Gastrointestinal and Colorectal Surgeon, Dr C / Gastroenterologist, Dr D / Gastrointestinal and Hepatobiliary Surgeon, Dr E / The Private Hospital

A Report by the

Health and Disability Commissioner

(Case 99HDC06799)

Health and Disability Commissioner
Te Toihau Hauora Hauātanga

Parties involved

Mr A	Consumer
Ms B	Complainant/Consumer's wife
Medical Centre	Medical Centre
Dr C	Gastrointestinal and Colorectal Surgeon
Dr D	Gastroenterologist and Endoscopist
Dr E	Gastrointestinal and Hepatobiliary Surgeon
The private hospital	Private Hospital
A public hospital	Public Hospital

Expert advice was obtained from two independent general and upper gastrointestinal surgeons.

Complaint

The Commissioner received a complaint from Ms B on 16 June 1999 regarding the services her husband, Mr A, received from Dr C, Dr E, Dr D, and the private hospital.

The complaint is as follows:

Dr C failed to:

- *Fully inform Mr A, prior to surgical intervention, of the risks, side effects and implications of surgery.*
- *Inform Mr A what follow-up care he would require post-operatively.*
- *Hold a practising certificate at the time of Mr A's surgery.*
- *Provide medical cover for Mr A while he was away on leave, instead informing Mr A to contact a nurse at the private hospital if he had problems.*
- *Inform Mr A about the haemovac and the fact that it was going to be in place for 12 days.*
- *Provide timely and appropriate treatment for the lump that occurred from Wednesday 28 April 1999.*
- *Ensure Mr A's iron levels were adequately maintained within normal levels.*
- *Ensure that Mr A understood and was reassured about his changing condition.*

Dr D failed to:

- *Provide timely intervention or refer Mr A for a second opinion about his lump that occurred from Wednesday 28 April 1999. Instead Dr D continued to drain the lump a further three times and arrange an MRI scan.*

Dr E failed to:

- *Provide timely and appropriate care, or refer Mr A for a second opinion when he saw him on Sunday 17 May 1999.*

An investigation was commenced on 5 October 1999.

Information gathered during investigation

Mr A advised that he thought he was born with a lumpy growth on his chest. He remembered his mother taking him to a general practitioner about the growth when he was young.

As Mr A grew older the lump became bigger and made certain body movement awkward. The lump became progressively more uncomfortable and, in the early part of 1999, began to affect his ability to work as an export manager. Mr A was 29 years old in 1999.

On 9 February 1999 Mr A consulted Dr F, general practitioner at the Medical Centre, about the lump on his chest. Dr F conducted a physical examination, including the lump, and recommended referral to a specialist. Mr A called his wife, Ms B, to check that they had medical insurance for this. She confirmed that they did, and Mr A agreed to the referral.

On the same day Dr F wrote to Dr C, gastrointestinal and colorectal specialist at the private hospital, asking for his "opinion and help" with Mr A. Dr F advised that Mr A had consulted the Medical Centre with a "large swelling over the right lateral chest wall".

First consultation
Mr A first saw Dr C at his consultation rooms at the private hospital on 17 March 1999. His wife, Ms B, accompanied him.

Dr C's consultation rooms are divided into two areas: one room contains his desk, and the other serves as an examination room. Dr C took Mr A into the examination room while Ms B remained in the consultation room. Ms B stated that she did not go into the examination room but could "vaguely hear what was going on". Ms B said that Dr C inserted a needle into the growth and removed some fluid. Mr A confirmed that Dr C had felt his abdomen and the lump on his chest and had taken a sample from the site of the lump for testing. Dr C and Mr A then returned to the consultation area.

The medical notes for the consultation show a diagram of the growth. The diagnosis of "haemangioma" was recorded, with the information that the growth may have been present since Mr A was a child. The notes do not state what options were discussed during the consultation, and there is no record of fluids being removed from the growth, or of the results of any tests.

Dr C advised me that Mr A was referred with:

> "an undiagnosed subcutaneous mass on the right side of the upper abdomen and lower chest. Clinically this was an haemangioma situated in the subcutaneous tissue and skin (mainly involving the tissue just under the skin). I aspirated this lump and

> confirmed the diagnosis. Clinically this felt like a cutaneous AV [arteriovenous – pertaining to the arteries and the veins] malformation attached to the skin and with lifting off the abdomen it appeared straightforward to excise and ligate the feeding vessels. It did not appear to involve the abdominal wall muscles to any great extent."

Dr C said he considered other investigations such as an MRI scan but that three years ago this was a new and expensive investigation, which was not fully covered by insurance and the results were not always interpreted accurately. Also with the lesion being close to the skin, it did not seem clinically warranted. On these grounds he decided to forgo the scan.

Dr C noted that he had experience in dealing with cutaneous AV malformations through working in vascular centres in the United Kingdom. He said that if the AV malformation had been anywhere else on the body he would have referred Mr A to a vascular or plastic surgeon. Dr C stated that he was unaware of any multi-disciplinary approach available at the time. He said that he had learnt from this experience and believes there is still a place for a general surgeon's involvement in a process that uses newer radiological techniques and the associated multi-disciplinary approach.

Ms B stated that Dr C diagnosed the lump as a "haemangioma" (a benign tumour consisting of a mass of blood vessels). He said that they could leave the lump as it was for the present or he could surgically remove it. He explained that if Mr A had been referred sooner he could have removed the growth using injections. Dr C said he would make four to five small incisions about two inches long and cut around the haemangioma to remove it. He likened the procedure to filleting a fish. Ms B said that Dr C told her husband that he would stay in hospital for one night and would then have to rest at home for three to four weeks. She advised that during the consultation there was no information provided about anaesthesia or the use of blood products. When Ms B was asked whether she or Mr A had been advised about the potential for pain, bleeding, or infection or the type of bandages to be used post-operatively, she replied that they had not received any of this information. Ms B said that Dr C did not tell them of the possibility of the lesion becoming malignant. She also stated that they were not told that surgery might not be necessary, except for cosmetic reasons.

Mr A also stated that no side effects or advantages and disadvantages of the operation were discussed at the consultation. He confirmed that he was advised that his recovery time would be a few weeks and he would be in hospital for two days and one night.

Dr C said that he allowed up to 45 minutes for the initial interview. As there was no significant past medical history and the diagnosis was made on examination, most of the consultation was spent discussing the management of the condition. Dr C said that they discussed the following:

- that the mass was a collection of blood vessels under the skin;
- in general the mass did not need to be removed except for cosmetic reasons, discomfort or if it was growing, as in rare cases malignancy can occur;

- the operation in some detail. They discussed that the blood vessels under the skin would be removed without moving much skin by using several small incisions, and Mr A likened this to filleting a fish.

In a letter to the Accident Compensation Corporation dated 20 September 1999, Dr C stated that he had estimated that Mr A would be off work for no more than three weeks to one month.

By the evening of 17 March Mr A and Ms B had decided to proceed with the operation. Dr C was told of their decision by a telephone call during office hours on the following day. Proposed dates for surgery were discussed and Mr A recalled that during that call Dr C advised them of the results of Mr A's blood test. Ms B stated that she made this call but cannot remember being informed of the blood test results.

On 18 March 1999 Dr C wrote to Dr F advising that on examination he had found a "large haemangioma with a significant venous [veins] component". Dr C advised that:

> "[a]lthough malignancy can occur in these lesions it is extremely rare. At this stage surgery does not seem to be necessary, except for cosmetic reasons but if it is truly increasing in size then it would be better to excise it while it is still of a manageable size."

Dr C advised Dr F that Mr A had gone away to think about his options and would get back to him in due course with his decision.

Events leading up to surgery

The private hospital provided a copy of a letter dated 1 April 1999 from Ms G, Dr C's secretary, which confirmed that Mr A's surgery was booked for 12 April 1999. The letter states in part:

> "Please find enclosed your admission booklet for [the private hospital]. There are two admission forms in the back which you need to complete and either post to the hospital prior to your admission or bring them with you."

Mr A and Ms B both stated that no additional written information about the surgery was provided and no additional consultation took place with Dr C prior to Mr A's admission to the private hospital. No other blood tests or radiological examinations were undertaken prior to the surgery. The material sent by the private hospital was not personalised to Mr A but contained general information about admission to the private hospital. The private hospital was not able to provide a copy of the admission booklet Mr A was likely to have received in 1998 but was able to provide copies of the 1997 and 2001 editions. The 1997 edition states:

> "Specialists and doctors are granted admitting privileges at [the private hospital] on the basis of their qualifications, skills and experience. Admitting privileges are reviewed individually and annually by the Hospital's Credentials Committee."

I accept that this statement or a statement very similar to this would have been in the private hospital's 1998 admission booklet.

Admission to the private hospital and surgery

Mr A arrived at the private hospital at 9.00am on 12 April 1999 for his operation, accompanied by Ms B and his mother. As instructed by the booklet sent to him by the private hospital, Mr A had had nothing to eat since dinner the evening before. On arrival at the hospital, a nurse showed him to his room. An undated integrated progress plan recorded that Mr A expected to stay in hospital for one night and to have a drain. It is likely that this plan was filled in prior to surgery, as it recorded that Mr A was shaved in preparation for surgery, which was scheduled for around 1pm that afternoon. In anticipation of Mr A's one night stay in hospital, Ms B had taken time off work to be with her husband.

Dr C, who was dressed in his theatre clothing, came and saw Mr A about one hour before the operation and drew a pen mark around the side of the lump. At this time, Mr A told Dr C that he was nervous. Dr C replied that Mr A would be all right.

The private hospital's records indicate that Mr A also saw the anaesthetist prior to his operation. Ms B said that this meeting lasted about 40 seconds. Mr A said that he was not asked to sign a consent form prior to surgery.

Ms B said that a nurse noticed that the form had not been signed. Her husband did not fill in or sign any written consent for his operation at any point before his operation. Ms B was asked to sign a form consenting to the use of blood products. Mr A was present, but ready to be wheeled into the theatre. Ms B said that she refused to sign the consent form until someone explained to her why blood could be needed and what the risks of surgery were. Dr C came and explained to her that there was a chance that Mr A would need to receive blood because of the nature of the surgery. He told her that the other risk was that an infection could develop after surgery. Ms B asked how blood was screened. Dr C's explanation satisfied her and she signed the consent form. Dr C said he discussed with Mr A the likelihood of needing a drain and the possibility that a blood transfusion might be necessary.

The 'consent to treatment' part of the the private hospital admission/consent form has been signed by Dr C and dated 30 March 1999. Ms B has also signed this part of the form but her signature was not dated. Mr A signed the 'cost' part of the form that was dated 12 April 1999, the day of the operation. The 'cost' part of the form reads: "I have been advised by the hospital that the hospital's costs are likely to be about $4-4500-00. I have made arrangements to pay these costs at the time I am discharged. I understand that specialists' and other fees will be billed separately. I authorise [the private hospital] to make credit inquiries provided they are reasonably required."

