Gynaecologist, Dr B

A Health Centre

A Report by the

Health and Disability Commissioner

(Case 01HDC01835)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Consumer
Dr B	Provider / Gynaecologist
Ms C	Circulating Nurse
Ms D	Anaesthetic Nurse
Dr F	Anaesthetist
Dr G	Plastic and Reconstructive Surgeon
Dr H	Breast and General Surgeon
Dr I	Gynaecologist
A Health Centre	Provider's employer

Complaint

On 1 February 2001 the Commissioner received a complaint from Mrs A about the services provided to her by Dr B. The following matters were notified for investigation:

- *On 26 October 2000 Dr B offered Mrs A a 'tummy tuck' and quoted $200-300 on top of the hysterectomy bill. Despite this she performed a full abdominoplasty, at a substantially higher cost and without consent.*
- *On 18 December 2000 Mrs A was unable to properly discuss the proposed surgery with Dr B because Dr B arrived late.*
- *While Mrs A spoke with Dr B pre-operatively she was, by that time, under the influence of a pre-med and was, therefore, not able to consent to the abdominoplasty.*
- *Dr B was inexperienced in the area of abdominoplasty but did not follow her usual procedure, which was to have a general surgeon from her practice attend to assist.*

An investigation was commenced on 30 May 2001.

Information reviewed

- Relevant medical records
- Information from the Accident Compensation Corporation (ACC)
- Information from the private hospital
- Information from Ms C, a circulating nurse; another nurse; Ms D, an anaesthetic nurse; Ms E, a nurse; and the theatre manager at the public hospital
- Information from Dr F, anaesthetist
- Responses from Dr B and submissions from her lawyer
- Report from Dr G, plastic and reconstructive surgeon, submitted on behalf of Dr B

Independent expert advice was obtained from Dr John Hutton, a gynaecologist in private practice.

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Information gathered during investigation

First consultation
On 18 October 2000 Mrs A, aged 33 years, consulted Dr B, a gynaecologist employed at a Health Centre. Mrs A had been experiencing uncontrolled vaginal bleeding and was advised by her general practitioner to see a gynaecologist.

At the initial consultation, Dr B established that the bleeding was "probably an ovulatory dysfunctional bleeding" and noted Mrs A's preference to have an abdominal hysterectomy. They agreed that Mrs A should make a second appointment to discuss matters further.

Dr B recalls that Mrs A was "an intelligent and assertive woman who was a law student in her final year".

Second consultation
On 26 October 2000 Mrs A consulted Dr B again.

At the second consultation, Dr B explained a number of treatment options for the vaginal bleeding, including a Mirena IUCD, an endometrial resection or ablation, or an abdominal hysterectomy. Dr B noted that Mrs A's preference was for an abdominal hysterectomy. Dr B considered this to be the safest option given that Mrs A had had three Caesarean sections previously.

Mrs A does not dispute that she consented to an abdominal hysterectomy. What is at issue is the discussion relating to any additional procedure to be performed, specifically a minor "tummy tuck" or, alternatively, a full abdominoplasty (a more complicated cosmetic procedure to the abdominal area).

Mrs A explained that she had a "pouch of skin" in her stomach area, which was the result of multiple Caesarean sections. This presented her with "practical difficulties" in terms of "getting bottom and top clothes in the same size".

Mrs A recalls that she made a "quip" at the second consultation about the "pouch of skin", to the effect of, "Oh, you can't do liposuction too, can you?" Mrs A said Dr B responded by stating that although she could not perform liposuction, she could remove the pouch. This could be done after the hysterectomy and involved removing "a wedge of skin". Mrs A understood this procedure to be a "nip and tuck" or "tummy tuck".

The parties have differing recollections of who raised the subject of a "tummy tuck": Dr B claims that it was Mrs A who "inquired as to whether she could have a tummy tuck", whereas Mrs A claims that Dr B "offered" her the "tummy tuck". However, it is clear that a "tummy tuck" was discussed and agreed to at the second consultation.

Mrs A stated that Dr B told her that the "tummy tuck" would take an extra 10 to 15 minutes of theatre time and would cost an additional $200 to $300. Mrs A recalls:

> "The cost was very important, as my [insurance] Policy does not cover cosmetic surgery, and we agreed that whilst the theatre fees would probably be credited to the

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> hysterectomy, I would have to pay the extra $200–300. I agreed to the removal of the small pouch on this basis."

Dr B points out that a "tummy tuck" would not have made any difference to Mrs A's clothes sizing, but only to the contour of her lower abdomen: "If [Mrs A] wished to change clothes sizes, a larger procedure such as the full abdominoplasty would have needed to be performed." Dr B recalls that she discussed both the option of a "tummy tuck" and the more costly option of an abdominoplasty with Mrs A at the second consultation. Dr B states that she gave Mrs A a "full explanation" of the "possible risks and complications" of an abdominoplasty. Mrs A disputes this, noting that "the word 'abdominoplasty' was *never* used at any time".

Dr B has the following recollection of the discussion:

> "I explained that the performance of [the abdominoplasty] procedure might make [Mrs A's] convalescence initially more uncomfortable. I also remember telling her that this was not a procedure I frequently performed although I had performed it on several occasions, and that the norm would be to invite one of the general surgeons from [the Health Centre] to come to theatre after the hysterectomy and that the surgeon and I would perform the abdominoplasty together. This would have the advantage of reducing time in theatre.
>
> I then told her that her health insurance would not cover any abdominoplasty, because it was a cosmetic procedure. [Mrs A] asked how much such a procedure would cost and I said I could get a proper estimate made up but it would probably be an extra $4,000.00 or $5,000.00 on top of the hysterectomy. [Mrs A] said that she could not afford this."

Dr B states that as Mrs A could not afford the cost of an abdominoplasty, they "formed an alternative plan" and she told Mrs A:

> "… [T]here was an alternative, which was that I would cut a wide incision at the time of the hysterectomy and take a wedge of fat and skin from the lower abdomen. This would include the Caesarean scars. Because this procedure would require very little additional work from myself, I was prepared to do it for a small extra fee. [Mrs A] requested me to perform this additional procedure at the same time as the hysterectomy. …
>
> [Mrs A] was very anxious not to incur any extra costs other than those covered by her insurance so we did not specify the extra large incision on the consent form as I was performing these two procedures for a price well within the normal range of pricing for a hysterectomy. If the procedure was detailed on the form [the insurance company] might attempt to apportion the costs between the hysterectomy and the 'tummy tuck'. The consent form for the hysterectomy was filled out and signed by [Mrs A] at this stage."

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Dr B recorded the consultation as follows in her contemporaneous notes of the consultation:

> "Wants hysterectomy requested abdominoplasty.
>
> Plan for TAH and abdominoplasty – Mon 18/12/00 @ [the private hospital]
>
> wedge not full because of cost. Not put on consent for same."

Dr B's notes support her recollection that an abdominoplasty was discussed; that Mrs A agreed to a wedge but not a full procedure; and that the consent form was only to the hysterectomy.

Mrs A signed a consent form that day (26 October 2000) listing only one procedure, an abdominal hysterectomy.

Confirmation of surgery
On 15 December 2000 Dr B's secretary telephoned Mrs A to confirm that surgery would be performed on 18 December 2000. Mrs A asked Dr B's secretary to remind Dr B that a "tummy tuck" would be performed at the same time. The secretary told her to "discuss this directly with [Dr B] prior to surgery on Monday, 18 December".

Hospital admission and pre-medication
On the morning of 18 December 2000 Mrs A was admitted to the private hospital, where an abdominal hysterectomy was scheduled to be performed by Dr B at 8.00am.

At 7.15am Dr F, an anaesthetist, attended Mrs A to discuss the proposed anaesthesia. Dr F noted that Mrs A had some concerns about pain relief as she had experienced some discomfort when undergoing two previous Caesareans. In light of Mrs A's concerns, Dr F recommended that a general anaesthetic together with a spinal anaesthetic be used. The medication prescribed by Dr F was on the basis of a two-hour procedure being performed, namely the abdominal hysterectomy alone.

Dr F also discussed using pre-medication with Mrs A, which she consented to. Pre-medication is given to patients to help relax or sedate them prior to surgery. At approximately 8.00am, Dr F administered pre-medication to Mrs A consisting of midazolam 7.5mg and ranitidine 150mg orally.

