Dr B

A Report by the

Health and Disability Commissioner

(Case 01/05619)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Consumer
Dr B	Provider, Hepatobiliary Surgeon
Dr C	Consumer's General Practitioner
Dr D	Radiologist
Dr E	Consumer's Gynaecologist
Dr F	Radiologist
Dr G	General Surgeon

Independent expert advice was obtained from Professor Iain Martin, Professor of Surgery and consultant general and upper gastrointestinal surgeon.

Complaint

On 23 May 2001 the Commissioner received a complaint from Mrs A about Dr B. The complaint is that:

- *Dr B, surgeon, did not correctly assess and diagnose Mrs A's condition during March 2001.*
- *Dr B did not give Mrs A any satisfactory alternative options other than major surgery for her condition.*

These actions undermined Mrs A's confidence in the medical fraternity.

An investigation was commenced on 11 October 2001.

Information reviewed

- Letter of complaint from Mrs A
- Response from Dr B and associated medical records
- Mrs A's clinical records from the District Health Board for the 20 April 2001 admission, together with letter following outpatient consultation 11 April 2001.

Information gathered during investigation

On 8 March 2001 Mrs A saw Dr C, her general practitioner, after experiencing abdominal discomfort. Mrs A had a previous history of a right salpingo-oophorectomy in 1977, a mastectomy in 1999 and removal of dermoid tumours and hysterectomy in August 2000. Following an ultrasound examination in 2000, Mrs A was also found to have cysts on her liver. A further ultrasound done on 8 March 2001 identified that the larger of the cysts had grown from 6cm to 9 or 10cm. Dr C referred Mrs A to Dr B, hepatobiliary surgeon, who made an appointment for her to have a CT scan and consultation on 29 March 2001. The CT scan was carried out by Dr D, a radiologist who reported a cyst measuring 7.8 by 7cm in segments 2 and 3 of the liver and further small cysts in the right lobe, the largest being just over half a centimetre in diameter.

On 29 March 2001 Mrs A had a consultation with Dr B. According to Mrs A he advised her that the cyst in the left lobe of the liver was in a difficult section and would require surgical intervention. Mrs A stated that because of her previous history she was "naturally concerned with the possibility of further cancerous tumours" and that Dr B, when asked, said he could not rule out the possibility of malignancy.

Dr B said that he discussed with Mrs A the probability that the cyst was a simple benign cyst and that there was a small possibility it might be a benign tumour or cystadenoma, which could become cancerous over time. Dr B noted that Mrs A was rather stressed owing to her medical history, the development of further problems, a recent separation from her husband and financial concerns over the surgery. Dr B stated that he reassured Mrs A that the cyst was unlikely to have anything to do with her previous dermoid cyst.

Both Mrs A and Dr B agreed that possible treatment options were discussed including deroofing (draining the cyst) laparoscopically. Dr B advised that while this was the "current vogue and simplest" treatment it was not the one he favoured. The other treatment approaches discussed were deroofing the cyst via open surgery and removing the cyst and part of the surrounding liver (hepatectomy) via open surgery.

Dr B stated that he advised Mrs A that if open surgery was the chosen option it would be preferable to remove the entire cyst via left hepatectomy. He claimed that Mrs A expressed her preference for one operation to resolve the matter once and for all. Mrs A stated that Dr B led her to believe that the only safe alternative was open surgery and hepatectomy because of the possibility of malignant cells spreading and the probability that the cyst would regrow. In his letter to Dr C following the consultation, Dr B said that the cyst would almost certainly re-form. Dr B stated that he discussed the risks of the hepatectomy in detail; Mrs A recalled that Dr B told her that the risks of haemorrhage and possible death were complications of this operation.