The operation notes documented that the operation removed most of the haemangioma but the growth involved the abdominal wall muscle and it was impossible to ligate (the procedure of tying off a blood vessel or duct with a suture or wire band) all of those vessels.

Most of the pectoralis major muscle (a large muscle of the upper chest wall that acts on the joint of the shoulder) was also removed, although this was not noted in the operation note. Dr C stated that the surgery proceeded uneventfully and the bulk of the AV malformation was easily excised. The larger feeding vessels coming through the muscle were ligated but smaller vessels were controlled with pressure. An external pressure dressing was applied over a closed suction drain.

The histology (microscopic) report of the specimen taken from the lump during the operation confirmed that the specimen removed from Mr A was a vascular malformation with features consistent with a large vessel haemangioma.

One Redivac (a type of pressurised tube) drain was inserted into the wound to remove fluids, including blood, from the wound site. Ms B said that Dr C told her after surgery that the operation had taken longer than expected. At about 9.00pm, Mr A's hands and face swelled up and he was unable to sleep. These symptoms were explained as a reaction to the anaesthetic. A large amount of blood drained out of the wound site during the first night after surgery.

The following day, when Ms B came to collect Mr A to take him home, Dr C told her that Mr A was not going home. Ms B said that her husband had to stay longer in hospital as there were concerns that he might need a blood transfusion.

Dr C said that he saw Mr A several times each day while he was in hospital and supervised his management. The drainage of blood-stained fluid was low in volume, and slowly decreased.

Discharge from hospital

Mr A was discharged from the private hospital on 15 April 1999. Prior to discharge Dr C told Mr A that a district nurse would be coming to his home to change his dressings and to empty his drain. Mr A said this was the first time he became aware of the need for district nurses to visit him at home to tend to the drain that was still in place. On discharge Dr C advised Mr A not to lift anything when he returned home, with the exception of a cup of coffee. Mr A advised that he was not given any written discharge information and he was not expected to undertake any wound management himself. An appointment was arranged for Mr A to see Dr C a week later.

The district nurse referral, dated 15 April 1999, stated that Mr A had been coached on how to empty the drain and keep a record of the amount of fluid in the drain. The discharge summary stated that Mr A was to empty the drain morning and night and record the amount drained. Dr C wrote a discharge letter to Dr F advising:

> "[Mr A] was comfortable enough to go home after the second day, but I did leave the drain insitu and have organised the district nurse to keep this under review. I expect the drain to come out shortly."

The instructions to the district nurses were to remove the drain when two consecutive amounts of less than 25mls of fluid had been drained from the wound site. The district nurses went to the house regularly to change and check bandages.

Ms B said that they were informed that the drain would only need to be on for a few days. She also stated that they had not been aware prior to the operation that they would need the services of the district nurses. They became aware of this only when Mr A was discharged from the private hospital.

Post-operative problems

Dr C said that he organised to see Mr A every few days, including on the weekends, to check progress. On 20 April 1999 Mr A consulted with Dr C for his first follow-up visit. At this time the bandages were taken off and Dr C and his nurse examined the wound. There is no record of this consultation in the clinical notes but an invoice confirms that this consultation took place.

Ms B advised that on Saturday 24 April 1999 the drainage bag was removed by a district nurse. Mr A stated that it was about two to three days following this that a lump started forming on his side under his armpit.

The stitches were removed on 28 April 1999 at a further follow-up consultation with Dr C. Dr C used a needle to withdraw some blood from the lump. Dr C told Mr A he was going overseas and if there were any problems he was to contact a nurse at the private hospital. There is no record of this consultation in the clinical notes. Dr C said that before he departed for an overseas conference he organised cover from his colleagues at the private hospital.

Getting assistance for the lump

Dr D

By Sunday 2 May 1999 a large lump had formed around Mr A's operation site and was causing him some discomfort. Ms B contacted the private hospital for assistance from "the nurse". However, she was advised that "the nurse" was not available. Instead Ms B was put in contact with Dr D, a gastroenterologist. He arranged to see Mr A the following day, Monday 3 May 1999.

Dr D (who had no previous knowledge of the problems that Mr A was experiencing) diagnosed a large subcutaneous haematoma (a collection of extravasated blood trapped beneath the skin). Dr D discussed Mr A's condition with Dr E, a gastrointestinal surgeon. Following this, 320mls of blood were drained from the haematoma, and a pressure bandage applied. Dr D suggested to Mr A and Ms B that Mr A might need further surgery.

Dr D advised that both he and Dr E felt that if the haematoma was kept dry, the wound would possibly start to heal and scar over. However, they calculated that to achieve this, the wound would need several aspirations (blood being drained from the wound).

Dr D wrote to Dr F (general practitioner) on 4 May 1999 advising that he had seen Mr A on 3 May 1999. He also advised that he had discussed the case with Dr E and they had decided to continue with a conservative course of action. He reported that Mr A did not have a temperature and there was no evidence of infection or discharge from the wound. Dr D advised Dr F that, although Mr A might require further blood removal from the haematoma, the area would gradually scar up and heal. Dr D also advised Dr F that he had arranged to see Mr A in three or four days' time to check his progress, and that he was willing to drain the haematoma as needed until Dr C's return.

As arranged, Mr A returned to see Dr D on 6 May 1999. By this time Mr A's chest wall had begun to swell again. Mr A reported that 48 hours after the last consultation, the pressure bandage had slipped off. The haematoma was again drained by Dr D, and 400mls of blood-stained fluid were removed. The compression bandage was re-applied. Mr A reportedly appeared shaken after this procedure and a blood count and iron level were taken. Mr A had a haemoglobin of 129 (normal range 130-180).

Mr A returned to see Dr D on 9 May 1999 with swelling and discomfort. The haematoma was drained again and the fluid analysed. The fluid was frank blood consistent with bleeding from the AV malformation rather than seepage from the wound. Dr D wrote to Dr F discussing the results of the two consultations on 6 and 9 May, and stating that the iron tests were within the normal range. Dr D wrote that the wound might need re-exploration and re-tying, but that this would depend on Mr A's progress. Mr A advised that Dr D thought that a vein had been left open during the surgery that Dr C had performed.

On 14 May 1999 Dr D again wrote to Dr F advising that he had seen Mr A on 13 May 1999 and that there was again a large collection of fluid present, which he had decided not to drain. Dr D said he had spoken to Dr H, radiologist, who had suggested that Mr A have an MRI (magnetic resonance imaging) scan to establish the source of the bleeding. Dr H also suggested a referral to Dr I, a plastic surgeon with a particular interest in AV malformations. Subsequently an urgent MRI scan was arranged by Dr D and was carried out on 14 May 1999. According to Dr D, the normal waiting time for an MRI scan was four weeks.

Ms B advised that she was told that the MRI scan would tell them where the blood was coming from and they would be able to make a decision about what to do next in conjunction with Dr C when he returned from overseas. She stated that the MRI scan had been "sold to us as a miracle cure". However, Mr A advised that he did not get this impression; rather, the MRI scan was for the purpose of diagnosing what was wrong with him.

In the MRI scan report of 14 May 1999 Dr H concluded that there was a tamponade (stoppage of the blood flow to an organ or a part of the body by pressure) caused by the haematoma remaining in place. The MRI scan result supported the clinical suspicion that there was an AV malformation. Dr H suggested that management of the malformation be discussed between Dr C and Dr I the following Monday.

Ms B advised that Dr D told them that Dr I should be consulted about Mr A's condition as a priority.

Dr D further advised that due to the tamponade, the safest course of action at that time was not to drain any more fluid from the wound until definite treatment could be arranged.

On 10, 11, 13, and 14 May 1999 Mr A saw Dr J (general practitioner) at the Medical Centre. Mr A advised that he went to see Dr J as he and Ms B were not having any luck finding out what was the matter with his lump and no one was returning the messages left for the doctors to contact them. Additionally, Mr A was feeling weak and had no energy. A blood test was organised. On Saturday 16 May 1999 Dr J rang Mr A to say that his iron levels were low and that he required iron supplements.

On 15 May 1999, Dr D left the country to attend a medical conference. He arranged for Dr E to continue interim care of Mr A until Dr C's return on 18 May 1999.

Dr E

The lump grew larger and Mr A continued to be uncomfortable. Ms B contacted the private hospital on Sunday 17 May 1999 and Mr A saw Dr E on that date. Mr A advised that Dr E did not seem to be interested in Mr A's condition and he wanted Dr C to deal with this on his return. Mr A said that he was not given any information by Dr E. Ms B also felt that Dr E brushed off their concerns. She stated that she found out at this short consultation that Dr I had not seen the MRI scan and did not know about Mr A's condition.

Dr E advised that he decided that he was not in a position to assist owing to the complexity of the case and that it would be better to await Dr C's return and Dr I's opinion. Dr E had some limited familiarity with AV malformations, but said that he was not the right person to manage a problem of this type. In his opinion the problem would not be resolved by draining the haematoma again. It looked at this stage as if resolving the problem would require input from a variety of disciplines. Dr E acknowledged that this was highly unsatisfactory for Mr A but stated that there was little he could do on a Sunday to change things. The problem was not urgent and could safely wait for Dr C's arrival the following day.

Dr C's return

Ms B attempted to contact Dr C on Monday 18 May 1999 and left a message for him to call her. Dr C did not call. Ms B then contacted Dr J on Tuesday 19 May 1999, and he contacted Dr C. Dr C called Mr A late that evening and said he would be at hospital the following day and that he would talk to Dr I and discuss the MRI scan with him. Dr C kept no record of this telephone call. Dr J's medical notes recorded that Ms B had called him twice on 19 May and that he had discussed her concerns with Dr C, who would contact them that evening. A referral to Dr I had been arranged.

On Thursday 21 May 1999 Mr A and Ms B had not heard from Dr C and once again called Dr J. Dr C called back that evening and made an appointment for Mr A to see him on Saturday 23 May 1999. Dr C said that surgery had been arranged with Dr I for Tuesday 26

May 1999 at a public hospital and information about the surgery should arrive in the post shortly. Dr C kept no record of this telephone call. Dr C advised me:

> "To avoid further costs I suggested taking [Mr A] under my care in public where I have an appointment at [a public hospital]. It was at this stage I learned that [Dr I] had a special interest in this condition and I welcomed his input and help."

At the consultation on 23 May 1999 Dr C withdrew 200ml of blood to make Mr A more comfortable. Ms B advised me that after this appointment the wound bled externally until 26 May 1999. Ms B suggests that Dr C caused the bleeding by taking the blood from the middle of the lump, as blood had previously been drained from under the lump.

