Breast & General Surgeon, Dr B

General Surgeon, Dr C

Specialist Clinic

A Report by the

Health and Disability Commissioner

(Case 02HDC10715)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Ms A	Consumer
Mr A	Consumer's husband
Dr B	Provider/Breast & General Surgeon (Specialist Clinic)
Dr C	Provider/General Surgeon (Specialist Clinic)
Dr D	Breast & General Surgeon (Specialist Clinic)
Dr E	Breast Physician (Specialist Clinic)
Dr F	Breast Physician Professional Standards Committee (Specialist Clinic)
Dr G	Radiologist Professional Standards Committee (Specialist Clinic)
Dr H	Breast & General Surgeon
Dr I	Plastic & Cosmetic Surgeon
Dr J	General Practitioner
Specialist Clinic	Provider

Complaint

On 17 July 2002 the Commissioner received a complaint from Ms A about services provided by breast surgeons Dr B and Dr C, and a Specialist Clinic. The complaint was summarised as follows:

Dr C
Between October 2000 and November 2001 general surgeon Dr C did not provide services of an appropriate standard to Ms A. In particular Dr C:

- *did not fully assess Ms A's clinical situation prior to arranging for a partial mastectomy of Ms A's right breast on 26 October 2000*
- *performed an inadequate reconstruction of Ms A's right breast at a Private Hospital on 5 December 2000*
- *did not have the appropriate expertise and qualifications to perform the reconstruction*
- *did not provide appropriate follow-up care. In particular, he did not adequately treat the infection in Ms A's left breast.*

Between October 2000 and November 2001 general surgeon Dr C did not give Ms A information that a reasonable consumer would expect to receive. In particular Dr C:

- *incorrectly advised Ms A that he would only be assisting Dr B with the breast reconstructive surgery. He did not tell Ms A that he would be responsible for performing the reconstruction of her right breast*
- *did not give Ms A a full and accurate explanation about the cause of her haemorrhage on 5 and 14 December and her subsequent delayed healing.*

Dr B
Between November 2000 and November 2001 general surgeon Dr B did not provide services of an appropriate standard to Ms A. In particular Dr B:

- *damaged an artery in Ms A's left breast during surgery at the Private Hospital on 5 December 2000*
- *did not take appropriate action to repair the damaged artery, or seek the assistance of a microvascular surgeon*
- *did not provide appropriate follow-up care. In particular, did not adequately treat the infection in Ms A's left breast*
- *on 11 October 2001 advised Ms A to have an implant/expander put in her left breast. This was inappropriate advice as she had very thin skin flaps.*

Between November 2000 and November 2001 general surgeon Dr B did not give Ms A information that a reasonable consumer would expect to receive. In particular Dr B:

- *overstated his experience and skill level with breast reconstruction*
- *did not give Ms A a full and accurate explanation about the cause of her haemorrhage on 5 and 14 December and her subsequent delayed healing.*

The complaint was received on 31 July 2002 and an investigation was commenced on 27 November 2002.

Ms A also made the following complaint about services provided to her by Dr D, a breast surgeon at the Specialist Clinic:

Dr D
Between April and October 2000 general surgeon Dr D did not provide services of an appropriate standard to Ms A as follows:

- *did not advise Ms A of the follow-up arrangements required after lumps were found in her right breast.*

The aspect of the complaint relating to Dr D was referred to advocacy services in April 2003 and was subsequently resolved between the parties.

Information reviewed

- Information from Ms A, Mr A, Dr B, Dr C, Dr D and Dr G.
- Ms A's records from Dr I, Dr J, another general practitioner, the Specialist Clinic, the Private Hospital, a Public Hospital, and ACC.

Independent expert advice was obtained from Dr John Simpson, general and breast surgeon, and Dr Sally Langley, plastic and reconstructive surgeon.

Information gathered during investigation

Summary
In October 2000 Ms A was diagnosed with ductal carcinoma-in-situ of the right breast and was booked for a partial mastectomy. However, as a preoperative mammogram showed widespread micro-calcification, Ms A was advised to have a bilateral mastectomy with simultaneous flap reconstruction of both breasts. Dr B and Dr C performed the surgery jointly on 5 December 2000. Dr B inadvertently damaged the latissimus artery in the left axilla and elected not to repair it.

Postoperatively, Ms A was admitted to the Public Hospital with a large haematoma in her back and a low blood count. She received a blood transfusion and subsequently underwent drainage of the haematoma at the Private Hospital. Ms A subsequently experienced delayed healing and infection, particularly of the left breast, and underwent further surgery.

Consultations at the Specialist Clinic
In February 1999 Ms A, then 51 years old, underwent a bilateral breast augmentation procedure (breast implants). In February 2000 she felt a lump in her right breast. Her general practitioner, Dr J, requested an ultrasound, which showed other benign appearing masses in both breasts. Dr J referred Ms A to the Specialist Clinic for assessment and monitoring of her breast lump.

On 29 April 2000 Ms A was reviewed at the Specialist Clinic by Dr D, breast and general surgeon. On the basis of her clinical examination and the ultrasound, Dr D considered the lump in the right breast to be consistent with a fibroadenoma (a benign tumour). Because there had been a "marginal" increase in its size since the previous (February 2000) ultrasound, and because of the proximity of the lump to the implant, Dr D decided to review Ms A, with Dr E, breast physician, in a month's time with a view to performing a biopsy.

On 12 May 2000 Ms A was reviewed jointly by Dr D and Dr E as scheduled. Dr D noted that there had been no increase in the size of the right breast lesion over the preceding three months. She also noted that the other, earlier identified "three to four" small lesions in both breasts appeared benign clinically and on ultrasound, and consistent with fibroadenomas. A decision was made that the clinical and imaging findings would be reviewed at a

multidisciplinary meeting, and follow-up of Ms A arranged accordingly. In a letter to Dr J dated 12 May 2000, Dr D stated:

> "On balance both [Dr E] and myself would prefer to continue with ongoing surveillance on an annual basis of these lesions in view of the risk. However, we will review all radiology and results thus far at our joint Panel Meeting prior to embarking on this management plan. [Ms A] is aware that we will contact her if there is any concern that these areas should undergo biopsy."

Dr D advised me that the decision whether to biopsy was then discussed at the Specialist Clinic's multidisciplinary (review) meeting and a decision was made to recall Ms A in six rather than 12 months' time. Ms A was due to be reviewed and have a mammogram in November 2000. As no record was kept of this meeting, the date it occurred is uncertain. However, Dr G of the Specialist Clinic's Professional Standards Committee advised me that the decision to review Ms A in six months' time and the scheduling of the review for November 2000 indicates that the meeting took place not long after Ms A's 12 May 2000 consultation. Dr G also advised me that the decision made at the meeting was inadvertently not communicated to Ms A or Dr J.

In late June 2000, Ms A went overseas. On her return in early July, having not heard from Dr D, Ms A went to the Specialist Clinic in a suburb and learnt that Dr D was on indefinite leave and was not available. Ms A advised me that a few days later, when she managed to contact Dr E, she was told that her case was discussed at the review meeting but because she (Dr E) was not at the meeting, she could not tell her what the outcome was.

Ms A said that Dr E suggested she wait until October[1] when Dr D would be back from leave.

Ms A stated that in September 2000 she telephoned the Specialist Clinic and was told that Dr D no longer worked at that branch of the Specialist Clinic; she was only available at another branch. According to Mr A (Ms A's husband), Ms A was concerned that her lump was getting larger. In early October she telephoned the Clinic and asked to see another breast surgeon. An appointment was made for her to see Dr C (a breast and general surgeon) and Dr F (a breast physician) in two weeks' time.

On 16 October 2000 Ms A was reviewed by Dr F, who also performed an ultrasound and a core biopsy. In a letter to Dr J dated 16 October, Dr F stated:

> "On clinical examination there is a palpable lump in the right breast in approximately the 1 o'clock position. On ultrasound this correlated to a complex lesion which has an unusual shape. It may well be a fibroadenoma with two smaller fibroadenomas in the vicinity but on other views of this lump it may be more a lobulated structure. After

[1] Reported by Ms A in an interview of 19 March 2003. In her letter to Dr B dated 21 November 2000, Ms A stated that she was told by Dr E that Dr D would be back at work "about August or September [2000]".

> discussion with [Dr C], a surgeon who was present today, I have done core biopsies through this. [Ms A] feels the lump has not changed as such. On further ultrasound review there are two other benign appearing nodules noted, one in the left breast in the 1 o'clock position and one in the right 11 o'clock position. I have mapped and measured these.
>
> At this stage [Ms A] will return when we have the results of the core biopsy and will discuss the next step with [Dr C]."

The core biopsies indicated that the tissue taken from the left breast appeared consistent with a fibroadenoma, but that of the right breast indicated a malignancy – ductal carcinoma in situ (DCIS).[2]

Dr C
On 19 October 2000 Dr C saw Ms A and in a letter to Dr J the same day stated:

> "I have discussed this [DCIS] diagnosis with [Ms A] and her husband today and explained that DCIS is entirely curable if treated promptly. This lesion is small and in the upper breast. It would be well treated by partial mastectomy although this will leave [Ms A] somewhat asymmetric. I did discuss the possibility of adjuvant radiotherapy and the requirement of further surgery should the margins prove positive. The other option would be a mastectomy either with or without immediate reconstruction as a precaution. [Dr F] biopsied two further ultrasound detected benign looking lesions in both the left breast and the right.
>
> I have arranged to see [Ms A] back again on Saturday [21 October] with the results of these and to discuss her definitive surgical treatment."

There was no record that Ms A was seen by Dr C on 21 October 2000. However, there was a consultation on 25 October, following which Dr C wrote to Dr J and stated:

> "… [T]he core biopsy from the right breast[3] has demonstrated a papillary lesion which, although almost always benign, require formal excision for definitive histology.
>
> [Ms A] therefore has two separate pathologies in this right breast. Firstly a palpable lesion that shows DCIS on core biopsy and this separate papillary lesion. She is keen to continue with breast conserving surgery at this stage. She does understand that excision of the DCIS will leave her breast somewhat asymmetrical particularly as this is in the upper part of the breast and any surgery does run the risk of damaging or causing an infection in her prosthesis. This risk, however, is slight.

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[2] Dr C advised me that DCIS is a non-invasive, precancerous condition and that to the best of his recollection, Ms A never had cancerous lumps. Ms A and Mr A, on the other hand, referred to the diagnosis of cancer.

[3] Performed on 16 October and reported on 18 October 2000.

> We also discussed today that should definite histology demonstrate an invasive focus of cancer an axillary dissection would be indicated and that secure margins will be required to ensure adequate treatment of her DCIS and this may require a second operation. Surgery has been scheduled for late this week."

On 26 October 2000, as scheduled, Ms A presented at the Specialist Clinic for a partial mastectomy and D-wire excision of DCIS and papillary lesion in the right breast. However, the surgery was not performed because a preoperative mammogram had been overlooked. The necessary mammogram was done and revealed widespread calcification in both breasts. In her report the radiologist commented:

> "There is widespread bilateral calcification. This is indeterminate in nature. Given the presence of DCIS in the right breast, calcification must be considered suspicious bilaterally and histological diagnosis is required.
>
> I note the patient has consulted [Dr C] and right mastectomy has been recommended.
>
> Surgical biopsy of the breast calcification may be feasible at that time. However the widespread nature of the calcification indicate that in order to obtain adequate clearance of calcification, virtually a total mastectomy will be necessary."

As a result of the mammogram findings, surgery was postponed until a clearer picture of the underlying pathology was established. Dr C arranged a radiological review of the mammogram and arranged to see Ms A the next day.

On 27 October 2000 Ms A was reviewed by Dr C. In his letter to Dr J with regard to this consultation, Dr C stated:

> "The microcalcification in her right breast has been graded as intermediate by our senior radiologist. Given the extent of the microcalcification, and the proven DCIS already in this breast, follow-up will be extremely difficult. [Ms A] has already decided that a mastectomy and reconstruction would give her the most peace of mind.
>
> We do, however, need to get a tissue diagnosis from the microcalcification in the left breast, the least invasive method would be a mammotome biopsy … This has been booked for the 7th November …
>
> Once it is clear what pathology is present in the left breast, we will be in a position to proceed in an organized fashion with a surgical strategy."

Ms A recalls the meeting with Dr C as follows:

> "… after absorbing the bad news and implications [we] arranged for a mammotome biopsy on the left breast to establish whether the microcalcifications in the left breast were something to be concerned about (and to be included in our thinking together with the right breast).

> At this stage it seemed that the right breast was more than likely to need a full simple mastectomy due to the total situation within the breast and the difficulty with future monitoring with each increase in the calcifications, implant and so on."

On 7 November 2000[4] Ms A underwent a mammotome biopsy of microcalcifications in her left breast. The procedure was performed by the radiologist on the dedicated prone table at the Specialist Clinic at the other branch. The histology finding was that of atypical ductal hyperplasia (ADH). According to Ms A, "the problem was much worse than anybody had anticipated".

On 9 November 2000[5] Ms A had a further consultation with Dr C, who advised a bilateral mastectomy. Ms A stated that the advice was based on the fact that she had DCIS in the right breast and the likelihood that the calcification in her left breast was an invasive cancer. In a later letter to Dr B she recalled:

> "At this meeting with [Dr C] we were now seemingly directed towards a bilateral mastectomy! This had escalated from a seemingly benign situation to a drastic situation in a matter of weeks in stages as we staggered from one situation to the next. Because of the speed of change to my circumstances, I have been trying to understand things well enough to make an informed decision. I have connected with the Cancer Society for literature and contacts plus people who have had mastectomies of different types to understand their expectations and outcomes, second opinions on surgery and reconstruction and so on."

Ms A advised me that when she enquired who would perform her surgery (bilateral mastectomy and immediate reconstruction), she was told by Dr C that Dr B was the reconstructive surgeon at the Specialist Clinic and that he would be assisting Dr B. An appointment was made for Ms A to see Dr B.

In a letter to Dr J dated 9 November 2000 Dr C stated:

> "[Ms A] is at an increased risk of developing cancer in her left breast by virtue of a diagnosis of DCIS on the right side. She has widespread microcalcifications which demonstrate ADH. There is a 10% chance at least of an associated area of DCIS. We have sampled this area with a mammotome biopsy. This sample is probably only 1% or less of the affected area. It would be impossible to effectively detect DCIS against the background of already suspicious microcalcifications in this breast. Given all this, it seems inevitable that [Ms A] will develop DCIS in this left breast if it is not already present. [Ms A] is acutely aware of this and requests a mastectomy and reconstruction

[4] In a letter to Dr B dated 21 November 2000 Ms A stated that the mammotome biopsy was performed on a Wednesday (8 November 2000), which conflicts with the date in the records provided by the Specialist Clinic, (Tuesday) 7 November 2000.

[5] In a letter to Dr B dated 21 November 2000 Ms A stated that she saw Dr C on a Friday (10 November 2000), which conflicts with the date in the records provided by the Specialist Clinic, which refer to the consultation of 9 November 2000, a Thursday.

on the left side at the same time as the surgery on the right. I have to concur with her decision.

We discussed surgery today. [Ms A] will be suitable for bilateral subcutaneous mastectomies. She will be able to avoid axillary dissection and reconstruction should be easily achievable with implants alone as [Ms A] has already pre-expanded her tissues with her current breast augmentation. We discussed the costs and complications of surgery, in particular the complications associated with implant surgery …"

Dr B

On 16 November 2000, Thursday, Ms A and her husband consulted Dr B at the Specialist Clinic as arranged by Dr C. At the time Ms A was suffering from a chest infection. In a letter to Ms A dated 16 November, Dr B stated:

"It is my brief to consult and discuss with you the pros and cons of reconstruction surgery. I would first note that you have ductal carcinoma in situ on the right side which is low grade. You also have atypical ducal hyperplasia on the left side and you also have bilateral breast implants.