According to Mrs A, Dr B said that the operation, a left hepatectomy, could be carried out on 24 April 2001 at a private hospital where he worked, at a cost of between $15,000 and

$23,000. Mrs A said that she asked if the operation could be carried out at a public hospital, but Dr B replied he no longer worked there and she gained the impression that there were no local surgeons who could perform the procedure safely. Mrs A stated that she felt she had "no other alternative but to accept his diagnosis and confirm the date for admission to [the private hospital]".

Dr B said that he discussed the option of surgery at a public hospital but that Mrs A did not want to go to the public hospital unless he was able to perform her surgery there. Dr B's clinical notes record "would prefer I operate and willing to accept my advice".

Once Mrs A had recovered from the shock of the diagnosis and considered the severity of the recommended treatment, she elected to discuss the diagnosis and procedure with Dr E, her gynaecologist, Dr F, a radiologist, and Dr C, her general practitioner. Mrs A was advised to seek a second opinion from Dr G, a general surgeon performing liver surgery at the public hospital. Dr E advised me that Mrs A "certainly wasn't aware" of Dr G. On 2 April 2001 Dr C referred Mrs A to Dr G.

On 4 April 2001 Mrs A saw Dr G. Mrs A stated that Dr G advised her he was certain the cyst was benign with no evidence of malignancy and he could perform a relatively straightforward draining of the cyst laparoscopically before the end of April. In a letter to Dr C, general practitioner, Dr G stated that he had reviewed the CT scan and discussed the findings with Dr F, radiologist. Dr G stated:

> "The ultrasound is more accurate in determining that this is a simple cyst with no irregularities in its wall and [Dr F] is quite emphatic that this has a very thin wall and no internal structure at all."

Dr G noted that Dr B had recommended liver resection but stated that he and Dr F were confident that this was a simple cyst and should not be treated unless symptomatic. Further, that as the cyst was symptomatic in Mrs A's case, "it could be dealt with by excising the window of the cyst wall laparoscopically if the fluid within the cyst is not bile stained on aspiration". Dr G stated that excising a part of the liver, although straightforward, was not required.

On 20 April 2001 Mrs A underwent a laparoscopy and incision of the liver cyst and was discharged from hospital the following day. On 7 May 2001 the biopsy results were reported and confirmed that the cyst was benign. In a letter to Dr C on 9 May 2001, Dr G stated that he had seen Mrs A and that the histology of excised tissue confirmed a simple benign cyst. He further noted that she had made a rapid recovery from the operation and that although there was a chance it might recur he did not think it was "a high chance" and did not see the need for follow-up.

Independent advice to Commissioner

The following independent expert advice was obtained from Professor Iain Martin:

"I, Iain Gregory Martin M.Ed MD FRCS FRACS, have prepared this report at the request of the Health and Disability Commissioner. I am Professor of Surgery and a consultant general and upper gastrointestinal surgeon. I have extensive experience of upper gastrointestinal and laparoscopic surgery. The report relates to the advice given by [Dr B], consultant surgeon, to [Mrs A] in March 2001.

The report will consist of four parts:

a) A summary of the relevant events
b) My interpretation of said events
c) Answers to specific questions raised by your office
d) My opinion on the standard of care in this case