By Monday 25 May 1999, Mr A and Ms B had received no information about the surgery. Ms B contacted Dr C, who informed her that surgery was scheduled for Wednesday 27 May 1999. Dr C wrote a referral letter to Dr I on 25 May 1999.

A note dictated by Dr I on 2 June 1999 stated that Dr C had referred Mr A to him. Dr I and Dr H reviewed the MRI scan and advised that the blood clot be drained. This procedure was arranged for 26 May 1999. Dr I sent a letter to this effect to Dr C on 26 May 1999.

The public hospital records state that Mr A and Ms B met with Dr I on 26 May 1999. Dr I showed them the MRI scan and explained the results. Ms B stated that this was the first time anyone had explained the MRI results. Later that day Dr I performed surgery on Mr A. He was subsequently discharged from the public hospital on 28 May 1999. Mr A advised that immediately after the surgery he felt a lot better.

Dr I advised Mr A after the operation that if there were any further problems he was to contact him. Subsequently the lump did not return and two weeks later Mr A had his dressings changed at the public hospital. He saw Dr I in the outpatient department at the public hospital, on 3 September and 5 November 1999.

Other issues

The private hospital

The private hospital is a limited liability company. The private hospital does not employ Dr C, Dr E, or Dr D. They are specialists who hold clinical privileges to use the facilities at the private hospital. Health professionals must apply to hold these privileges and applicants are screened by members of the Private Hospital's Practitioners' Association ("the Association"). Privilege agreements can be terminated. Only those with clinical privileges at the private hospital are permitted to use the facilities or to admit patients to the hospital.

The rules governing independent practitioners using the private hospital facilities at the time were the private hospital Practitioners' Association Regulations Governing Practitioners at the private hospital (26 April 1995) ("the Regulations"). These were revised in January 2000.

The purpose of the Regulations is, in part, to "provide through and on behalf of the Board a means of appointment and control of all Practitioners wishing to practise at [the private hospital]" (Regulation 2.1) and to "ensure that all patients receiving treatment at [the private hospital] receive the best possible care" (Regulation 2.2).

Under the 1995 regulations a practitioner applied for clinical privileges in a particular form and the application was considered by the Practitioners Advisory Committee (PAC). Interim privileges could be granted until full privileges were approved. Once approved, practitioners became subject to the clinical privileges agreement, which set out standards and required practitioners to maintain the professional standards of their speciality/college, including re-certification.

The Regulations allow for review of a practitioner's performance where any specific aspect of performance is not acceptable (Regulation 1.1 Schedule II) and to cancel privileges in certain circumstances.

Mr K, the General Manager of the private hospital, stated that he believed that the private hospital did not have any liability in this matter as it does not employ Dr C, Dr D or Dr E, and the incidents that are the subject of the investigation occurred two weeks after Mr A was discharged from the private hospital. Dr C does not receive money from, or pay money to, the private hospital. He independently contracts with his patients for the provision of his professional services and his fee is a matter between him and his patient. The private hospital has no involvement in the establishment or payment of that fee, as these matters are Dr C's business. The private hospital has no influence on the hours that Dr C keeps or the annual leave that he takes. There are no rosters for professional services. The private hospital cannot require Dr C to see a particular patient.

If Dr C's patients require inpatient treatment, he has the option of suggesting to the patient that he or she be treated at the private hospital. Dr C does not have to suggest the private hospital and the patient does not have to choose the private hospital. If the private hospital is chosen, it will contract with the patient for services, which include accommodation, nursing care, medical supplies and theatre expenses.

Through the admissions booklet, patients who are treated at the private hospital are made aware of the fact that the hospital is separate from the surgeon and anaesthetist. The 1997 booklet states:

> "Your specialist should discuss estimated costs with you before your admission.
>
> The total cost of your treatment will include:
>
> - A charge from the hospital covering theatre, medical supplies, accommodation, and specialised nursing care. (The doctors aren't on our staff so they'll bill you separately for their fees.)
> - separate charges for services like x-rays and physiotherapy (if you need these).
> - A charge from your surgeon or medical specialist.

- A charge from your anaesthetist."

The private hospital also notes that the referral made by Mr A's general practitioner was to Dr C, not to the private hospital.

Ms B stated that she and her husband believed that Dr C was employed by the private hospital. She said that all letters from Dr C were on the private hospital letterhead stationery and Dr C had rooms at the private hospital. Dr C never informed them that the private hospital did not employ him. It was only when the private hospital wanted to meet with her, after she made her complaint, that she was informed that Dr C was not an employee but rather a contractor to the private hospital.

Dr C
Section 9 of the Medical Practitioners Act 1995 states that all medical practitioners are required to have a current practising certificate before they are able to practise as a medical practitioner. All practising certificates are renewable each year on 1 April. Dr C's practising certificate for the year 1 April 1998 to 31 March 1999 expired on 1 April 1999. Dr C paid for his new practising certificate on 10 June 1999 and the certificate is dated 10 June 1999 to 31 March 2000.

The private hospital informed me that every year practitioners are required to re-apply for the renewal of clinical privileges. Amongst other questions practitioners are asked to tick a box confirming that they have a practising certificate. The application for the renewal of privileges occurs in June/July of each year and this demonstrates the private hospital's actions to ensure that practitioners have a current practising certificate. The Credentials Committee ensures that each applicant has a current practising certificate. Unless there is any evidence to the contrary, the Committee will accept the practitioner's undertaking. The private hospital considers that the processes of the Medical Council of New Zealand indicate that it is the responsibility of the individual practitioner, as opposed to the employer, to ensure that the annual certificate is renewed, and this is consistent with the application of section 51(1) of the Medical Practitioners Act 1995. In June 1998 and July 1999, as part of the clinical privileges process, Dr C confirmed that he held a practising certificate.

Independent advice to the Commissioner

The following expert advice was obtained from an independent practitioner, a Professor of General and Upper GI Surgery, Dr Iain Martin:

> "I, Iain Gregory Martin MEd MD FRCS, have prepared this report at the request of the Health and Disability Commissioner. It details the treatment received by [Mr A] between February 1999 and June 1999 for a large arterio-venous malformation of the right chest wall.
> The report will comprise four components:-
>
> 1. A chronological summary of the events pertaining to this complaint.
> 2. My interpretation of said events.
> 3. Answers to specific questions raised by the office of the commissioner.
> 4. My comments as to the standard of care received by [Mr A].
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> This report has been prepared using the written materials provided by the Office of the Commissioner.
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> **Section 1: Chronological summary**
> - 9th Feb 1999. [Mr A] was seen by his general practitioner [Dr F]. He was complaining of a swelling over his right lateral chest wall. This was a large swelling extending from the axilla to the right costal margin. He was referred at that stage to [Dr C] at the [the private hospital].
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> - 18th March 1999. [Mr A] was seen at [the private hospital] by [Dr C]. It was noted that this lesion on the chest wall had been present since childhood and had slowly been enlarging. [Dr C] made the diagnosis of a large venous haemangioma and suggested that surgery was probably not required, excepting cosmetic reasons. A discussion was had regarding the merits of surgery and [Mr A] left to think whether he wishes to pursue a surgical course.
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> - 12th April 1999. [Mr A] underwent surgery for the chest wall lesion. This was described as a radical excision of a large subcutaneous cavernous haemangioma. The operation was performed by [Mr C] at [the private hospital].
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> - 15th April 1999. A note, from [Dr C] to the GP [Dr F], indicates that [Mr A] had decided to pursue a surgical course. [Mr A] was discharged from hospital with a wound drain in place. Arrangements were made to see [Dr C] postoperatively.
>
> - 28th April 1999. Apparently [Mr A] was seen in his rooms by [Dr C]. The drain had been removed the week previously. [Dr C] removed stitches and evacuated a small amount of blood from the area of surgery. I was unable to find any written record of this consultation. At this visit [Dr C] indicated that he would be absent for a number of weeks on leave. He suggested that if problems arose that [Mr A] should contact a named nurse at the hospital for advice.

- 3rd May 1999. [Mr A] was seen at the [the private hospital] by Consultant Physician [Dr D]. [Mr A] had contacted the hospital because of increasing swelling of the wound from his recent surgery. He was noted to look well but to have a large fluctuant swelling beneath the wound. After discussion with his surgical colleague, [Dr E], 400mls of blood stained fluid was evacuated from the wound and a pressure bandage applied. Arrangements were made for review in 3-4 days.

- 12th May 1999. A note from [Dr D] to the GP [Dr F], indicate[s] that [Mr A] had been seen two times with further accumulations of blood beneath the wound. On each occasion 400mls of fluid were aspirated from the wound. The fluid was noted to be frank blood on each occasion. It was noted that [Mr A's] blood count and iron levels were normal (Haemoglobin was 129g/l, just below the normal range). At this stage [Dr D] indicated that he felt further surgery may be required. He discussed the case with [Dr H], consultant radiologist at [the private hospital] who suggested that prior to surgery a magnetic resonance scan may be useful in precisely delineating the problem. It was also suggested that the opinion of [Dr I], a plastic surgeon with an interest in arterio-venous malformations may be useful. The MRI scan was arranged on the 13th May and carried out the following day.

- 14th May 1999. The MRI scan was performed and reported by [Dr H]. This showed a large blood clot beneath the wound. It was noted that some of the muscle of the chest wall had been excised and that there may be some residual abnormal blood vessels. The report concluded that 'appearance is suggestive from previous history, histology and outcome that there was a large extensive VM on the lateral right chest wall mainly excised by previous surgery, now with a blood leak into subcutaneous tissues that are currently acting as a tamponade for further bleeding'.

- 17th April 1999. [Mr A] was seen at the [the private hospital] by [Dr E]. At this stage the bleeding was controlled with internal pressure from the blood clot. In light of the complex nature of this problem [Dr E] elected not to do anything that night but to consult with [Dr C] the following day upon his return.

- 25th May 1999. [Mr A] was referred by [Dr C] to [Dr I], consultant plastic surgeon for further management of this problem.

- 26th May 1999. [Mr A] was seen by [Dr I] in [the public hospital]. It was arranged that the blood clot be evacuated in the first instance and that [Mr A] be kept under review. This operation was performed that day by [Dr I].

- 28th May 1999. [Mr A] discharged from hospital.

- 5th November 1999. [Mr A] reviewed in the vascular anomaly clinic by [Dr I]. Repeat MRI scan had demonstrated a small amount of residual vascular malformation not requiring active treatment. Review arranged for two years.