As you are aware this has complicated your work up considerably and it means that reconstruction requires special technique in your case. In view of the fact you have quite thin skin and a thin line of breast underneath it, I would not recommend implant reconstruction alone.

As we have discussed I think the best option is for you to have a bilateral mastectomy with nipple preservation on the left side. The left side diagnosis is atypical ductal hyperplasia and I think the nipple can be preserved in this instance.

I would recommend you have latissimus dorsi[6] flap placed across the front and you have reconstruction using approximately 130ml polyurethane coated implants.

I have explained the full costs and complications of this procedure to you and organized for you to see one of our patients who has undergone a similar procedure [bilateral mastectomy] today at the Woman's [Clinic]."

Dr B advised Ms A that he would ask Dr C to telephone her on Monday (20 November 2000) regarding her chest infection and if it had settled would schedule the surgery for Tuesday (21 November) at the Private Hospital. He also advised her that if she wished to consult a plastic surgeon, he suggested she see another doctor, also of the Specialist Clinic, who would also be available to do reconstruction with Dr C.

Ms A and Mr A advised me that Dr B described himself as "the best reconstructive surgeon in [the city] and better than any plastic surgeon in [the city]" because "he did more

[6] A large flat muscle covering the lower back and converging on a tendon which attaches to the humerus (the bone in the arm between the shoulder and elbow).

operations and got more experience" – he "did the best boobs in [the city]". Dr B, on the other hand, advised me that he explained to Ms A that he had "extensive training and experience with reconstruction surgery and in particular had performed many hundreds of latissimus dorsi flap reconstructions". He also explained "the complications of reconstruction surgery which included infection, bleeding, flap failure, wound infection, revision surgery, nipple reconstruction, implant failure, post-operative pain, limitation of shoulder movement and scarring".[7]

Second opinion
On 21 November 2000 Ms A wrote to Dr B and stated:

> "Because of the speed of change to my circumstances, I have been trying to understand things well enough to make an informed decision. I have connected with the Cancer Society for literature and contacts plus people who have had mastectomies of different types to understand their experiences and outcomes, second opinions on surgery and reconstruction and so on. All very confusing and intimidating to the ordinary person as you can imagine …
>
> Our remaining concerns are: One breast at a time or two, length (time) of operation, potential for transfusion requirements, potential for clots, and workmanship for final appearance outcome … To this end my husband ([…]) and I would like a brief tidy up meeting perhaps with both [Dr C] and yourself if practical to set our course and move ahead."

Also on 21 November 2000 Ms A and her husband saw Dr H, a breast and general surgeon, for a second opinion. In a letter to Dr J dated 21 November, Dr H stated:

> "I have arranged for [Ms A] to meet with [another doctor from the Specialist Clinic] with whom I perform my reconstructive procedures and we have both spent some time discussing treatment options with [Ms A] and her husband. The rationale for performing a left mastectomy is based on a significant risk of DCIS in association with the atypical ductal hyperplasia that has been demonstrated on mammotome biopsy. I cannot see any logic in preserving the left nipple whilst removing the right one in this situation. [The doctor] and I feel that bilateral mastectomy and reconstruction could result in a very long procedure with the attendant risk of a long anaesthetic and have suggested dealing with the two sides separately. A right mastectomy with immediate lat[issimus] dorsi reconstruction to deal with the known DCIS and then a few weeks later a similar procedure on the left breast. This would reduce the risk of [Ms A] requiring a blood transfusion (something that she was keen to avoid) and would also

[7] Dr B advised me that he has operated on more than 2,000 breast cancer patients and performed over 600 breast cancer reconstruction operations. Of the last 81 reconstructions (more than ten of which were bilateral) he and his colleagues performed at the Specialist Centre, six had complications (three infections and three haematomas or bleeding). This complication rate is "commensurate with other surgical practices of a similar nature in the literature".

allow a quicker and more comfortable recovery in that she would have the use of the non-operative arm during her mobilization."

Ms A stated that Dr H informed her that it would take more than five hours for him to perform surgery on just one breast. She assumed that Dr B was faster because of the number of such operations he performs, and was therefore able to do both breasts at the same time. Ms A advised me that she specifically asked Dr B if it was better to have one breast operated on at a time or have both done at the same time, and was assured by him that because of her fitness, "it was fine to do both simultaneously". Dr B told her that he did not think a blood transfusion would be necessary and because two surgeons would be operating in tandem, it would ensure that the breasts were symmetrical. Ms A's recollection was that Dr C would be operating with Dr B under supervision.

Mr A advised me that he and his wife decided to stay with Dr B because he had been helpful with their health insurance company and "he had advised that he could do both breasts at the same time, more quickly, and of course, it was cheaper that way". Proximity to Christmas and the availability of surgeons at that time of the year was another factor in their choice of Dr B.

Mr A recalled that Dr C informed him and his wife that he would be assisting Dr B during surgery.

Mastectomy and breast reconstruction

On 5 December 2000, at the Private Hospital, Ms A underwent bilateral mastectomy and bilateral latissimus dorsi flap reconstruction[8] with implants. The surgery was performed by Dr B and Dr C. The breasts were operated on in tandem – Dr B operated on the left breast while Dr C operated on the right breast.

Dr C advised that surgery to the right side was uneventful and a good oncological and cosmetic result was obtained. He considered it to be "successful". The nipple was removed with a postoperative nipple reconstruction planned.

The surgery to the left breast proved more problematic. Dr B advised me that the most complicated stage of this surgery is in the axilla. In order to allow the dissection of the latissimus dorsi artery and vein and the rotation of the muscle through the axilla, he and Dr C assisted each other on respective sides. The axillary dissection on the left side was complicated by previous implant surgery (scarring) and resulted in an inadvertent "damage" to the latissimus artery and vein. To control the bleeding the decision was made to divide and ligate the damaged vessels. Although damage to the artery can affect the blood supply to the flap, Dr B noted that there was "excellent" blood supply to the flap from the serratus anterior artery and vein.[9]

[8] Using the harvested latissimus dorsi myocutaneous flaps over the implants.

[9] These blood vessels supply blood to the lower half of the serratus anterior muscle, the muscle that extends from the shoulder blade to the front of the chest wall.

> "The flap was looking viable and had fresh bleeding from the edge. In view of the fact that this was a nipple-preserving mastectomy on the left side all of the superficial skin was excised from the flap leaving the dermis skin. This bled profusely and it was clear that there was an excellent arterial supply and also excellent venous drainage as the flap at no time was looking congested or of concern."

In the operation note Dr C stated:

> "On the left the thoracodorsal trunk was inadvertently divided during dissection. The serratus branch was preserved which maintained reasonable, although suboptimal perfusion. Haemostasis was ensured. Platelet gel was applied."

Although it was decided to "do nothing further at this stage" (leave the flap in place and do no further reconstruction), Dr B stated that because "the bleeding was so good we elected to place an implant beneath the flap and to reconstruct the left breast totally". He advised me that he had "considerable experience with bleeding of flaps" and that this flap looked "absolutely viable" to him. For that reason he decided to proceed with the full reconstruction rather than perform it at a later date. Bilateral 245ml polyurethane silicone implants were inserted and "good symmetry and volume match" achieved.

Mr A advised me that after the operation Dr C told him that "everything went fine". He mentioned that while bringing the flap around "a bit died off, which it does", but explained that it was "fixed up". No mention was made of intra-operative damage to an artery. In response to this matter, Dr C advised me:

> "I completely refute the allegation that I withheld full and accurate disclosure. I clearly recollect my operative note detailing accidental division of the vascular pedicle on the left side by [Dr B]. It has also been my policy to copy all operative notes to the patient's GP. Not the actions of someone intent on withholding information."

The operation note had been received by Dr J.

Postoperative period

Dr B advised me that the day after the surgery, 6 December 2000, "we" explained to Ms A "exactly what had occurred on each side and in particular that the artery and vein had been divided high in the axilla". He recalled that "[Ms A] had explained to her that there was a double blood supply to the muscle and the second blood supply looked very satisfactory at the time of surgery". Dr B stated:

> "This was a discussion which was held between myself, [Ms A] and her husband after surgery on 6th December. I can remember this well. Essentially we had been operating on [Ms A] in the afternoon and her husband was in the room when [Ms A] was returned from the recovery ward to the room.
>
> I explained to [Ms A's] partner after the surgery exactly what had occurred at the time of surgery. In particular, he was staying in the room with her and I explained that the room had to be kept specially warm. This was to make sure that the flaps had an

> ambient temperature which kept them warm and they did not go to spasm. In particular, I distinctly explained to him, as is my practice, what had occurred at surgery and in particular what the findings were at surgery.
>
> …
>
> More particularly I explained, as is my common practice, any unusual things that occurred at the time of the operation. I distinctly remember explaining that one of the blood vessels to the left side latissimus dorsi flap had been transected at the time of surgery. I explained, however, that there was a double blood supply to this muscle. I further explained that this double supply was more than sufficient by my observation at the time of surgery to supply blood to the area."

Mr A recalled that the day after the surgery his wife was seen by the anaesthetist, who was then joined by Dr C. Dr B was not on the round. Mr A said that Dr C informed him and his wife that the operation went "OK", that the surgery performed by Dr B (the left breast) was "a bit slower", that they had "lost a little bit of tissue" and that loss of tissue sometimes happened. He said that Dr C was happy with the outcome and commented that "everything will be fine". Nothing was said about an artery being inadvertently cut during surgery.

Ms A's postoperative recovery period was largely unremarkable. She required minimal analgesia. On 10 December it was noted that her breasts, particularly the left one, were swollen and warm to touch. That evening she also had an elevated temperature of 38.8ºC. Blood tests (full blood count) on 6 December revealed low haemoglobin levels of 97 and 87 g/L (normal range 115-155 g/L), and 93 g/L on 8 December.[10] Ms A recalled that several days after her surgery, when the surgical tapes were removed from her breasts, she could see that her left breast was still leaking blood. She also recalled speaking to the anaesthetist who told her that if her "blood count" did not improve, she would need to have another operation. On 11 December her haemoglobin was 90 g/L and she was discharged from hospital. A follow-up appointment with Dr C was scheduled for 14 December.

Admission to the Public Hospital

On 14 December 2000, at approximately 2am, Ms A got up to go to the toilet at home and collapsed. Mr A reported that she lost consciousness and had a convulsion lasting some five seconds. Ms A was scheduled to see Dr C at 9 or 9.30am that day for a first postoperative consultation. Because she felt very dizzy when she got up to have a shower, and realising that she would be unable to travel for the appointment, Mr A telephoned Dr C at about 8.30am, informed him what had happened during the night and asked him to come and see his wife at home. Dr C recommended that they call their general practitioner. Their general practitioner was unable to come out but, suspecting that it could be serious, advised Mr A to call for an ambulance and have his wife taken to hospital. An ambulance was called at 10.59am and arrived at 11.07am. At that stage Ms A was fully conscious and

[10] Her preoperative haemoglobin, taken on 9 November 2000, was 139 g/L.

although her blood pressure was 100/55 mmHg, her vital signs, including heart rate, were unremarkable. She was taken to the Public Hospital where she arrived at 11.44am.

On admission, a blood test at 12.35pm showed a haemoglobin level of 62 g/L. She was diagnosed with postoperative anaemia secondary to a bleed, most likely into the latissimus dorsi site. Mr A recalled that his wife's back "had filled with fluid and looked like a waterbed". He telephoned Dr C late that afternoon and asked him to come to the hospital to see his wife's back. He said that Dr C advised him over the telephone that he thought it would only be a collection of some fluid, which was normal. However, Dr C agreed to come to the hospital and review Ms A. He did so between 6 and 7.00pm.

In the hospital notes, Dr C recorded:

> "[Ms A] had a bilateral mastectomy and LB [left breast] reconstruction [illegible] implants 10/7 ago. Problem-free recovery. Hb was 90 on discharge. Apparently well until collapsed in middle of might. Hx [history] of PU [peptic ulcer] and has been on NSAIDS [non-steroidal anti-inflammatory drugs], however no signif[icant] GI [gastrointestinal] symptoms. Fluid under donor site normal, however this appears to have increased considerably today – on aspiration this is heavily bloodstained, although does not clot, suggesting blood/serum mix. Initially she needs the planned Tx [treatment]. If [illegible] is negative she will require exploration of donor site."

Mr A stated that after seeing Ms A and aspirating blood from her wound, Dr C arranged her transfer to the Private Hospital for exploration of the donor site. Mr A stated that Dr C described the event as a secondary bleed which was unrelated to the breasts and that "this sort of thing happens from time to time". He and Ms A accepted that explanation at the time.

Dr C refuted Mr A's allegation that he reluctantly attended Ms A at the Public Hospital. He said that when contacted he attended "expediently", diagnosed the underlying problem ("encountered within Dr B's operative field") and arranged treatment.

That night, starting at 10.25pm, Ms A was transfused with four units of blood. Her post-transfusion haemoglobin level, at 9.10am on 15 December 2000, was recorded at 123 g/L.

Readmission to the Private Hospital

On 15 December 2000 Ms A was discharged from the Public Hospital with a referral to a district nurse and advice "to see surgeon from [the Specialist Clinic] ASAP". That evening, at the Private Hospital, Dr C performed an incision and drainage of the haematoma from the latissimus dorsi donor site. Dr B did not participate in the surgery.

With regard to this operation, Dr B advised me:

> "The haematoma was drained completely and the contralateral right side was also explored to exclude any bleeding in that area. There was no active bleeding point as the blood vessels had tamponaded.

> I distinctly remember asking [Dr C] if the haematoma was at all originating from the axilla but his statement was that the axilla had no bleeding in that area and the flap looked viable and satisfactory. He did not wish to explore deeper into that area for fear that he would do more damage than good."

Dr B stated that the bleed had nothing to do with the flap or the divided artery and vein to the flap. He advised:

> "This bleeding was from the harvest site which was located in the posterior back region rather than in the axilla or breast. … Unfortunately they [staff at the Public Hospital] did not drain the haematoma rather they transfused her and discharged her. In view of this she was reviewed by [Dr C], her primary Surgeon, the next day after discharge. He was alarmed at the size and pressure of the haematoma which was filling the whole of the back and expanding into the axilla."

The haematoma placed pressure on the latissimus dorsi flap in the lower axillary region.

On 17 December 2000 Ms A's dressing on the left breast was taken down and "slight ooze ? infection" noted. She was discharged on antibiotics (Augmentin) and with drains, which were to be removed by Dr C the next day. There is no record whether a swab was taken to determine what micro-organism might be causing the infection.

Subsequent events

Ms A advised me that after her discharge from the Private Hospital on 17 December 2000, the wound on her left breast continued to weep and would not heal properly. Over the weeks that followed, almost on a daily basis, she had the breast collection expressed and the dressing changed by the Specialist Clinic's breastcare nurse or, when she was not available, by a district nurse.

On 18 December 2000 Ms A consulted Dr C. In his letter to Dr J, Dr C stated:

> "There was a little residual haematoma in the left breast which has started to liquefy. We milked this out today and [Ms A] will return on a daily basis for further attention from our breastcare nurse. … All being well I have arranged to see [Ms A] here early in the New Year."

On 20 December 2000 Ms A saw Dr B who took a wound swab and prescribed Ciproxin, a broad-spectrum antibiotic. There is no record of a microbiology result.

