Decision 21HDC00317
12 December 2025

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Insufficient information provided to patient prior to total hip replacement

1. The Health and Disability Commissioner (HDC) received a complaint from Mr A regarding the consent process for his left hip replacement surgery at Rotorua Hospital and the information he was given about the subsequent complication he experienced.

Background

2. Mr A had undergone two previous hip replacement operations on his right hip in 1997 and 2012, respectively. Both had used a posterior approach (accessing the hip joint from the back of the body). He recalled that the surgeons involved in both surgeries spent quite some time outlining the proposed posterior approach procedure.

3. On 31 January 2017, Mr A had a consultation with orthopaedic surgeon Dr B at the orthopaedic clinic at Rotorua Hospital, having been referred by his general practitioner (GP), for consideration of a replacement of his arthritic left hip joint.

4. Following an examination and review of X-rays, Dr B confirmed that Mr A had severe left hip joint arthritis and would benefit from a hip joint replacement. That day, Mr A signed a standard consent form for hip replacements that listed several risks but did not document the technique planned for the procedure or any additional risks relating to that technique.

5. Dr B anticipated that he would be performing the surgery and planned to use his preferred technique, the direct lateral/modified Hardinge approach (the Hardinge technique[1]). However, Mr A anticipated that the posterior approach would be used, as with his previous surgeries.

6. Orthopaedic surgeon and head of department at the time at Health NZ | Te Whatu Ora Lakes (Health NZ Lakes), Dr D, told ACC and Mr A (in response to his complaint made directly to Health NZ Lakes) that the Hardinge technique has a significant risk of detachment of the repaired lower third of the gluteus medius/minimus insertion or failure of the repair. Dr D said this is extremely common but not always symptomatic, but, when it is, the symptom is abductor muscle weakness. He said that trochanteric bursitis (inflammation of the fluid-filled sac that cushions the hip joint) is also far more common and problematic after a Hardinge technique. Dr D stated that, in his opinion, any surgeon using this approach should include these risks in the informed consent discussion for the procedure.

[1] A curved split is made through the anterior of the gluteus medius and vatus muscles to access the anterior face of the hip joint.

Names have been removed (except Health New Zealand Lakes and the clinical advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

7. Mr A said that Dr B did not explain the proposed Hardinge technique and spent all his time evaluating whether or not Mr A had 'enough points' to merit immediate surgery. Mr A said that he received no warning that there was significant potential for failure of the repair to the abductor muscles, which are detached to gain access to the hip joint.

8. Dr B told HDC that, apart from a brief discussion about his usual approach, he did not go into detail about this approach or discuss other possible approaches. Dr B said that he did not discuss the risks of muscle detachment with the Hardinge technique because, at the time of consent, he had done more than 250 hip joint replacements in New Zealand, none of which had had a problem with failure of the abductor repair. He said that listing a potential complication that he considered rare in his personal experience would not be part of his usual consent process.

9. Mr A was taking prednisone 8mg (a steroid) daily for polymyalgia rheumatica (an inflammatory condition). Dr B said that he did consider steroid use as a reason to change the surgical approach. However, he said that Mr A clearly needed a hip replacement, and he considered that the doses of prednisone usually prescribed for polymyalgia would not have a significant effect on healing, and therefore this was not something that required discussion with Mr A.

10. Dr B did not see Mr A again. As Dr B was about to take annual leave, he would have been unable to perform Mr A's surgery until May 2017.

11. Mr A was seen in the preoperative assessment clinic (PAC) on 14 March 2017. The clinical nurse specialist at the PAC noted: '[Mr A] wishes if there is any way for another surgeon to do the operation faster (as [Dr] B is having some leave).' Health NZ Lakes said that Mr A was a pooled patient (i.e., one of a group of patients who could be operated on by any of the surgeons).

12. Mr A therefore underwent a total hip replacement on 27 April 2017 performed by orthopaedic surgeon Dr C after a brief five-minute discussion immediately before the surgery. Again, there was no mention of the technique that would be used during the surgery. Dr C told HDC that he did not know what approach had been used in Mr A's previous right hip replacement surgeries, as that information was not available in his notes.