Corridor discussion pre-surgery
By 8.30am Dr B had not arrived at the hospital despite the operation having been scheduled for 8.00am. A call was made to Dr B to ascertain her whereabouts. Dr B confirmed that she was "five minutes" away. A decision was made by assisting staff to transfer Mrs A to the theatre waiting area, in preparation for Dr B's imminent arrival.

At approximately 8.45am Dr B arrived at the hospital. She had been delayed by heavy traffic. Upon her arrival Dr B spoke to Mrs A, who was at that point situated in the waiting area immediately outside of theatre, in a hospital bed.

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Dr B claims that she was unaware that Mrs A had been given pre-medication prior to their discussion, and that Mrs A did not tell her:

> "She knew she needed to discuss with me how large the wedge of skin or fat I was going to remove prior to theatre so I thought she would know better than to have a premedication. She seemed perfectly lucid and we had a conversation where she told me that her daughter had fractured both of her wrists and I asked her if she still wished to proceed with the surgery in that case as she would be recovering at the same time as her daughter."

Dr B further commented that Mrs A seemed "very lucid" and "appeared to follow our conversation well, and responded in an appropriate manner to questions".

Mrs A believes Dr B should have "checked the patient chart" which would have recorded the administration of pre-medication, in order to ensure that she was competent to give consent at the time. In response to my provisional opinion, Dr B commented:

> "The patient notes were in Theatre, but the patient was in the corridor, so I did not have ready access to the notes … and was not therefore aware that she had had a pre-med.
>
> [Dr F] is not an anaesthetist I work with normally … pre-medication is not the norm for my patients.
>
> I was not comfortable discussing [Mrs A's] surgery in the corridor and I probably should have insisted that she was returned to her hospital room to do this. However we were already running late and I didn't wish to delay procedures any further.
>
> I realise now that I should have gone and got the notes from Theatre, to see whether she had had any pre-medication."

Dr B recalls that Mrs A queried "how much of her tummy" she intended to remove. Dr B told Mrs A that she would need to "have a look" before deciding. Dr B claims that Mrs A's instructions were as follows:

> "She asked me to cut away as much as I possibly could as she had lost some further weight and she wished as much of the excess fat and skin of her abdomen to be removed as possible. She said I could cut away as much as I liked and she didn't care how far down her navel was. I said I couldn't do this as it would be disfiguring and if she really wanted that much of the excess skin and fat removed then we would have to perform a full abdominoplasty with relocation of her umbilicus."

Dr B recalls that Mrs A was "eager to achieve the cosmetic result she wanted".

Dr B told Mrs A that, "since it was Christmas", she would perform the abdominoplasty "for no extra cost, just the quoted cost of her abdominal hysterectomy"; Mrs A would still have to meet the costs of the "extra theatre time and anaesthetic time and any extra sundries that were incurred by the extra surgery". Dr B estimated that the abdominoplasty

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would take a further 45 minutes and require "an extra $450.00 to $500.00 in theatre time". Dr B was unsure, however, what the anaesthetist's additional costs would be.

According to Dr B, Mrs A:

> "then said she wished to go ahead with this [the abdominoplasty] and I asked her again if she was sure she wished to have this done. She said that she did and so I informed the theatre nurses that we would be performing an abdominoplasty after the hysterectomy."

Although Dr B and Mrs A were observed talking immediately prior to surgery, there are no independent witnesses who can attest to the specific contents of their conversation. Ms D, the anaesthetic nurse, saw Dr B talk with Mrs A immediately prior to surgery, but did not hear what was discussed. Ms D thought the conversation took approximately five minutes.

Preparations in theatre
Dr B recalls events subsequent to her discussion with Mrs A as follows:

> "I then went into theatre and told the theatre nurses that we would be performing an abdominoplasty after the hysterectomy. I said this in front of the anaesthetist who was in theatre at the time. One of the theatre nurses pointed out that this was not noted on the consent form and should be added to the form. I told [Mrs A] this. She queried whether it was necessary to record the abdominoplasty on the consent form as she did not want [the insurance company] to start querying what part of the price she was paying was attributable to the hysterectomy. I responded that this was now a separate procedure. She was in a [private] hospital and that accordingly, concealing the nature of the procedures undertaken would not be possible. The abdominoplasty was then added to the consent form by one of the nurses. This was done in front of [Mrs A] and she agreed to this. At the time [Mrs A] was still on her bed. She had not yet been transferred to the operating table and had not been administered any anaesthetic."

Dr B's account is not corroborated by the assisting staff.

Ms C, the circulating nurse, confirms that Dr B first told her about the additional procedure while she and another nurse were in the scrub bay, not theatre. Dr B requested certain sutures, which differed from those ordinarily used for an abdominal hysterectomy. Ms C queried why different sutures were to be used, at which point Dr B told her that she would be performing an abdominoplasty as well. Ms C told Dr B that the abdominoplasty was not on the theatre list, to which she responded that she had spoken with Mrs A who had agreed to it. Ms C states that the anaesthetist was "not within earshot" of Dr B when this discussion took place.

Ms C then went into theatre and queried with the anaesthetic nurse, Ms D, whether the abdominoplasty was noted on the consent form. Ms D confirmed that it was not, and it was agreed that Ms D would need to contact the theatre manager about the proposed amendment.

Ms D, the anaesthetic nurse, confirms that it was the circulating nurse, Ms C, who told her that Dr B was going to perform a "small tummy tuck" in addition to the abdominal

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hysterectomy. Mrs A was on the operating table in theatre at the time. Ms D had, at that stage, begun attaching electrodes while the anaesthetist was preparing the IV lines. Ms D had earlier seen Dr B enter the scrub bay and talk with Ms C and one of the nurses. As they were some distance away, she was unable to hear the discussion in the scrub bay from her position in theatre.

Ms D confirms the abdominoplasty was not listed on the consent form when Ms C queried it with her. Ms D pointed this out to Ms C and they went to discuss the matter with the theatre manager. Ms D told the theatre manager that Dr B wanted to perform a "small tummy tuck", but it was not on the consent form; only the abdominal hysterectomy was listed. The theatre manager told Ms D that the additional procedure would need to be added to the consent form. The theatre manager confirms that she was approached by Ms D, and told her that the operation could not proceed unless there was consent.

Ms D states that when she told Dr B that the consent form would need to be altered, Dr B commented, "You don't need to bother" or words to that effect. I note that this verbal exchange was not documented on the incident report completed by Ms D that day. Ms D then explained to Mrs A that the consent form needed to be changed to include the "small tummy tuck" and amended the form in front of her. She said Mrs A was "just fine" with the amendment. A copy of the amended consent form is attached as Appendix A. The addition "abdominoplasty" in a different pen and script from the original recording of consent, is evident.

Dr F, the anaesthetist, also confirms that Dr B had not informed her of her intention to perform a full abdominoplasty until after Mrs A was sedated. Dr F was particularly concerned that her anaesthetic plan would not fulfil the patient's needs, as she had not prepared her for an abdominoplasty, which she estimated (at the time) would take an additional two hours. Dr F found this of particular concern, given that Mrs A had earlier expressed some anxiety about adequate pain relief. An abdominoplasty is also usually performed on a different theatre list, being the plastic surgery list.

Dr F overheard the anaesthetic nurse, Ms D, comment to Mrs A, "I have added the word abdominoplasty. Is that okay with you?" in reference to the consent form. Dr F notes:

> "This was the first time that I had heard this mentioned … I continued to put [Mrs A] to sleep saying aloud that it must just be a wound revision. My reasons for presuming this were that I had not been informed that another major procedure was to take place, and the time constraints of a morning list. Once [Mrs A] was asleep [Dr B] informed us all that a full abdominoplasty was indeed to be performed."

Dr F confirms that Mrs A was awake at the time the consent form was amended. Pre-medication of 7.5mg of midazolam had been administered one hour previously, which commonly has the effect of "amnesia of events" and relaxing the patient.

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As Dr F was concerned about the events of that morning, she made the following record in her personal billing notes:

> "(Unaware of abdominoplasty prior to operation. Consented only for TAH. Abdominoplasty from 10.30am. Only knew once patient asleep!) If two separate accounts. Abdo hys → 6 +7 units Abdominopl. → 10 units."

Dr F also made a similar note on the anaesthetic record:

> "(Unaware that abdominoplasty was to be performed until after patient asleep. Initially only consented for TAH.)"