The following day, on 21 December 2000, the Specialist Clinic's multidisciplinary panel meeting took place at which the management of Ms A's case was discussed. A letter to Ms A and Dr J from Dr C and another breast and general surgeon at the Clinic stated:

> "The panel agree[s] with all the treatment you have had so far and agree that the next step would be physiotherapy and counseling. No further treatment is recommended and follow up will be advised by your clinician."

Ms A recalled that one night prior to Christmas while Dr B was on leave, she telephoned the Specialist Clinic's on-call surgeon and spoke to the breast and general surgeon and arranged a consultation. The breast and general surgeon examined her wound and was concerned about the infection – "he did not want me to lose my implant". The breast and general surgeon prescribed "stronger" antibiotics – "stronger than what [Dr B] had prescribed". No record of this consultation was provided by the Specialist Clinic.

On 8 January 2001 Ms A consulted Dr C. She advised me that by this stage it was obvious that one of her breasts was higher than the other. In respect to this consultation, in a letter to Dr J, Dr C stated:

> "The discharge from her left breast reconstruction has almost ceased and this continues to heal well. The breast is still sitting high but the shape is beginning to improve and I have reassured [Ms A] that it should continue to improve over the next three months or so.
>
> [Ms A] was a little concerned about an area of erythema on the interior aspect of her right breast, this was non tender and represents inflammation rather than infection and is probably transient reaction to her polyurethane implants."

On 11 January 2001 [Ms A] and her husband consulted Dr B. Despite the antibiotic cover, the infection in the left breast was not resolving. She recalled that Dr B informed them that because of the infection, further surgery might be necessary and could involve a removal of the [left] implant.

In a letter to Dr J dated 11 January, Dr B stated:

> "I reviewed [Ms A] today. She continues to have leakage from the left breast and in view that I am concerned that she is getting rejection in the implant. I have recommended that she have implant exploration on the left side. I have warned her that if we find any sign of infection the implant will need to be removed, the cavity washed out and antibiotics given prior to implant replacement at a later date."

On 15 January 2001 Ms A underwent further surgery (exploration of left breast implant) at the Specialist Clinic. The procedure was performed by Dr B because "the flap had developed an infection and there was obvious swelling with fluid build-up round the left breast implant". As there were signs of infection, the implant was removed and infected (necrosed) tissue debrided. Dr B stated:

> "The observation there was that at least two thirds of the flap was viable, bleeding and satisfactory. Flap loss measured approximately 30% and was associated with infection hence the implant required removal. The infection was slow to settle and seemed to have tracked into the pectoralis muscle which also became thinned."

On 18 January 2001 Ms A consulted Dr B who in a letter to Dr J stated:

> "I reviewed [Ms A] today. Her wound is looking healthy. The flap looks quite satisfactory. We have redressed the wound following removal of the implant and I will review her in a week's time."

Following a consultation on 1 February 2001, in a letter to Dr J, Dr B stated:

> "I reviewed [Ms A] today and explained she has a stable but healing latissimus dorsi flap. There is no sign of any infection on the recent swabs and we have packed it and plan to see her twice a week for dressings. I have given her support person to discuss ongoing surgery which will be needed.
>
> Basically she is unhappy with the size of the right breast implant and when we revise and place the implant in the left breast we will insert two larger implants to give her symmetry. At the same time we will reconstruct her right nipple areolar complex."

Dr B referred Ms A to radiation oncologist at the Specialist Clinic, for "further treatment". The radiation oncologist saw her on 14 February 2001. The radiation oncologist advised Dr B that Ms A did not need any postoperative radiation treatment and did not recommend any form of adjuvant treatment. He stated than Ms A was happy with that decision.

Ms A advised me that on 1 March 2001 she was given an "all clear" by Dr B, who suggested that she have a break of two to three months before seeing him again. However, on 5 March she was seen by Dr C, who in a letter to Dr J stated:

> "The left breast wound is continuing to heal slowly. There is no sign of any overt infection. I would anticipate this site healing over the next month – six weeks, following which we can proceed to reconstruct this breast. It may be that an expander will be [Ms A's] best option.
>
> The right reconstruction is essentially fine although it is a little low and lacks some projection. If [Ms A] wishes we can certainly replace or reverse this side."

Ms A had three further consultations with Dr B – on 15 March, 7 June and 16 August 2001. Following the 7 June consultation Dr B wrote to Dr J and stated:

> "I reviewed [Ms A] today. She is looking and feeling excellent. However, she continues to have some ongoing problems with respect to some tightness and discomfort in the right reconstructed breast. The left breast has now shrunk since we removed the implant and I have explained to her that I will be referring her in two months' time to [Dr I] for consideration of a free abdominal flap transfer to reconstruct the left breast and also some modification and improvement plus nipple reconstruction on the right."

Ms A advised me that she raised the matter of a second opinion with Dr B and that he suggested Dr I. She recalled that she enquired about another surgeon but that Dr B did not recommend him because that surgeon's experience and training was similar to his (trained overseas). Dr I, on the other hand, was "in a younger age group and had different training and would therefore offer a different perspective".

Following the 16 August 2001 consultation Dr B wrote to Dr J and stated:

> "I reviewed [Ms A] today. She is now almost 90% happy with the reconstructed right breast. There is still a little bit too much ptosis and we can correct this by excising some redundant skin in the inflammatory fold.
>
> There is also some fullness affecting laterally which I can fix with liposuction.
>
> With respect to the left breast, I have recommended that she have an expander placed into this area and I have made arrangements for her to see a lady who has got an expander in so she can see if this would be the best option for her."

Ms A stated that Dr B told her that use of an expander was suitable and it could be replaced with implants after the blood supply to the affected tissue was restored. She stated: "Over time I continued to work towards the option of putting in the expander on Dr B's advice. My husband expressed concern that there was not sufficient tissue coverage to retain an implant." She stated that Dr B sought a second opinion from a colleague overseas.

On 29 August 2001 Dr B received an email from his colleague, a consultant at a university overseas, whom he described as a mentor and an internationally recognised expert in breast cancer reconstruction. Dr B's colleague stated:

> "I did look at the photos of [Ms A]. I have seen similar cases in the past.
>
> I do not think she will be too much of a problem. You are lucky, because she seems to have a reasonable amount of good quality skin remaining on the left side, which should make reconstruction fairly easy.
>
> I think the left breast can be reconstructed by inserting a new implant (submuscular). I honestly don't think you need soft tissue expansion, it looks to me like the skin envelope is pliable enough that it would stretch out over a modest sized implant. Perhaps as a secondary procedure scar revision around the areolar and/or tattooing might be beneficial.
>
> If you cannot create a large enough space to accommodate the prosthesis without excessive tension on the closure, then I would insert an expander and do her in stages. As far as the right breast goes, the inframammary fold looks a bit low, which gives the inferior pole an unusual curve. But again, there is plenty of soft tissue to work with. I would raise the fold (either by capsulectomy and closure or some capsular advancement flap).
>
> I think at the appropriate time you can easily do her nipple/areolar with the tissue from the latissimus. I would do a skate flap for the nipple and a full thickness inner thigh skin graft for the areola. I would put a pursestring suture (Gortex) around the border of the reconstructed areola and completely eliminate the latissimus skin island. I think she would have an excellent result.

> This is a case I would be very optimistic about, because I think she will get a good result [in] the end."

On 6 September 2001 Dr B reviewed Ms A and in a letter the same day informed Dr J that Ms A had developed an infection in the reconstructed left breast, which necessitated the removal of the implant. The wound had "gradually settled" and a replacement of the implant was required to achieve symmetry. Some modification to the right breast was also required. Dr B estimated the cost of further surgery to be approximately $8,000, which he thought would be covered by Ms A's insurer.

Following Dr B's colleague's advice and confirmation that the proposed surgical management was appropriate, Dr B wrote to Ms A's insurance company on 14 September 2001 maintaining that as it covered the initial procedure, complications of that procedure should be fully covered.

Dr I

Ms A was "not comfortable" with the surgery proposed by Dr B and concerned that there was inadequate tissue for reconstruction. On 19 September 2001 Ms A consulted Dr I, a plastic and cosmetic surgeon at a second private hospital, for another opinion. She contacted Dr I of her own accord.

Dr I recalled that Ms A came to him because she was not happy with the outcome of previous surgery. She came to discuss revisional surgery to regain the size and symmetry of her breasts, if possible. On examination Dr I noted that the right implant reconstruction was low in position[11] and that on the left side "there is the equivalent of a mastectomy defect with nipple preservation and a transverse scar but extremely thin soft tissue cover with no apparent latissimus dorsi muscle palpable, certainly in the lower half of the breast and some suggestion that part of pectoralis major muscle is missing as well". In a post-consultation (summary) letter to Ms A dated 19 September 2001, Dr I stated:

> "The aim of salvage and revisional reconstruction would be to achieve the best possible symmetry and shape but clearly now this [is] a much more difficult proposition given the events of the past. In view of the extremely thin soft tissue cover on the left side I am reluctant to suggest a simple tissue expander-implant reconstruction for I fear that this would only lead to more complications in the future with poor shape, capsule contracture or even implant extrusion. In my opinion it will be necessary to provide some extra soft tissue padding or cover on the left side before one might consider placing an implant there. Usually this soft tissue cover would come from latissimus dorsi but since this has already been used the abdominal tissues become the preferred choice. It would be possible to take part of your lower abdominal tissues to provide this cover beneath which would rest an implant. Combining this with an adjustment on the right side would, I believe, have the potential for successful reconstruction in terms of

[11] In a letter to ACC dated 21 December 2001, Dr I stated that the infra-mammary crease was "too low (by 4 cm or so)".

> symmetry of shape and volume. This abdominal tissue transfer is called a TRAM flap and if it is done by pedicle technique using one of the rectus abdominis muscles attached from above half of the lower abdominal tissues can be successfully transferred enough to provide the cover we need in combination with an implant for volume. …
>
> An alternative approach would be a microvascular TRAM flap whereby all of the lower abdominal tissues were transferred onto the left chest wall and blood vessels rejoined with microsurgery to restore blood supply. This could provide enough volume to match the right side without the need for an implant on the left side and also carries the advantage of only requiring a small amount of muscle from your abdomen therefore potentially leaving less risk of weakness or problems with the abdominal donor site. The problem however is that this is a more lengthy surgery ….”

The procedure involved in the second option was considerably longer and did not involve revision of the right breast, which would have to be done separately at a later date. Ms A was asked to consider the options and other information provided by Dr I and return at a later date for further consultation and formulation of a surgical management plan.

Ms A advised me that on 11 October 2001 she saw Dr B regarding the assessment and recommendations made by Dr I. She said that Dr B re-examined her and concurred with Dr I's assessment that there was "quite a diminishment in the available tissue". In a letter to Dr J dated 11 October, Dr B stated:

> "I agree that [Dr I] is suggesting the safest and best procedure in a TRAM flap reconstruction of the left breast.
>
> …
>
> However, she had a complication of surgery which required removal of the left breast prosthesis.
>
> It looks to me as if the infection she developed in the left breast has indeed destroyed quite a lot of the medial latissimus dorsi flap and some of the underlying pectoralis major muscle.
>
> I have recommended that she proceed with the procedure and plan to review her for her cancer follow-up in six months' time."

In response to Ms A's health insurer's statement that the cost of further surgery should be covered by ACC, on 17 October 2001 Dr B wrote to the company arguing that the further surgery was an extension of the initial procedure and should be covered by the company. He stated: "I do not regard this as a medical mishap, rather a medical complication."

On 30 October 2001 Ms A had further discussions with Dr I about surgical options. She chose to proceed with a microsurgical TRAM flap. In a letter dated 30 October, Dr I informed Dr B of Ms A's decision. In reference to Dr B's letter to the insurance company, Dr I stated:

> "I agree with the contents of your letter for the most part and reinforced to them [Ms A and Mr A] today that these were medical complications and to pursue an ACC claim was probably not appropriate and discouraged them from this course of action. However, on subsequently reviewing [Dr C's] operation note dated December 6, 2000, I note that on the left side the thoraco-dorsal pedicle had been divided and the flap was left on a reverse flow serratus branch supply. There is a significant chance that under-perfusion led to muscle necrosis and following that wound infection. This sequence of events is more consistent with medical mishap rather than a medical complication and hence on that basis felt I should draw your attention to this matter for your consideration and further action as appropriate."

On 2 December 2002 Ms A underwent salvage reconstruction of the left mastectomy defect with a TRAM flap. The surgery was performed by Dr I at the second private hospital.

ACC

On 28 November 2001 Ms A lodged a medical misadventure claim with ACC to cover the cost of reconstructive (salvage) surgery. In considering Ms A's claim, ACC's Medical Misadventure Unit obtained independent advice from a plastic and reconstructive surgeon, Dr John de Geus. Dr de Geus considered that the complications Ms A suffered, including the haemorrhage on 14 December 2000, resulted from inadequate blood supply to the latissimus dorsi flap and ensuing tissue necrosis and infection. In his report dated 1 February 2002, Dr de Geus stated:

> "In this instance however, the loss of the vascularity was surgical trauma. Although such trauma does happen from time to time, the fact that no attempt was made to repair the artery, was most unfortunate. Although it is not very clear from the information provided, some vascularity was thought to be present in the flap but it was not thought to be optimal. No mention was made of an assessment being carried out of the flow through the vessels using Dopler technique ….
>
> Again, although there is an acknowledged failure rate for latissimus dorsi muscle and skin reconstruction of the breast, the failure rate of this is very low. The causes are sometimes not established but they are almost always due to inadequate vascularity of the flap for one reason or another.
>
> In this instance, the vascularity was damaged at the time of surgery and known to be damaged. The range of expertise of surgeons engaged in such surgery normally includes the ability to repair such damaged vessels with microvascular techniques. Such an attempt should have been made in this case. Since no such attempt was made, the treatment was suboptimal and falls into the Medical Error bracket."

On 6 March 2002 Dr B was advised of the medical error decision by ACC. Dr B challenged that decision claiming that his decision to mobilise the latissimus dorsi flap on the serratus anterior branches was vindicated by the literature and his experience, and that the use of microvascular anastomosis could have resulted in a worse outcome. In his letter to ACC dated 26 March 2002, Dr B stated:

> "I realized that the thoracodorsal pedicle had done a double turn near the tendon and was divided whilst mobilizing the tendon.
>
> Haemostasis was secured. I then examined the serratus anterior branch as it is my practice to conserve this branch at all times and often to leave it intact and have a double vascular supply to the muscle when transferring it.
>
> I also wrapped the latissimus dorsi island flap in a warm cloth and after waiting 5 minutes I wrapped it and tested the circulation.
>
> There was excellent capillary bleeding in all areas of the flap and in particular we de-epithelialised a large portion of the skin flap and this de-epithelialisation resulted in ready bleeding.
>
> There is no doubt that it was not as good as the other side but it was certainly very satisfactory. …
>
> The skin at no time showed any poor vascularity. In particular I state in my clinical notes [not provided] post-operatively that the skin flap was extremely healthy. This is important as I was watching this flap very carefully."

Dr B acknowledged that initially the flap had suboptimal perfusion but that it recovered giving him the confidence to complete the reconstruction with the implant as planned. He stated that there was no problem with healing in the postoperative period until the haemorrhage of 14 December 2001 (nine days after the surgery) and that there was no apparent problem with the skin flap when the haematoma was drained by Dr C on 15 December 2001.

Dr B advised me that it was "difficult to quantify and qualify where the exact complication and necrosis of the flap occurred" and that it was "unfair to solely blame the damage to the flap from the original ligation of the artery and vein to flap". He pointed out that there were two further significant traumas which led to poorer perfusion to the area and flap damage: direct pressure on the latissimus dorsi flap by the haematoma (originating in the harvest site in the back), and the significant and sustained drop in haemoglobin following the haemorrhage. Because these separate events caused damage to the flap, the outcome would have been similar even if intra-operative microvascular anastomosis had been performed.