Section 2: Interpretation
[Mr A] had a large area of abnormal blood vessels in the right lateral chest wall. This was almost certainly a congenital vascular malformation. This lesion was excised by [Dr C]. A small amount of residual abnormal blood vessels remained and these bled slowly into the wound space over the next month. Percutaneous draining of this blood merely resulted in further bleeding (the pressure of the blood itself stopping further bleeding). Once the blood was formally evacuated the bleeding stopped spontaneously. The treatment of these large vascular malformations is complex and relies upon appropriate imaging and multi-disciplinary care. This is not an area in which I have specific expertise but I include with this report two articles that make this point. One is from an undergraduate text in Surgery and the other from a specialist journal. The conclusion of both articles is that imaging is key and that MRI scanning is probably the modality of choice.

Section 3: Answers to Specific Questions
These will be addressed in the order raised in the Commissioner's letter. No inference as to importance can be drawn from the order.

With reference to the complaint, specifically:-

1. Was [Mr A] fully informed about the risks and side effects of surgery?
   There is no documentation with which to answer this question. This issue is not raised in [Dr C's] initial letter and it appears that no further consultation took place before admission. The consent form appears to have been signed by [Mr A's] partner [Ms B]. On the basis of the information I have available, consent was not fully informed.

2. Was [Mr A] informed of the follow up care required?
   He appears to have been informed after the operation what care would be required. It would appear from the records that I have available that the operation was larger than [Dr C] had initially anticipated.

3. I cannot comment on the issue of the practising certificate.

4. Should specific medical cover have been arranged during [Dr C's] absence?
   It is not usual to notify outpatients of specific arrangements for medical cover during annual leave. I believe that it was entirely appropriate to ask [Mr A] to contact the hospital nurse in the first instance. I can see no ground for complaint in this issue.

5. Should [Mr A] have been informed about the need for a drain pre-operatively?
   It would not be unusual for drains to be left in after operations, when pre-operatively this need had not been anticipated. It would not be normal practice to warn patients of such a possibility. However, I do believe that [Mr A] was not fully informed about either the diagnosis or the surgery.

6. Was timely and appropriate treatment provided for the post operative haematoma?
   I believe that a trial of aspiration was entirely appropriate in the first instance. The realisation that this approach had failed was perhaps delayed but this is debatable.

7. Were [Mr A's] iron and haemoglobin levels adequately monitored?
   Contrary to the complaint, [Dr D] clearly did measure [Mr A's] haemoglobin and iron levels. There are I believe no grounds for upholding this part of the complaint.

Questions regarding specific practitioners:-

[Dr C]

- Was [Dr C's] choice of initial intervention appropriate for [Mr A]?
  I believe that prior to any consideration of surgery this complex and large vascular malformation should have been investigated further. A magnetic resonance scan should have been performed prior to surgery to fully define the lesion and therefore the nature of any intervention planned. These large vascular malformations often require complex interventions. It may have been that surgery was the most appropriate intervention but this cannot be categorically stated without having pre-operative investigations.

- Was [Dr C's] treatment timely?
  I am not certain to what aspect this question refers. There is no question of the timing of the initial operation. With respect to the treatment of the post operative haematoma I believe that it was appropriate just to evacuate the haematoma in the first instance. The recurrences of the haematoma were treated during his absence. On his return [Dr C] referred [Mr A] for further management to a plastic surgeon. This occurred some eight days after [Dr C's] return and it may well have been possible to expedite this a little. I do not have any of [Dr C's] comments relating to this period to know what actions he took between the 18th and 25th May. It would be important to see these comments before judging his actions in this period.

- Was it appropriate for [Dr C] to arrange for [Mr A] to call a nurse in the first instance?
  As I have indicated above, it is not normal for consultants to specifically arrange medical cover with outpatients. It would be not unusual to ask a patient to call either a ward nurse or the patient's own general practitioner in the first instance. I see no problems at all with this course of action.

- What cover is usual for a surgeon going on holiday?
  If the surgeon has in-patients under their care then a specific colleague(s) will be identified to provide continuing care. For out-patients the situation is less clear but generally no specific arrangements will be made. It is usual that a patient would use their general practitioner as the first point of call. In this situation it was made clear that a call to the nurse should be the first point of call and this is acceptable if the nurse then seeks appropriate medical advice as happened here.

- Was [Mr A] informed by [Dr C] about the operation and its potential complications?
  As I have indicated above, I do not believe that [Mr A] was fully informed about the surgery and in particular its likely magnitude. However the complication that did arise was a blood clot. This can occur after any operation and would not usually be specifically mentioned on a consent form. It is not clear what information [Mr A] was given once the blood clot had occurred.

- Were the interventions appropriate?
  As I have indicated above, I believe that without appropriate pre-operative imaging the choice of initial operation is uncertain. It was I believe appropriate to aspirate the blood clot in the first instance. It was also appropriate to refer [Mr A] on to [Dr I] for further management. The only issue in this regard is whether this should have happened on the 18th or 19th April and not the 25th April. This would not have had a material effect upon the outcome of [Dr I's] surgery but would have hastened the treatment by 5-6 days. Comment is needed by [Dr C] on his actions during this period. If he had been speaking to the plastic surgeons during this period and the plan of action was agreed then no criticism can be attached to [Dr C's] action in this regard.

[Dr D]

- Did [Dr D] provide appropriate care?
  [Dr D] provided careful and well documented care for [Mr A]. He sought a specific surgical opinion early in his involvement in [Mr A's] care and followed this through. Once it was clear that this conservative approach was failing, he sought appropriate further opinions and acted upon these. It would appear that [Mr A] was informed throughout this period by [Dr D].

- Was it appropriate for [Dr D] to provide this care?
  I have no knowledge of [Dr D's] background or expertise. Although not surgically qualified he sought an appropriate surgical opinion and acted on it. I think this was appropriate.

- Was it appropriate to continue to drain [Mr A's] haematoma?
  This was done twice by [Dr D]. At the second occasion it was evident that this approach was not working and an alternative course was sought. This was I believe an appropriate plan by [Dr D].

- Were there alternative actions at this stage?
  The second time that the haematoma was drained [Dr D] clearly recognised that this approach was not working. The need for potential surgery was discussed with [Mr A] and an appropriate investigation arranged.

  I do not believe that the care provided by [Dr D] fell below acceptable professional standards.

- Was the MRI scan appropriate?

This was indeed the appropriate investigation. At that stage nothing else should have occurred.

- Should iron levels and blood tests have been checked by [Dr D]?
  The notes clearly state that they were checked by [Dr D]. This is documented in his letter and the result are filed. This portion of the complaint is clearly without basis.

[Dr E]

[Dr E] saw [Mr A] on one occasion and had discussed the case with [Dr D]. When [Dr E] saw [Mr A] it was on the Sunday prior to [Dr C's] return. It was clear at this stage that this was a complex problem requiring specialist intervention. He was aware of the result of the MRI scan and the probable plastic surgical referral. I do not believe that at that stage any other action was appropriate. It clearly would not have been appropriate for [Dr E] to intervene surgically in this case. On the basis of the records that I have seen, I see no grounds for believing that the care provided by [Dr E] fell below an acceptable professional standard.

The notes that I have seen are clear. The comments that I would make are as follows:

- There is no record of a discussion between [Mr A] and [Dr C] to discuss the planned surgery.

- [Mr A] did not sign a consent form. It was signed by his partner.

- The operation note made no record of the fact that a large portion of the pectoralis muscle was excised during the initial operation.

- There were no records of [Mr A's] first post operative consultation with [Dr C].

- That, from [Dr D] first seeing [Mr A] to [Dr C's] return all the actions taken are fully documented with the exception of the consultation with [Dr E] on Sunday 17th April 1999.

- There is no record of [Dr C's] actions between his return and the referral to [Dr I] on the 25th April.

  In terms of communication between different providers this seems to have been satisfactory and is generally well documented. When [Dr C] left on annual leave, [Mr A] was an outpatient and as such I do not believe that [Mr A's] case should have specifically been mentioned to a colleague.

Section 4: Summary Comments

This is a complex case involving several practitioners. In summary I do not believe that the care provided by either [Dr D] or [Dr E] fell below an acceptable professional standard and that there are no grounds on which to uphold complaints.

I believe that the care provided by [Dr C] fell below acceptable standards in the following areas:-

- Failure to appropriately and adequately investigate [Mr A] prior to surgery.

- Failure to obtain informed consent prior to operation. I do not believe that without the appropriate investigations consent can have been informed.

- I believe that all the other issues directly stemmed from these two initial points and are the crucial issues in this case."

Dr Martin was subsequently contacted to clarify three aspects of his advice:

1. Haemangioma or AV Malformation
   Dr Martin was asked whether there was a difference between an AV malformation and a haemangioma. Dr Martin stated that there is a clear difference between the two conditions, although they are both congenital abnormalities of the blood vessels. Dr Martin stated that it was reasonable for [Dr C] to have made an initial diagnosis of haemangioma.

2. Use of tamponade
   Dr Martin was asked whether the use of a tamponade on an AV malformation was appropriate. Dr Martin stated that a tamponade was a management option but was not optimal. The underlying cause needs to be found and addressed. However, using a tamponade was not a breach of the duty of care. In this particular case, involving [Dr D] who was not a surgeon, the doctor's actions were appropriate. [Dr D] sought advice from a radiologist and another surgeon on how to manage the underlying condition in the interim.

3. Iron count
   [Mr A] had an HB of 129, iron of 5 and saturated I.C.P of 122. Dr Martin stated that [Mr A] was deficient in iron but no action would be taken on an HB of 129, especially in a male patient. If the underlying problem causing the deficiency was treated and with a good diet a male patient would go back to a normal iron count very quickly. An HB count of 129 was enough for the body to carry on with.

After receiving [Dr C's] response to the provisional opinion further advice was obtained from Dr Iain Martin:

> "Thank you for asking me to comment further in this case in the light of the response from [Dr C]. I have read through my advice in the initial report and rechecked the notes provided to me again.
>
> I do not think there is anything factual in my report which conflicts with the information contained with [Dr C's] response. The issue here remains one of post-operative investigation and consent. I believe, and think this is supported by the literature, that

such vascular malformations should be managed by a multi-disciplinary team and that preoperative imaging is needed to decide on the most appropriate treatment. If this issue becomes one of contention a second opinion from a specialist plastic surgeon would be appropriate. It is evident from [Dr C's] response that he would perhaps now alter his approach in such patients.

I do not believe that [Dr C's] technical competence is in any way brought into question by this case. Essentially we have a series of events which stemmed from the treatment of a complex vascular malformation. The post operative course could have been identical even if the lesion had been fully evaluated before hand and do not indicate any failure of technical competence.

[Dr C] points out that there was discussion prior to signing the consent form of the risks of surgery. I can only comment on the written information that I have been provided with and is often the case there is discrepancy between the recollections of the two parties.

I am still unclear as to why the patient did not sign the consent form, although in itself this does not alter the issues, it is not clear that the patient's partner was their legal guardian.