Surgery
Dr B recalled that Mrs A's surgery began at 9.20am and finished at 12.40pm. The surgery "proved to be quite technically difficult" and both procedures (the hysterectomy and the abdominoplasty) took longer than she had expected. Dr B thought that half of the surgery time taken was spent on the abdominoplasty. Dr B had to draw back from a total abdominal hysterectomy to a "subtotal hysterectomy, leaving the cervix behind, because it is so difficult to get the bladder away from the cervix. In relation to the relocation of [Mrs A's] navel, I aligned it level with the [iliac crest]. This is the accepted placement of a navel."

Dr B's estimates of the time taken to perform the two procedures differ from Dr F's. Dr F's recollection is that surgery commenced at the earlier time of approximately 8.55am, not 9.20am. The hysterectomy proceeded until approximately 10.30am, at which point Dr B commenced the abdominoplasty. Surgery was not completed until 12.48pm. Dr F itemised the length of each procedure separately for the purposes of billing. This was on account of the abdominoplasty being a cosmetic procedure, which is not ordinarily met by insurance.

Post-surgery
Dr B states that, post-operatively, Mrs A was pleased with the abdominoplasty. Dr B visited Mrs A on the ward later that day (Monday, 18 December 2000). She noted that during this visit:

> "[Mrs A] enquired as to whether I had performed the abdominoplasty or not. I informed her that I had but unfortunately it had taken extra time and that this would mean an extra cost to her. [Mrs A] was quite anxious about the cost but pleased that she had had the operation performed."

Dr B states that the following day, Tuesday 19 December 2000, Mrs A again confirmed that she was happy with the surgery:

> "The following morning I again explained both the hysterectomy and abdominoplasty to [Mrs A]. I also examined the navel to see that it was still healthy. [Mrs A] was pleased with the surgery but anxious regarding the costs."

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Dr B states that on the morning of Wednesday 20 December 2000 Mrs A was still "happy and pleased with the results of the surgery". Dr B described this visit as follows:

> "I took down all the dressings and stood her in front of the mirror so she could see the full effect of the surgery. She was delighted with the operation and we joked that it was a shame that we had not taken before and after photographs.
>
> [Mrs A] was still, however, very concerned about the cost. I was also concerned that I had underestimated the time for the abdominoplasty by about 45 minutes. Accordingly, I offered to reduce my fee by $200.00 or $300.00. This was in effect reducing my fee for the hysterectomy, since I was not charging [Mrs A] for the abdominoplasty. [Mrs A] declined this offer. She said she was delighted with the surgery and I had worked hard to perform it and that she would sort the costs out with [the hospital]."

Dr F, the anaesthetist, visited Mrs A on the afternoon of Wednesday 20 December 2000. Mrs A enquired how long the surgery had taken, saying that she had only expected there to have been a "tidy up removal of fat", taking half an hour or so. Dr F recalls that Mrs A was very surprised to learn that the surgery had taken so long and that there had been two procedures. At the time, Dr F suggested that Mrs A discuss her concerns with the surgeon, Dr B, and the hospital. She also offered to provide Mrs A with two separate accounts.

On Thursday 21 December 2000 Dr B was informed that Mrs A had concerns about the abdominoplasty. The hospital advised Dr B that they had received a complaint from Mrs A that she had not given proper consent to the abdominoplasty as she had been under the influence of pre-medication at the time. Dr B advised:

> "This was the first time that I was aware that she had had a pre-med when I spoke to her. I was also told at that time that [Mrs A] was going to complain to the Health and Disability Commissioner regarding this matter if I did not pay for the extra time and other costs incurred."

Dr B's lawyer has since referred to a statement made by Ms E, a nurse at the hospital, who was assigned to Mrs A during various shifts post-operatively. Ms E states that the only concern Mrs A expressed about the surgery related to the additional costs:

> "I remember having a discussion with [Mrs A], I think day 1 post surgery, regarding the fact that she had decided to have this addition to her surgery, and she had not discussed it with her husband first and she was not sure how he was going to respond to the extra surgery costs, as well as extra time spent recuperating. This is the only concern I recall her expressing regarding the surgery. She did not express to me concern that the abdominoplasty had been performed. Quite the contrary. At no time did she give me the impression that she had not wanted the abdominoplasty procedure performed."

Dr B's lawyer submits that Ms E's statement "shows" or "renders unlikely" Mrs A's "account that she had no recollection of, and certainly was not consenting to, the abdominoplasty surgery because she was under the effect of a pre-med". Dr B's lawyer further states that Mrs A's "only concern was with the cost of surgery, and the fact that her husband did not know about it". Mrs A disputes this.

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Mrs A states that she did not realise that a full abdominoplasty had been performed until Wednesday 20 December 2000. She maintains that she has no recollection of the discussion with Dr B immediately prior to surgery:

> "From the time of surgery on Monday morning until Wednesday morning, I consider that I was absolutely incapable of having realised that a full abdominoplasty had been performed. Following recovery from the anaesthesia on Monday, I became very ill on Tuesday. My intake of morphine-based painkillers was extremely high and additionally I was being administered anti-nausea medication. In fact I was so ill on Tuesday night, that [Dr B] was telephoned because the nursing staff were worried about stomach distension and my general condition. Because I was unable to keep anything down, I was given fluids and morphine intravenously and panadol in suppository form. This is all recorded on my medical records.
>
> …
>
> It was not until Wednesday morning that I felt capable of even having a conversation, although I was still on morphine for pain relief. I remember standing in front of the mirror on Wednesday *morning* with [Dr B] and being absolutely **stunned** at the sight of my navel which she had 'relocated'. It was at this time that I realised that something had gone very wrong and that she had performed part of my surgery without my consent.
>
> [Dr B] removed my navel and 'relocated' it, as well as pulling all my skin up to my ribs and across from my hips. This has resulted in a wound/scar which goes from the top of one hip to another. Upon discovering this, I was extremely distressed, and discharged myself from hospital on Thursday, 21 December."

In relation to the additional costs of the full abdominoplasty (as opposed to the earlier quoted lesser cost for the "tummy tuck"), Mrs A comments:

> "As a full-time mother of two toddlers, we are a one-income family. At no stage would I have consented to a full abdominoplasty for two reasons. Firstly, and most importantly, the cost would be prohibitive. Secondly, I have had three children; I am not a physically 'beautiful' person and have no interest in having a 'flat' stomach. My body is a testament to the rigours of having had three lovely children and I was perfectly comfortable with the way it was. The small nip and tuck I agreed to was merely something of a practical consideration for fitting the same size clothes top and bottom."

Following Mrs A's discharge from hospital on 21 December 2000, she developed an infection in the wound. Dr B advised me that she attempted to ensure adequate follow-up for Mrs A following her early discharge.

Mrs A was subsequently admitted to a public hospital on 10 January 2001 where she was noted as having developed an infection and cellulitis (inflammation of the connective tissue). Mrs A felt that her overall recovery was impeded by the abdominoplasty, and that it caused her "substantially more physical distress than a hysterectomy alone". Dr B

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responded that wound infection is a known risk of abdominal hysterectomy, and there is no suggestion that it was attributable to medical error.

Dr B's experience
Dr B's experience in performing an abdominoplasty, which is a cosmetic procedure, has been considered as part of this investigation. Mrs A notes that Dr B is a "gynaecologist and not a plastic surgeon" and submits that Dr B was not experienced or qualified to perform the abdominoplasty without the assistance of a general surgeon.

Dr B advised me:

> "I … remember telling [Mrs A] that this was not a procedure I performed very often although I have performed it on a few occasions and that the norm would be to invite one of the general surgeons from the [Health Centre] to come to theatre after the hysterectomy and we would perform the abdominoplasty together."

Dr B confirmed that she had "performed several abdominoplasties" and was "fully competent to carry out the procedure".

When Dr B's employer, the Health Centre, was provided with an opportunity to comment on the allegations, it noted the decision of its Professional Standards Committee that Dr B had "acted both professionally and appropriately at all times".

In relation to her specific experience, Dr H, a breast and general surgeon at the Health Centre, confirmed that Dr B had assisted him with "one" procedure (prior to the events in question). He stated:

> "[Dr B] is a gynaecologist and obstetrician working at [the Health Centre] where I practise as a breast and general surgeon.
>
> [Dr B] and I performed an abdominoplasty on a patient last year [2000]. I was the primary surgeon for part of the procedure, but [Dr B] performed half the procedure with my supervision. Her understanding of the various stages of the procedure of abdominoplasty together with the technical skill demonstrated allows me to support her full competence at performing the procedure of abdominoplasty.
>
> I understand that this is a single case, but [Dr B] has had prior experience and exposure to the operation of abdominoplasty."