Dr de Geus reviewed Dr B's response to ACC's medical error decision but did not alter his opinion. In a letter to ACC dated 21 May 2002, Dr de Geus stated:

> "The latissimus dorsi myocutaneous is an axial pattern flap meant to survive on the latissimus dorsi vessels. Should these be divided during reconstructive surgery, the vascularity if relied on the anterior serratus anterior branch, has to be so good that there is no risk to the flap. Clearly, during this operation, it was thought to be sub-optimal.
>
> I therefore have to stand by my opinion that an attempt should have been made to have these vessels repaired. Not to do so, I think constituted an error of judgment.

There is also a precedent for calling in [a] microvascular surgeon during such mishaps."

The independent legal opinion to ACC concurred with Dr de Geus's opinion that a medical error had occurred.

On 25 June 2002 Ms A was advised by ACC that her medical misadventure claim had been accepted on the basis of medical error. She advised me that it was only after being provided with copies of Dr C's and Dr B's reports to ACC that she learnt that an artery on her left breast had been ruptured during the surgery on 5 December 2000, and not repaired. She said that Dr C or Dr B at no time informed her of the intra-operative mishap or that her poor recovery was related to the intra-operative event. In response, Dr C advised me:

"I am amazed to learn that [Ms A] was unaware as to the underlying cause of the problem on the left side. In my discussions with [Dr B] it was certainly my impression that he had fully informed [Ms A] during their postoperative / follow-up consultations.

I completely refute the allegation that I withheld full and accurate disclosure. I clearly recollect my operative note detailing accidental division of the vascular pedicle on the left side by [Dr B]. It has also been my policy to copy all operative notes to the patient's GP. Not the actions of someone intent on withholding information."

Dr B advised me that Ms A was "extremely well informed" about the preoperative complication rate and that she was managed appropriately postoperatively, "befitting the difficult complications" she experienced. No records were provided to substantiate the information he provided Ms A in respect of the intra-operative event.

ACC review hearing

On 22 August 2002 Dr B submitted an application for review of the ACC medical error decision. Prior to the hearing on 20 March 2003, Dr B's counsel submitted an independent report from a plastic and reconstructive surgeon who, in response to a request to comment on the cause of the necrosis (death of the flap), stated:

"The flap initially showed some vascular insufficiency with duskiness but pinked up and was reported as fine until post-op day 9 when a haematoma developed. The haematoma could have been due to a secondary haemorrhage from a ligated major vessel, a venous congested muscle flap or from a necrosing muscle flap with secondary infection. One can only surmise about this, but I agree that it is unusual to get a significant haematoma after 7 days when the flap viability appears normal. Certainly the compressing force of an expanding haematoma on the already compromised flap, could well have caused it to fail completely."

At the hearing an opinion on the case was also provided by another plastic and reconstructive surgeon. The review report states:

"[…], surgeon, was of the opinion that [Dr B] had not used the appropriate skills or approach in this case and as a result the patient was compromised. He did not believe the treatment was properly given in the circumstances. He believed the plastic and

> reconstructive surgeon's report said it all, namely that micro repair should have been done. Dr B had a micro-surgeon in his team."

The application was dismissed.

Other comments
Dr C advised me that his role in the surgery involving Ms A was that of "a junior surgeon working under supervision and direction of the senior surgeon", Dr B. He stated:

> "As the supervised (i.e. temporary NZ medical registration with [Dr B] as designated supervisor) junior surgeon it would be entirely correct for [Ms A] to be advised I was assisting [Dr B]. This encompasses operating under direction. … As to the question of perioperative delegation of workload, this was at the discretion of the senior surgeon on the day."

The responsibility for postoperative care and follow-up lay with Dr B.

Dr B advised me that Dr C was "recognized as a full specialist [overseas] and had completed specialist breast training with two rotations, one of which involved rotation to a Breast Clinic with a sessional commitment to plastic surgery where he learned and trained in reconstructive surgery".

Dr C's certificate of registration with the Medical Council of New Zealand states that he held temporary registration and was permitted to practise medicine as a specialist in general surgery in the employment of the Specialist Clinic, under the supervision of Dr B.

Independent advice to Commissioner

Breast and general surgeon
The following expert advice was obtained from Dr John Simpson, an independent breast and general surgeon:

> "**<u>Confidential report to the Health and Disability Commissioner</u>**
> **Complaint by [Ms A] concerning the care given by [Dr C] and [Dr B]**
> **HDC File No 02/[10715]/AM**
>
> 1. This report is written by John Stuart Simpson, medical practitioner of Wellington, vocationally registered in general surgery.
>
> 2. I am a Fellow of the Royal Australasian College of Surgeons (1977) and formerly General Surgeon at Wellington and Hutt Hospitals. I have been involved with general and breast surgery over a period of 32 years. I am a former Chairman of the RACS Section of Breast Surgery. I am currently Executive Director of Surgical

Affairs (NZ) for the Royal Australasian College of Surgeons and continue to practice in the field of breast disease.

3. In writing this report, I have had access to copies of certain medical records, reports and letters but have not interviewed any of the parties concerned.

4. **The complaint**
The complaint is that between October 2000 and November 2001 [Drs C and B] did not provide services of an appropriate standard to [Ms A].

5. **Background**
In April 2000 [Ms A] was referred to [the Specialist Clinic] with a lump in her right breast. The clinical diagnosis at that time was a fibroadenoma. She returned in May and again on 16 October when a core biopsy was performed on the lump. The histological diagnosis was ductal carcinoma in situ (DCIS) together with a separate papillary lesion. [Ms A] was advised to have surgery and as part of the preparation for surgery had a mammogram which showed widespread bilateral calcification. A mammotome biopsy on the left breast revealed extensive atypical ductal hyperplasia (ADH) but no invasive cancer or DCIS.

[Ms A] was advised by [Dr C] to have a bilateral mastectomy with immediate reconstruction using the latissimus dorsi flap technique, together with insertion of implants. The procedure was carried out jointly by [Drs C and B] on 5 December 2000 at [the Private Hospital]. [Dr B] did the operation on the left side and [Dr C] did the right side. While dissecting in scar tissue in the left axilla [Dr B] damaged what he has termed the 'latissimus' artery and [Dr C] called the thoraco-dorsal trunk. In order to control bleeding [Dr B] divided and ligated the 'latissimus' artery and vein, which [Dr B] indicates provided a significant part of the blood supply to the latissimus dorsi muscular flap. [Dr B] judged the flap to be viable. The operation was completed without any apparent further problems.

[Ms A] was discharged home 7 days after the operation and 2 days later bled significantly and probably suddenly, into her back wound and required an acute admission to [the Public Hospital]. Her haemoglobin fell to 60 G and she received a blood transfusion and then was discharged home, without drainage of a large haematoma. After being seen by [Dr C] she was readmitted to [the Private Hospital] for drainage of the haematoma which was performed on 15 December. Following this drainage she had a persistent infection on the left side and despite antibiotic treatment required further surgery on 15 January 2001, to remove the implant and to debride dead skin.

[Ms A] was left with effectively no reconstruction on the left side and was also unhappy with the result of the right side reconstruction and sought a second opinion from a plastic surgeon, [Dr I], to whose care she later chose to transfer to.

6. **General comments**

This has been a prolonged, unpleasant and unsatisfactory saga for [Ms A]. She has had a poor result and unexpected morbidity from what is normally a very safe and reliable procedure. The surgical complication of inadvertent division of a major feeding vessel to the flap is very unusual also. This event must have had an impact on the events that followed: namely problems with the flap and infection. The secondary bleed 9 days postoperatively may or may not have been linked to the blood vessel injury but will, almost certainly, have contributed to the flap problems.

7. **Complaints**

Do these problems amount to provision of services of an adequate standard to [Ms A]? I will take the components of [Ms A's] complaints separately in order to answer this.

a) **Regarding [Dr C]:**

1. Pre-operative assessment

This presumably refers to booking [Ms A] for partial mastectomy without having mammography performed first. Although this was an unfortunate omission, it was recognised in time and although it caused [Ms A] some anguish and alarm did not result in inappropriate surgery.

2. Inadequate reconstruction of right breast

This is a somewhat difficult matter to judge on an objective basis. [Ms A] is of the opinion that the breast is both too low and also of poor shape. [Dr I] appears to agree with this assessment. Achieving perfect position and symmetry is commonly difficult in the context of bilateral reconstruction and clearly this was an issue in [Ms A's] case. I was surprised to say the least to read [Dr C's] letter to the Commissioner in which he defends his reconstruction on the grounds that the initial result was successful and events after that were beyond his control. To quote [Dr C's] own description, that surely is disingenuous!

3. Qualifications and expertise

This is always a difficult issue on which to give a clear opinion in relation to specific procedures. He was, as a temporarily registered doctor in New Zealand, under the direct supervision of [Dr B]. This means that he was in a role somewhat akin to that of a senior trainee in a NZ hospital. Looking at his part in this operation in this light, it seems reasonable that he should perform surgery of this type under supervision. However, [Dr B] appears to portray [Dr C] as an independent contractor who was trained to perform such procedures. I would take the view that [Dr C] was not trained in reconstructive surgery based on one session per week for one year while working [overseas]. In view of [Dr C's] description of his role as 'a junior surgeon under the supervision and direction of [Dr B]', my opinion would be that [Dr B] was responsible for [Dr C's] actions in this context and that [Dr C] was qualified to fulfill the junior role.

4. Follow-up care.
This is a question that I cannot answer in the light of the paucity of information available. [Dr C] clearly states in his letter of 5 January 2003 that responsibility for postoperative care and follow up lay with [Dr B]. [Dr B] took a role in the postoperative care as evidenced by the letters he wrote. It is unclear to me just how the allocation of responsibility lay for this care in the absence of an explicit statement. In terms of management of infection, my main concern would be that [Dr C] was perhaps slow in detecting the infection. He states in his letter of 8 January 2001 that an area of erythema over the right breast 'was probably inflammation rather than infection' and suggests 'a reaction to the implants'. This is, in my view, a very unlikely explanation and I would take the view that infection was the likely cause of the redness. Beyond that I have no comment to make on this aspect.

5. [Dr C's] role
I think that [Dr C's] role was not precisely defined but in terms of his registration status and hence supervision by [Dr B] his explanation of his role to [Ms A] was fairly accurate. As the senior surgeon, it was probably [Dr B's] job to inform [Ms A] about division of responsibility.

6. Explanation of bleeding during the operation and 9 days later
These were very important issues for [Ms A] and required detailed explanation by either or both of the surgeons. [Ms A] states that she was never told what happened, [Dr B] says, she was. It comes down to which version you choose to accept.

Regarding [Dr B]
7. Damage to artery
[Dr B] states that he damaged the artery while dissecting in an area of scar tissue. This is a highly undesirable thing to happen and one that carries the risk of serious blood loss as well as affecting the blood supply to the flap. There is no dispute over the facts of this aspect of [Ms A's] complaint.

8. Did not repair the artery
Again there is no dispute over the facts. [Dr B] divided and ligated the artery and vein. He did not seek the assistance of a microvascular surgeon. I am uncertain whether [the Private Hospital] has the facilities for microsurgery and even more uncertain about whether a suitable surgeon would have been available at the time of the arterial injury. In a perfect world a repair would have been attempted but I am not critical of [Dr B] for ligating rather than repairing the vessel. Whether he should have continued with the flap reconstruction is an entirely different issue.

9. Follow up care
As for the same issue for [Dr C], it is very difficult to comment through lack of information. [Dr B] prescribed an appropriate antibiotic and did further surgery to remove the implant and excise dead tissue. The information provided is inadequate to comment further.

10. Advice to have expander in left breast
This was [Dr B's] suggestion to restore the size of [Ms A's] breast. It seems unwise and unlikely to succeed due both to the presence of thin skin flaps and also because of a fairly recent infection.

11. Breast reconstruction experience and skill
I do not know exactly what [Dr B] told [Ms A] about his experience. If he had indicated that he was better than a plastic surgeon, I would find this quite unacceptable but it comes down again to whose word you believe. [Dr B] has most certainly had very extensive experience of breast reconstruction surgery. I cannot say whether or not he exaggerated his experience in talking to [Ms A].

12. Explanation of bleeding
This gets the same answer as 6 above. There are different versions of what was said.

8. Specific questions

Concerning [Dr C]

1. Pre operative, surgical and follow-up care
The preoperative assessment was quite fragmented involving [at least three] doctors in addition to [Drs C and B]. This makes it difficult to assess the adequacy of the actions of individuals. The standard for Breast Screen Aotearoa patients undergoing surgery includes a pre-operative mammogram. This situation is different in that [Ms A] had a palpable lump but the Breast Screen standard is probably the most relevant. The NZ Surgical Guidelines are also relevant to pre-operative, surgery and follow-up. I cannot identify any standard that has obviously not been met.

2. Standard of reconstruction ([Dr C's] side)
This was a less than totally satisfactory reconstruction as has been discussed in 2 above. It was not a total failure but certainly and quite reasonably, did not meet [Ms A's] expectation. It was probably just at an acceptable standard for a surgeon of [Dr C's] experience.

3. Qualifications and experience
As discussed in 3 above, [Dr C] could not be described as a trained breast reconstruction surgeon but was adequately trained to do a latissimus dorsi reconstruction under supervision of someone who was trained.

4. Treatment of infection
There is nothing to add to 9 above. There is inadequate information to go further.

5. Cause of haematoma
There are 2 main possibilities for the cause of the haematoma. First a secondary bleed from a small vessel in the back that did not bleed at the time it was divided and chose to bleed 9 days later. This is not uncommon after many types of surgery. This would be the more likely in my view and would be unconnected with the vessel

injury at the time of surgery. Secondly it could be bleeding associated with necrosis of the muscle flap as suggested by Dr John de Geus. This would be caused by a very poor blood supply to the muscle caused by ligation of its main feeder vessel.

6. Damage done by haematoma

A haematoma is significant sized collection of blood which can have a number of effects:

a) Pain due to stretching of nerve fibres
b) Cosmetic impairment by discolouration at first and swelling and scarring later
c) Providing a suitable environment for bacteria to live in, increasing the chances of infection occurring and also increasing the likely severity of an infection
d) Kinking or pressure on blood vessels leading to an impaired blood supply and the possibility of loss of a flap.

[Dr B]

7 Pre-operative, surgery and follow-up

As for [Dr C] see 1 above.

8 Experience and qualifications

As described previously [Dr B] had 2 distinct roles: one as the operating surgeon and the other as supervisor of a more junior surgeon.

Without doubt, [Dr B] has had a great deal of experience of breast reconstruction even though he is not a trained plastic surgeon. Thus he must be regarded as adequately trained and experienced for the role as operative surgeon. I do however have some reservations about his role as a supervisor. These comments apply entirely to his role with regards to reconstruction, there could be no debate about his ability to supervise other types of surgery for breast cancer and benign disease.

9 Standard of surgery

The division of the artery was a serious event and one that would be regarded as a departure from the standards that would be expected of a surgeon of [Dr B's] seniority. All surgeons make very occasional mistakes and this event must be seen in that context.

10 Decision not to repair the artery

There are clearly different opinions about what should have been done in this instance. [ACC's plastic and reconstructive surgeon advisor] takes the view that a surgeon doing this type of surgery is likely to be able to repair a damaged vessel using microsurgical techniques and should do so. I would take a different view and suggest that the logistics of getting a surgeon and equipment to a private hospital in order to do such a repair might prove impossible. In my view [Dr B's] actions were reasonable under the circumstances.

