects a person. Even a below or above the knee amputation can still be so much more functional. But to have your pelvis missing as well is indescribable. At one side I try to be strong and do as much as possible … but every step forwards to imitate any bit of a normal life will rub my nose immediately into the fact that my handicap will always keep me far away from the person I was. Every step forwards makes you aware that it's actually just 1 step forwards from 10 steps back. Trying nothing is safer. At least you don't get reminded constantly of the invalid you have become. And the biggest despair hits me when I realize that this amputation could have, should have, and would have been prevented if I was diagnosed and referred to [Dr D] only a few months earlier."

Mr A has subsequently been diagnosed with metastatic disease in his lungs, and is receiving palliative care. He observed:

> "It is clear that [Dr B] withheld crucial information and made the outrageous decision to direct me to what 'he thought was better' … This is a violation of my rights for informed choices and of getting the best treatment options. It is also a violation of doctor-client relationships which are today based on complete information sharing and empowerment."

Code of Health and Disability Services Consumers' Rights

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

Right 4
Right to Services of an Appropriate Standard

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

Right 6
Right to be Fully Informed

(1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –

…

(b) an explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option …

Relevant Standards

The Medical Council publication 'Good Medical Practice – A Guide for Doctors' (2000) states that doctors must:

> "keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed".

Opinion: Breach – Dr B

Information about treatment options – Mr A's complaint
Mr A complained that in March and April 2003 Dr B did not fully inform him about possible treatment options for his chondrosarcoma, that Dr B unduly pushed for one particular treatment option (hemipelvectomy and titanium implant), and that Dr B failed to adequately convey to him the urgency with which treatment should have been sought. Mr A alleges that Dr B's failures in this respect resulted in a completely avoidable hindquarter amputation and in unacceptable delays in treatment, which increased his risk of metastatic disease.

Information, options and emphasis on appropriate treatment
It is clear from the information gathered in the course of my investigation that Dr B met with Mr A on one occasion in late March to discuss the management of his chondrosarcoma. Mr A has stated that he was advised of three treatment options: hindquarter amputation, which Dr B described as a procedure that would have been done in the old days; removal of part of the pelvis, which Mr A understood would leave a "dangling" leg; and titanium implant, which Dr B referred to as a new procedure performed successfully in the second Public Hospital on three or four occasions, and which was "unique in the world". Mr A has also stated that he was aware that a specialist from a third Public Hospital had another treatment option but that Dr B did not regard that option as necessary to consider at that time. Mr A requested details of that option to be given to him but never received such details from Dr B.

Dr B has not provided me with any details of what was discussed at this consultation, although he advised that he did discuss the possibility of having Dr E of the second Public Hospital give an opinion on management. He also stated that he had recommended the case to be reviewed by Dr D at the third Public Hospital in the third city.

It was following this meeting that Dr B received the opinion of Dr D, who recommended resection of the tumour coupled with a femorosacral arthrodesis (fusion of the femur to the pelvis). Dr D had formulated his opinion after review of the relevant clinical information and imaging, in conjunction with the New Zealand Bone Tumour Registry Review Group on 3 April (and subsequently on 10 April). Dr D's notes indicate that he telephoned Dr B with the group's opinion, and that Dr B advised that he would be reviewing the patient and would put the options to him.

There was a further telephone discussion between Dr B and Mr A on or about Wednesday 9 April, following which Mr A sought further clarification by letter dated 11 April. In that letter, Mr A clearly indicates: "[I] would like to continue *as discussed* with the [second Public Hospital] surgery option *that you were organising for me* … and that *while waiting* I would like to receive second opinions re diagnosis and treatment" [my emphasis].

Dr B formally referred Mr A to Dr E at the second Public Hospital on 29 April 2003, having previously forwarded relevant X-ray and biopsy reports.

Dr B has confirmed that he did not advise Mr A of Dr D's option for treatment – namely internal hemipelvectomy with a femorosacral arthrodesis as a reconstruction. Dr B has stated that he did not present this option as he did not consider Mr A's chondrosarcoma to be resectable at a level that would allow a viable reconstruction.

Right 6(1) of the Code affirms a patient's right to receive the information that a reasonable patient, in that patient's circumstances, would expect to receive. In particular, Right 6(1)(b) of the Code identifies a patient's right to receive information about the options available for treatment. I consider that a reasonable patient in Mr A's circumstances would expect to receive the information presented to Dr B by Dr D about a femorosacral arthrodesis. Indeed I find that Mr A specifically requested to be advised of this "[third Public Hospital] option". It is also clear that Dr B was well aware of Mr A's interest in seeking alternative treatment options (second opinions) as evidenced by his letter of 11 April.

While I accept that Dr B is entitled to formulate his own clinical view on the viability of a particular treatment option, he nevertheless needed to put Dr D's option to Mr A. This is particularly the case as the option was considered and formulated by a specialist bone tumour peer review group, and a respected orthopaedic surgeon from whom Dr B had sought an opinion. Dr B's stance that resection and femorosacral arthrodesis was not a realistic option for Mr A did not absolve him of his obligation to provide his patient with full information (all the information that a patient in Mr A's circumstances would expect to receive) to enable him to make an informed choice. Moreover, in putting the various options to Mr A (including femorosacral arthrodesis) Dr B needed to explain those options and the risks and benefits of each. Additionally, in my opinion, surgeons have a responsibility to locate their own opinions within the spectrum of professional views about possible procedures, and to contextualise their views, rather than simply preferring their own, which in effect deprives the patient of informed choice.