In summary, I have no reason to alter the opinion expressed in my initial report. I made this judgement, particularly with respect to the issues of informed consent, on the basis of the written information provided which is the only evidence I have available to me; I do recognise further discussions probably took place.

I fully appreciate and understand the stress that such an investigation places on a practising doctor. In preparing these reports I try to be as objective and impartial as I can be and try to place my reports in the context of surgical practice as described in the literature as was done in this case."

The following expert advice was obtained from an independent general and intestinal surgeon:

"I am willing to provide Medical Expert Advice on this case on the agreed basis. That is that my name will not be revealed at any stage of the proceedings.

…

The condition and its treatment
A haemangioma is not a common problem for a general surgeon to deal with. It means literally a tumour ('oma') of blood vessels ('haemangio'). It is a benign condition that is usually due to disordered development of blood vessels, or an arterio-venous malformation. These are highly vascular and therefore prone to bleed. In this case it was mainly in a subcutaneous position, but was also involving muscles of the chest wall. As it collapsed when the patient was supine and because there was no bruit or thrill

associated with it, it was probably more a venous malformation than having a major arterial component. Successful treatment involves ligation of all feeding and draining vessels, at the time of excision.

[Dr C]
[Dr C's] choice of intervention was appropriate, i.e. surgery. However, complete excision was not achieved. 'A number of large veins lying with the muscle … impossible to excise completely' (letter by [Dr C] to [Dr F] 15 April). No feeding vessel was found.

The questions about the surgery that I would raise are:

1. Was the haemangioma investigated appropriately before embarking on surgery. A lesion this large should be investigated with an angiogram to ensure that the full extent of the lesion is identified. This might have been achieved with a triphasic CT scan or a magnetic resonance scan with arterial and venous reconstructions. This appears to have only been done after there were problems. A radiologist would be better able to comment on the best approach to imaging this lesion.

2. The GP had raised concern about a harder area in the lesion. That is a further reason to consider a scan.

3. Was it appropriate for [Dr C] to undertake the surgery for a lesion of this magnitude, or should it have been referred to somebody else. I note that there is a specialist centre at [a public hospital]. Specific expertise was available.

The timing of surgery was acceptable. The patient returned requesting it. As [Dr C] mentioned in his letter to [Dr F] (18 March), surgery was not essential for this condition. The indication for surgery was stated to be cosmetic. If the lesion was enlarging then it would be better to deal with it early. The request for surgery appeared to have come from the patient as [Dr C] states 'at this stage surgery does not seem to be necessary, except for cosmetic reasons. But if it is truly increasing in size then it would be better to excise it while it is still of a manageable size'.

Calling the nurse is reasonable, although it would be usual practice for the surgeon to make himself available to the patient as well. The nurse would be expected to be able to seek help from the appropriate doctor, should that be necessary.

It is usual practice for a surgeon to hand over all patients to the care of another surgeon, by direct discussion, prior to going on holiday. Arranging cover is the responsibility of the surgeon. It may be that [Dr C] considered that there was such a low risk of problems in the case of [Mr A], that he did not consider it necessary to arrange cover. The patient does have access to their GP, the local Emergency Department, District Nursing etc. In this case the colleagues of [Dr C] stepped in and provided cover. In other words there was cover available. I do not know whether [Dr C] discussed this case with his colleagues prior to going on holiday.

The adequacy of information given to [Mr A] is not easy to ascertain. What is written in letters and hospital records does not always reflect the full extent of discussion nor all of the issues covered. I do not believe that I can answer the question.

The issue of whether [Dr C] treated [Mr A's] condition in accordance with good professional standards is difficult. My concerns are:

- Whether [Dr C] took on a condition beyond his expertise and training. Further preoperative investigation might have helped delineate the extent of the lesion and therefore help with preoperative planning. The excision was incomplete. A multidisciplinary unit with special expertise was available to treat this patient.

- It does not appear that there was a specific handover of care to another surgeon. It appears that [Mr A] ended up, by default, being cared for by a gastroenterologist.

[Dr D]
I consider that [Dr D] acted appropriately and with good professional standards in the treatment of [Mr A's] complication. Percutaneous drainage of the haematoma and application of pressure was reasonable. When this failed it was appropriate to investigate with an MRI.

[Dr E]
I have no concerns about the care given by [Dr E].

Commenting on dialogue between providers is not possible when we have only got the record of what has been written. I don't know whether there was additional telephone discussion between the care providers.

It is not possible to be certain about what level of information was provided.

The level of documentation appears reasonable."

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 4
Right to Services of An Appropriate Standard

(1) Every consumer has the right to have services provided with reasonable care and skill.

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; …

RIGHT 7
Right to Make An Informed Choice and Give Informed Consent

(1) Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.
…
(6) Where informed consent to a health care procedure is required, it must be in writing if -
(a) The consumer is to participate in any research; or
(b) The procedure is experimental; or
(c) The consumer will be under general anaesthetic; or
(d) There is a significant risk of adverse effects on the consumer.

Opinion: No Breach – Dr C

Right 4(1)

Failure to arrange medical cover while on leave

On 28 April 1999 Dr C saw Mr A for the two week follow-up after the operation. By the time of this appointment a lump appeared at the wound site and Dr C removed blood from the lump. At the consultation he told Mr A that he was going overseas and if he had any problems to contact one of the nurses at the private hospital. Dr C said that he arranged for his colleagues to cover for him while he was absent at an overseas conference.

Dr Martin, one of my expert advisors, commented that it is not normal for consultants to specifically arrange medical cover for outpatients. It is entirely appropriate to ask the patient to call either a nurse or their general practitioner in the first instance. With regard to Mr A it was made clear that he should contact a nurse as first point of call. My advisor concluded that this was acceptable if the nurse then seeks appropriate medical advice.

My other expert advisor stated that it was usual practice for surgeons to hand over patients to the care of another surgeon prior to going on holiday. However, my advisor noted that patients have access to their general practitioner and nurses. When Mr A required assistance, there was cover available from Dr C's colleagues. My advisor also noted that Dr C may not have considered it necessary to arrange cover for Mr A as he considered there was a low risk that Mr A would have any additional problems.

In my opinion, Dr C set up an adequate system to address any problems that Mr A might have in his absence and his instruction that Mr A first contact a nurse was appropriate. It appeared the nurse knew to seek further advice from one of Dr C's colleagues, as occurred in Mr A's case. Accordingly, in my opinion Dr C did not breach Right 4(1) of the Code in relation to this aspect of the complaint.

Failure to ensure that Mr A's iron levels were adequately monitored

Dr C was absent from New Zealand and played no part in Mr A's care from 29 April to 18 May 1999. During that time Dr D provided Mr A with care and monitored Mr A's iron levels (see discussion at pages 29-30 below). Accordingly, Dr C was not responsible for his care during this period and did not breach Right 4(1) of the Code.

Failure to provide timely and appropriate treatment for lump

On Wednesday 28 April 1999 Mr A presented to Dr C's rooms for his post-surgery check-up. The stitches were removed and it was noted that there was a lump at the site of the wound. Dr C drained the lump. My advisor informed me that it was appropriate to drain the blood clot in the first instance. I accept this advice and conclude that in regard to this aspect of the care provided to Mr A, Dr C did not breach Right 4(1) of the Code.

From 29 April to 18 May 1999 Dr C provided no care to Mr A, as he was out of the country. When he returned to work on 18 May 1999 he saw the notes written by Dr D and the results of the MRI scan. I accept that Ms B had also left a message asking Dr C to call her and it is likely that he received that message and was aware that Mr A's condition was

of concern. It was therefore a priority for Dr C to liaise with Dr I to organise further care and treatment for Mr A. Dr C's letter of referral to Dr I was dated 25 May 1999, eight days after he returned. Dr Martin noted that it may well have been possible to expedite this a little. However, if Dr C had been speaking to the plastic surgeon during this time and the plan of action had been agreed then no criticism could be attached to Dr C's actions.

In a memorandum dated 2 June recording a discussion with Dr C and details of surgery performed on 26 May, Dr I refers to a referral from Dr C and a discussion with Dr H about an appropriate course of treatment for Mr A. The appropriate date for surgery was also discussed and it was jointly agreed that surgery would take place on 26 May. Dr C, in a telephone conversation on 19 May with either Mr A or Ms B, said that he would be discussing the case with Dr I on the following day. In another telephone conversation with Mr A or Ms B on 21 May Dr C informed them Dr I would operate on Mr A at the public hospital on 26 May. This was reinforced at the appointment on 23 May.

I conclude from this that Dr C consulted with Dr I on 20 or 21 May about Mr A's condition, a management plan was agreed and Dr C referred Mr A to Dr I on this date. The referral letter of 25 May from Dr C to Dr I merely confirmed this arrangement.

Dr C said that he suggested taking Mr A under his care as a public rather than private patient to minimise costs to Mr A and he also sought the advice of Dr I. I accept that Dr C took steps to organise appropriate treatment for a condition that, although distressing for Mr A and Ms B, was not life-threatening, by seeking the advice and clinical input of Dr I during this period. Accordingly, in my opinion Dr C provided services with reasonable care and skill and did not breach Right 4(1) of the Code in relation to this aspect of the complaint.

Right 6(1)

Provision of information about drain after surgery

During the surgery a drain was inserted into the wound and a drainage bag attached to contain the fluid draining from the wound. The nursing care plan recorded before the surgery indicates that Mr A was aware that a drain would be inserted. Dr C confirmed that he discussed this with Mr A prior to surgery. The nursing care plan written after the surgery also records that Mr A had been instructed on how to empty the drain and to record the amount of fluid drained from it.

Ms B states that when her husband was discharged they were told that the bag would be in place only for a few days. Instead the bag remained in place for 12 days.

The instructions to the district nurses were that the drain was to be removed when on two consecutive occasions 25mls of fluid or less had been drained from the wound. This occurred on 24 April, when the drain was removed. It appears likely that Mr A was told that the drain would be removed when the amount of fluid taken out of the wound had reduced to a certain point and that it was thought that it would take a few days, as this was the usual length of time. Instead it took longer than usual. I accept that it was impossible to know exactly how long it would take before a drain was no longer necessary and that the

best information that could be provided to Mr A was a general indication of the standard time within which a drain of this type would be removed. I therefore consider that Dr C did not breach Right 6(1) of the Code in relation to this matter.

Opinion: Breach – Dr C

Right 4(1)
In my opinion Dr C breached Right 4(1) of the Code by failing to conduct an adequate examination of Mr A and to consult with a multi-disciplinary team.

When Mr A arrived for his first consultation, Dr C conducted a physical examination of the growth and did a biopsy to check for malignancy. Dr C diagnosed a haemangioma. Dr C acknowledged in his letter to Dr F that the growth was large and had a significant venous component.