Part 1 – Summary of events

- 21st March 2001. [Mrs A] … was seen by her general practitioner [Dr C]. A past history of breast cancer requiring mastectomy and left sided ovarian cysts was noted. The pertinent point was that [Mrs A] was having some symptoms of abdominal discomfort and had had an ultrasound scan showing cysts in the liver and kidneys. She was referred to [Mr B] for advice.
- 29th March 2001. [Mr B] arranged for [Mrs A] to undergo a CT scan of her abdomen. This was performed and reported by [Dr D] at [a radiology clinic]. The main finding was of a 7.8 x 7cm thin walled simple cyst in the left lobe of the liver. Several small cysts in the right lobe of the liver were also noted, together with some lesions in the kidneys which probably represented the cysts seen on the previous ultrasound.
- 29th March 2001. [Mrs A] was seen by [Dr B] in his rooms at the [private hospital]. The finding of the ultrasound and CT scans were discussed with [Mrs A]. It was clearly indicated by [Mr B] that these were, most likely, simple cysts. Treatment options including laparoscopic deroofing and left hepatectomy (liver resection) were discussed. At the conclusion of the consultation it was decided to proceed with left sided liver resection on the 24th April 2001. It was stated by [Dr B] that 'almost certainly it (the cyst) will reform' if treated by laparoscopic deroofing.
- 2nd April 2001. [Mrs A] again consulted her general practitioner [Dr C]. [Mrs A] was uncomfortable with the recommendation to proceed with liver resection and it was arranged for her to see [Dr G], consultant surgeon […] for a second opinion.
- 4th April 2001. [Mrs A] was seen by [Dr G] in his outpatient clinic. [Dr G], after reviewing the scans, felt confident this was a simple cyst of the liver and recommended laparoscopic deroofing of the cyst.

- 20th April 2001. [Mrs A] underwent laparoscopic surgery for her left sided liver cyst. The roof of the cyst was removed and sent for histological examination. The procedure was uneventful and she was discharged from hospital on 22nd April.
- 9th May 2001. [Mrs A] was seen for review in the outpatient clinic by [Dr G]. It was noted that the pathologist had confirmed that this was a simple benign cyst of the liver. She was discharged from further follow up at that stage.

Section 2 – Interpretation of events

Mrs A has a simple cyst of the left lobe of the liver. These cysts are relatively common and most require no treatment. A small proportion slowly enlarge and cause pressure related symptoms and at this point surgical intervention is considered. The diagnosis in this case was made using ultrasound and CT scanning which would be recognised as the standard investigations.

Treatment would usually involve excising a portion of the cyst wall allowing the remaining cyst to drain freely into the abdominal cavity. This operation can be performed at open or laparoscopic surgery with most authors now recommending the laparoscopic approach as the treatment of choice. There is a risk of recurrence with such an approach of around 10%.

The use of a liver resection to treat simple cysts has the advantage of removing the chance of recurrence and has been described in the surgical literature. Most surgeons would not adopt this approach, believing that the risk of recurrence is more than offset by the increased morbidity associated with liver resection. For your information I have attached a copy of a recent review article summarising the assessment and treatment of such cysts.

Section 3 – Answers to specific questions

a) Assessment and diagnosis of [Mrs A's] condition. There is no doubt that the condition was assessed appropriately and recognised as a simple cyst of the liver by [Dr B].

b) Choice of treatment by [Dr B]. There is considerable variance between [Mrs A's] recollection of the clinic consultation and the clinic letter and hand written notes of [Dr B]. At no point in this documentation was malignancy mentioned by [Dr B] although this clearly features highly in the recollections of [Mrs A]. I can only base my interpretation of events upon the written evidence contained within the documentation provided to me.

   To me, it was clear that [Dr B] had recognised that this was a simple cyst and had described two treatment options, namely laparoscopic deroofing and liver

resection. The risks of both approaches were discussed although I believe that the risk of recurrence with deroofing as almost inevitable was overstated when one considers the published evidence (see attached article).[1] Personally I would have recommended laparoscopic deroofing over resection, a view which most surgeons working in this area would support.

In itself, is the use of resection inappropriate or undesirable? My belief to this question is no. Provided the consultation process is open and the patient is fully aware of the options then this approach can be considered but is generally only required in unusual cases. However in this [Mrs A] was not given appropriate information with which to make the decision.

(c) Was enough information given to [Mrs A]? On the basis of the written evidence I would suggest that the information given to [Mrs A] was reasonable with the one exception that the risk of recurrence with deroofing was I believe greatly over estimated.

(d) Should [Mrs A] have been referred to [the public hospital] given her concerns over the cost of the proposed operation? On the basis of the evidence I have before me I cannot answer this question. Clearly [Mrs A] believes that [Dr B] had indicated to her that he was the only surgeon in [the city] capable of performing her surgery but there is no indication of this in the clinic notes. I therefore cannot comment any further on this point.