13. Dr C said he did not repeat the consenting process when he saw Mr A on the morning of his surgery because he knew that Dr B had already obtained Mr A's informed consent during his outpatient clinic appointment, and Dr C had sighted the signed consent form in Mr A's file.

14. Health NZ Lakes told HDC that when patients are pooled, there is no formal transfer of care to the newly allocated surgeon, and although some clinicians ask to see the patient in the outpatient clinic prior to surgery, the formal consent process is not repeated, and the first signed consent form is regarded as sufficient consent to proceed with the surgery. Health NZ Lakes noted that if a 'meet and greet' outpatient appointment takes place, generally the discussion is related to any new issues or questions that may have arisen since the time the surgery was booked.

15. Dr C agreed that although the consent form stated that complications had been discussed, it did not specifically mention the risk of muscle detachment. He said that he did not notice this at the time and, as he knew that Dr B used the same Hardinge technique as he did, he expected that the possible complications associated with the technique had already been explained to Mr A. Dr C said that usually he would avoid discussing risks and complications immediately before surgery to avoid causing the patient stress. However, he accepts that it would have been prudent for him to have done so, and he now sees that relying on the consent taken by a colleague was an error of judgement on his part and failed Mr A.

16. Dr C was aware that Mr A had been taking prednisone, but he did not believe this to be a contraindication to Mr A having a hip replacement using the Hardinge technique, so the steroid issue was not specifically discussed with him on the morning of his surgery.

17. Dr C performed the total hip replacement using the Hardinge technique. Mr A was discharged on 28 April 2017, and an orthopaedic registrar saw him on 14 June 2017 for a six-week follow-up.

18. Six months after the surgery, Mr A experienced pain and difficulty with mobilisation. He said that he undertook an extensive exercise regimen to try to regain the use of his gluteal muscles, without success.

19. The follow-up appointment one year post surgery (i.e., April 2018) planned by the orthopaedic registrar was not arranged. X-rays of Mr A's left hip and pelvis were organised by his GP. These were taken on 7 May 2018 and showed a 'little lucency' (a clear or translucent area) on the femoral stem. On 8 May 2018, Mr A's GP made a referral to the orthopaedic clinic.

20. At a clinic on 8 October 2018 attended by Dr D and another orthopaedic registrar, Mr A's pain, discomfort, and difficulty in walking up stairs for the previous six to nine months were attributed to greater trochanter bursitis.

21. X-rays of Mr A's left hip and pelvis were taken on 12 November 2018 and reported that the lucency had reduced. Following a clinic appointment that day, the orthopaedic registrar noted that Mr A had a 'negative Trendelenburg gait' — indicating that the hip abductor muscles were functioning normally.

22. Dr D told HDC that gluteal muscle detachment was considered, but as no management or treatment was possible other than non-operative management with steroid injections for pain and exercises to strengthen the remaining abductors, an MRI was not ordered, and muscle detachment was not discussed with Mr A.

23. Mr A questioned the decision-making process that justified Dr D not informing him what he thought might have happened and not confirming the diagnosis by requesting an MRI scan to confirm or disprove the diagnosis. Mr A said that given his continued complaints of pain and difficulty in walking upstairs or up sloping ground and knowing the Hardinge technique's reputation for the repaired muscles and tendons to rupture, the initial diagnosis should have been reconsidered and an MRI scan undertaken to confirm or discount that diagnosis.

24. Mr A agreed that the clinical management was not going to change, but he said that the difference for the patient is knowing that there will be no improvement. Prior to 11 April 2019, he had been unaware that the detached muscles are rarely reattached successfully, so he continued to try to improve his ability to walk without discomfort and hoped for improvement. Mr A stated that he should not have been kept in ignorance for a further six months that any improvement would have been negligible.

25. On 8 April 2019, Mr A saw an orthopaedic surgeon privately for a further opinion. This doctor considered that the symptoms were from abductor deficiency following the Hardinge technique. He arranged for Mr A to have an MRI scan on 11 April 2019, and the results confirmed detachment of the majority of the left gluteus medius muscle.

