Ophthalmologist, Dr C

Southland District Health Board

A Report by the

Health and Disability Commissioner

(Case 05HDC12122)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Complainant/Support person
Mrs B	Consumer
Dr C	Provider/Ophthalmologist
Southland District Health Board	Provider/Employer
Dr D	Ophthalmologist (former employee of Southland District Health Board)
Mr E	Group Manager of Surgical Services, Southland District Health Board
Dr F	Chief Executive Officer, Southland District Health Board
Ms G	Chief Operating Officer, Southland District Health Board

Complaint

On 22 August 2005, the Commissioner received a complaint from Mrs A about the services provided to Mrs B by Dr C. The following issues were identified for investigation:

Dr C

- *Whether Dr C provided Mrs B with adequate information about her treatment options, including the cost of those options.*

- *The appropriateness of Dr C's management of Mrs B's treatment in both the public and private sector.*

Southland District Health Board

- *Whether Southland District Health Board took adequate steps to ensure that Mrs B was appropriately managed following her referral to the Southland Hospital waiting list for cataract surgery.*

An investigation was commenced on 9 March 2006. The investigation took over a year to complete owing to the complexity of the issues, delays in provider responses, and conflicting information from Dr C and the Southland District Health Board.

Information reviewed

- Complaint from Mrs A
- Information from Mrs B
- Responses from Dr C
- Responses from Southland District Health Board
- Comment from Dr David Geddis, Ministry of Health
- Comment from Dr Ray Naden, Ministry of Health

Independent expert advice was obtained from ophthalmologist Dr Peter Haddad.

Information gathered during investigation

Summary
On 27 June 2005, Mrs B (aged 82) had cataract surgery at Kew Hospital (also known as Southland Hospital) performed by ophthalmologist Dr C. Mrs B is concerned that Dr C charged her for preoperative and postoperative appointments in relation to surgery that she understood was funded through the publicly funded health system.

Initial appointment with Dr C
Dr C first saw Mrs B as a private patient on 3 December 2003, after she was referred to him by her optometrist on 17 October 2003 — for review of a watering right eye. Dr C performed a procedure to relieve the watering.[1] He also noted that there was "enough cataract" to explain her somewhat blurred vision and planned to review her again in a year. Dr C's fee was $95, which Mrs B paid that day.

Private first specialist assessment
Dr C next saw Mrs B on 9 December 2004 and concluded that her visual symptoms had reached the stage where she would benefit from cataract surgery. Dr C assessed Mrs B under the National Clinical Priority Assessment Criteria (CPAC) tool for cataract surgery, and forwarded her name onto the hospital waiting list with a score of 35. Mrs B was invoiced $75 on 9 December 2004 by Dr C, and paid that day.

Dr F, Chief Executive Officer, Southland District Health Board (SDHB) advised that patients being seen privately for first specialist assessments (FSAs) is accepted practice and occurs across all specialities. Mrs B's position on the waiting list was then determined by her priority score. It was Dr C's responsibility to review the waiting list in relation to his patients[2] and alter any priorities as required.

[1] Dr C performed a bilateral punctoplasty and syringed both nasolacrimal ducts.

[2] From December 2004 to August 2005 there were two opthalmologists at Southland Hospital.

Arrangements for surgery

Dr C informed me that Mrs B remained his private patient throughout her publicly funded cataract treatment. Dr C stated:

> "It is my standard practice to advise patients requiring cataract surgery, of the available options which include surgery in the public hospital or surgery privately.
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> I advise private patients that they can have their name forwarded directly to my operating list at Southland Hospital from my private rooms, and that I will review them and perform intraocular lens measurements at my rooms prior to their surgery and that I will follow them up at my rooms after their surgery.
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> …
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> [Mrs B] chose to have her name forwarded from my rooms for surgery at Southland Hospital under my care, and I sent a waiting list form to Southland Hospital, giving her a supra-threshold score.
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> …
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> I found that most patients in that situation appeared to expect this to happen, and it was my understanding that that was why they had been referred to my private rooms in the first place rather than directly to Southland Hospital. I gained the impression that many chose this option because they particularly wanted me to be their surgeon rather than have surgery done by my colleague at Southland Hospital."

SDHB confirmed that it did not provide any information about any residual costs associated with surgery for patients such as Mrs B. Dr F stated:

> "No information is given to a private patient by SDHB [Southland District Health Board]. At this stage of the process for patients such as Mrs B, SDHB believes any information ought to be given by [Dr C] as the patient is not within the public system."