Section 4 – Opinion on the standard of care

The assessment and diagnosis of [Mrs A] by [Dr B] was entirely appropriate and professional. The treatment options presented by [Dr B] to [Mrs A] were options that were appropriate to consider. I believe that the risk of recurrence given for the laparoscopic deroofing operation was over estimated and not supported by published literature. However, liver resection is a described option for such cysts although generally not used because of its much greater associated morbidity.

Does the presentation of the evidence by [Dr B] to [Mrs A] which led to her initial decision to undergo liver resection indicate that the standard of care applied by [Dr B] fell below an acceptable standard? After careful consideration I feel that such a conclusion can be drawn. In many areas of medicine there is no consensus as to the most appropriate treatment and judgements have to be made balancing various aspects of treatment and its associated side effects. In order for an informed decision to be

[1] Cowles, R. and Mullholland, M., 'Solitary Hepatic Cysts', *Journal of American College of Surgeons,* vol.191, No.3, 311-321, at 317-318, September 2000.

made the evidence given to the patient needs to be balanced and fair reflecting not only personal experience but published results. I would disagree with [Dr B's] belief in the very high risk of recurrence with laparoscopic deroofing and do not believe that if the operation had proceeded that consent would have been fully and appropriately informed."

Further independent advice

In Professor Martin's original advice he stated that "at no point in this documentation was malignancy mentioned by [Dr B]". However, in his response to notification of my investigation, Dr B stated that he advised Mrs A that there was a small possibility that the cyst might be a cystadenoma, a few of which become cystadenocarcinomas; and that he told Mrs A the advantages of the (hepatectomy) option included removing the small possibility that the cyst might be a cystadenoma.

Professor Martin was asked to clarify whether Dr B overstated the possibility that the cyst might be a cystadenoma.

Professor Martin advised me that the risk of malignancy was extremely low; he has no evidence of anyone else using this approach (hepatectomy), and it does not reflect current practice for the majority of surgeons.

Professor Martin said that he agreed with Dr G that such cysts are only ever treated if symptomatic. However, Professor Martin did not know what stress Dr B had put on the possibility of cancer when he talked to Mrs A, and that was not apparent in the information he reviewed.

Response to Provisional Opinion

In response to my provisional opinion Dr B said that the report drew heavily on Mrs A's recollection of events and on Professor Martin's opinion in a field outside his expertise. Dr B stated that he believed the distinctions between the views of Professor Martin, Dr G and himself to be "relatively subtle". A further interview was conducted with Mrs A, and Dr C, Dr F and Dr E were interviewed. Further expert advice was sought from Professor Martin.

Dr B said that his advice to Mrs A was based both on his knowledge of the literature and on his own experience. Although he was aware of the tendency to treat large cysts with laparoscopic deroofing, his personal experience had demonstrated the "shortcomings" of such an approach. Dr B cited two examples from his own experience where simple cysts

have been demonstrated to be cystadenomas, one with changes requiring complete resection and the other where the cyst had re-formed.

In relation to the question of malignancy, Dr B said that he was clear that although the possibility was small, it nonetheless existed despite Dr G's and Dr F's assurances. Further, Dr B said that his advice to Mrs A was based on the belief that hepatectomy was the best way to achieve a "final resolution of the cyst" and at the same time deal with the small possibility of malignancy. Dr B said there was an increased risk of recurrence in Mrs A's case as her cyst had already grown considerably in a short space of time and there was therefore an increased likelihood of recurrence of a symptomatic cyst. Mrs A told me that the options Dr B gave her were not options as she was led to believe that major surgery was inevitable whatever choice she made and she therefore felt pressured into agreeing to Dr B's recommendation.