11 Treatment of breast infection
See comments relating to [Dr B] 9 above and also to [Dr C].

12 Advice about expander
See 10 above. I disagree with [Dr B] and see this suggestion as a recipe for further trouble.

General

13. Pre-operative mammogram
[Ms A] most definitely needed a mammogram as part of her pre-operative assessment or even earlier before a decision about surgery was made. I would expect all the doctors who had seen her to be looking out for a mammogram result and would not limit the responsibility to a single individual.

14. Cause of delayed healing and bleeding
Impaired blood supply and infection together with the presence of foreign material (an implant) all contribute to delayed healing. Any of these factors can cause secondary bleeding. It is uncertain whether [Ms A] had a big sudden bleed at about the 9th day or whether she bled slowly over a period of time.

15. Cause of infection
Causes of infection in this context include multiple procedures, length of procedure, poor blood supply leading to tissue death, [and] haematoma. There is also the possibility that sterile technique was suboptimal at some point.

16. Simultaneous procedures
If suitably skilled surgeons are available, it makes sense to almost halve the length of the procedure. This seemed an appropriate thing to do in this situation.

17. Microvascular resources present
As already stated, such a vessel injury is very rare and it would not be reasonable to have a suitable surgeon on stand-by. The alternative is for this operation only to be done by surgeons with micro-vascular skills. This also seems unreasonable.

18. Information pre- and post-operatively
A description of the procedure and the roles of the two surgeons in that procedure would be the norm. She should have been informed about problems that may be encountered and the consequences of those problems. After the operation [Ms A] should have been told what had been done and any problems encountered.

[Dr C's] role as the junior member of the team should have been explained and that he was under the supervision of [Dr B].

Division of artery is part of the above account of what happened. [Ms A] should have been told what is likely to mean for the survival of her flap. Surgery to the back is part of the latissimus dorsi operation and hence an essential part of her briefing about the operation.

19. Cause of delayed healing and infection
This has been covered in the last section.

9. **Conclusion**
This is an unhappy story with an unexpectedly poor result. A number of factors contributed to the poor result and the morbidity [Ms A] suffered. There is no single act or event that caused the sequence of events that followed. Some aspects of [the Specialist Clinic] team approach to a complex problem such as this could benefit from review."

Plastic and reconstructive surgeon
The following expert advice was obtained from Dr Sally Langley, an independent plastic and reconstructive surgeon:

"I, Sally Langley, have been asked to provide an opinion to the Health and Disability Commissioner about the case of [Ms A], who underwent bilateral mastectomies and reconstruction with latissimus dorsi flaps and implants, on 5th December 2000, case number 02/10715.

I have read the guidelines for independent examiners and agree to follow them.

My full name is Sally Jane Langley. I am a registered medical practitioner having gained my medical degree from the University of Otago in 1980. I trained as a plastic and reconstructive surgeon in New Zealand and became a fellow of the Royal Australasian College of Surgeons in 1988. I worked as a fellow in hand and microsurgery in Louisville, Kentucky, USA, for six months in 1988 and as a fellow in plastic and reconstructive surgery in Oxford, United Kingdom, for a year in 1990. I have worked as a plastic and reconstructive surgeon in Christchurch since April 1990. My work is general plastic and reconstructive surgery with a significant workload of breast reconstructive surgery of all types. I work with plastic surgical colleagues and breast surgeons at Christchurch Hospital and in my private practice. I am involved with the training of registrars in plastic surgery. Breast reconstructions of all types following mastectomies are undertaken in my public and private practices.

I have read the instructions from the Commissioner and the supporting information. I also include the background of the complaint, all of which follow:

Purpose
To provide independent advice about whether [Ms A] received an appropriate standard of care from [Dr C] and [Dr B].

Background
[Ms A] had bilateral breast implants. She attended [the Specialist Clinic] in April 2000 concerned about a lump in her right breast. She had an ultrasound and it was thought that the lump was a fibroadenoma. She was also noted to have other benign appearing masses also in her left breast.

In October 2000 a core biopsy of the lump in her right breast was performed and ductal carcinoma-in-situ was diagnosed. [Ms A] was booked for a partial mastectomy; however, her partial mastectomy could not go ahead as planned, as a mammogram had not been performed. She had the mammogram which showed that there was widespread micro calcification, particularly in her right breast but also in her left breast (atypical ductal hyperplasia). [Ms A] was advised to have bilateral mastectomies with a simultaneous flap reconstruction of both her breasts.

[Dr B] and [Dr C] performed the surgery jointly on 5 December 2000. [Dr C] performed the mastectomy and reconstruction of [Ms A's] right breast and encountered no difficulty. However, [Dr B] inadvertently divided the latissimus dorsi vessel in [Ms A's] left breast. He elected to not repair the vessel and proceeded with the mastectomy and the reconstruction.

[Ms A] remained in [the Private Hospital] for nearly a week and suffered from a low blood count. She was discharged home and two days later (nine days after the surgery) she collapsed with a haemorrhage. She was admitted acutely to [the Public Hospital] with a large haematoma in her back. [Dr C] re-admitted [Ms A] to [the Private Hospital] and operated on her back and removed the haematoma.

Post-operatively [Ms A] experienced delayed healing and infections, particularly of her left breast. She had to have further surgery to debride the breast. Her implant and surrounding tissue and muscle had to be removed.

[Ms A] was unhappy with her right breast reconstruction (which was sited too low). In respect to her left breast, [Dr B] advised her to have a breast expander with a view to an implant being inserted later. However, [Ms A] was unhappy with this advice and sought a second opinion from a plastic surgeon, who advised against this strategy as he felt [Ms A's] skin flaps were too thin and would not support an implant. He recommended an abdominal muscle transfer. [Ms A] transferred her care to this plastic surgeon.

[Ms A] advised that she was not told at any stage by either [Dr C] or [Dr B], that a vessel had been severed during the original surgery. [Ms A] advised that her understanding was that she had a bleeding problem of unknown cause which was complicating her recovery.

Complaint

[see pages 1-2]

Supporting Information

- Response and medical records forwarded by [Dr B] marked 'A' (1-97)
- Response from [Dr C] marked '8' (98-100)
- Medical records from [the Private Hospital] marked 'C' (101-179)
- ACC file marked 'D' (180-312)
- Medical records from [the Public Hospital] marked 'E' (313-344)

- [Ms A's] letter of complaint and supporting information from ACC and relevant medical records marked 'F' (345-444)
- Transcript of interview with [Ms A and Mr A] marked 'G' (444-459)
- Medical records from [Dr J] marked 'H' (460-508)
- Medical records from [Dr I] marked 'I' (509-540)
- Medical records from […] marked 'J' (541-547)
- Information supplied by [Dr D] marked 'K' (548-551)
- Expert advice provided by a general surgeon Dr John Simpson marked 'L' (552-558)
- Photographs of [Ms A] marked 'M'
- Letter and paper sent by [Dr B] 19/01/2004

I will address each complaint as listed by the Commissioner.

To advise the Commissioner whether, in your professional opinion, [Dr B] and [Dr C] provided services to [Ms A] with reasonable care and skill.

Dr C

- In relation to [Dr C's] pre-operative consultations, surgery and follow-up, please advise on the expected standards and whether these standards were met.
- Please comment on the standard of [Dr C's] reconstruction of [Ms A's] right breast.
- Does [Dr C] have the appropriate qualifications and experience to perform the breast reconstruction surgery?
- Please comment on [Dr C's] treatment of [Ms A's] left breast infection. Was it timely and adequate in the circumstances?
- [Dr C] operated to remove a large haematoma from [Ms A's] back nine days following her original surgery. Please advise what was likely to have caused this haematoma.
- What damage does a haematoma cause?

- ***In relation to [Dr C's] pre-operative consultations, surgery and follow-up, please advise on the expected standards and whether these standards were met.***

In relation to [Dr C's] pre-operative consultations re investigations and management of breast disease I am not able to comment. As a plastic and reconstructive surgeon I do not have expertise in the management of benign and malignant breast disease. The pre-operative consultations with respect to breast reconstructive surgery were undertaken by [Dr B].

The expected standards of pre-operative, surgical and follow-up care would be as generally apply to all medical care and are as follows: thorough history, examination, investigations, appraisal of such, review by multidisciplinary team if appropriate (patient not present), more than one consultation with treating physicians/surgeons, presence of relative or friend, support to gain second opinion, access to information, discussion about complications outcome and post-op care, surgery performed to an acceptably high standard at an institution that meets standards, follow-up by treating surgeon or

delegated colleague in hospital and at clinic, review of results of surgery in all aspects (histology, need for other treatments, aesthetic outcome).

I consider that [Dr C] did meet expected standards of care.

- ***Please comment on the standard of [Dr C's] reconstruction of [Ms A's] right breast.***

[Dr C] seems to have performed his right sided surgery satisfactorily. A reasonable but not perfect breast mound has been achieved. I have viewed the photographs of [Ms A's] right breast reconstruction and consider it is acceptable but is short of being ideal. There is looseness and blunting of the inframammary fold. A revisional operation should improve it though that also is not always satisfactory and carries with it a risk of surgical complications. It is not unusual to have a shortfall in the quality of the result. The patient's perception of the result may be affected by circumstances such as here. The definition of the inframammary fold is partly related to how the mastectomy is done.

- ***Does [Dr C] have the appropriate qualifications and experience to perform the breast reconstruction surgery?***

[Dr C] had temporary registration with the New Zealand Medical Council to work as a specialist in general surgery in the employment of [the Specialist Clinic] subject to supervision by [Dr B] for one year 01/04/2001 to 01/04/2002. His role in [Ms A's] surgery was as a supervised surgeon. It is appropriate to undertake much of the surgery himself as has been the case here. Supervision does not need to be direct and [Dr B] was there doing the same surgery. Both were available to assist each other. [Dr B] was present to deal with any problems [Dr C] may have had with the operation. [Ms A's] follow-up seems to have largely been with [Dr B].

[Dr C] is a fully trained general surgeon who has done two attachments in breast surgery overseas, April 1997 to September 1997 and October 1998 to September 1999 during his training. I see no evidence in his curriculum vitae that he has had more than minor experience in reconstructive surgery. There is no further qualification required for [Dr C], a general surgeon with an interest in breast surgery, to practise breast reconstructive surgery. Working with an experienced breast surgeon such as [Dr B] for one to two years should have been giving him some working experience, akin to a fellowship. Therefore I must say that [Dr C] has all the qualifications required to practise breast reconstructive surgery, on his own, but probably not the experience. He was working supervised which should be the ideal teaching situation.

- ***Please comment on [Dr C's] treatment of [Ms A's] left breast infection. Was it timely and adequate in the circumstances?***

[Dr C's] treatment of [Ms A's] breast infection was appropriate. [Dr B], [another Specialist Clinic doctor], and nurses at [the Specialist Clinic] were also involved. It seems that [Dr C] was involved with [Ms A's] follow-up appropriately as part of [the Specialist Clinic] team. When [Ms A] was admitted to [the Public Hospital], [Dr C] was

contacted and responded appropriately. I was surprised to read that it was [Mr A] who contacted him rather than any of the staff at [the Public Hospital]!

- ***[Dr C] operated to remove a large haematoma from [Ms A's] back nine days following her original surgery. Please advise what was likely to have caused this haematoma.***

The haematoma will have developed because of a bleed from either a blood vessel or multiple sites of ooze. This may have been one big bleed or a slow ooze over days. Often no specific bleeder is found. The active bleeding is likely to have stopped due to time and pressure before the surgery to evacuate it.

- ***What damage does a haematoma cause?***

A haematoma causes damage in several ways. The blood loss may be enough to cause a drop in the blood pressure and hypovolaemia with poor perfusion of all parts of the body including the surgical area. The haematoma causes pain and anxiety to the patient. Pressure can be exerted by the haematoma on adjacent tissues compressing the blood supply and this is even more likely if the blood pressure is low. There is usually a need for blood transfusions, anaesthesia and surgery, all with risks. Hypovolaemia can cause the patient to collapse and trauma can be caused as the person falls. A further injury can be sustained to the body including the operated area(s).

[Dr B]

- In relation to [Dr B's] pre-operative consultations, surgery and follow-up, please advise on the expected standards and whether these standards were met.
- Please advise whether [Dr B] was appropriately experienced and qualified to perform the reconstruction and mastectomy of [Ms A's] left breast.
- Was [Dr B] suitably qualified and experienced to supervise [Dr C] in breast reconstruction operations?
- Please comment on the standard of [Dr B's] surgery at [the Private Hospital] when he performed the left breast mastectomy and reconstruction.
- Was [Dr B's] decision to not repair the latissimus dorsi vessel reasonable in the circumstances? In particular, should he have sought the assistance of a microvascular surgeon?
- Given [Dr B's] decision to not repair the latissimus dorsi vessel, should he have continued with the surgery?
- Was [Dr B's] treatment of [Ms A's] left breast infections timely and adequate in the circumstances?
- Was [Dr B's] recommendation that [Ms A] have a breast expander inserted in her left breast appropriate advice in the circumstances?

- ***In relation to [Dr B's] pre-operative consultations, surgery and follow-up, please advise on the expected standards and whether these standards were met.***

The expected standards are the same for [Dr B] as for [Dr C] listed above.

[Dr B] is documented to have appropriately managed [Ms A] at pre-operative consultations.

Follow-up care by [Dr B] has mostly been satisfactory. He and other members of his [Specialist Clinic] team were involved. I consider that [Ms A] was kept waiting too long before undergoing surgical debridement of the infected dead flap and implant. Unfortunately the surgeon involved can lose sight of the correct picture in the hope that the infection would go away and tissues would settle. [Ms A] would have returned to reasonable physical health sooner if the infected dead tissue had been debrided sooner. I don't think she would have had any less tissue removed.

- ***Please advise whether [Dr B] was appropriately experienced and qualified to perform the reconstruction and mastectomy of [Ms A's] left breast.***

[Dr B] is appropriately experienced to perform the mastectomies and latissimus dorsi reconstructions. He should have microvascular expertise or access to someone who has for these situations.

- ***Was [Dr B] suitably qualified and experienced to supervise [Dr C] in breast reconstruction operations?***

[Dr B] was suitably qualified to supervise [Dr C] in most aspects of breast reconstructive surgery. [Dr B] performs only some of the techniques available to reconstruct breasts. If patients need or request some of the other techniques he calls in the services of a plastic surgeon. With [Dr B's] vast experience of several hundred latissimus dorsi breast reconstructions, I consider he knows the technique well and would be able to demonstrate and teach it. It is only the specific complication that occurred here (division of thoracodorsal trunk) that is the shortfall. [Dr B] has knowledge of using the serratus branches of the thoracodorsal artery and vein with retrograde flow to give the flap its blood supply if the main trunk of the thoracodorsal vessels is absent or ligated. There are references in books and journals that say that it can be done. [Dr B] has provided several references. However several series of latissimus dorsi breast reconstructions have an incidence of flap loss which must be due to lack of adequate blood supply after damage or maybe traction to the main thoracodorsal trunk. Really very few cases of successful use of latissimus dorsi flap based on the serratus branch after immediate division have been reported.