Dr B was asked to confirm her experience in performing an abdominoplasty, either on its own, or consecutively with an abdominal hysterectomy. She advised as follows:

> "My first experience of abdominoplasty was assisting [Dr I], Gynaecologist, in … 1999. I think this was on two or three occasions where people had an abdominoplasty, in addition to a hysterectomy, because of obesity. This surgery was performed at [a Public Hospital]. Also in 1999, I assisted [another doctor] with two abdominal hysterectomies, which were followed by abdominoplasties, performed by [another doctor] and myself. These were performed at [a private hospital] … I also performed an

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> abdominal hysterectomy followed by abdominoplasty with [Dr H], a breast and general surgeon, on 30th October 2000. You already have a letter from [Dr H], regarding my ability to perform abdominoplasty. I have only performed abdominoplasties in conjunction with abdominal hysterectomies. I have never performed an abdominoplasty on its own, as I am not a general or plastic surgeon."

The doctor whom Dr B provided assistance with performing abdominoplasties could not be contacted. Dr I and the doctor to whom Dr B provided assistance with performing abdominal hysterectomies were contacted and asked to verify Dr B's experience.

Dr I confirmed that Dr B had assisted him with "many major surgical procedures in …" but was unable to "ascertain" specifics of the procedures performed. He did, however, recollect her assisting on "one occasion" with an abdominoplasty:

> "I am sure that on at least one occasion I performed an abdominoplasty at the time of total abdominal hysterectomy with [Dr B]. I performed the procedure in a situation of a grossly obese patient requiring radical pelvic surgery, the abdominoplasty of access certainly very much assists surgical access for radical surgery in the pelvis. I do not however advocate it as a routine procedure or a procedure for cosmetic reasons."

Dr I commented that Dr B "was a good surgical assistant and had skills quite appropriate for her level of training".

The doctor to whom Dr B provided assistance with performing abdominal hysterectomies confirmed that Dr B assisted with an abdominoplasty on one occasion:

> "[Dr B] assisted me with an abdominal hysterectomy on 24th July 1998. An abdominoplasty was carried out by [the surgeon] immediately following the hysterectomy. Both myself and [Dr B] assisted at this procedure. The procedure was carried out at [the private hospital] …"

Dr B has (in response to my provisional opinion) provided me with two testimonial letters, from a senior lecturer in obstetrics and gynaecology, and a Nurse Manager of a Surgical Centre. Both state their confidence in Dr B's abilities, and note that they have always found her to be very professional.

Absence of general surgeon/plastic surgeon

In relation to having a general or plastic surgeon present to assist with the abdominoplasty, Mrs A stated that "it seems that in this case, no telephone call was made to see whether a surgeon was in fact available".

Dr B stated:

> "Had [Mrs A] decided to go ahead with the abdominoplasty prior to the day of surgery, then I would have requested [Dr H] or [another surgeon] to come and assist with the abdominoplasty. This is not because I am incapable of performing an abdominoplasty, but because it is quite a lengthy procedure and it is more expedient to have a second surgeon, rather than pay for the extra time in Theatre and anaesthetic costs."

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Dr B went on to note the additional costs of theatre time and "anaesthetic time" which she calculated to be approximately $230 every 15 minutes. She further noted:

> "I would have been unable to arrange a second surgeon at the time of [Mrs A's] surgery, as the surgeons whom I normally work with were already operating at the time. Also I offered not to charge [Mrs A] for the abdominoplasty but informed her that she would incur the extra anaesthetic and Theatre costs and, although I am able to waive my own surgical fee, I certainly cannot waive another surgeon's fee, so if I had enlisted the help of a second surgeon, there would have been a surgical fee attached to that service."

ACC

Following the incident Mrs A filed a claim with the Accident Compensation and Rehabilitation Corporation ("ACC"), claiming medical misadventure on the basis that consent was not properly given for the abdominoplasty. The claim was accepted by ACC on 18 October 2001 as medical error due to lack of informed consent.

Expert advice was initially provided to ACC by an obstetrician and gynaecologist, and a specialist anaesthetist. In upholding the claim the experts made various comments.

ACC's obstetric and gynaecological advisor stated:

> "I have noted above that the matter of the pre-medication and its possible amnesic effects needs to be established, but in general the consent process should be established completely prior to the administration of the pre-medication. It would be the Surgeon's responsibility to ensure that the consent process was carried out appropriately. I would further add that where Surgeons are embarking upon operative procedures which are not normally within the bounds of their practice, it would be appropriate for a somewhat more rigorous consent process to be put in place to ensure that the patient was entirely aware of the risks of such a procedure. [Dr B] indicated that it would be normal practice for her to enjoin an Abdominal or Plastic Surgeon to assist with any abdominoplasty. However, clearly it was decided in this instance that this was not required and [Dr B] felt capable of undertaking the procedure even though this was not within the bounds of her normal gynaecological training."

The issue surrounding the effects of midazolam was referred to a specialist anaesthetist for further comment. She noted that midazolam when orally administered is absorbed rapidly. She further noted that the pre-medication would have "certainly [been] working" within 45 minutes after the dose was administered, when the discussions were held with Dr B.

The specialist anaesthetist also confirmed that "anxiolytic, amnesic and hypnotic effects could be expected" with the dosage of midazolam administered to Mrs A. She concluded that the pre-medication administered to Mrs A may have had "an amnesic effect, in that it may have affected her memory of events".

She also noted her own experience that patients given benzodiazepine pre-medication can appear "normal … [the] only difference being a tendency to fall asleep if the surroundings are peaceful, and a diminution in their anxiety".

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A plastic surgeon was asked to review the file and concurred with ACC's advisors commenting:

> "In my opinion the informed consent process was inadequate because a substantive part is the pre-operative decision to proceed with the additional surgery after the hysterectomy was made in a conversation with the patient immediately before the operation and at least half an hour after she had pre-medication which included Midazolam. Midazolam taken orally is fast acting and has a powerful amnesic effect. It is entirely possible that [Mrs A] would seem to carry on a lucid conversation after this pre-medication but remember nothing of this after the operation."

In terms of the 'performance' of the procedure itself, the plastic surgeon noted:

> "The boundaries of surgical specialities are not sharply defined and different surgeons develop different 'niches' as their career progresses. I would comment however that when moving beyond these, albeit poorly defined, boundaries, the process of informed consent becomes even more stringent."

Independent advice to Commissioner

The following expert advice was obtained from an independent gynaecologist, Dr John Hutton:

> "I write in reply to your letter of 2nd December 2002. In preparing this reply, I have reminded myself of the HDC 'Guidelines for Independent Advisors'.
>
> Documentation on which the Report is based
>
> I have studied the following documents you forwarded me:
>
> A Complaint from patient dated 30th January 2001.
> B Subsequent correspondence from patient dated 18th April 2001, with letter from (a lawyer) of 11th April, and letter from [Dr B] dated 4th April 2001, a further letter from patient dated 29th May 2001, operation consent form, anaesthetic questionnaire and 30 pages of peri-operation notes from [the private hospital], HDC file note of 17th August 2001, and letter and typed fax from patient dated 7th August 2001.
> C Letter from [another lawyer now acting for [Dr B] of 30th July 2001, with letter from [Dr B] with her cv, a detailed letter from [Dr B] dated 27th July 2001, a copy of the quote for the operation, a letter from [Dr B's] secretary, a reference from [Dr H] dated 22nd July 2001, a further letter from [Dr B's] lawyer] dated 31st May 2002 and a qualifying statement from [one of the nurses at the private hospital] dated May 2002, and a letter from [Dr B] detailing her experience in abdominoplasty with the request from the HDC dated 8th July 2002.

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D HDC Interview notes with [the theatre manager] on 29th April 2002, [Ms D] on 29th April 2002, [Ms C] on 29th April 2002, [the private hospital's] Incident report form of 18th December 2000, statement by [the private hospital's] Manager of 18th April 2001, and copy of [the private hospital's] notes for the patient, as well as a copy of the Probationary Registration to [Dr B] agreed by [the private hospital] dated 18th May 2000.
E [The Health Centre's] letter to HDC dated 28th May 2002, and 13th May 2002.
F HDC notes of interview with [Dr F] of 1st July 2002, with letter from patient to [Dr F] dated 4th January 2001, and invoices relating to the operation, as well as a statement by [Dr F] dated 9th December 2001 that responds to issues raised for [Dr F] in an HDC letter dated 3rd December 2001.
G Letter from [a doctor] dated 7th December 2001 with copy of consultations with patient between September 2000 and October 2001.
H Letter from [the doctor] of 12th August 2001 about experience of [Dr B] with [himself and the other doctor that Dr B had performed abdominal hysterectomies and abdominoplasties with].
I Letter from Dr I of 21st November 2002 about experience of [Dr B] with [Dr I].
J Notes (23 pages) from hospitalisation with [a public hospital] from 10th January 2001.