Dr B said that if performed by an experienced liver surgeon, removal of the left lateral segment of the liver is relatively safe and straightforward. However Mrs A said that Dr B told her that such an operation was "pretty serious and quite dangerous" and would involve six to ten days in hospital including high dependency nursing for two to three days, six weeks off work and a cost of $15,000–$23,000. Mrs A gained the impression that the operation was very serious and there were only a few people in the country with the requisite skill to perform it, one of whom was a doctor mentioned by Dr B.

Dr B said that he did advise Mrs A that Dr G at the public hospital was an experienced liver surgeon and could give her an opinion that would not necessarily concur with his. Further, he said that Mrs A indicated she had done her homework and was satisfied that he was the liver surgeon she wished to be treated by. Mrs A said Dr B did not advise her she could have her surgery done at the public hospital or seek a second opinion there. She said that she did believe that Dr B was the best person for the job; at that point she had confidence in him and a second opinion was not even an issue. Dr B said that Mrs A was "rather stressed" and may not have taken in the information.

Dr E said that Mrs A was not aware of Dr G at the public hospital when he spoke to her following her consultation with Dr B and that he advised her that Dr G was able to provide a second opinion that was equally valuable. Further, Dr E said that he felt that the treatment Dr B planned for Mrs A was out of proportion to what was required from his understanding of the cyst. Dr F said that he advised Mrs A to seek a second opinion when she rang him after seeing Dr B. Dr F suggested that Mrs A see Dr G at the public hospital and said that Mrs A did not seem to be aware of Dr G as another liver surgeon.

Further independent advice

The following further independent expert advice was obtained from Professor Iain Martin:

> "Thank you for supplying me with the provisional opinion and the various responses and additional information provided.
>
> I have read and considered the response for [Dr B], the interviews with [Mrs A] and [Drs F, E] and [Dr C].
>
> I have not seen anything within the new material that conflicts with the evidence previously provided.
>
> In answer to [Dr B's] comments that this case is without my sphere of expertise, I would like to comment as follows. I consider that my major area of sub specialist interest is in the field of diseases of the oesophagus, stomach, biliary tract and pancreas. Although I no longer carry out resectional liver surgery, I treat patients with liver disease and have performed and would continue to perform laparoscopic procedures in this area. I respect the fact that undoubtedly [Dr B] has far greater experience than me in liver resection, however I do not believe that this precludes commenting on the issues here. This is especially true when one considers that the issue here is largely one of the issue of informed consent and what that implies in terms of the information that would be given to a patient.
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> In light of [Dr B's] comments, I have entirely anonymously (in terms of patient details) and with no reference to the office of the Health and Disability Commissioner, sought the opinion of three other liver surgeons (two in New Zealand and one in the UK) and asked how they would treat a simple cyst such as this. There was unanimity in their opinion. Firstly they would only intervene if the cyst was symptomatic and secondly, laparoscopic deroofing would be the first treatment of choice. I therefore remain of the opinion that the opinion I gave you reflects current practice.
>
> The main issue here is what constitutes appropriate information to impart to a patient when considering treatment for a patient. It is clear that the standard that we are expected to apply is *'what a reasonable patient would expect to know in the circumstance'*. In this case there were two possible options, namely resection of the left side of the liver or laparoscopic deroofing of the cyst. It is clear that both options were explained to the patient and that the potential complications of the more major resection were described to [Mrs A]. To this point I have no debate with [Dr B]. However, I believe that a reasonable patient would wish to know that the vast majority of surgeons working in this area would not contemplate resection as the initial treatment for such a simple cyst and that the laparoscopic operation yields good results in the vast majority of patients.