In summary, Dr B had an obligation to inform Mr A of the option of resection and femorosacral arthrodesis – even if he disagreed with the viability of this treatment option – and to facilitate discussion regarding this option. By failing to discuss this information with Mr A, including the risks, benefits and side effects, Dr B breached Right 6(1)(b) of the Code.

Documentation

Dr B has been unable to provide me with any record of his meeting with Mr A in late March, or clarification as to the date of that meeting. However, he has indicated that such documentation likely does not exist, because the options for treating Mr A's chondrosarcoma were "in evolution" at the time. Dr B clarified this statement by observing that the treatment options available are refined by subsequent clinical investigations.

I note also that there was a telephone conversation with Mr A on 9 April where treatment options were also discussed. There is no record of this conversation.

I accept that clinical investigations alter the treatment options available and that often treatment options can be evolving. However, these factors do not alter the obligation on a medical practitioner to document consultations including (but of course not limited to) discussions regarding treatment options. The documentation of consultations is important to ensure an accurate record for other health professionals involved in a patient's care, and appropriate continuity of care. As Dr B has pointed out, there were varying treatment options available to Mr A which were evolving and which, in one instance, resulted in a difference of clinical opinion. Given the gravity of the decision Mr A faced, and the likelihood of future discussions with other health professionals, it was important not only to provide such information to him, but to ensure that such discussions were adequately documented. By contrast, I note Dr D's full notes documenting the extent of the discussions he had with Mr A at the time of his involvement.

The Medical Council has a clear expectation that doctors will "keep clear, accurate, and contemporaneous patient records".

In my opinion, by failing to document his consultations with Mr A, both in late March and following his telephone call with Mr A on 9 April, Dr B did not provide services that complied with professional standards, and therefore breached Right 4(2) of the Code.

Opinion: No further action

Mr A raised concerns regarding the appropriateness of his referral to the second Public Hospital for a titanium implant, and believes that the referral should not have taken place. Though I have not been presented with any information that demonstrates the referral was inappropriate, Mr A is clearly of the view that titanium implants are obsolete and that a saddle prosthesis would have been a preferable reconstruction for his pelvic resection.

In my view the concerns raised by Mr A in this respect are intrinsically linked to the quality of information provided to him, and his ability to make a fully informed choice regarding treatment options. It is therefore problematic determining the extent to which Dr B's referral was appropriate. However, as I have already reached findings in respect of the information Mr A received, I consider that it is unnecessary for me to take any further action on this part of Mr A's complaint.

Opinion: No Breach

Vicarious liability
Under section 72(2) of the Health and Disability Commissioner Act 1994, employers are responsible for ensuring that their employees comply with the Code. Pursuant to section 72(5) of the Act, it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the acts or omissions leading to an employee's breach of the Code.

Dr B has advised that he was employed by a university and, as part of that employment contract, he worked 50% of his time for the first Public Hospital under an employment arrangement between the university and the first Public Hospital.

Dr B has been found in breach of Right 4(2) and Right 6(1)(b) of the Code. Accordingly, pursuant to section 72 of the Act, his employer is vicariously liable for his breaches. However, in this case, I am satisfied that Dr B's breaches of the Code are as a result of independent clinical judgement and, therefore, neither the university nor the first Public Hospital is vicariously liable for those breaches.

Other comment

Urgency and delay in treatment
Mr A has alleged that he was not made aware of the urgency for treating his condition. Mr A's allegation in this respect is corroborated in Dr D's notes of 20 June, which state: "It seems that [Mr A] was not aware of the significance of his disease. He tells me that he was informed that there was no rush for him to make a decision about his pelvic tumour."

Dr B, in his response to ACC, asserted that Mr A's seeking of second opinions "significantly delayed" the ultimate treatment – although in Dr B's opinion these delays did not materially influence the outcome. I note also that the treatment option agreed upon involved a 4–6 week wait, while construction of the titanium implant took place.

Dr D, however, on 12 June, expressed concern at the significant delays in treatment for Mr A.

On the information available to me I am unable to conclude the degree of urgency that was required for Mr A to seek treatment, and whether Dr B ought to have conveyed to him a greater sense of urgency. Certainly, it is clear that a nearly 6-week delay in Mr A's treatment was caused by financial issues at the second Public Hospital, culminating in Mr A's referral to the third Public Hospital. The tumour did grow during this time. However, this delay cannot be attributed to Dr B.

Nevertheless, I am concerned by Dr B's statements suggesting that Mr A contributed to the delays in treatment by seeking second opinions from overseas.

Every patient is entitled to seek second opinions regarding his or her treatment. This may, in some cases, cause delays in care. However, I do not believe that any delay can be attributed to Mr A in this case. Mr A's letter of 11 April clearly indicates that he understood that the second Public Hospital option was in the process of being organised by Dr B, and that any second opinions sought would be while he was awaiting the outcome of the second Public Hospital referral. That is, the second opinions were being sought concurrently with the second Public Hospital referral. I am therefore concerned that Dr B did not formally refer Mr A to Dr E until 29 April. However, there is insufficient evidence available to me to ascertain the reasons for the delay in the referral, and whether such delay was unreasonable. I am also unable to comment on the effect that such delay had on the course of Mr A's illness. Nevertheless, I ask Dr B to fully consider and reflect upon my comments in this respect.

Actions taken

Dr B has apologised to Mr A for his breaches of the Code.

Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand and the Royal Australasian College of Surgeons.

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