Nature of the Complaint

Your letter of request to me summarised the complaint and the situation well. Nevertheless, and as required of your instructions, I summarise the situation as I have pictured it from the above information.

The patient provided appropriate informed consent in October to an abdominal hysterectomy that included some form of revision of the scar and would not add significantly to the operation – this revision would not involve additional anaesthetic or hospital fees, but possibly $200-300 of surgical fee that could not be disclosed to the insurance company.

Sometime between consent and the hospitalisation, [Dr B] concluded that the patient's 'tummy tuck' should not be performed but rather the much more extensive procedure of an abdominoplasty, which is not normally performed by gynaecologists. The patient was not informed about this decision until after she had had midazolam, and was in the theatre suite on a trolley. [Dr B] was late for theatre, was contacted by theatre staff about 30 minutes after the scheduled start and arrived about 15 minutes later. [Dr B] informed the patient of the proposed alteration to the cosmetic part of the operation, and probably obtained a form of verbal consent to the additional procedure, but this addition was not obtained in written form, and was not initially obvious to the anaesthetist or theatre staff. A member of theatre staff wrote 'abdominoplasty' on to the patient's consent form after the start of the anaesthetic for the operations, and informed the theatre manager as well as subsequently completing the hospital incident form. The hysterectomy was complicated because of scarring from the previous Caesarean sections and a sub-total rather than total hysterectomy was therefore performed. This operation was therefore prolonged from a standard time of about 60 minutes to about

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90 minutes, after which an abdominoplasty lasting at least 120 minutes was undertaken. Whilst in hospital, the patient declared to [Dr B] and hospital staff that the physical outcome of the cosmetic surgery was very satisfactory. She discharged herself early from hospital. The patient was subsequently admitted to hospital about two weeks later with an infection in the incision area – this fortunately did not extend into the abdominoplasty, and was also not a pelvic infection consequent upon the hysterectomy.

I note [Dr B's] experience of abdominoplasty prior to obtaining written informed consent for the operation was between 1997 and 1999 and probably numbered two, one of which was performed as a cosmetic procedure by a surgeon presumably experienced in abdominoplasty, and the other for gross obesity so that radical intra-abdominal pelvic surgery could be undertaken by the gynaecologist. After obtaining consent for the hysterectomy including revision of the Caesarean scar on the 30th October [2000], [Dr B] assisted [Dr H] with a third abdominoplasty.

Qualification to provide an opinion:

I began training as an obstetrician and gynaecologist in 1970, and became a registered specialist in 1978.

I was the Professor of Obstetrics and Gynaecology at Wellington Hospital until March 1994, since when I have practised privately with 70% of my practice being fertility work, 20% management of menstrual disorders (such as this patient had) and 10% Menopause consulting work.

I know [Dr B] (having been Chairman of the RNZCOG Board of Education) when she was undergoing some of her training. I have met and talked with her on about three occasions that I recall, but none in the last 5 years.

As a gynaecologist I have been consenting patients for operations such as hysterectomy for 30 years. During all this time, I have always recognised that patients' perceptions about consent were affected by sedative premedication – originally this was an opiate, but more recently drugs such as Valium and Hypnovel. I have noted that premedication such as 7.5mg of midazolam, can have a profound amnesic effect. I am especially aware that some patients who have just had midazolam may appear to the staff as very lucid, but subsequently (2 days later!) have no memory, or an altered memory of the events that differs from that observed by staff at the time! My experience with midazolam is considerable as we use it for sedation at the time of oocyte pick-ups at the time of IVF.

I have been involved with many women who have previously had Caesarean sections, and who request a hysterectomy to include scar revision. At the time of abdominal surgery, I have often experienced comments about tummy tuck operations. At the time of abdominal hysterectomy, I often excise Caesarean scars, and sometimes to include excision of fat so that the lower and upper flaps are of similar thickness – no additional consent is obtained, and no extra charge is invoiced as it does not add significantly to

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the operation. I also have many patients who have two pre-school children and am conscious of the pressures that do exist within families, especially before Xmas.

I operate now only at [the private hospital] so am familiar with their procedures, but have not operated at the hospital at which the event occurred. I do not personally undertake abdominoplasty at the same time, believing that I am not trained or skilled to undertake them, and instead refer them to a plastic surgeon should they wish this operation undertaken concurrently. In such situations I refer the patient to the plastic surgeon who informs the patient and then consents her separately. We then liaise on the timing of the operation. Occasionally I may, at a patient's request (and sometimes prompted by the general practitioner) agree to remove a mole or skin nodule, but always in these situations obtain additional written consent. If such procedures are agreed after the initial written consent, then I always have the patient initial the amended written consent form as an acknowledgment. I do not obtain written consent for any amendment unless this had been clearly discussed with the patient prior to their being transferred to theatre, and certainly not after administration of a premedication.
I believe the consent process for gynaecologists may be different than in other specialties. However, I am providing this opinion based on the standard that applies generally within gynaecology, and as I practise and observe it. I acknowledge that as a 57 yr old male gynaecologist who has lived through the 'Cartwright Inquiry' and practises as a member of a team, I may not be regarded as a peer to [Dr B] who is a female in her first year of practising her specialty which she is doing in isolation from her peers and in a clinic dominated by breast surgeons.

I have also reviewed the standard expected of consent for gynaecological practice that is stated by our College – these were last updated in 2000. For reference purposes these are attached or available on line at http://www.ranzcog.edu.au/ then to College Statements….CGen2).

Specific Responses

In response to your questions:

What specific professional and other relevant standards apply in this case and did [Dr B] meet those standards?

The professional standards that I would have demanded in this case were to agree the significant parts of the operation with the patient in a consultative setting and to allow adequate time for questions and possibly reflection. I would not wish the patient to be sedated, nor to undertake the consultation in a theatre ante-room or corridor. I would regard an abdominoplasty as a significant operation in its own right, requiring specific consent some interval of time pre-operatively, and if I was not to be responsible for that part of the operation, then the person responsible for it to obtain that consent. I would wish to discuss with the patient, preferably in street clothes, the nature of the operation, of the significant risks and complications, and to alert the patient of any competency or other issues related to my ability to carry out the agreed operation. I would offer the patient alternatives, including the possibility that there may be others more competent

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to perform the operation, especially if I believed I was not competent to inform the patient (including with handouts) or undertake the operation. I would urge them to affirm their decision with their husband/partner/support person, preferably in their own home before ultimately giving consent. (I regard written consent as only one event in the whole consent process.)

As [Dr B] practised as a gynaecologist, I believe she had a duty to practise at the above standard. Thus she did not fulfil any of the above steps in the consent process for the operation additional to the hysterectomy. Her failure to personally obtain the written/legal consent for the abdominoplasty is inexcusable, and the writing of the additional operation by a nurse is probably also inexcusable – but an incident form was completed about this.

Was the consumer in a position to give consent after the 'pre-meds' had been administered?

In this case, the patient could not provide informed consent because of the sedation, but because of the nature of midazolam, may have appeared to have given consent to an abdominoplasty. However, even if no such pre-medication had been given it was inappropriate to seek consent in the theatre corridor or ante-room, with the patient in a gown and lying on a theatre trolley, and not offer the opportunity to discuss the additional operation with her husband.

Was it appropriate to seek the consent of the consumer to an additional procedure (the abdominoplasty) immediately prior to surgery?

No, and in addition to my comment to the previous question, I believe that at the time of the written consent being obtained in October that [Dr B] was not going to undertake major cosmetic surgery. I appreciate that you are not keen for experts to speculate, but I believe that this procedure was only formed by [Dr B] after she assisted [Dr H] on the 30th October 2000 – regardless of when she did formulate the proposal, she should have contacted the patient before hospitalisation, and arranged an appointment at the clinic to discuss all the issues associated with the abdominoplasty, including obtaining written consent.

Was it appropriate to advise the consumer of the additional costs of the abdominoplasty immediately prior to surgery?

No, definitely not. See above.

Should [Dr B] have proceeded with the abdominoplasty in the circumstances or deferred it?