Mrs B advised me that she found it hard to recall what occurred when Dr C assessed her for surgery in December 2004, but provided the following account. Mrs B stated that when Dr C recommended cataract surgery, she requested that he refer her to Kew Hospital because she could not afford the expense of private surgery. From this point on, she assumed that any further treatment she received in relation to her cataract surgery would be free. Mrs B does not recall any discussion about her treatment options. Mrs B was unaware that she remained Dr C's private patient, and this was not explained to her by Dr C.

Dr C's lawyer submitted:

> "[Dr C's] position is that his usual practice at the time was to discuss with patients their options for treatment and whether they remained private patients or were

> dealt with in the public system. [Mrs B's] position … is that she cannot remember such a discussion. That is not a denial by [Mrs B] that such a discussion took place; just that she can't remember the discussion."

Dr C explained:

> "It is not my usual practice to discuss the actual costs of future private appointments and I do not specifically explain to each private patient during a consultation that any future private appointments with me will indeed incur a fee, as my experience is that patients realise that to be the case. However, my usual practice for patients choosing public hospital cataract surgery at the time I saw [Mrs B] was to specifically offer them the options of '*free*' care at Southland Hospital (by being referred for a FSA at Southland Hospital outpatient department) or to remain as a '*private*' patient, with the implication that if they chose to remain as a '*private*' patient they would be charged for private consultations.
>
> My experience is that the average person realises, when one of two options offered is specifically described as '*free*' that a second option described as '*private*', implied that a private fee was to be expected.
>
> Furthermore, the expectation that patients pay for private appointments was and still is written at the bottom of all appointment letters sent out from my private rooms, including those that went to [Mrs B]."

Dr C explained that the other option would have been to refer Mrs B to the outpatient clinic at Kew Hospital. In that situation, all her care would have occurred under the public system, and there would have been no charge. However, the backlog is such that there would have been a significant delay before Mrs B would have been able to be seen to be assessed for cataract surgery. The ophthalmologist who reviewed her would have decided on the need for cataract surgery. Once a score above the threshold had been achieved using the national scoring tool, Mrs B would have received surgery in approximately six months (as indeed she did after her supra-threshold private FSA).

On 24 December 2004, Mrs B received a letter from the hospital ophthalmology department advising that her score was 35 out of 50 and her name had been placed on the ophthalmology elective list.

On 13 May 2005, Mrs B was scored for her cataract surgery by the Kew Hospital ophthalmology department nurse. On 18 May 2005, Mrs B received a follow-up letter from Kew Hospital confirming that her clinical priority score was 38 (and that she should expect to be offered cataract surgery within six months).

Dr C performed a preoperative biometry for Mrs B on 7 June 2005. (Mrs B was accompanied by Mrs A.) Dr C's consultation fee had risen to $85, and Mrs B paid that

day. He explained to Mrs B the requirement for two follow-up appointments. His letter to Mrs B stated:[3]

> "Before you leave the hospital you will be given an appointment time to see me at [my rooms] in 2 days … I will then see you again at about 2 weeks to check that all is well with your eye."

Mrs B had her right eye cataract surgery at Kew Hospital on 27 June 2005. The procedure was uneventful. After the procedure, it appears that information about follow-up treatment was provided by ophthalmology department staff to Mrs B.[4]

On 28 June 2005, Mrs B received a telephone call from the ophthalmology department at Kew Hospital, reminding her of her follow-up appointment with Dr C.

Dr C saw Mrs B for postoperative reviews on 29 June and 13 July 2005, at his rooms. Mrs B did not understand why Dr C charged her for these appointments. On both occasions Mrs B paid an $85 fee at the end of the consultation. She informed me that she received no explanation from Dr C about why he was still charging her, and thought it was "odd", as she had elected to receive publicly funded cataract surgery. However, she did not question Dr C, as she found him quite intimidating and did not want to start an argument with him.

Mrs B's support person, Mrs A accompanied Mrs B to her first postoperative appointment on 29 June 2005.[5] Mrs A commented that Mrs B was very pleased with the results of her surgery. Mrs A informed me that she was surprised when Mrs B paid a fee to Dr C's receptionist after the consultation. Mrs A stated that Mrs B was "quite indignant" about the charges when they were later discussed. Mrs A discussed Dr C's charges with Mrs B at some point during the subsequent month, although Mrs A cannot recall precisely when the discussion occurred.