My advisors informed me that the treatment of vascular malformations is complex, requiring appropriate imaging and multi-disciplinary care. The two articles enclosed by Dr Martin about AV malformations and haemangiomas also make this point. Dr Martin stated that when considering a growth of this size and complexity, before giving any advice about the merits of surgery, Dr C needed to undertake further investigations. My other expert advisor concurred.

Dr C states that he considered whether an MRI scan was necessary but decided that it was not because of the clinical presentation of the haemangioma and because he felt that MRI results at that time were not always interpreted accurately. He also considered that an MRI was an expensive option, not fully covered by insurance. Dr Martin, my expert advisor, considered Dr C's response but remained of the view that an MRI was a necessary part of this type of procedure to fully define the growth and determine the appropriate intervention. I accept Dr Martin's advice that an MRI scan should have been performed prior to surgery. In failing to undertake an MRI scan I consider that Dr C did not provide services with reasonable care and skill and breached Right 4(1) of the Code.

Both of my advisors and the articles provided by Dr Martin note that consultation with a multi-disciplinary team prior to surgery is advisable. Dr C stated that he was unaware of any multi-disciplinary approach at the time. He also stated that had the haemangioma occurred on any other part of Mr A's body he would have referred Mr A to a vascular or plastic surgeon.

After reviewing Dr C's response, Dr Martin confirmed his view that the literature supports management of haemangiomas or AV malformations by a multi-disciplinary team. My other advisor (who did not see Dr C's response) noted that there was a specialist centre at the public hospital. As a practitioner working in this field in the same geographical area, Dr C could reasonably be expected to have known about the Centre and sought advice on Mr A's

management. Even if Dr C was not aware of the Centre, he should have sought additional advice before proceeding.

In my opinion Dr C's decision to proceed with surgery without adequate investigations (including an MRI scan or alternative) and multi-disciplinary consultation meant that he did not provide services with reasonable care and skill and breached Right 4(1) of the Code. I note that Dr C indicates that he has changed his practice and, if the same circumstances present, will seek the involvement of a multi-disciplinary team and use imaging techniques before recommending and commencing surgical intervention.

Right 6(1) and 7(1)

In my opinion Dr C breached Right 6(1) and Right 7(1) of the Code. Mr A had a growth on his chest and was referred to a specialist for further advice and management. At the specialist appointment Mr A had a right to an explanation of his condition, the options available to him, and the benefits, costs and side effects of each option so that he could make an informed choice and give informed consent. In my opinion Dr C did not provide Mr A with sufficient information at the first consultation to make an informed choice. Although he was subsequently given a limited amount of other information, it was provided immediately before surgery and did not allow sufficient time for reflection by Mr A so as to make an informed choice.

Mr A and Ms B said that Dr C provided them with very little information. Dr C countered that he spent a good part of the 45 minute consultation on 17 March 1999 describing Mr A's condition and the procedure he proposed to use to remove the haemangioma if Mr A wanted to proceed with this option.

I accept that Dr C explained to Mr A that a haemangioma was a collection of blood vessels under the skin. I also accept that it was clear to Mr A that it was his choice when and if he underwent the procedure. However, I am not satisfied that Dr C told Mr A that if the tumour was left to grow it could, in very rare cases, turn malignant. This information was recorded in Dr C's letter to Dr F, Dr C said it was discussed during the consultation, but neither Mr A nor Ms B recalled being told of the possibility that, left untreated, the haemangioma could in rare cases turn malignant. They were both aware of the possibility that the haemangioma could grow larger.

Mr A and his wife gained the impression during the consultation with Dr C that the surgical procedure he proposed was relatively simple and straightforward, involving a few small incisions, and that Mr A would require a general anaesthetic, one night in hospital and three to four weeks off work. I consider that Mr A was not informed of the risks of the procedure, including the high risk of bleeding with the possibility that a blood transfusion could be required, the possibility of infections or other complications developing post-operatively, and the need to have a drain.

Although there was some discussion of the possible need for a transfusion and that a drain would be inserted into the wound, this discussion occurred immediately prior to the surgery

commencing. At this point, in my opinion a reasonable patient may not have been able to appreciate the significance of some of the information provided.

Dr Martin, my expert advisor, also said that without appropriate investigations to determine the magnitude of the surgery, consent to the surgery cannot have been fully informed. I agree.

In his letter to Dr F, Dr C referred to the large size of the growth and the significant "venous component". The implications of this description for Mr A's surgical procedure were significant. Although Dr C did not appreciate the full scope of the surgical procedure, as indicated by his failure to conduct an MRI scan prior to surgery, he should nonetheless have been aware that it could be a complex procedure and should have advised Mr A accordingly. I accept Dr Martin's advice about the complexity of providing treatment to patients with AV malformations or haemangiomas.

Dr C did not tell Mr A that it was possible to undertake further tests to determine the extent of the haemangioma prior to undertaking surgery, specifically an MRI scan of the area. Dr C considered that an MRI was not clinically warranted but also said that it was an expensive test not fully covered by insurance and that this was a factor in deciding that a scan was not required. I accept that in general a medical practitioner does not have to discuss possible tests with the consumer when he considers those tests are not clinically warranted. However, if one of the reasons for not undertaking the test is the cost, the patient should be informed and thereby enabled to make a decision about how much weight to give that factor. It is all too easy for doctors to make false assumptions about what costs a patient is willing or able to incur for medical treatment.

I am not satisfied that Mr A received a full explanation from Dr C of what the diagnosis of haemangioma entailed in general terms, or an explanation about the particular characteristics of its growth. In my opinion Dr C did not provide Mr A with the information a reasonable patient in his circumstances would expect to receive, and therefore breached Right 6(1) of the Code. Without this information Mr A could not make an informed choice to have surgery, and therefore Dr C also breached Right 7(1) of the Code.

Right 7(6)
Where informed consent to a health care procedure is required, it must be in writing if there is a significant risk of adverse effects to the patient and/or the patient will be under a general anaesthetic.

Mr A's operation was to be performed under a general anaesthetic and carried a significant risk of adverse effects. An operation to remove a haemangioma can be a serious operation requiring multi-disciplinary input and potentially necessitating a blood transfusion. Written consent was therefore required from Mr A.

Mr A signed the portion of the consent form devoted to payment on the date of the operation. There is no suggestion that Mr A was, in any way, not competent to make

decisions for himself, yet Mr A's wife signed the parts of the consent form relating to the procedure, the anaesthetic and the possibility of a blood transfusion.

Ms B refused to sign the form until she received additional information about the possible risks of the procedure and an explanation why her husband might have to receive blood during the operation and how blood was screened in New Zealand. Dr C was summoned from theatre to give this information to Ms B and Mr A, who were both present. Ms B then signed the form. Dr C was therefore aware that Mr A had not signed the form. Mr A had not been medicated to the point where he lacked the competence to sign the form. Although it was a pragmatic response to ask Ms B to sign the consent form on behalf of her husband, Mr A was the "consumer" whose consent to the operation and the anaesthetic was required in writing. Accordingly, in these circumstances, Dr C breached Right 7(6) of the Code.

Opinion: No breach – Dr D

Right 4(1)

On 2 May 1999 Dr D was asked by a nurse to review one of Dr C's patients, Mr A, who was having problems after his recent surgery. Dr D stated that when he received the telephone call from Ms B and Mr A on 2 May 1999 he had no previous knowledge of Mr A's problem. He arranged to see Mr A at the first available opportunity, which was at his clinic the following day on Monday 3 May 1999. From his letter to Dr F of 4 May 1999 it is apparent that Dr D discussed the case with Dr E. They considered that a conservative course was the best in the circumstances. Dr D arranged to see Mr A to check progress.

On 6 May 1999 when Mr A returned to consult Dr D a further drain of the haematoma was done and a blood count taken which showed "minor changes from the normal range".

On 9 May Dr D again drained the haematoma. When Dr D saw Mr A on 13 May 1999 and saw that the haemangioma (or AV malformation) had reappeared he spoke to Dr H who suggested an MRI scan. It was decided to carry out an MRI scan. It was also recommended by Dr H that he seek the advice of Dr I, a plastic surgeon with a particular interest in this type of lesion. An MRI scan was carried out on 14 May 1999.

Dr D was presented with a complex case of which he had no prior knowledge. He acknowledged to Mr A that he was a physician rather than a surgeon. At the first consultation Dr D consulted with a colleague who was a surgeon, and followed his advice. Both of my advisors considered that this was appropriate. Dr D ensured that the patient was followed up. When the draining of the clot did not have the desired effect he took further advice from a colleague from yet another discipline and arranged for an urgent MRI scan. Dr Martin informed me that an MRI was the appropriate investigation and nothing else should have occurred at this stage. I accept my advice that the approach adopted by Dr D was appropriate and that he sought additional advice when required.

I also note that Dr D took steps to monitor Mr A's iron levels. Dr Martin advised that although Mr A's levels were slightly beneath the normal range (haemoglobin 129, normal range 130-180), it was more important to treat the problem causing the anaemia, as in an adult male the iron levels recover quickly. Treatment of anaemia for a male patient is not required unless the iron level is significantly lower.

In my opinion Dr D provided services that were timely and appropriate and sought additional advice when his initial management was unsuccessful. Accordingly, Dr D provided services with reasonable care and skill and did not breach Right 4(1) of the Code.

Opinion: No Breach – Dr E

Right 4(1)

Dr E saw Mr A on Sunday 17 May 1999. Mr A presented with a large swelling caused by a haematoma and was in considerable discomfort. Dr E was aware of Mr A's prior medical history as he had provided advice to his colleague, Dr D, who had been providing care to Mr A in Dr C's absence. Dr E was aware that Mr A had recently had an MRI scan and that a recommendation had been made by the radiologist that the assistance of Dr I, a plastic surgeon, should be sought. Dr E was also aware that Dr C was returning on the following day.

Dr E advised that he had come to the conclusion that Mr A's problem "might not be easily resolved". He had limited experience with AV malformations. My advisor noted that it was clear that Mr A had a complex problem requiring specialist intervention. Dr E thought that Mr A's problems would not be resolved by a further removal of blood from the clot and that it was preferable to transfer Mr A's care to a surgeon with experience and expertise in the handling of this type of condition. Dr E therefore decided that, as Dr C was due back the following day, it would be preferable to await his return. My expert advisor, Dr Martin, did not believe that any other action by Dr E would have been appropriate in these circumstances and considered that Dr E provided care in accordance with a professional standard. My other advisor agreed that Dr E provided appropriate care.

Although Mr A was clearly in significant discomfort, and he and his wife were naturally very worried, I am satisfied that Dr E's decision that no urgent action was required was reasonable and in accordance with professional standards.