Responses to provisional decision

26. Health NZ was provided an opportunity to respond to my provisional decision and had no further comments to make.

27. Dr B was provided an opportunity to respond to my provisional decision and accepted the findings as they relate to him.

28. Dr C was provided an opportunity to respond to my provisional decision and accepted the findings as they relate to him.

29. Mr A was provided an opportunity to respond to my provisional decision and did not provide a response.

Decision: Dr B — breach

30. Rights 6 and 7 of the Code of Health and Disability Services Consumers' Rights (the Code) require that consumers are provided with the information that a reasonable person in that person's circumstances would expect to receive, including the expected risks and benefits of the treatment option in order that they can make an informed choice and give informed consent.

31. Dr B did not explain the Hardinge technique in any detail. I accept that surgeons are not required to discuss in detail the surgical approaches they do not intend to use, but they are required to discuss the nature of the planned procedure. Mr A had had two previous hip replacements using the posterior approach, and he expected that the same technique would be used for his left hip replacement. Dr B has stated that doctors generally do not have access to information about what previous surgical approaches were used when surgery is done at a different institution, such as in this case. However, in the context of two previous hip replacements, I consider that it was particularly important that Dr B explicitly tell Mr A which he intended to use, noting that this may have differed from the technique used in Mr A's previous two surgeries. In my view, it is understandable that Mr A expected that the posterior approach would be used, as in his prior two hip replacement surgeries. I consider that a person in Mr A's circumstances would expect to be told that Dr B proposed to perform a different technique, and to have that technique explained.

32. Furthermore, it is accepted practice to outline any pertinent potential risks for the chosen surgical approach. In this case it was known that muscle detachment or repair failure is

relatively common following the Hardinge technique for hip replacement surgery. I do not accept that Dr B having not previously experienced this complication is a pertinent factor. In my view, a reasonable consumer in Mr A's circumstances would have expected to be informed of the benefits and risks of the Hardinge technique, including the risks of muscle detachment or repair failure. However, that discussion did not take place.

33. Dr B was aware that Mr A's long-term steroid use could affect healing but concluded that the risk was not significant, so he did not discuss this with Mr A. I sought a steer from my in-house clinical advisor, vocationally registered GP Dr David Maplesden, on the significance of long-term steroid use in relation to healing from hip joint replacement surgery. Dr Maplesden advised that long-term chronic corticosteroids at doses greater than 6mg per day increase the risk of infection as a perioperative complication. Dr Maplesden noted that, although the general risk of infection is covered as part of the informed consent process, it might be reasonably expected that the additional increased risk associated with the long-term use of corticosteroids is something that is discussed when relevant. In my view, the implications of Mr A's long-term steroid use is something that a person in Mr A's circumstances would expect to be told. I acknowledge that Dr B did not consider this to be a contraindication to the surgery, but my expectation is that Mr A should have been informed of the increased risk, and Dr B's reasoning should also have been discussed with him.

34. Although Dr B did not perform Mr A's surgery, I consider that he was responsible for the informed consent process undertaken on 31 January 2017. In my view, Dr B failed to provide Mr A with the information that a reasonable person in that person's circumstances would expect to receive and would need to make an informed choice and give informed consent. As such, I consider that Dr B breached Rights 6(1)[2] and 6(2)[3] of the Code. It follows that Mr A did not give informed consent and that Dr B also breached Right 7(1)[4] of the Code.

Decision: Dr C — adverse comment

35. As Dr B was on leave, Dr C performed Mr A's surgery. However, Dr C had only a five-minute discussion with Mr A immediately before the surgery. In my view, Dr C should have informed Mr A that he proposed to use the Hardinge technique and ensured that he understood the risks of the procedure. I accept that it was Dr C's understanding, based on the signed informed consent document, that the potential risks had already been outlined by Dr B and that, as he knew that Dr B used the same Hardinge technique, he had assumed any discussion that had occurred was in the context of the Harding technique. However, the consent form does not specifically mention the risk of muscle detachment. I am critical that

[2] Right 6(1) states: 'Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including … an explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option.'
[3] Right 6(2) states: 'Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent.'
[4] Right 7(1) states: 'Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.'