Complaint

In her letter of complaint dated 15 August 2005, one month after Mrs B's second postoperative review, Mrs A stated:

> "What did surprise me and her [Mrs B] immensely was the fact that for several pre-op[erative] appointments [Dr C] charged her $90 each; and for her

[3] Dated: 7 June 2005. This letter makes no reference to payment.

[4] The discharge planning section of Mrs B's medical record has two columns. The following items of the first column are box-ticked (in descending order): mobile, contact number, wound check and script. The following items of the second column are box-ticked (in descending order): analgesia, follow-up appointment, post-op instructions and tolerating fluids. The handwritten comments "discussed" appears closest to the ticked box "analgesia" — but apparently refers to all the ticked boxes.

[5] In her notes about Mrs B for 29 June 2005, Mrs A recorded: "Took to f-up [follow-up] eye appointment (post-op). Doing fine. [Mrs B] on a high."

> postoperative appointments — likewise — for each another $90 thank you![6] Now why was he not conducting these pre[operative] and postop[erative] appointments from Southland Hospital as part of the general outpatients system if her surgery was being done publicly?"

Mrs B stated that some of her friends asked why she did not have her surgery done at Kew Hospital, as it was free — and she replied that she did.

Response from Dr C

Dr C's lawyer noted that Mrs B found it hard to recall what communications occurred between her and Dr C and submitted that her account therefore could not be relied on. The lawyer drew particular attention to the following information provided to Mrs B:

> "[Mrs B] attended [Dr C] as a private patient on her optometrist's referral. That referral recorded that she and her family were expecting to pay for that consultation (see letter 17 October 2003).[7] At that time, [Mrs B] was [81] years of age. [Mrs B] continued to attend [Dr C's] rooms, in a private capacity, for her eyesight difficulties (see medical notes).
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> On 1 December 2004 a letter was sent to [Mrs B] from [Dr C's] surgery advising of her next appointment. At the bottom of that appointment letter was information regarding payment, which I am instructed by [Dr C] is standard for all appointment letters.[8]
>
> [Mrs B] received a letter dated 7 June 2005 advising her of the steps for her surgery, and that the operation would be at Southland Hospital, but that the biometry and follow-up appointments would be with [Dr C] at his rooms in two days' time, and two weeks' time.
>
> A copy of the hospital notes dated 27 June 2005 headed *'Discharge planning'* shows that this window contains a checklist with 12 boxes requiring ticking. One box is labelled *'Follow up appointment'*. This box is ticked. There is a comment in the surrounding box stating *'Discussed'*. This is a contemporaneous record that suggests that there was a conversation with [Mrs B] by the day surgery nurse regarding her follow up appointment, which was at [Dr C's] rooms. There is no comment there to suggest that [Mrs B] queried this or expressed concern.
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> A photocopy of the *'Day Theatre telephone follow up'* is included in the file. The date that [Mrs B] was telephoned was 28 June 2005. On the line headed *'Follow up*

[6] As noted on page 4 above, Dr C's fee for his preoperative and postoperative consultations was actually $85.

[7] Mrs B's optometrist's letter concludes: "Her [Mrs B's daughter] would like the account sent to her at PO Box […, ...]"

[8] Dr C's appointment letters state: "*Please note that payment is required on the day of each appointment. This can be made either by cheque or cash but we don't accept credit cards nor EFTPOS payments*."

appointment' is written *'Check they have rung to make an appointment on Wednesday.* On the next line headed *'General Comments'* there is written *'Resting today. Family around'*. There is no comment regarding any concern about the fact that her follow up was at [Dr C's] private rooms."

The lawyer submitted:

"[Dr C] says that he gave an explanation to [Mrs B], in accordance with his usual practice, regarding her remaining as a private patient if she elected to do so. The correspondence certainly confirms that appointments were made at his rooms, and that on some of the correspondence there was notification that she would have to pay. In addition, the initial referral was made through an optometrist, and she could only have expected to be seen as a private patient. [Mrs B] clearly has memory difficulties … [Mrs B] has been expected to recall, with those difficulties, issues that occurred some years previously. The quality of her recollection must remain in question and therefore it is submitted that there is no basis for a breach finding in this regard.