In my opinion Dr E provided services with reasonable care and skill and 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 Act 1994 ("the Act") an employing authority may be liable for acts or omissions by an employee, an agent or a member.

Section 72(1) of the Act states that the term "employing authority" means a health care provider or a disability services provider. Section 3(a) of the Act states that a health care provider includes the licensee of a licensed hospital. The private hospital is a licensed hospital in terms of the Hospitals Act 1957.

I have had to consider whether Dr C was acting as an employee or an agent of the private hospital when providing services to Mr A and, if so, whether the private hospital is vicariously liable for any actions of Dr C that breached the Code of Rights.

The private hospital is a limited liability company. Specialists, such as Dr C, hold clinical privileges at the private hospital. Health professionals must apply to hold these privileges and applicants are screened by members of the private hospital Practitioners' Association ("the Association"). I accept that Dr C was not employed by the private hospital.

The private hospital disputes my provisional opinion that Dr C was an agent of the private hospital. The private hospital submits that Dr C was an independent contractor and was not an agent. Health providers are not vicariously liable for the actions or omissions of independent contractors and therefore a private hospital cannot be vicariously liable for the acts and omissions of Dr C. (A summary of the private hospital's submission is attached in appendix one.) I accept that Dr C is an independent contractor.

I agree that an organisation is usually not vicariously liable for the acts or omissions of any independent contractors. However, in rare cases an independent contractor may be considered an agent of the person or organisation with whom he or she contracted.

The private hospital referred to a test for determining whether a person is an agent or employee or independent contractor established by the Court of Appeal in *Lower Hutt City v Attorney General*.[1]

> "The determination whether the actual wrongdoer is a servant or an agent on the one hand or an independent contractor on the other depends on whether or not the employer not only determines what is to be done, but retains the control of the actual performance, in which case the doer is a servant or agent; but if an employer, while prescribing the work to be done, leaves the manner of doing it to the control of the doer, the latter is an independent contractor."

However, English, Australian and Canadian case law examining the responsibilities of hospitals has moved away from the existence of control over subordinates as the sole test in

[1] [1995] NZLR 65, 72.

determining whether an organisation is vicariously liable or not. Control is merely one factor to be considered. The courts examine the "totality of the relationship between the parties".[2]

The private hospital retains some degree of control over practitioners in that it maintains the ultimate sanction of not renewing clinical privilege agreements. It also has mechanisms to deal with concerns about a practitioner's competence to practise.

The private hospital states that Dr C is not authorised to act for the private hospital and has no authority to bind the private hospital to third parties.

Aityah states that "… [t]he term agent must be used in a very wide sense. It is indeed impossible to consider stopping short of treating an agent as any person who is authorised to do anything on behalf of another."[3] The private hospital's submission defined an agent as a person who has power or authority to alter a principal's legal relations with third parties.[4]

Agency may arise by virtue of actual or ostensible authority. In *Arthur Watson Savage v Kathleen Taylor* Richardson P. stated: [5]

> "The legal principles relating to ostensible or apparent agency are well settled. A person who by words or conduct has allowed another to appear to a third party to be his or her agent cannot afterwards repudiate that agency."

In my opinion the private hospital initially allowed Dr C to appear to be an agent of the private hospital. When referred, Mr A and his wife were under the impression that the private hospital employed Dr C. They were referred by their general practitioner to Dr C at the private hospital. Dr C's rooms were at the private hospital. Most importantly, Dr C arranged for Mr A's admission to the private hospital to undergo a surgical procedure. In doing this he was committing the private hospital to provide a service. The private hospital has a symbiotic relationship with practitioners who use its facilities. Each benefits from the other. Dr C needs access to surgical facilities to practise. The private hospital benefits from the reputations of the practitioners who use its facilities. It appeared to Mr A that Dr C was in the employ of the private hospital and was its agent. It was reasonable for Mr A to make that assumption.

I accept that the information booklet forwarded to Mr A stated that the private hospital would negotiate its own fees with Mr A and therefore had a degree of separation from Dr C. But, despite this, Mr A and his wife still believed that the private hospital were responsible for Dr C's conduct. I do not consider that the statement about fees was sufficient to dispel the reasonable assumption that Dr C had authority to act on behalf of and bind the private hospital.

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[2] *Stevens v Broadribb Sawmilling Co Pty* (1986) 160 CLR 16.
[3] PS Atiyah, *Vicarious Liability in the Law of Torts* (Butterworths, London, 1967) 100.
[4] *Crow v Palmer* (1888) 6 NZLR 408.
[5] Unreported, 19 March 1999, Richardson P, CA103/95

I agree with Atiyah's comment:[6]

> "… [T]he man in the street tends to personify an organisation and treat it as a composite entity which ought in justice to pay for the damage which 'they' have caused. In many circumstances there is little doubt that the man in the street would find it hard to grasp the law's fine distinctions between a servant and an independent contractor, and would not wish to enquire too closely into the precise relationships existing in one organisation. This is particularly the case where the liability is of contractual or semi-contractual nature, as, for example, in the case of hospitals. A person injured by the negligence of someone in a hospital tends to think of the hospital as a unit which ought to be responsible for the consequences, and he is unlikely to be impressed by arguments that the negligent party was, say, a visiting consultant who ought to be treated as an independent contractor."

Hughes suggests that the relevant question when attempting to determine whether a principal should be held liable for the actions of his or her agent is, "What is necessary for the reasonable protection of an innocent third party?"[7] Lord Wilberforce has observed that the answer to this question will depend on a "judgement of value".[8]

The purpose of the Health and Disability Commissioner Act 1994 is to promote and protect consumers' rights when receiving health or disability services. The imposition of vicarious liability in these circumstances encourages principals (in the present case, the private hospital that is an "employing authority" in relation to the nursing staff it employs) to take reasonable steps to ensure that all the health professionals who work on its premises are practising competently. For the individual patient this is important, irrespective of whether the practitioner is a staff member or a consultant. These policy factors lead me to the view that section 72(1) and (3) of the Health and Disability Commissioner Act 1994 should be interpreted liberally, to better protect the rights of health and disability services consumers. Accordingly, in my opinion, Dr C was an agent of the private hospital.

Express or implied authority

Section 72(3) provides that an employing authority will not be liable for the actions or omissions of an agent if the act or omission is done without the employing authority's express or implied authority, precedent or subsequent. The private hospital submits that a health provider will always expect an employee or agent to treat patients appropriately and has rules that doctors must obtain informed consent and provide services in accordance with professional standards.

The private hospital authorised Dr C to treat patients provided that he complied with the private hospital's rules. The hospital submits that the moment Dr C deviated from these

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[6] As above note 3, at p 335.

[7] John Hughes, "Vicarious Liability" in Stephen Todd, *The Law of Torts in New Zealand*, 2nd Edition (Brookers, Wellington, 1997) 1157-1158.

[8] *Launchbury v Morgans* [1973] AC 127, 135.

rules, he was no longer acting with the private hospital's authority. I do not accept this argument. The courts are quite clear in the context of an employee/employer relationship that "prohibitions relating to the mode of carrying out the work, but not limiting the actual work that the employee is required to do, will not take the prohibited act outside the scope of employment".[9] This approach is equally applicable to the agency context. The private hospital authorised Dr C to provide health services using its facilities. Dr C was acting within the broad scope of his agreement with the private hospital and was authorised to provide services to Mr A. He did not cease to be an ostensible agent of the private hospital simply because his provision of services was in some respects substandard.

Defence to liability, section 72(5)

Under section 72(5) it is a defence for an employing authority to prove it took such steps as were reasonably practicable to prevent the employee from doing or omitting to do the thing that breached the Code. The question is whether this section can be used as a defence by an employing authority for the actions of an agent. The plain reading of this provision would suggest that it is available in respect of employees. However, in *Totalisator Agency Board v Gruschow*[10] Gallen and Gendall JJ. considered the meaning of section 68 of the Human Rights Act 1977 (the corresponding provision to section 72). They stated:

> "In so far as vicarious liability for the acts of others is concerned however, s 68 may be seen as providing a code. Section 68(1) [the equivalent provision to section 72(2) of the Health and Disability Commissioner Act 1994] covers the case of a direct employer/employee relationship. Subs (2) [the equivalent provision to section 72(3) of the Health and Disability Commissioner Act 1994] covers the case of principals and agent. … Because subs (2), dealing as it does with principal and agent deals with a situation which extends beyond that contemplated by subs (1), it is appropriate that there should be a defence available which reflects the less direct nature of the relationship.
>
> Subs (3) [the equivalent of section 72(5) of the Health and Disability Commissioner Act 1994] provides a general defence, covering all cases of vicarious liability."

Adopting this approach I accept that section 72(5) applies as a defence to liability under section 72(3).

Dr C's breach of Right 4(1) of the Code related to his professional decisions about the management of a patient. Although the private hospital had given Dr C privileges to use its facilities, it is difficult to see how the private hospital could have prevented Dr C's actions. Dr C's other breaches of the Code related to informed consent. The private hospital had standard forms for practitioners to use to record informed consent and provided some guidance for practitioners in relation to informed consent. Given that The private hospital has a system in place to check on a practitioner's competence (albeit I have my reservations about some aspects of the private hospital's system), and has a policy about informed

[9] See above note 7, 1139.
[10] [1998] NZAR 529.

consent, I am satisfied that the private hospital took such steps as were reasonably practicable to prevent Dr C breaching the Code.

In these circumstances the private hospital is not vicariously liable for Dr C's breaches of Right 4(1), 6(1), 7(1) and 7(6) of the Code.

Opinion: Breach – The private hospital

In my opinion the private hospital breached Right 4(2) of the Code, as it failed to have a system in place to ensure that medical practitioners working at its facility comply with the requirements of the Medical Practitioners Act and the requirements of its own clinical privileges agreement with approved practitioners.

The private hospital's regulations require that practitioners maintain professional standards, including re-certification. I note that from 1 April 1999 to 10 June 1999, during the time these breaches occurred, Dr C had not renewed his annual practising certificate. Although failure to renew an annual certificate does not of itself indicate a decline in or lack of professional standards or competence, the private hospital has appropriately made a current practising certificate a requirement for maintaining clinical privileges. However, the private hospital did not have an adequate process in place to ensure that this requirement had been met.

The private hospital has made a number of submissions on this issue, which are summarised in the Appendix to this report. I do not accept the argument that a breach of Right 4(2) cannot be found without receiving advice on practice amongst contemporary health providers. The legal standard applicable in these circumstances is set out in section 9 of the Medical Practitioners Act 1995:

> "No person shall practise medicine under the title of a medical practitioner (as defined in section 2 of this Act) unless he or she holds –
> (a) Both –
> (i) Probationary registration, general registration, or vocational registration; and
> (b) A current practising certificate; or
> (ii) Temporary registration or interim registration."