In the circumstances, [Dr B] should not have proceeded with the abdominoplasty. The Clinic secretary should not have said to the patient that [Dr B] would see the patient on the day of surgery. The nature of an obstetrician's work is such that they often run late and then important issues such as consent and descriptions of risks and complications

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become overlooked because of the time constraints. I believe a secretary who understood the nature of practice of an obstetrician and gynaecologist would not have provided such assurances. Even had the patient not had sedation, I would not have agreed to a second operation, especially in a patient who had had two Caesarean sections, and bleeding and or infection can be expected to be complications. [Dr B] had an additional chance during the surgery to postpone the abdominoplasty when she had to draw back from a total to a sub-total hysterectomy. Furthermore, having started nearly 60 minutes late, and with a subsequent case on the list and with the presumed time constraint of 1230 for list completion time, there were lots of 'red lights' to use as excuses for not proceeding with the abdominoplasty, even if the patient insisted that it be done! I would also wonder whether there had been a problem such as sleep deprivation the previous night with obstetric care that affected [Dr B's] judgment – such an event is, however, not an excuse, but an effort to determine a reason for a judgment that was hopefully out of character.

Was [Dr B] sufficiently experienced to perform the abdominoplasty without the supervision or assistance of an experienced surgeon?

No – not only was she inexperienced in the operation, but she was not skilled in making the decision as to whether the operation was actually necessary, and if it was, then not informing and consenting the patient appropriately. I note the patient was 75kg, but even if she was very short (height not recorded in information forwarded), the patient would not be classed as obese, but just overweight. Abdominoplasty for cosmetic reasons should be done by surgeons practised in informing and consenting patients about cosmetic procedures, and this is not part of the training of gynaecologists.

Was it ethical for [Dr B] to have proposed the inclusion of the costs of a 'tummy tuck' in the cost of an abdominal hysterectomy which was to be billed to [Mrs A's insurance company?

Yes, I think this is ethical because it may reduce the infection or haemorrhage rate postoperatively, reducing the amount of 'dead-space'. Additionally the extra time of 3-5 minutes is relatively insignificant, and it is not possible to apportion time in this situation to the hysterectomy even if you consider a revision of Caesarean scar a cosmetic operation. Additionally one may, by not excising the scar and fat, get additional bleeding that takes 3-5 minutes to control, or which consequently is associated with postoperative infection.

Any other issues raised by supporting documentation?

The opinions of the practitioners at [the Health Centre] are probably the result of insufficient understanding of the facts about the standard of consent required of gynaecologists. It is unfortunate that some of their correspondence has included issues that appear to criticise the patient for making this complaint without themselves being aware of all the facts about consent and sedation relevant to this case. The patient's expression of satisfaction of the outcome of the abdominoplasty does not affect the serious lack of judgments that occurred prior to the surgery.

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The nurses and staff at [the private hospital] clearly were concerned about the consent issues, and tried to 'blow the whistle'. I think, however, the Theatre Manager could have exercised her power a little more, even by saying, at 1030 'if you proceed with this part of the operation, then we will cancel your second patient because we have an afternoon list starting at 1300' or 'we do not have written consent for this major operation, and will not be setting up for it or assisting with the provision of staff or equipment'. [Dr F] was also clearly concerned and was the medical practitioner who could have 'blown the whistle' and protected the patient as well as [Dr B] by being more forceful – but I do appreciate that both tried to inform [Dr B] and she did not listen! I suspect [Dr B's] relative inexperience as a specialist (and perhaps also [Dr F's], but I do not have her CV), or the ethos of her working from a breast and cosmetic clinic may have been factors in her poor decision making. Certainly, [Dr B] was in her first year as a consultant specialist which I note she does independently being the only obstetrician/gynaecologist in [the Health Centre] – working with access to a team of gynaecologists might have avoided the consent problem. [The private hospital's] management were possibly also not wishing to discourage a doctor who had been recently approved to operate.

The patient's complaint is not frivolous or vexatious, but undertaken, I believe in a genuine attempt to improve at least [Dr B's] medical practice, and she feels genuinely aggrieved being 'let down' by another woman.

I hope [Dr B] does acknowledge that her action of directing anaesthetists to not prescribe sedatives as a premedication is not just the sole response as there are more serious lapses of judgment about consent as outlined above. In addition, I would hope [Dr B] would acknowledge that:

- When she is stressed, (such as by running late or tiredness), she now recognises that her judgment could be impaired and she will be even more careful.

- She will better recognise when other members of the health care team are unhappy with her practice and will adjust her practice to the benefit of her patients as well as others.

- As a commitment to a team approach, she will notify other members of the team when running late, and will be proactive rather than reactive with her communication with other team members.

- She is isolated from her peers, and is making arrangements to have regular peer review."

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Response to Provisional Opinion

In response to my provisional opinion, Dr B stated: "I accept that it was wrong to obtain [Mrs A's] consent to a surgical procedure when she was under the influence of a pre-med and I am deeply sorry for this." Dr B explained that she had "no other motive in performing the abdominoplasty, other than to please the patient". She added: "There was no financial gain for me, and I note that I am a salaried employee of [the Health Centre]."

Dr B's lawyer also noted that Dr B accepts that she "was in error in obtaining [Mrs A's] consent to a procedure when she was under the influence of a pre-med, and so shortly before surgery … [and that] she should have insisted that Mrs A be returned to the ward for a proper discussion, with her notes present".

Dr B acknowledges that her "communication with other professional staff could have been better on that day [of surgery]".

Explanation for omissions
By way of explanation for her actions, Dr B notes the following:

> "I would like to emphasise that there were a number of unusual circumstances, which led to my deviating from my usual practice on 18th December. I raise these matters so that you may place in context my error that I made regarding the consent process.
>
> I was very late to get to the [public hospital], because of particularly severe traffic delays that morning. …
>
> The Theatre staff made the decision to move [Mrs A] around to Theatre from her hospital room. I do not understand that this is normal practice for [the private hospital]. I had not experienced it before or since.
>
> It is my invariable practice to see the patient in the ward with their notes before surgery. This is good practice as it enables me to answer any last minute questions patients have and generally check that everything is in order.
>
> I was not aware that [Mrs A] had been taken down to Theatre when I arrived at the hospital. I found her in the corridor, outside Theatre. She was at one end of the corridor, facing the window, so no foot traffic was passing her and I could examine her abdomen, without anybody viewing this. However, I do feel that these circumstances were less than ideal for discussion of an operation, prior to surgery. The patient notes were in Theatre, but the patient was in the corridor, so I did not have ready access to the notes. The notes would normally be in the patient's room with the patient, when I go to discuss the operation prior to surgery. The notes were not readily available for me to see and I was not therefore aware that she had had a pre-med.
>
> [Dr F] is not an anaesthetist I work with normally. I note that Dr Hutton says that pre-medication is a relatively common practice for patients in [Mrs A's] situation. However, it is certainly the case that pre-medication is not the norm for my patients.

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> I was not comfortable discussing [Mrs A's] surgery in the corridor and I probably should have insisted that she was returned to her hospital room to do this. However we were already running late and I didn't wish to delay procedures any further.
>
> I realise now that I should have gone and got the notes from Theatre, to see whether she had had any pre-medication. From [Mrs A's] demeanour I had no suspicion of her having been pre-medicated. She was very lucid and answered questions appropriately. At no stage on that morning was I told by anyone that she had been pre-medicated."

Dr B also noted that she did not question Mrs A's ability to make the decision without consulting her partner, as she knew Mrs A to be an intelligent and assertive final year law student.

Expert advice from Dr G

Dr B also provided me with a report from Dr G, a plastic and reconstructive surgeon in private practice, who reviewed this case.

Dr G concludes that Dr B had failed to obtain "adequate informed consent for the additional surgical procedure of abdominoplasty". However, he notes several mitigating factors, including the following:

"1) [Dr B], in 2000, was in her first year as a specialist gynaecologist.

2) [Dr B] was practising at the [Health Centre], essentially as a solo practitioner, as she was the only gynaecologist there. She worked only in conjunction with General Surgeons, seemingly lacking suitable peer review. I have been advised that subsequently [Dr B] has organised participation in a peer review process.

3) [Dr B] spent time at the second consultation discussing the additional procedure of wedge excision/tummy tuck/abdominoplasty, and there was a consent form signed contemporaneously, omitting mention of the additional procedure at the request of [Mrs A].

4) [Mrs A] spoke to [Dr B's] secretary 3 days prior to surgery and requested the additional procedure be performed at the time of the abdominal hysterectomy.