Clearly this is a matter of debate. At what point, and with what weight, can an individual practitioner put personal opinion and their own experience into the equation when discussing matters with patients? This is further complicated by the 'shifting sands' of issues surrounding informed consent. I spent a considerable amount of time considering which side of the fence I would come down on when I gave my initial opinion and I have again spent time reflecting on the issues here. I have to say, that however experienced a surgeon is, when discussing issues with patients, you have to fully reflect not only on your own opinion but that of the broader medical population in which you work. I believe that if we use the standard of what a reasonable patient would wish to know, then a reasonable patient would wish to know that the majority of expert surgeons working in this area would not use a particular technique as first line treatment. I fully recognise that this is an opinion which can and perhaps will be challenged and that many medical practitioners would see such advice as demeaning their many years of experience in an area, but I think in the context of 2002 that this is the standard to which we have to practice."

Code of Health and Disability Services Consumers' Rights

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

RIGHT 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 –*

    a) *An explanation of his or her condition; and*

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

Opinion: Breach – Dr B

Right 6(1)(a) and (b)
When Mrs A attended her appointment with Dr B on 29 March 2001 she had undergone an abdominal and pelvic ultrasound scan on 8 March and a CT scan earlier that day. Both scans identified a large, simple cyst in the left lobe of the liver. The ultrasound report stated that the cyst appeared stable and benign with no solid component.

Dr B was required to provide Mrs A with an explanation of her condition and an explanation of the expected risks, benefits and side effects of the available options for treating the symptomatic cysts on her liver. Dr B told Mrs A the probability was the cyst was a simple cyst but that there was a small possibility it was a benign tumour or cystadenoma, a few of which could become cancerous.

Both parties agree that options discussed were deroofing the cyst laparoscopically, deroofing the cyst through open surgery, and removing the cyst and part of the surrounding liver (hepatectomy) through open surgery. Dr B stated that he advised that if open surgery was the preferred option, then it would be preferable to remove the entire cyst via resection of the left lateral segment of the liver or left hepatectomy. Dr B made it clear to Mrs A that he did not favour the laparoscopic deroofing approach and advised her that there was a probability the cyst would would re-grow and require further surgery. Mrs A was left with the impression that the only safe alternative was a liver resection or hepatectomy. A resection of the liver is a major operation, the complications of which include haemorrhage and possible death. The financial costs of such a major operation are also significant.

Mrs A sought a second opinion from Dr G, who advised that the ultrasound scan was a more accurate way of determining the nature of the cyst. Dr G stated that he and Dr F, radiologist, were confident the cyst was a simple cyst that only required treatment because it was symptomatic. Dr G advised Mrs A that the cyst could be dealt with satisfactorily by laparoscopic deroofing.

Dr B's concern that there was a small possibility the cyst was a cystadenoma was inconsistent with the findings of the ultrasound scan and CT scan. My expert advised that he agreed with Dr G's statement that such cysts are only ever treated if symptomatic, as the risk of cancer is extremely low. Dr B therefore overstated the risk of cancer in advising Mrs A that the cyst was possibly a cystadenoma, a few of which could become cancerous.

Professor Martin advised me that Dr B also overstated the risk of recurrence with the laparoscopic deroofing approach when he told Mrs A the cyst would almost certainly regrow. I am advised that the actual risk of recurrence is around 10% and that most

surgeons would not elect liver resection to treat a simple cyst such as that Mrs A had. Cowles and Mullholland, in a review of assessment and treatment of such cysts, state:[2]

> "Hepatic lobectomy for simple cysts has been reported and is associated with good results, but a procedure of this magnitude with its associated risk, is not often necessary. …
>
> Because of the excellent overall results obtained with laparoscopic unroofing of simple liver cysts, this should be considered the procedure of choice for treatment of these lesions."

Although the use of liver resection may be appropriate where there is an open consultation process and the patient is fully informed of the options, Mrs A was not given adequate information to make the decision. My expert advisor noted that in many areas of medicine there is no consensus and judgements have to be made by balancing various aspects of treatment and associated side effects. An informed decision on the part of the patient requires balanced and fair information reflecting both personal experience and published results. I wholeheartedly agree.