- ***Please comment on the standard of [Dr B's] surgery at [the Private Hospital] when he performed the left breast mastectomy and reconstruction.***

There is the concern with the surgery that [Dr B] did not take different action when the thoracodorsal vessels were damaged. I consider that in modern times an effort should be made to repair the damaged vessels, either by micro surgically suturing tears, or dividing and repairing the artery and vein. This would change the latissimus dorsi flap from a pedicled to a free microvascular flap which would normally have about a 95% chance of survival. A microscope, though it gives the best magnification to repair the

vessels, is not necessarily required since the thoracodorsal vessels are not tiny. Magnifying loupes, microvascular clamps and instruments, sutures, and heparin along with expertise are required. I consider that these days the surgeon should have the equipment available and the skills. It is a second rate hope that the latissimus dorsi flap would survive on the branch to serratus anterior despite papers supporting it. Latissimus dorsi flap survival on this serratus branch is cited in the literature. This is more likely to apply to those patients who have had the thoracodorsal divided some time (probably years) earlier, i.e. the previous division acts as a 'delay' phenomenon. Though cases are recorded to have survived, one would not know the percentage of complete survival, or partial or total failures. However, put in this situation, some surgeons would be obliged to see how the latissimus dorsi goes on the serratus branch since the skills to micro surgically repair are not there. The paper by Fisher, Bostwick and Powell, 1983 documents adequate retrograde blood flow through the serratus branch in a primate model and patients. [Dr B] considered that the flap had adequate blood supply during surgery. It is possible that the venous drainage was not adequate and the effect of that would be slower to evolve, many days, with oozing from a venous congested flap causing a bruising and then a haematoma.

- ***Was [Dr B's] decision to not repair the latissimus dorsi vessel reasonable in the circumstances? In particular, should he have sought the assistance of a microvascular surgeon?***

I have already commented above that I consider [Dr B] did not act appropriately when he damaged the thoracodorsal vessels. All other aspects of the surgery seem appropriate.

Though I have said the thoracodorsal vessels should have been repaired, knowing that [Dr B] could not do that, he should have made some effort to call a microvascular surgeon. It is unlikely that one would have been able to come.

- ***Given [Dr B's] decision to not repair the latissimus dorsi vessel, should he have continued with the surgery?***

Despite the division of the thoracodorsal vessels, [Dr B] was obliged to continue with the surgery. He had already taken the flap from the back to the front. The flap was already only attached minimally, probably only by the serratus branch. He has documented that initially the perfusion was suboptimal but later thought it was good. He comments about bleeding from the flap. Though this may have been 'normal' blood flow, there is the possibility the flap was bleeding because of poor venous drainage. Without endeavouring to convert the flap to a free flap, he was obliged to see how it went rather than waste it. There would have been no value in placing the flap back in its original position in the back.

- ***Was [Dr B's] treatment of [Ms A's] left breast infections timely and adequate in the circumstances?***

It is difficult to judge whether [Dr B's] treatment of [Ms A's] left breast infection was appropriate. Wound care and antibiotics are likely to have been appropriate. Unfortunately the only definitive treatment for infected dead tissue surrounding a foreign body (implant) is debridement of dead tissue and removal of the implant. Until that was done [Ms A] could not get better. Therefore there was some time delay.

- ***Was [Dr B's] recommendation that [Ms A] have a breast expander inserted in her left breast appropriate advice in the circumstances?***

The recommendation by [Dr B] that [Ms A] should have a tissue expander breast reconstruction on the left was inappropriate. Again I think [Dr B] was hoping he would be able to remedy the situation himself with the only other method available to him. Her skin flaps and chest muscles would certainly have been inadequate for the tissue expansion method. The history of infection means an implant technique should be far less likely to be considered unless combined with another muscle to cover it. Support for the expander/implant advice by [Dr B's colleague overseas] is unfortunate. [Ms A] has subsequently undergone a method of reconstruction appropriate in these circumstances but it is a difficult undertaking also with risks.

In general:

- [Ms A] was not booked in for a mammogram prior to her partial mastectomy. Please comment on the appropriateness of this. Please also advise who had responsibility to make this booking.
- What caused [Ms A's] delayed healing and ongoing bleeding problem? What caused [Ms A's] left breast infections?
- Please comment on the appropriateness of [Dr B] and [Dr C] performing two breast procedures simultaneously.
- Please comment on the appropriateness of this operation being performed without microvascular resources in place.
- What information would you expect [Ms A] to have been provided with before and after her surgery on 5 December 2000? Please make specific reference to:
  – Whether [Ms A] should have been informed that [Dr C] would be solely performing the right breast reconstruction? If so, who by?
  – What she should have been told about the division of her latissimus dorsi vessel during the surgery on 5 December 2000? When?
  – What information should [Ms A] have been given about the surgery to her back? When should she have been told this information and whose responsibility was it to provide this information?
  – What information she should have been given as to what was causing her delayed healing and infections? At what point should she have been told and by whom?

- ***[Ms A] was not booked in for a mammogram prior to her partial mastectomy. Please comment on the appropriateness of this. Please also advise who had responsibility to make this booking.***

I am not qualified to comment on whether [Ms A] should have had a mammogram prior to partial mastectomy.

- ***What caused [Ms A's] delayed healing and ongoing bleeding problem?***

The cause of [Ms A's] delayed healing would be related to partially or totally ischaemic left latissimus dorsi flap. Dead tissue becomes infected. Good wound care and antibiotics can seem to treat the infection and wound but if there is dead tissue around an implant there is no other management than debridement and removal of implant possible. The poor healing would be partly related to the haematoma and its sequelae but that is unlikely to be the main cause.

[Ms A] suffered some bleeding at the time of her initial surgery and some ongoing losses post-operatively. This does not seem unusual after this operation. She suffered a haematoma at day 9. This is unfortunate but can occur. No bleeding point was found which is often the case with a haematoma. It does not sound as though [Ms A] had a coagulopathy and I found no record of impaired coagulation. I do not think she had ongoing blood loss. She had moderately large blood loss with initial surgery and major with the haematoma. It is possible that some haematoma near the implant and axilla was still present and slowly liquefied causing fluid drainage and blood clot extrusion. There is no answer as to why [Ms A] bled secondarily. As I have said above, it is possible that the latissimus dorsi flap was venous congested and constantly oozing venous blood. If that was the case, the haematoma would have been developing slowly. [Ms A's] haemoglobin could have been lower than usual because of ongoing ooze from the flap. I am not sure whether that would have been the situation.

Many women having breast reconstructions, which are big operations, have post-operative haemoglobin that become lower after several days, sometimes requiring blood transfusion. Many women are cared for with quite low haemoglobin knowing that they will build it up over a few weeks since only women in good health have this operation.

- ***What caused [Ms A's] left breast infections?***

It is not possible to say what caused the infection. It is likely to be related to having ischaemic tissue and also residual blood clot and fluid. There is an incidence of infection with clean surgery in the order of 5%. This incidence is possibly higher for long operations with extensive dissection and involving an implant. Infections are thought to come from one of several sources: the patient, the environment, medical staff. The 'inoculation' may be at the time of surgery or from later interventions.

- ***Please comment on the appropriateness of [Dr B] and [Dr C] performing two breast procedures simultaneously.***

It was appropriate for [Dr B] and [Dr C] to perform the surgery to both sides simultaneously in a healthy woman. This is a major undertaking and should ideally be done with two teams as was the case here. It would be safer to do the surgery on one side at a time but that does need two operations and periods of time to recover.

- ***Please comment on the appropriateness of this operation being performed without microvascular resources in place.***

I consider that these days, if there is a risk of a significant alteration to the outcome of the surgery as was the case here, microvascular resources should have been available. This is a far-reaching comment since many breast surgeons will not have microsurgical skills and the risk of damage to the thoracodorsal vessels is small in the order of 1 %. A plan should be made to deal with this situation as there is occasionally for an orthopaedic surgeon who damages an artery during bone or joint surgery.

- ***What information would you expect [Ms A] to have been provided with before and after her surgery on 5 December 2000? Please make specific reference to:***

  – Whether [Ms A] should have been informed that [Dr C] would be solely performing the right breast reconstruction? If so, who by?
  – What she should have been told about the division of her latissimus dorsi vessel during the surgery on 5 December 2000? When?
  – What information should [Ms A] have been given about the surgery to her back? When should she have been told this information and whose responsibility was it to provide this information?
  – What information she should have been given as to what was causing her delayed healing and infections? At what point should she have been told and by whom?

[Ms A] was presented with what seems all appropriate information prior to surgery. [Ms A] knew [Dr C] and that he was involved with the surgery. Also she knew that [Dr B] was the surgeon primarily responsible for her care. I do not think that [Ms A] had to have an explanation about the details of [Dr C's] role. I consider [Dr C] was working in a similar capacity to a registrar in advanced surgical training.

[Ms A] should have been told about the division of the main blood vessels to her reconstructive flap and the possible consequences. [Dr B] says he informed her the next day but [Ms A] says she did not know until she investigated her case. Ideally [Dr B] should have explained the incident within days of surgery when [Ms A] could understand and remember and again at follow-up, and particularly in the context of flap failure. He may have done that.

The question has been asked about what information [Ms A] should have been given about the surgery to her back. I presume this applies to explorations and the drainage of

haematoma. She should have had the haematoma explained prior to drainage and again while recovering from that surgery. Any queries she made should have been discussed. The haematoma is a major incident but does not need a lot of explanation. [Dr C] who was involved at that time should have explained about the haematoma and is likely to have done so.

When [Dr B] realized that there was dead flap tissue and infection, he should have explained this to [Ms A] and may have. He should have explained the link between dead tissue and infection and that it would not settle without surgical debridement and removal of the implant. I cannot tell from the documents sent what [Ms A] was told by [Dr B] and when.

Conclusion

I have reviewed the case of [Ms A] and aspects of her care by [Dr B] and [Dr C]. Her poor outcome, failed left breast reconstruction secondary to division of thoracodorsal vessels, haematoma, and infection, is most unfortunate. All methods of breast reconstruction carry a significant risk of major complications as have occurred here. Usually latissimus dorsi flap with implant (compared with TRAM flap and tissue expander/implant) would carry the lowest risk. Having both sides operated on at one sitting certainly adds to the risks to the patient. Bilateral mastectomies and reconstructions would take a minimum of 5 hours and more likely 7-8 hours.

…

References:

Fisher, J., Bostwick, J III, Powell, RW. latissimus dorsi blood supply after thoracodorsal vessel division: The serratus collateral. Plast Reconstr Surg 72:502, 1983

Shigehara, Takeo et al. A reversed-flow latissimus dorsi musculocutaneous flap based on the serratus branch in primary shoulder reconstruction. PRS 99:566-569, 1997."

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

…

e) Any other information required by legal, professional, ethical, and other relevant standards; …

Opinion: No breach – Dr C

Preoperative assessment
Ms A complained that Dr C did not fully assess her clinical situation prior to the arrangement for a partial right mastectomy scheduled for 26 October 2000, and specifically overlooked the need for a preoperative mammogram. Because the mammogram was not performed, the surgery had to be postponed.

Between February 2000 when Ms A was referred by Dr J to the Specialist Clinic and 26 October 2000 when she was scheduled for a partial mastectomy, Ms A was seen by a number of doctors at the Clinic. On 29 April she saw Dr D, a breast and general surgeon, who examined her and performed an ultrasound. On 12 May she was jointly reviewed by Dr D and Dr E, a breast physician, who arranged a review of their clinical and imaging findings at the Clinic's multidisciplinary team meeting which took place later that month. On 16 October Ms A saw Dr F, another breast physician, who performed an ultrasound and core biopsy, which revealed DCIS in the right breast. The findings were discussed with Dr C, who saw Ms A on 19 October and recommended that she have a partial right mastectomy and D-wire excision of a papillary lesion in the right breast. The surgery was scheduled for 26 October. When Ms A presented for surgery on 26 October, it was noted that a preoperative mammogram had not been done. Surgery was postponed and a mammogram promptly performed to establish a clearer picture of the underlying pathology.

The mammogram showed widespread calcification. Subsequent radiological review and mammotome biopsy, promptly arranged by Dr C, resulted in a recommendation for more extensive surgery (bilateral mastectomy).

Dr John Simpson, my general and breast surgical advisor, stated that Ms A "most definitely" required a mammogram as part of her preoperative assessment. Although it was not performed in the period leading to the surgery, its omission was recognised in time and, notwithstanding any distress caused to Ms A, did not result in any inappropriate surgery.

Dr Simpson noted that Ms A's preoperative assessment was fragmented and involved several doctors, including Dr C. He stated: "I would expect all the doctors who had seen her to be looking out for a mammogram result and would not limit the responsibility to a single individual." In that regard "this makes it difficult to assess the adequacy of the actions of individuals". Although the omission of the preoperative mammogram was unfortunate, neither Dr Simpson nor Dr Sally Langley, my plastic and reconstructive surgical advisor, could identify any relevant standard that has not been met. Accordingly, in my opinion, Dr C did not breach the Code with regard to Ms A's preoperative assessment, including the inadvertent omission to perform a mammogram earlier.

Right breast reconstruction

Ms A complained that on 5 December 2000 Dr C did not perform an adequate reconstruction of her right breast. She was not happy with the cosmetic result.

Preoperatively Ms A appears to have been provided with different information about the postoperative symmetry of her breasts. Whereas Dr B told her that because two surgeons would be operating in tandem, breast symmetry would be ensured, Dr C stated that Ms A understood that excision of the DCIS would leave her breasts somewhat asymmetrical.

On 5 December 2000 Ms A underwent a bilateral mastectomy and bilateral latissimus dorsi flap reconstruction with implants. The breasts were operated on in tandem with Dr B operating on the left breast and Dr C on the right one. According to Dr C, the surgery to the right breast was uneventful and he was of the view that a good cosmetic result was obtained.

However, in the postoperative period Ms A became aware that that her right breast was lower than the left one. This was acknowledged by Dr C at the 8 January 2001 consultation. Ms A's dissatisfaction with the size of her right breast was noted by Dr B at the 1 February consultation, when she was told that symmetry would be restored by replacing the implant in her left breast with a larger implant. When he saw her on 5 March, Dr C commented that although the left breast was "a little low and lacks some projection", it was "essentially fine". On 7 June Dr B noted "some ongoing problem with respect to some tightness and discomfort" in the right breast and on 16 August despite "still a little too much ptosis [drooping]", Ms A was "almost 90% happy" with the reconstructed right breast.

However, Ms A remained unhappy about the outcome of her surgery (left and right breast reconstructions), and on 19 September 2001 consulted Dr I, a plastic and reconstructive surgeon, for a second opinion. Dr I and Dr B's colleague overseas who was asked for advice on this case, observed that the right implant reconstruction and the inframammary fold were low.

My advisors, Dr Simpson and Dr Langley, considered that the reconstruction of Ms A's right breast by Dr C was less than ideal. Dr Simpson commented that in the context of bilateral reconstruction, achieving perfect position and symmetry is often difficult. It was not achieved in Ms A's case and according to Dr Simpson, the reconstruction was "less than

totally satisfactory …. It was not a total failure but certainly and quite reasonably, did not meet [Ms A's] expectation." Dr Langley commented that "a reasonable but not perfect breast mound has been achieved. … it is acceptable but is short of being ideal. … It is not unusual to have a shortfall in the quality of the result." Despite the less than ideal result, Dr Simpson and Dr Langley were of the view that the reconstruction appeared to have been performed appropriately. Respectively, Dr Simpson and Dr Langley stated that "it was probably just at an acceptable standard for a surgeon of Dr C's experience" and that he "seems to have performed his right sided surgery satisfactorily". owever, Dr Simpson questioned Dr C's claim that the initial result of the surgery to the right breast was successful and doubted that what happened to the breast subsequently was beyond his control.

Having considered all the facts and my expert advice, I am satisfied that despite the less than ideal cosmetic result, the surgery to the right breast was performed appropriately and that Dr C did not breach the Code.

Qualifications and role in breast reconstruction
Ms A complained that Dr C did not have the appropriate expertise and qualifications to perform breast reconstruction. She also complained that Dr C misinformed her about his role in the surgery – he informed her that he would only be assisting Dr B with the surgery, and did not tell her that he would be responsible for the reconstruction of her right breast.