The private hospital is providing a hospital service, including a facility where medical practitioners provide health or disability services to the public. It has a responsibility to ensure that medical practitioners who provide services to patients within its facility comply with the law, including the requirements of the Medical Practitioners Act. The private hospital has appropriately recognised this by making a current practising certificate a requirement for its clinical privileges application and renewal process. However, The private hospital's system is inadequate in that its regular checks occur three months after

practising certificates expire on 31 March. This gap in the system allowed Dr C to provide health services to patients in contravention of section 9 of the Medical Practitioners Act.

In my opinion any employing authority or facility that allows registered health professionals (irrespective of their employment status) to provide services using its premises is required to have an effective system in place to check that the registration requirements for that practitioner are in order. This is necessary so that the facility can reassure itself, and the public, that services provided within that facility are provided lawfully. I do not consider that an effective system checks compliance with legislative requirements three months after the date by which the practitioner should have complied. As the private hospital currently has a system in place to verify that a practising certificate has been obtained I do not believe that it is unduly onerous to require the private hospital to confirm a practitioner's practising status in a more timely manner. I agree that it is the individual practitioner's responsibility to maintain his or her practising certificate but it is the organisation's responsibility to ensure that those who practise within its premises comply with the law. An organisation can and should refuse to allow a practitioner to continue to practise until he or she has complied with legal requirements.

Other comments

Communication with Mr A after Dr C's return on 18 May 1999
If Dr C's actions at the time of his return on 18 May 1999 can be criticised, it is with regard to his communication with Mr A and Ms B. When Dr C returned he found that Mr A had experienced a number of problems and, in his absence, had been seen by both Dr D and Dr E. Mr A had also had an MRI scan. It was clear that Mr A's condition had not improved and that additional surgery was likely to be required, probably in consultation with Dr I. It must have been obvious that Mr A and Ms B were concerned about his condition and uncertain about what was being done to resolve it.

Although Dr C did contact Mr A on two occasions, Ms B, through Dr J, initiated these contacts. Dr C did not take a proactive approach and initiate contact himself, nor did he return calls in a timely fashion. Mr A and Ms B were not kept sufficiently informed of what actions Dr C was taking to manage Mr A's condition. I appreciate that Dr C was likely to have been busy having recently returned from a three week absence. However, it would have taken little time to explain to Mr A and Ms B what he was doing and why he was doing it. This would have probably made the wait for treatment more bearable for Mr A and Ms B.

Practising without a practising certificate
I am concerned that when Dr C provided services to Mr A from 1 April 1999 to 10 June 1999, he did not have a current practising certificate as required by the Medical Practitioners Act 1995.

Section 9 of the Medical Practitioners Act 1995 states:

> "No person shall practise medicine under the title of a medical practitioner (as defined in section 2 of this Act) unless he or she holds –
>
> (a) Both –
> (i) Probationary registration, general registration, or vocational registration; and
> (ii) A current practising certificate; or
> (b) Temporary registration or interim registration."

This issue will be referred to the Medical Council, as the body with the statutory jurisdiction over the registration of medical practitioners.

Actions

I recommend that Dr C:

- Apologise in writing to Mr A for his breaches of the Code. This apology is to be sent to the Commissioner and will be forwarded to Mr A.
- Review his practice in light of this report.

I recommend that the private hospital:

- Apologise in writing to Mr A for its breach of the Code. This apology is to be sent to the Commissioner and will be forwarded to Mr A.
- Review its operations in light of this report.

Other Actions

- I will refer this matter to the Director of Proceedings under 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 C.
- A copy of my opinion will be sent to the Medical Council of New Zealand and the Licensing Office of the Ministry of Health.
- A copy of this opinion with details identifying Mr A removed 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, the New Zealand Private Hospitals Association, and

Quality Health New Zealand, and placed on the Health and Disability Commissioner's website, www.hdc.org.nz, for educational purposes.

APPENDIX

Response from [the private hospital] to provisional opinion

[The private hospital] has requested under section 67(b) of the Health and Disability Commissioner Act 1994 that its submission or a summary of its submission be appended to my final report. The following is a summary of the private hospital's submission:

Agent or independent contractor

- [Dr C] was at all material times an independent contractor to [the private hospital] and was not [the private hospital's] agent;
- Health providers are not vicariously liable for the actions or omissions of independent contractors; and therefore
- [The private hospital] is not vicariously liable for the acts or omissions of [Dr C].

The differences between an independent contractor and an agent is set out in *Lower Hutt City* v *Attorney-General* [1965] NZLR 65 at 72.

> "The determination whether the actual wrongdoer is a servant or agent on the one hand or an independent contractor on the other depends on whether or not the employer not only determines what is to be done, but retains the control of the actual performance, in which case the doer is a servant or agent; but if the employer, while prescribing the work to be done, leaves the manner of doing it to the control of the doer, the latter is an independent contractor."

The factors establishing someone is an agent set out in the above case are:

- The principal supervises the agent;
- The individual is acting until the control of the agent;
- The principal determines what is to be done;
- The individual is paid by the principal.

The factors set out in the above case indicating that someone is an independent contractor are:

- The principal, while prescribing the work to be done, leaves the manner of doing it to the control of the principal;
- The individual is left to do the work when and how he wants to do so;
- The chance of profit or less lie with the individual;
- The individual is carrying on business for himself or on his own behalf and not merely for the principal.

In the above case the fact that the contractor worked on the premises was not determinative of an agency relationship.

Vicarious liability of health providers was considered in *Ellis* v *Wallsend District Hospital* (1989) 17 NSWLR 553.

At 591 the judgement stated:

> "Although an employer can be vicariously liable for the wrongs committed by his employees during the course of their employment, it has long been established that the principle of an independent contractor is not, as a general rule, vicariously liable for the wrongs committed by the contractor during the course of the engagement."

The test in *Ellis* was "In treating the [patient] was [the doctor] engaged in his own business or the hospital's?" (598). Key factors were:

- An employee unlike an independent contractor, can be told by his employer not only what work to do, but also how to do it.
- Whether the doctor receives remuneration from the hospital;
- The determination will be a matter of fact turning on the nature of the contractual relationship between the parties.

The key facts in *Ellis* were as follows:

- The doctor was an honorary medical officer;
- Public patients could be assigned to the doctor's care and he could treat them free of charge;
- The doctor was required to comply with a roster;
- The doctor was selected and appointed by the hospital board for a three year term;
- 28 days' notice of intention to resign had to be given;
- the doctor was not paid by the hospital;
- the doctor was not permitted to be absent from his duties without first obtaining leave and nominating a substitute;
- the doctor was required to consult when requested by a colleague;
- the doctor was under the control of the hospital's Chief Executive;
- the doctor was integrated into the discipline and direction of the hospital;
- on admission patients signed a form confirming that they could not be given an assurance that a particular patient would treat them;
- the doctor could be required to provide professional services as required by the Board.

The Court found:

> "the performance of surgery was a vital incident of [his] practice, and required the use of facilities which could be obtained only in a hospital which provided operating theatres with their standard fixtures and fittings … Without these resources [the doctor] could not have carried on his practice as a surgeon" (598).

[Dr C's] relationship with [the private hospital]

- Dr C does not receive money from nor pay money to the private hospital.
- He independently contracts with his patients for the provision of his professional services and his fee is a matter between him and his patient. [The private hospital] has no involvement in the establishment or payment of that fee, as these matters are [Dr C's] business.

- [The private hospital] has no influence on the hours that [Dr C] keeps or the annual leave that he takes.
- There are no rosters for professional services, which [Dr C] adheres to.
- [The private hospital] cannot require [Dr C] to see a particular patient.
- If [Dr C's] patients require inpatient treatment [Dr C] has the option of suggesting to the patient that he or she be treated at [the private hospital]. He does not have to suggest [the private hospital] and the patient does not have to choose [the private hospital]. If [the private hospital] is chosen [the private hospital] the patient with services that include accommodation, nursing care, medical supplies and theatre expenses.
- The referral made by [Mr A's] general practitioner was to [Dr C], not to [the private hospital].
- [The private hospital] regards specialists as its clients because of the nature of the relationship, and the commercial need for [the private hospital] to have specialists continue to use its services.
- Patients who are treated at [the private hospital] are made aware of the fact that the hospital is separate from the surgeon and anaesthetist in the admissions booklet. The 1997 booklet states:

  "Your specialist should discuss estimated costs with you before your admission.

  The total cost of your treatment will include:

  - a charge from the hospital covering theatre, medical supplies, accommodation, and specialised nursing care. (The doctors aren't on our staff so they'll bill you separately for their fees.)
  - separate charges for services like x-rays and physiotherapy (if you need these).
  - A charge from your surgeon or medical specialist.
  - A charge from your anaesthetist."

- The fact that [Dr C's] consulting rooms are at [the private hospital] should attract little weight. [Dr C's] address, phone number and fax number are different from [the private hospital's].
- The correspondence written by [Dr C] was on paper bearing the heading [the private hospital] Gastroenterology Centre with no mention of the Hospital; the only similarities are the name [the private hospital] and an unidentified logo.
- A number of providers unrelated to [the private hospital] use the name and logo.
- [Dr C] is not authorised by and does not act for [the private hospital] and cannot bind [the private hospital] to third parties.

Other submissions

Parliament could have defined 'employee' or 'agent' in the Health and Disability Commissioner Act 1994 to include 'independent contractor' but chose not to.

Therefore [Dr C] was not an agent of [the private hospital] but was an independent contractor.

Implied authority
[The private hospital] submits that a health provider will always expect an employee or agent to treat patients appropriately. [The private hospital] had rules that doctors must obtain informed consent and must provide services in accordance with professional standards. [Dr C] acted outside of [the private hospital's] rules in the manner in which he obtained consent and treated the patient. All [the private hospital] could do was to establish rules under which specialists practise. [The private hospital] authorised [Dr C] to treat patients provided he complied with [the private hospitals'] rules. As soon as [Dr C] deviated from these rules he was no longer acting with [the private hospital's] authority.

Right 4(2)
- A breach of Right 4(2) cannot be made without a comparison of the conduct of the health provider in question with accepted contemporary practice amongst comparable health providers. Such a comparison cannot be made without seeking expert advice;
- [The private hospital] does have a process to ensure, on an annual basis in June/July of each year, that practitioners have practising certificates;
- It is the responsibility of the individual practitioner to ensure that the annual certificate is renewed, not the employer;
- A health provider must have a greater obligation to ensure that employees or agents have current certificates than it would to ensure independent contractors have practising certificates;
- A finding that [the private hospital's] systems are inadequate would be an added administrative responsibility, which is neither necessary nor reasonable. "Health providers should be able to rely on individual practitioners to accept some responsibility for maintaining their certificates."

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.