Dr B did not give Mrs A an accurate interpretation of the ultrasound findings and overstated the risk of recurrence of the cyst. Furthermore, Dr B gave undue weighting to his preference for a procedure associated with much greater morbidity and not supported by current research.

In response to my provisional opinion Dr B said that his own considerable experience is a factor in the advice that he gives and that he believed my independent expert to be providing an opinion on a field outside his area of expertise. I am satisfied that my expert is sufficiently qualified to comment and I accept his further advice that "the vast majority of surgeons working in this area would not contemplate resection as the initial treatment for such a simple cyst". A patient is entitled to information that fully reflects not only an individual surgeon's own opinion but also the majority opinion within the particular field.

Mrs A also claimed that Dr B gave her the impression, in answer to her question whether the operation could be performed in the public system, that surgeons at the public hospital could not perform a left hepatectomy, and that her only option was to have that operation performed by Dr B at a private hospital at a cost of $15,000 or $23,000.

In response to my provisional opinion Dr B said that he did advise Mrs A that Dr G at the public hospital was an experienced liver surgeon who could give her an opinion; however,

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[2] Cowles, R. and Mullholland, M., "Solitary Hepatic Cysts", *Journal of American College of Surgeons*, vol.191, No. 3, 311-321, at 317-318, September 2000.

Mrs A was stressed and may not have taken the information in. Further, he said Mrs A indicated she wished to be treated by him. Mrs A said Dr B did not tell her she could have her surgery done at the public hospital or seek a second opinion there. She said she had confidence in him at that point and a second opinion was not even an issue. Both Dr E and Dr F said that Mrs A did not appear to have heard of Dr G or be aware that she could have the operation done at the public hospital.

It is clear that Dr B's communication about alternatives to the operation he favoured was less than effective. Dr B was aware that Mrs A was stressed and for that reason may not have fully appreciated the information she was given. He led her to believe that she required highly specialised and costly surgery that only a small number of surgeons were able to do and that could not be done at the public hospital.

In my opinion, Dr B exaggerated the benefits of hepatectomy by raising the cancerous potential of the cyst and overstating the risk of recurrence when all available evidence was to the contrary. Dr B presented Mrs A with an unbalanced explanation of her condition that supported his own treatment preference. Dr B also failed to give Mrs A adequate information about the alternative of treatment in the public system. In these circumstances Dr B breached Right 6(1)(a) and (b) of the Code of Health and Disability Services Consumers' Rights.

Opinion: No Breach – Dr B

Right 4(1)
Dr B was required to provide services to Mrs A with reasonable care and skill in his assessment and diagnosis of her condition. My expert advised that Dr B appropriately assessed Mrs A's condition and recognised it as a simple cyst of the liver. I am guided by my expert's advice. Accordingly, Dr B did not breach Right 4(1) of the Code.

Opinion: No Breach – the Private Hospital

Vicarious liability
Under section 72 of the Health and Disability Commissioner Act 1994 ("the Act") an employing authority may be liable for acts or omissions by an employee, an agent or a member.

Dr B held clinical privileges at the private hospital but was not an employee. This hospital is a limited liability company and health professionals apply for and are credentialled before

being granted clinical privileges to the facilities. The hospital had granted Dr B privileges to use its facilities but could not reasonably be expected to have prevented any omissions by Dr B to give adequate information in his area of clinical expertise. Accordingly, in my opinion the private hospital is not vicariously liable for Dr B's breach of Right 6(1)(a) and (b) of the Code.

Actions

- I have decided to refer this matter to the Director of Proceedings in accordance with section 45(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any further action should be taken in relation to Dr B.

- A copy of this opinion will be sent to the Medical Council of New Zealand.

- A copy of this opinion with all identifying details removed (other than the name of Dr B), will be sent to the New Zealand Chair of the Royal Australasian College of Surgeons.

- A copy of this opinion, with all identifying details removed, will be sent to the Royal Australasian College of Surgeons and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

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