Dr C is an overseas-trained breast and general surgeon who, in December 2000, held temporary registration with the Medical Council of New Zealand. Under the temporary registration Dr C was permitted to practise medicine as a specialist in general surgery in the employment of the Specialist Clinic under the supervision of Dr B. My advisors, Dr Simpson and Dr Langley, commented that Dr C was working in a similar capacity to that of a registrar in advanced surgical training in a New Zealand hospital.

Dr C confirmed his temporary New Zealand registration status and the restrictions on his practice. His role was that of a "junior surgeon working under supervision and direction of the senior surgeon". Dr C felt that it was entirely appropriate for him to advise Ms A that he was assisting Dr B during the surgery. My advisor, Dr Simpson, concurred with this view.

Dr Simpson was of the opinion that "[Dr C's] role as the junior member of the team should have been explained to [Ms A] and that [Dr C] was under the supervision of [Dr B]", who was responsible for Dr C's actions. In this context and "as the senior surgeon it was probably [Dr B's] job to inform [Ms A] about division of responsibility". Nevertheless, Ms A was informed by Dr C of his junior role and the explanation was "fairly accurate". Dr Langley, on the other hand, commented that Ms A knew that Dr B was the surgeon primarily responsible for her care and did not think that Ms A "had to have an explanation about the details of [Dr C's] role". She considered that Ms A was provided with appropriate information.

The role confusion, or lack of clarity, may have been caused by Dr B's reference to Dr C as Ms A's "primary surgeon" and comment that overseas he was recognised as a breast specialist. My advisor, Dr Simpson, observed that Dr B "appears to portray [Dr C] as an independent contractor who was trained to perform such procedures". This was at odds with Dr C's experience, temporary and conditional New Zealand registration and Dr C's description of himself as a junior surgeon. Nevertheless, my advisors agreed that although Dr C could not be described as a trained breast reconstruction surgeon, as a general surgeon with an interest in breast surgery he was adequately trained to perform breast reconstruction surgery under the supervision of a suitably trained surgeon. Dr B was such a surgeon, in attendance and with supervisory responsibility for Dr C's actions.

I am satisfied that Dr C was adequately trained to perform the breast reconstruction under supervision. I agree with Dr Simpson that Ms A was entitled to an explanation of the role that the two surgeons would undertake during her surgery. I am concerned about the adequacy of the explanation Ms A received (see my comments on page 54), but I do not consider that any shortcomings were Dr C's responsibility. Accordingly, in my opinion, Dr C did not breach the Code in relation to these matters.

Follow-up care and explanation of haemorrhages
Ms A complained that Dr C did not provide her with a full and accurate explanation for the cause of the haemorrhages she suffered on 5 and 14 December 2000, and the delayed healing in her left breast. She also complained that Dr C did not adequately treat the infection in that breast.

Although Dr C was involved in Ms A's preoperative assessment and subsequent surgery, Dr B was the surgeon primarily responsible for her care. Other staff at the Specialist Clinic also provided an input into her postoperative care, including the multidisciplinary panel.

The first haemorrhage occurred intra-operatively on 5 December 2000 when the thoracodorsal vessels were inadvertently damaged during the rotation of the latissimus dorsi flap. The complication related to Ms A's left breast, which was operated on by Dr B, not Dr C. It was Dr B who elected not to anastomose the damaged blood vessels to the muscle flap.

On 11 December 2000 Ms A was discharged from hospital with a haemoglobin of 90 g/L. Dr Langley advised me that this was not out of the ordinary and that many women having breast reconstructions have postoperative haemoglobin that becomes lower after several days. Many women are cared for with quite low haemoglobin knowing that they will build it up over a few weeks, since only women in good health have this operation.

Ms A alleged that at no time did Dr C or Dr B inform her of the intra-operative mishap or (later) that her poor recovery (infection and subsequent flap failure) was related to that event. Mr A stated that the day after the surgery, on 6 December 2000, he and his wife were told by Dr C that the operation went "OK", that the side operated on by Dr B (the left breast) was "a bit slower", that they had "lost a little bit of tissue", and that the loss of tissue sometimes happened. He said that Dr C was happy with the outcome and commented that

"everything will be fine". Nothing was said about damage to the blood vessels. They learnt of the damage and the decision by Dr B not to repair the blood vessels at the time when they received documentation from ACC after lodging their medical misadventure claim.

There is no information to substantiate Dr B's claim that the day after the operation he explained to Ms A "exactly what had occurred on each side and in particular the artery and vein had been divided high in the axilla", that "there was a double blood supply to the muscle and that the second blood supply looked very satisfactory at the time of surgery". In his response Dr C stated:

> "I am amazed to learn that [Ms A] was unaware as to the underlying cause of the problem on the left side. In my discussions with [Dr B] it was certainly my impression that he had fully informed [Ms A] during their postoperative / follow-up consultations.
>
> I completely refute the allegation that I withheld full and accurate disclosure. I clearly recollect my operative note detailing accidental division of the vascular pedicle on the left side by [Dr B]. It has also been my policy to copy all operative notes to the patient's GP. Not the actions of someone intent on withholding information."

The second haemorrhage occurred on and in the period leading to 14 December 2000, the day Ms A was scheduled for a first postoperative review by Dr C. Although the cause and location of this haemorrhage, and the length of time over which the haematoma developed, was uncertain, a combination of factors have been considered as the likely causes. They include tissue necrosis and infection resulting from impaired blood and venous congestion (the consequence of intra-operative damage to the thoracodorsal vessels) and the presence of foreign material (breast implant). Dr C reviewed Ms A following her admission to the Public Hospital on 14 December, aspirated blood from the wound and arranged her transfer to the Private Hospital where he performed incision and drainage of the haematoma the following day.

Mr A acknowledged that on 14 December 2000 Dr C described his wife's haemorrhage as a secondary bleed unrelated to the breast and as a recognised complication of this type of surgery. Mr A also acknowledged that he and his wife accepted that explanation at the time.

No definite answer was found for the secondary bleed Ms A suffered. Dr Langley commented that the haematoma would have developed because of a bleed from either a blood vessel or multiple sites of ooze. There may have been one big bleed or slow ooze over a period of days. In such cases a specific bleeder is often not found and in this case active bleeding is likely to have stopped due to time and pressure created by the haematoma. Dr Simpson too was uncertain whether Ms A had a large sudden bleed on or about 14 December 2000 or bled slowly over a period of time. He stated that the bleeding could have resulted from a small vessel in the back that did not bleed at the time it was divided but bled days later, or may have been associated with necrosis of the muscle flap caused by poor blood supply resulting from the ligation of the main feeder vessel.

Dr Langley considered that Dr C responded appropriately when contacted and informed that Ms A had been admitted to the Public Hospital. She commented that Dr C should have explained the haematoma to Ms A prior to drainage and again while she was recovering from its incision and drainage. Any queries should have been discussed with her. Dr Langley also commented that "the haematoma is a major incident but does not need a lot of explanation. [Dr C] who was involved at that time should have explained about the haematoma and is likely to have done so."

Given the uncertainty as to the exact cause and location of the bleed and in light of other comments made by my advisors, it appears that the explanation provided by Dr C at the time of admission and in the immediate postoperative period (while in the Private Hospital) was reasonable.

The first signs of infection were noted at the time of Ms A's discharge from the Private Hospital on 17 December 2000 when she was commenced on antibiotics (Augmentin). The infection was primarily in the left breast, which had been operated on by Dr B. Almost all the consultations leading to the removal of the left breast implant on 15 January 2001 and the subsequent monitoring and management of the wound were undertaken by Dr B. This is consistent with Dr C's claim that the responsibility for postoperative care and follow-up lay with Dr B and, as noted by Dr Simpson, is evidenced by the letters Dr B wrote over that period.

Although the infection was primarily in the left breast, on 8 January 2001 Dr C noted Ms A's concern about an area of erythema on the interior aspect of the right breast, which he felt represented inflammation, possibly caused by a "transient reaction" to the implant, rather than an infection. Dr Simpson commented that although it was not clear from the documentation how the responsibility for follow-up care was allocated, with regard to infection management, his main concern was that Dr C "was perhaps slow in detecting the infection". Dr Simpson felt that inflammation was an unlikely explanation for the redness and that an infection was a more likely cause. However, Dr Langley noted that Dr B, another doctor from the Specialist Clinic and the nurses at the Specialist Clinic were all involved in the management of Ms A's infection and that Dr C's involvement, as part of the Specialist Clinic team, was appropriate. She considered that Dr C met the expected standard of care. Overall, I am satisfied that Dr C's management of Ms A's infection was reasonable in the circumstances and that he did not breach the Code.

With regard to information disclosure, Dr B was the surgeon primarily responsible for Ms A's surgery and the information conveyed to her in the preoperative and postoperative period. However, Dr C also provided information to her. In particular, on the day following surgery Dr C is said to have informed Ms A that the operation went "OK", that the surgery performed by Dr B was "a bit slower", that they had "lost a little bit of tissue", and that the loss of tissue sometimes happens. Dr C is said to have been happy with the outcome and commented that "everything will be fine".

I commend Dr C on his endeavours to be open about the complication during surgery. However, it is clear that his discussion was not sufficient and left Ms A unclear about what

happened and its significance. In my view, Dr C should have had a careful and full discussion about the complication with Ms A and/or facilitated a meeting between Dr B and Ms A to discuss the matter. I draw this matter to his attention for his future practice.

Opinion: Breach – Dr B

Damage to an artery during surgery
Ms A complained that during the surgery on 5 December 2000 Dr B damaged an artery in her left breast and did not take appropriate corrective measures to repair the damaged artery or seek the assistance of a microvascular surgeon.

Dr B stated that the most complicated stage of the type of surgery Ms A underwent was the dissection of the latissimus dorsi artery and vein and the rotation of the muscle through the axilla. Dr B acknowledged that during this procedure he inadvertently damaged the latissimus artery and vein. According to Dr Simpson the division of the artery was a serious event and one that would be regarded as a departure from the standard expected of a surgeon of Dr B's experience. However, he was not overly critical of Dr B and felt that the error needed to be put in context.

To control the intra-operative bleeding Dr B elected to divide and ligate the damaged vessels with the knowledge that this is known to affect blood supply to the flap. Dr B observed that there was "excellent" blood supply to the flap from the serratus anterior artery and vein, and considered the flap to be "absolutely viable". The operation note completed by Dr C, on the other hand, stated that although the perfusion from the serratus branch was reasonable, it was suboptimal.

Although Dr Simpson questioned whether Dr B should have continued with a flap reconstruction given the damage to the thoracodorsal vessels, Dr Langley was of the view that Dr B had no option but to proceed with the surgery. As he had already taken the flap from the back to the front, nothing was to be gained by placing the flap back in its original position in the back. The key issue was whether the blood supply to the flap from the remaining blood vessels was adequate or a repair of the damaged vessels was required.

There was some variance in opinion among the advisors about whether a repair of the damaged blood vessels should have been performed in this case. The plastic and reconstructive surgeons – my advisor, Dr Langley, and the ACC advisors – agreed that microvascular repair should have been performed or an attempt made to access a microvascular surgeon. However, my general and breast surgical advisor, Dr Simpson, was of the opinion that Dr B's decision to ligate rather than repair the damaged blood vessels was reasonable in the circumstances. He stated that "such a vessel injury is very rare and it would not be reasonable to have a suitable surgeon on stand-by". Dr Simpson felt that "in a perfect world a repair would have been attempted" but that "the logistics of getting a

surgeon and equipment to a private hospital in order to do such a repair might prove impossible". He was not critical of Dr B's response to the situation.

Dr Langley and the ACC advisors took a different view. Dr Langley considered that once damaged the thoracodorsal blood vessels should have been repaired. Knowing that he could not perform the repair, Dr B should have had a contingency plan for such eventualities, to access a microvascular surgeon and necessary equipment. If he had no such plan, he should at least have made an effort to access such a surgeon. There was no evidence that Dr B made such an attempt.

Although Dr Langley considered other aspects of Ms A's surgery to have been appropriate, she felt that Dr B's response to the damaged thoracodorsal vessels was not. An effort should have been made to repair the damaged vessels, either by microsurgically suturing the tears or dividing and repairing the artery and vein. By doing so the latissimus dorsi flap would have become a free microvascular flap with a chance of survival in the range of 95%. In her opinion it was "a second rate hope that the latissimus dorsi flap would survive on the branch to serratus anterior despite papers supporting it". Dr Langley noted that "these days, if there is a risk of a significant alteration to the outcome of the surgery as was the case here, microvascular resources should have been available".

Dr B, on the other hand, disputed the need for microsurgical repair of the damaged blood vessels, maintaining that the flap was well perfused at the time of surgery. He did not think that it was fair to solely attribute the failure of the flap to his ligation of the artery and the vein to the flap. He considered that the haematoma Ms A developed following the surgery on 5 December 2000 and the associated drop in her haemoglobin prior to 14 December 2000 contributed to the failure of the flap. He was also of the view that the failure of the flap would have occurred even if intra-operative microvascular anastomosis had been performed.

In summary, I acknowledge the divergent views of the advisors in this case in respect of the damage to a blood vessel during surgery. The question is whether Dr B performed the surgery with reasonable care and skill and in accordance with the standard expected of a breast and general surgeon in such circumstances.

While Dr Langley, and the ACC advisors were critical of the fact that Dr B did not perform microsurgical repair after the inadvertent division of the blood vessel, Dr Simpson was critical of Dr B for damaging the blood vessel. Dr Simpson considered Dr B's decision not to perform microvascular repair reasonable; Dr Langley did not comment on the damage to the blood vessel caused by Dr B.

Dr Simpson was clear in his view that "the division of the artery was a serious event and one that would be regarded as a departure from the standard that would be expected of a surgeon of [Dr B's] seniority". In his opinion Ms A had "a poor result and unexpected morbidity from what is normally a very safe and reliable procedure". Although the surgical complication of inadvertent division of a major feeding vessel to the flap was unusual, it was

related to the problem with the flap and the infection. The haemorrhage that resulted in Ms A's admission to the Public Hospital nine days after the operation may have been related to the blood vessel injury, but in Dr Simpson's opinion it would "almost certainly have contributed to the flap problems". This view was shared by Dr Langley.

Since Dr Langley and the ACC advisors are plastic and reconstructive surgeons whereas Dr Simpson is a general and breast surgeon, and therefore a peer of Dr B, his view carries greater weight as a matter of law. Accordingly, I consider that in damaging the blood vessel during surgery on 5 December 2000 Dr B did not exercise the care and skill expected of an experienced breast and general surgeon, and breached Right 4(1) of the Code.

Explanation of postoperative complications
Ms A complained that Dr B did not give her a full and accurate explanation for the cause of her haemorrhage on 5 and 14 December 2000 and subsequent delayed healing of her wound.

My expert advisors, Drs Simpson and Langley, were in agreement that preoperatively Ms A should have been informed about problems that might be encountered during surgery and their consequences. After the operation, she should have been told what had been done and what problems, if any, had been encountered. In this case, Ms A should have been told that the inadvertent division of an artery and vein had occurred and what implications it had for the survival of the flap. This was an essential part of her postoperative briefing about the operation.

Ms A stated that she was never told by Dr B about the intra-operative damage she suffered to her blood vessels on the left side and was not aware that the damage had occurred until after the ACC medical error finding in March 2002.

Dr B disputes Ms A's allegations. He claims that preoperatively he explained to Ms A the complications of reconstructive surgery including infection, bleeding, flap and implant failure, and the possible need for revision surgery, and that postoperatively he explained to her what had occurred during the operation. In particular, Dr B claims that the day after the operation (6 December 2000) he told Ms A and Mr A that one of the blood vessels to the left side latissimus dorsi flap had been transected at the time of surgery, that there was a double blood supply to the muscle, and that this double supply was more than sufficient (from his observation at the time of surgery) to supply blood to the area.