Dr C did not confirm Mr A's informed consent, but I note that in part this was a consequence of the system Health NZ Lakes had in place at the time for managing pooled patients.

36. I accept Dr C's statement that it would not have been appropriate for him to initiate a conversation of that nature immediately prior to the surgery. Dr C has since changed his practice to include repeating the full informed consent procedure even when a patient has been consented previously by another orthopaedic colleague. He has also decided to re-adopt the posterior approach and has undergone refreshment training for that. I consider these changes to be appropriate.

Decision: Health NZ Lakes — breach

37. Health NZ Lakes was aware for over a month prior to the surgery that Dr B would not be performing the surgery. Health NZ Lakes told HDC that although some clinicians ask to see the patient in the outpatient clinic prior to surgery, the formal consent process is not repeated, and the first signed consent form is regarded as sufficient consent to proceed with the surgery. Health NZ Lakes also noted that if a 'meet and greet' outpatient appointment takes place, generally the discussion is related to any new issues or questions that may have arisen since the time the surgery was booked. I note that HDC's expectation is that consent is an ongoing process. It is not a one-time event but a continuous interaction between the provider and the consumer throughout the period of care. I agree with Dr C that immediately prior to surgery is not an appropriate time to provide the necessary information about the procedure and the risks. I am critical that Health NZ Lakes' systems did not allow for or require a consenting discussion between Dr C and Mr A prior to the day of the surgery.

38. Dr D said that a detached muscle diagnosis was considered on 8 October 2018 but that an MRI scan was not ordered and the diagnosis was not discussed with Mr A because of the lack of treatment options. It was a further six months before Mr A received the diagnosis of a detached gluteal muscle. I accept that attempts at surgical repair of the detached gluteal muscle would have been futile. However, I acknowledge Mr A's comment that he needed to know the diagnosis and that there would be no improvement. I note that as Mr A was unaware of this possible diagnosis, he spent a further six months trying to improve his ability to walk without discomfort, when in all likelihood, any improvement would be negligible. In my view, the Health NZ Lakes clinicians who consulted with Mr A over this period should have informed him of the possible diagnosis of a detached muscle in October 2018. By not informing Mr A of the possible diagnosis of a detached gluteal muscle in October 2018, in my view Health NZ Lakes failed to provide Mr A with the information that a reasonable person in that person's circumstances would expect to receive. As such, I consider that Health NZ Lakes breached Right 6(1) of the Code.

Recommendations

39. I recommend that Health NZ Lakes, Dr B, and Dr C each separately apologise to Mr A for the criticisms in this report. The written apologies are to be sent to HDC within three weeks of the date of this decision, for forwarding.

40. I recommend that within three months of the date of this decision Health NZ Lakes develop a process to ensure that in situations where the intended surgeon changes after informed

consent has been obtained, sufficient time is allowed prior to the procedure for the new surgeon to check and verify that the patient has been fully informed of the risks and has given informed consent. Health NZ Lakes is to report back to HDC on the development of the process.

41. I recommend that within three months of the date of this decision Health NZ Lakes, in the context of this case, remind staff of the importance of a consumer-centred approach to information sharing, in particular relating to postoperative complications, and provide HDC with evidence of this reminder.

42. I recommend that within three months of the date of this decision, Dr B undertake additional education on person-centred care and effective communication with health consumers and complete the HDC online modules for further learning: https://www.hdc.org.nz/education/online-learning/. Evidence of attendance at related training and completion of the online modules is to be provided to HDC.

43. I acknowledge that Dr C has made changes to his practice, as stated above. I remind Dr C of the importance of carefully discussing the potential and common risks of hip replacement surgery with surgical candidates.

Follow-up actions

44. A copy of the sections of this report that relate to Dr B and Dr C will be sent to the Medical Council of New Zealand.

45. A copy of this report with details identifying the parties removed, except Health NZ Lakes and my in-house clinical advisor on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Nāku iti noa, nā

Rose Wall
Deputy Health and Disability Commissioner