5) On the day of surgery [Dr B] was not aware that [Mrs A] had received Midazolam premedication at the time they had their preoperative discussion. It was her practice to see patients before they went to theatre and normally they did not receive premedication.

6) I can see nowhere in the documents that the anaesthetist or the theatre staff tried to inform her that [Mrs A] had received premedication. Accordingly, she was not aware that [Mrs A] could not give adequate informed consent …

7) No one in the theatre block attempted to stop [Dr B] from proceeding with the wedge resection/tummy tuck/abdominoplasty on the basis that there was no informed consent; rather they insisted that the consent form must have

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'abdominoplasty' written on it, even though the patient had received premedication. ...

8) [Dr B] did not communicate well with other health professionals. At the same time, no-one in the theatre communicated any concerns to [Dr B] re reservations about abdominoplasty consent (other than form filling) nor advised her of premedication affecting [the] patient.

9) [Dr B] was very late arriving at the hospital and there was significant pressure to get on with the surgery. [Mrs A] (according to [Dr B]) wanted the abdominoplasty performed. [Dr B] (a newly practising specialist) acquiesced to the patient's request. She [did] not understand that the patient was under the influence of premedication."

Comments on expert advice from Dr Hutton

In responding to my provisional opinion, Dr B and her lawyer take issue with various aspects of the independent advice provided by Dr Hutton. In particular, Dr B's lawyer points to the following examples of assumption or speculation by Dr Hutton:

1) That "some time between consent and the hospitalisation, [Dr B] concluded that the patient's 'tummy tuck' should not be performed but rather the more extensive procedure of abdominoplasty".

2) That Dr B "formulated" the proposal to perform an abdominoplasty after she assisted Dr H on 30 October 2000.

3) That nurses and staff at the private hospital tried to "blow the whistle", and that they and Dr F "tried to inform [Dr B] and she did not listen".

Dr B's lawyer submits:

"Neither of the theatre staff, or [Dr F] have claimed that they tried to warn [Dr B] that she should not proceed with the abdominoplasty, or that the patient had had a pre-med so could not consent to the procedure, nor have they claimed that they expressed to [Dr B] any of their concerns other than the concern that the consent form properly document the procedures.

Professor Hutton seems to have conceived of a situation where [Dr B] has, without having previously discussed the abdominoplasty procedure with [Mrs A], formulated a plan to perform it, obtained [Mrs A's] consent for the procedure whilst she was under the influence of a pre-med, and then proceeded with it in the face of protests from nursing staff and the anaesthetist. One can understand why this would be viewed as a serious breach of the standards expected of a medical practitioner. However the facts, even as narrated in the draft report, do not support this construction."

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Review of practice
Dr B has acknowledged that she will follow the recommendations of my expert, Dr Hutton, namely that she will:

- recognise that her judgement could be more impaired when she is stressed (such as by running late or tiredness) and be even more careful;

- better recognise when other members of the health care team are unhappy with her practice and adjust her practice to the benefit of her patients as well as others;

- notify other members of the team when running late, and be proactive rather than reactive in her communication with other team members, as a commitment to a team approach;

- make arrangements to have "regular peer review".

Dr B advised me:

> "I make those acknowledgements without hesitation. In particular I have previously identified peer review and support as an issue for myself and in early 2000 organised to attend peer support and review meetings. I am aware of the need to be assiduous in my communication with other health professionals and am now more conscious of this as an issue."

Concluding submission
In conclusion, Dr B's lawyer submitted:

> "[Dr B] has acknowledged the deficiencies highlighted by this investigation and has taken steps to address them. This was an isolated incident, and occurred because [Dr B] believed [Mrs A] wanted a procedure and had given informed consent to it. [Dr B] is usually a careful practitioner, meticulous about all aspects of the consent process (see testimonials).
>
> The significance of [Dr B's] mistake can only be properly measured when regard is had to the documented discussion at the second consultation regarding the various alternative cosmetic procedures."

Furthermore, it was submitted that Dr B's error, when viewed in context, "is not so serious as to warrant … referral to the Director of Proceedings".

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

…

4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.

5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

RIGHT 5
Right to Effective Communication

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

RIGHT 6
Right to be Fully Informed

1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –
…
b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; …

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.

2) Every consumer must be presumed competent to make an informed choice and give informed consent, unless there are reasonable grounds for believing that the consumer is not competent.

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Opinion: Breach – Dr B

Informed consent and effective communication
Informed consent is a process. It involves effective communication, adequate information disclosure, and an informed decision made by a competent patient.

The Code of Health and Disability Consumers' Rights (the Code) recognises these separate elements of informed consent and places specific legal obligations on providers. Right 5(2) of the Code provides that every consumer (when discussing matters with a provider) is entitled to "effective communication". This includes the right to an environment that enables them to communicate openly, honestly and effectively with the provider. Right 6(1)(b) of the Code states that every consumer has the right to be adequately informed about proposed services, and Right 7(1) of the Code states (subject to specific exceptions not relevant for present purposes) that services may only be provided to a consumer who has made an informed choice and given informed consent.

Environment for effective communication
Dr B concedes that prior to the morning of surgery (18 December 2000) Mrs A had only consented to an abdominal hysterectomy and a minor 'tummy tuck'. The minor 'tummy tuck' was to have been at a cost of an additional $200 to $300 and taken an extra half an hour to perform.

On 15 December 2000 (three days prior to surgery) Mrs A was advised by Dr B's secretary that any further questions about the 'tummy tuck' would need to be put to Dr B on the date of surgery.

Mrs A claims that she was effectively denied the right to ask Dr B any questions prior to surgery as Dr B arrived late. She further claims that any consent given that morning to the additional procedure of a full abdominoplasty was invalid as she was under the influence of pre-medication at the time.

It is clear from Dr B's evidence and that of assisting staff that Dr B arrived some 45 minutes late for surgery, at approximately 8.45am. At that point Mrs A had already received pre-medication of 7.5mg midazolam at 8.00am, and had been moved to an area immediately outside theatre, where she was lying in a hospital bed.

It is not appropriate to discuss an additional surgical procedure when a patient is situated in a theatre ante-room or corridor and in a theatre gown. This is not a proper setting for an effective discussion. Dr B admits that the circumstances were "less than ideal for discussion of an operation prior to surgery". Equally, it is not appropriate to discuss extra surgery immediately prior to an operation, even if there has been some prior discussion about the additional procedure at an earlier consultation. I note that Dr B acknowledges that she was "in error in obtaining [Mrs A's] consent … so shortly before surgery".

Competence to consent
A practitioner should ensure that a consumer is competent to give consent before seeking consent. Right 7(2) of the Code provides that a consumer is to be presumed competent to

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make an informed choice and give informed consent, unless there are reasonable grounds for believing otherwise.

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists in its "Guidelines for Consent and the Provision of Information Regarding Proposed Treatment" (October 2000) states:

> "To gain consent and satisfy the duty to inform, a doctor must ensure that the patient is competent, understands what is being proposed and that the information provided is accurate and material to that patient … A Patient who is not legally competent cannot give a valid consent."

The anaesthetist, Dr F, and the records confirm that Mrs A was administered pre-medication of midazolam 7.5mg 45 minutes before Dr B's discussion with her on the date of surgery.

Dr B was apparently unaware that pre-medication had been administered to Mrs A at the time the abdominoplasty was discussed and consented to. I do not consider this to be a valid excuse. In my view, a practitioner in Dr B's situation should have ascertained whether pre-medication had been administered. This is especially the case given that surgery was originally set down for 8.00am, and Mrs A was already in the corridor outside the theatre when Dr B arrived late.

The administration of pre-medication is a relatively common practice for patients undergoing major surgery. Although Mrs A may have appeared "lucid", Dr B should still have considered the possibility that pre-medication had been administered, especially in circumstances where she was working with an anaesthetist with whom she had not worked before. Dr B should have been aware that pre-medication was an 'option' and either checked with Dr F or reviewed Mrs A's notes.

Dr B admits that she should have retrieved Mrs A's patient notes from theatre. I agree that she should have done so, especially given her late arrival, the fact that the patient notes were in the immediate vicinity, and her "invariable practice" to see patients (usually in the ward) with their notes before surgery.

It is no excuse that theatre staff and the anaesthetist did not alert Dr B that Mrs A had received pre-medication, nor that Mrs A should have known not to take pre-medication (in light of her conversation with Dr B's secretary three days previously about the need to discuss the extent of the "tummy tuck") prior to surgery.