According to Mr A, Dr B was not on the ward round on 6 December 2000, which was attended only by Dr C and the anaesthetist. The extent of information provided by Dr C was that intra-operatively everything went "OK", the surgery to the left breast took longer than normal and that some tissue had been lost. Nothing was said about an artery being cut.

Dr Langley stated that Dr B should have explained to Ms A the inadvertent intra-operative division of the main blood vessel to her reconstructive flap and the possible consequences. Ideally this should have taken place within days of surgery when Ms A could understand

and remember what she was told, and again at follow-up appointments, particularly in the context of flap failure. When Dr B realised that there was dead flap tissue and infection, he should have explained to Ms A the link between dead tissue and infection and that it would not settle without surgical debridement and removal of the implant. Although he may have done so, no documentation was provided to determine what Ms A was told by Dr B or when.

I accept that the available documentation does not clearly state what Ms A was told by Dr B about the intra-operative events and their relationship to subsequent complications. As Dr Langley noted, "These were very important issues for [Ms A] and required detailed explanation by either or both of the surgeons." Ms A stated that she was never told what happened, although Dr B denies this.

In the absence of independent witnesses it is difficult the resolve the conflicting versions of events from Dr B and Ms A and her husband. However, on balance, I am inclined to accept that Dr B either did not explain the events or did not explain them in a way that Ms A and her husband could understand. I note that following the initial surgery Dr C was Ms A's primary contact and any explanations she sought were obtained from him. Dr C did not indicate that he informed Ms A of the intra-operative complications experienced on 5 December. He was under the impression that Dr B had done that himself. Given the significance of the event, the information given to the patient should have been documented. There is no evidence in the hospital notes that this occurred and no consultation notes from Dr B verify the discussion. Ms A's comments that she felt responsible for her wound not healing, and the length of time taken by Dr B to debride the wound and remove the implant on the left side, suggest a lack of acknowledgement on his part of the underlying reasons for the delayed healing, and that Ms A was unaware that the vessels supplying blood to her flap were damaged during surgery and that the resulting poor vascular perfusion was causing the tissue necrosis and infection.

Doctors have duty of candour and patients have a right to full disclosure when something goes wrong. Open and honest disclosure of surgical complications is consistent with ethical values of honesty and respect for autonomy. Candour promotes trust in the medical profession. Disclosure of adverse events also serves to minimise the potential harm of unknown conditions going untreated. Omission of information or provision of misleading information about the outcome of an operation calls the doctor's professional conduct into question.

Dr B either did not inform Ms A about the complication that arose during the operation, or gave her an inadequate explanation. This is information that Ms A would want to know and would expect to receive – and was entitled to under Right 6(1)(a) of the Code. The nature and the extent of the operative complication was not clearly communicated to Ms A. This was a breach of Dr B's professional and ethical duty. In my opinion, in failing to inform Ms A of the complications of the surgery or to provide her with the information in a way that she could understand, Dr B breached Right 6(1)(a) and (e) of the Code.

Follow-up care

Ms A complained that Dr B did not provide her with appropriate follow-up care, and in particular did not adequately treat the infection she developed in her left breast.

Ms A developed infection in her left breast, which had been operated on by Dr B. Indications of an infection first appeared on 17 December 2000, the day she was discharged from the Private Hospital following the incision and drainage of a haematoma (her second operation). She was discharged on Augmentin, a broad-spectrum antibiotic. Because of continuing wound leakage Ms A attended the Specialist Clinic on an almost daily basis to have the collection expressed and the wound dressed by nursing staff. When seen by Dr B on 20 December, a wound swab was taken and another broad-spectrum antibiotic, Ciproxin, was prescribed. On 8 January 2001 Dr C considered that the left breast was healing well and the right breast had an area of redness. At the 11 January consultation Dr B noted that the wound continued to leak despite the antibiotic cover, and that the infection was not resolving. He attributed this to the rejection of the implant and indicated to Ms A that wound exploration and implant removal on the left side might become necessary. This was duly done by Dr B on 15 January – the implant was removed and the necrosed tissue debrided.

According to my expert advisors, the management of Ms A's wound infection was largely satisfactory – appropriate antibiotics appear to have been prescribed and further surgery performed to remove the implant and excise dead tissue. However, while Dr Langley thought the follow-up care by Dr B had mostly been satisfactory, she expressed concern about the length of time taken by Dr B to remove the breast implant and excise the necrosed tissue. She stated: "Unfortunately, the only definitive treatment for infected dead tissue surrounding a foreign body (implant) is debridement of dead tissue and removal of the implant. Until that was done Ms A could not get better. Therefore there was some time delay." Had this been done sooner, earlier healing would have occurred.

I note that Ms A's breast implant was not removed, and the necrosed tissue excised, until 15 January 2001 at which time Dr B still considered the infection to be a reaction to the implant rather than suboptimal blood supply to the flap. Despite the loss of approximately a third of the flap, he believed the flap to be viable and maintained that view until Ms A sought and obtained a second opinion from Dr I in September 2001. Although Dr B indicated that in June 2001 he informed Ms A that he would be referring her to Dr I in "two months' time" for consideration of a free abdominal flap transfer to reconstruct the left breast, the consultation with Dr I on 19 September 2001 appears to have resulted from the initiative taken by Ms A rather than a direct referral by Dr B.

There is general agreement among my advisors and the ACC advisors that the tissue necrosis and the ensuing infection resulted from inadequate blood supply to the latissimus dorsi flap at the time of initial surgery. While one of the ACC advisors was of the opinion that the bleeding that resulted in the haematoma evacuated on 14 December 2000 was caused by progressive tissue necrosis and infection, Dr Simpson thought that a secondary bleed nine days after surgery was a more likely explanation (unrelated to the blood vessel

injury at the time of the initial operation). Dr Langley raised the possibility of inadequate venous drainage following the initial assault on the blood vessel and that the resulting venous congestion of the flap resulted in a slowly evolving haematoma. However, she felt that although the haematoma would have contributed to the poor healing, it was unlikely to have been the main cause; it was partially or totally due to the ischaemic left latissimus dorsi flap (sustained at the time of the initial surgery).

While I accept that initially Dr B managed Ms A's breast infection appropriately and eventually took the correct action by removing the left breast implant and debriding the necrotic tissue causing the infection, he failed to recognise or respond to the underlying cause of Ms A's infection in a timely manner. In failing to intervene surgically sooner or to refer Ms A for a second opinion, Dr B's postoperative management of Ms A fell below an appropriate standard. Accordingly, in my opinion, Dr B breached Right 4(1) of the Code.

Opinion: No breach – Dr B

Insertion of an expander
Ms A complained that on 11 October 2001 Dr B advised her to have an implant (expander) inserted into her left breast. Given that she had very thin skin flaps, she did not think that this was appropriate advice.

The available documentation indicates that a tissue expander implant was considered by Dr B long before October 2001. After the operation on 15 January 2001 and with the infection resolving, Ms A expressed dissatisfaction with the cosmetic result of the surgery. On 1 February Dr B noted that Ms A was unhappy with the size of her right breast (the breast was slightly low and lacked projection) and in his letter to Dr J indicated that he was planning to replace the right breast implant with a larger one and reinsert the one to the left breast to achieve symmetry. When reviewing Ms A on 5 March, Dr C also indicated that an insertion of a breast expander was perhaps the best option for the planned reconstruction of the left breast. On 16 August 2001 Dr B recommended placement of an expander in the left breast. It seems that at this time Ms A was under the impression and expectation that this would take place.

However, also around this time, Ms A and her husband expressed concern that there was insufficient tissue to retain an implant on the left side. It seems that as a result of their concern, Dr B sought an opinion from experienced breast reconstruction surgeon overseas. The surgeon confirmed to Dr B that his proposed surgical management (insertion of a new implant) was appropriate. However, Ms A was uncomfortable with that advice and sought the opinion of Dr I who, in light of the thin soft tissue cover on the left side, recommended soft tissue expansion (flap reconstruction) before considering placement of a tissue expander implant. Subsequently Dr B concurred with this assessment.

My advisors concurred with the assessment and advice provided by Dr I, that a tissue expander breast reconstruction was not appropriate in this case. In view of the thin skin flaps (inadequate soft tissue) and recent history of infection, the procedure proposed by Dr B was unlikely to succeed. In Dr Simpson's opinion it seemed "unwise and unlikely to succeed due both to the presence of thin skin flaps and also because of a fairly recent infection". Dr Langley considered the surgeon's advice to Dr B to be "unfortunate".

From Dr B's actions, it seems that he thought he could remedy the problem with a tissue expander implant, the only remaining option available to him. In his judgement it was a viable option. In response to Ms A's and her husband's concern that there was inadequate tissue to retain an expander implant, he sought overseas expert advice, which validated his thinking. Dr B's assessment and opinion differed from that of my advisors, but I am satisfied that Dr B acted in good faith and in what he thought were Ms A's best interests. Although in retrospect it appears that a different procedure would have been more appropriate, in my opinion Dr B exercised reasonable professional judgement in the circumstances. Accordingly, Dr B did not breach Right 4(1) of the Code in relation to this matter.

No further action – Dr B

Experience
Ms A complained that in her dealings with Dr B he overstated his level of skill and experience in breast reconstructive surgery. She alleged that Dr B told her and her husband that he was "the best reconstructive surgeon in [the city] and better than any plastic surgeon in [the city]" because "he did more operations and got more experience".

Dr B acknowledged that he told Ms A that he had extensive training and experience in breast reconstructive surgery and that he had performed hundreds of latissimus dorsi flap reconstructions. My advisors agreed that Dr B was an experienced surgeon and appropriately qualified to perform mastectomies and latissimus dorsi reconstructions. However, Dr B was not a trained plastic surgeon and it would be of concern if he had made the alleged remark about being "better than any plastic surgeon in [the city]". In the absence of independent witnesses I am unable to conclude exactly what was said by Dr B about his experience as a breast surgeon and his skills in plastic surgery or whether he exaggerated his experience and skill when talking to Ms A. Accordingly, no further action will be taken on this aspect of Ms A's complaint.

Other comments – Dr B

Role explanation
Dr B was the surgeon primarily responsible for Ms A's care. Dr C's role was that of a junior member of the team working under the supervision of Dr B. Dr C held temporary New Zealand registration permitting him to practise medicine in this country as a specialist in general surgery in the employment of the Specialist Clinic under the supervision of Dr B. Dr B therefore had two roles – one as an operating surgeon and the other as a supervisor of a more junior surgeon. Dr C's role does not appear to have been adequately explained to Ms A, nor assisted by Dr B's reference to Dr C as Ms A's primary surgeon.

I have noted Dr Langley's comments that in her view Ms A was presented with "what seems all appropriate information prior to surgery" and that she did not think Ms A needed to have an explanation about the details of Dr C's role (Ms A knew Dr C and that he was involved with surgery and that Dr B was the surgeon primarily responsible for her care). However, in my view Dr B did have a responsibility to explain Dr C's intra-operative role, and that Dr C was a junior member of the team under his supervision. If this had happened the confusion that arose from Dr C's comments – that he was only assisting Dr B even though he was primarily responsible for the surgery on the right breast – may not have arisen.

Although Dr C seems to have appropriately described his role to Ms A as that of a junior surgeon, Dr B appears to have portrayed Dr C as Ms A's primary surgeon, an independent contractor trained to perform breast reconstructive surgery.

Dr Simpson noted that although Dr C was adequately trained to perform latissimus dorsi reconstructions under supervision, he was not a trained breast reconstruction surgeon able to practise independently. Dr B's description of Dr C raises questions about his supervision of Dr C. I draw to Dr B's attention Dr Simpson's reservations about his role as Dr C's supervisor.

Record-keeping
Dr B has not provided me with a copy of the notes of his consultation with Ms A. Although the correspondence to various parties enabled me to establish the consultation dates, and the key reasons for or outcome of each consultation, it is not a substitute for the actual consultation notes.

The Medical Council of New Zealand "Guidelines for the Maintenance and Retention of Patient Records" (October 2001) state:

> "1. Maintaining patients records
>
> a) Records must be legible and should contain all information that is relevant to the patient's care.

b) Information should be accurate and updated at each consultation. Patient records are essential to guide future management, and invaluable in the uncommon occasions when the outcome is unsatisfactory."

I draw this matter to Dr B's attention and recommend that he review his record-keeping accordingly.

Opinion: No breach – Specialist Clinic

Continuity of care
Preoperatively, in addition to Dr C and Dr B, Ms A was seen and assessed by at least three other Specialist Clinic doctors. Postoperatively Ms A was also reviewed by another doctor at the Specialist Clinic, the Clinic's nurses and the Clinic's multidisciplinary panel. As stated by Dr Simpson, some aspects of the Specialist Clinic team approach to the management of Ms A's problem was fragmented. This made it difficult to assess the adequacy of the actions of individuals.

With regard to Dr C and Dr B, the allocation of responsibility for postoperative care was also not made clear. Whereas Dr C stated that responsibility for Ms A's postoperative care and follow-up lay with Dr B, Ms A's first postoperative appointment was scheduled with Dr C and it was he who managed the haematoma she developed nine days after the operation. Subsequently Ms A was reviewed by Dr C and Dr B.

The complexity of Ms A's surgery, the complications she subsequently developed and the postoperative care she required, made it essential that there was good continuity and co-ordination of her care. Although Dr Simpson stated that no single act or event caused Ms A's poor result and morbidity, he considered that some aspects of the Specialist Clinic team approach to complex problems such as that presented by Ms A could benefit from a review. I draw these comments to the attention of the Specialist Clinic.

Record-keeping
Right 4(2) of the Code affirms the right of all patients to have services provided that comply with professional standards. Good record-keeping is an essential component of good health care – it guides future management. The standard of record-keeping did not form part of Ms A's complaint and has not been a focus of this investigation. However, I note that despite being seen by Dr C and Dr B on numerous occasions, as well as other Specialist Clinic doctors including Drs D, E, F, other doctors from the Specialist Clinic and nurses, copies of Ms A's notes for these consultations were not provided during the investigation.

The absence of such consultation notes is a departure from accepted standards of practice. I am reassured to note that since this incident the Specialist Clinic has moved from handwritten notes to an integrated computerised note system.

Vicarious liability
Employers are responsible 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. Under section 72(5) it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the employee from doing or omitting to do the thing that breached the Code.

Dr B was a director and an employee of the Specialist Clinic. It was in his capacity as an employee of the Specialist Clinic that he assessed and treated Ms A.

Although Dr B breached Right 4(1) of the Code by failing to recognise or respond to the underlying cause of Ms A's infection in a timely manner and by failing to intervene surgically sooner or refer Ms A for a second opinion, these matters involved clinical decisions of an individual practitioner, and were not reasonably foreseeable or preventable by the Specialist Clinic.

The Specialist Clinic is therefore not vicariously liable for Dr B's breach of Right 4(1) of the Code. Nor is the Clinic liable for Dr B's inadequate explanation of the postoperative complications and breach of Right 6(1).

Recommendations

I recommend that Dr B:

- apologise in writing to Ms A for his breach of the Code. The apology is to be sent to the Commissioner's Office and will be forwarded to Ms A
- review his practice in light of this report in relation to his breast and reconstruction surgery, follow-up care, the provision of information to patients (particularly where an adverse event has occurred) and record-keeping.

I recommend that the Specialist Clinic review its practice in light of this report in relation to co-ordination of care, provision of information to patients (particularly where an adverse event has occurred) and record-keeping.

Follow-up actions

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

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.