I note the advice of my independent expert that Mrs A was not in a position to give informed consent after the pre-medication had been administered to her, because of its sedative effects. I am satisfied that Mrs A was not competent to give valid consent immediately prior to surgery, owing to the effect of the pre-medication, and that Dr B should have realised that Mrs A was unable to consent.

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Validity of consent
I accept Dr B's evidence that, during the corridor conversation prior to surgery, Mrs A said that she wished to have a full abdominoplasty. Mrs A cannot recall the conversation because of the amnesic effect of the pre-medication, but I do not doubt that it occurred.
It is perhaps understandable that Dr B thought that Mrs A's belated request for a full abdominoplasty was a genuine consent. Mrs A appeared lucid; the procedure had been discussed at the consultation on 26 October 2002 (having regard to Dr B's contemporaneous records, I do not doubt this to be the case, even though Mrs A maintains that the word "abdominoplasty" was not used); and Mrs A's reluctance at that time seemed to be because of the extra costs ($4,000–$5,000), most of which Dr B agreed to waive on the day of surgery.

Nonetheless, Mrs A was not in a state to make an informed choice and give informed consent immediately prior to surgery. She lacked the capacity to consent at that time. Accordingly, her assent to surgery did not constitute a valid consent.

Dr B's lawyer submitted that Mrs A was "happy" with the abdominoplasty in the initial days after surgery, and that her only concern was the extra costs and time recuperating, and the fact she had not discussed the extra procedure with her husband. The evidence of the nurse who cared for Mrs A post-operatively, supports this version of events. But whatever the reason for Mrs A's change of heart, she had not given valid consent pre-operatively, and her post-operative behaviour is legally irrelevant to the issue of consent.

Information about costs
Right 6(1)(b) of the Code provides that a patient is entitled to an explanation of the options available, including the costs of each option.

I accept that Dr B advised Mrs A of the likely additional costs of a full abdominoplasty (estimated at $4,000 to $5,000) both at the second consultation of 26 October 2000 and immediately prior to surgery on 18 December 2000. Mrs A's statement that she would never have considered a full abdominoplasty as the cost was prohibitive is in itself evidence that she was told about the costs. Dr B's contemporaneous records (on 26 October) state "not full because of costs". I am satisfied that Dr B did provide adequate information about costs of the full procedure, at the 26 October consultation; I do not take account of the information given during the 18 December corridor conversation, as Mrs A was in no state to understand it at that time.

Findings
Taking into account all of the matters outlined above, I find Dr B in breach of Rights 5(2), 6(1)(b) and 7(1) of the Code. Dr B did not take sufficient steps to ensure, in the face of the unusual circumstances of the morning of surgery (lateness, different anaesthetist, lack of medical records, corridor conversation), that Mrs A's apparent consent to the more extensive procedure (which she had previously discounted as too expensive) was valid. Dr B did not provide an environment for effective communication and did not obtain informed consent to the full abdominoplasty procedure she performed.

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In so doing, Dr B also breached Right 4(2) of the Code by her failure to comply with relevant professional standards when seeking to obtain consent to the full abdominoplasty.

Opinion: Breach – The Health Centre

Vicarious liability
Employers are vicariously liable under section 72(2) of the Health and Disability Commissioner Act 1994 for ensuring that employees comply with the Code of Health and Disability Services Consumers' Rights.

The Health Centre employed Dr B as a gynaecologist. It was in this capacity that she provided services to Mrs A.

In order to negate the presumption of vicarious liability under the Act, an employing authority must prove pursuant to section 72(5) that it took such steps as were reasonably practicable to prevent its employee's acts or omissions.

The Health Centre has provided me with no such evidence. I therefore find it in breach of Rights 4(2), 5(2), and 7(1) of the Code of Health and Disability Services Consumers' Rights.

In doing so, I note the Health Centre's Professional Standards Committee's advice of 28 May 2002, in which it is stated that Dr B "acted both professionally and appropriately at all times". I trust that the Health Centre will review that advice in light of this report.

Further comments

Nature of breaches of Code
In determining whether a provider's acts or omissions breached the Code, the motivation for the provider's conduct is irrelevant. However, I accept that Dr B had no financial motive in performing the full abdominoplasty; as a salaried employee of the Health Centre, she stood to make no personal financial gain. It appears that Dr B, in her own words, was seeking "to please" her patient.

This case is a warning to health professionals of the dangers of making clinical decisions – in particular a decision to proceed to surgery – to appease a patient. It is never wise to take short-cuts in the process of effective communication, adequate information disclosure, and an informed decision.

There is, however, no evidence that Dr B deliberately sought to proceed in the absence of a valid consent. I do not regard Dr B's behaviour as high-handed or outrageous. I am satisfied that she genuinely, albeit naively, thought that Mrs A had given a proper consent.

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In my opinion, there is no evidence that Dr B's actions were in flagrant disregard of Mrs A's rights as a patient.

Dr B's experience and lack of supervision
A further issue in my investigation was Dr B's experience in performing full abdominoplasties, and her failure to follow her usual practice of having a general surgeon from the Health Centre attend during the procedure.

I note that, at the time of the incident, Dr B was in her first year as a consultant. She was practising in an area where she did not have the benefit of gynaecological peer support.

Dr B has conceded that it was her usual practice to have another surgeon from the Health Centre present during such procedures, which she does not frequently perform. She estimated that she had assisted in only six or so abdominoplasties and that she had "never performed an abdominoplasty on its own, … not [being] a general or plastic surgeon".

My expert advisor, an experienced gynaecologist, stated that "not only was [Dr B] inexperienced in the operation, but she was not skilled in making the decision as to whether the operation was actually necessary, and … informing and consenting the patient appropriately".

However, Dr H, of the Health Centre, a general surgeon who had previously supervised Dr B on one occasion, commented that Dr B was suitably qualified to perform the procedure:

> "Her understanding of the various stages of the procedure of abdominoplasty together with the technical skill demonstrated allows me to support her full competence at performing the procedure of abdominoplasty."

In light of the conflicting opinions expressed, and in the absence of any specific standards set by the Royal Australasian College of Surgeons, I am unable to make a conclusive finding on whether Dr B was qualified to perform the full abdominoplasty.

While I am unable to reach a finding on this issue, I note my serious concern at Dr B's action in proceeding in the circumstances of Mrs A's case. I concur with my expert advisor that Dr B should have sought to delay the procedure as there were several "red lights" to proceeding.

Co-operation amongst providers and minimising the potential for harm
There is clear evidence from theatre staff that Dr B did not properly advise the anaesthetist of her intention to conduct a full abdominoplasty. This could have had serious consequences for Mrs A, especially given the additional time required to perform the procedure. As it transpired, the procedure took about an extra two hours. Dr B's omission to properly advise Dr F of the additional procedure before sedation was unwise and unprofessional. It is also of concern that there appears to have been some confusion amongst theatre staff about what procedure was to be performed.

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There is a responsibility under the Code for health care providers to co-operate and to provide services in a manner that minimises the potential for harm to a patient, under Rights 4(5) and 4(4) respectively. In my opinion Dr B failed to fulfil this responsibility.

I note that Dr B has acknowledged the "need to be assiduous in [her] communication with other health professionals".

Amending consent forms
It is inappropriate to amend a consent form while a patient is in theatre and under the influence of anaesthetic. Furthermore, any amendments to a consent form should be clearly marked, dated and initialled by the patient.

Actions

- In accordance with Section 45 of the Health and Disability Commissioner Act 1994, I will refer this matter to the Director of Proceedings to determine whether any further action should be taken.

- A copy of this report will be sent to the Medical Council of New Zealand and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

- A copy of this report, with details identifying the parties removed, will be sent to the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Women's Health Action, and the Federation of Women's Health Councils Aotearoa/New Zealand, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

The Director of Proceedings laid before the Medical Practitioners Disciplinary Tribunal a charge alleging professional misconduct or conduct unbecoming. The charge of professional misconduct was upheld by the Tribunal and it imposed a penalty of payment of $19,267.86 towards the costs and expenses of and incidental to the prosecution and hearing. Dr B appealed the substantive decision to the District Court "on the grounds that a disciplinary sanction was not warranted and that if it were, then the level should be 'conduct unbecoming'". This involved a legal argument on the definitions of the levels of charge under the Medical Practitioners Act 1995. It was common ground that the level of offending was at the lower end of the scale. The Court agreed with the Tribunal that Dr B's conduct should be marked by an adverse disciplinary finding but, disagreeing with the Tribunal's interpretation of the levels of charge, it substituted a finding of conduct unbecoming.

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