…

[Dr C] has had considerable experience with elderly patients, and advises that he maintains a good rapport with them. He also instructs that many understandably have memory difficulties, and he always takes this into account when providing treatment … The Commissioner has referred to [Mrs B] finding [Dr C] quite intimidatory. [Dr C] is surprised and upset by that comment and had noted in his notes that [Mrs B] was chatty; he regarded her as relaxed. He has instructed me that he tries to have a friendly and open rapport with all his patients, and takes particular care of those who are elderly, and may have difficulties either in mobility or memory."

The lawyer commented that the "key issue" was where Mrs B wanted to be followed up and treated. She stated:

"[Dr C's] position is that he would have discussed that with her, and proceeded according to her views. There is favourable evidence for this, in [Mrs B's] return to his practice. She could have asked the optometrist to refer her into the public hospital system; she did not."

The lawyer emphasised that there was no intention on Dr C's part to exploit Mrs B. She stated:

"I am instructed by [Dr C] that if he inadvertently did not, on that particular occasion make [Mrs B's] options sufficiently clear, that was neither intentional nor an attempt to exploit [Mrs B] … [Dr C] is saddened by any suggestion that [Mrs B] felt intimidated and says that had [Mrs B] advised him that she wished to be followed up at Southland Hospital that would have been arranged. The effect of this would have been that the secretary at Southland Hospital would have needed

> to cancel another patient from the hospital clinic for each of the extra appointments."

The lawyer highlighted the benefits, and the necessity, of offering a mixed private/public option for preoperative and postoperative appointments for cataract surgery. She submitted:

> "[Dr C] points out that, for an operating list with four cataracts on it, each patient would create a minimum of four consultations relating to that operation. Firstly there is the initial consultation to decide on the need for surgery. Later is the preoperative check and biometry. Following surgery is at least a two-day and a two-week check and in many cases additional visits and longer-term follow-up appointments. Each weekly operating list with four cataracts therefore generates a minimum of 16 associated outpatient visits and that is more than the number of outpatient appointments [Dr C] could see each week in his weekly public clinic.
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> …
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> Whilst (rightly or wrongly) it was accepted by [Southern Health] that private patients could be placed directly on the waiting list for surgery, the effect of their then filling the outpatient clinics with preoperative and postoperative checks, would be to prevent those who had been waiting for a first specialist assessment at the public hospital, from being seen."

As a result of Mrs B's complaint, Dr C no longer offers private patients the option of being referred directly to the waiting list from his rooms and having the pre and postoperative care done privately. His patients are now provided fully public or fully private surgery.

Comment from the Ministry of Health
Dr David Geddis, Chief Medical Advisor, Ministry of Health, confirmed that the practice of referring patients directly onto the waiting list after a private FSA is widespread. However, he emphasised that, for a public patient, all care following FSA is covered under the public system.

Dr Ray Naden, Clinical Director, Elective Services, Ministry of Health, provided the following advice on the issues raised by the practice of a specialist providing some services to a patient in a private capacity and some in a public capacity:

> "Thank you for the opportunity to comment on the general situation raised by your investigation of the situation involving [Mrs B] and [Dr C].
>
> I understand you wish me to comment on the issues raised by the practice of a specialist providing some services to a patient in a private capacity and some in a public capacity.

New Zealand has an inherently mixed private and public health system. Whereas public hospital services are free to the patient, provided by publicly-funded health professionals, general practitioner services are essentially provided by private practitioners, with publicly-funded subsidies in some cases, as are services of pharmacists, physiotherapists, etc.

It is common in New Zealand for medical specialists to work part of their time in both a private and public capacity. It is not uncommon for a specialist to treat the same patient for the same episode of care at times in a private capacity and at other times in a public capacity; for example, seeing a patient privately, arranging their surgery in the public hospital, perhaps even performing the surgery in their role as a public hospital specialist, and seeing the patient later for follow-up again in their private capacity. In my opinion, this practice is not inherently unethical or inappropriate, but it is important to ensure that:

a) the patient is fully informed of their options, both their publicly and privately funded options
b) the publicly-funded options are as freely available to the patient as to any other similar patient (i.e., free from inappropriate discrimination)
c) there are no pressures brought to bear on the patient to choose the private option (i.e., free from coercion).

While there may be nothing inherently unethical or inappropriate about a practitioner providing a patient with a mixture of public and private care, it is a situation which carries considerable risk of misunderstanding and misperception by the patient with the consequence (even if not intended by the practitioner) of the patient feeling misinformed, discriminated against or coerced. Clearly a specialist providing such a mixture of care would need to take great care to avoid this outcome. The onus is on the practitioner to ensure that his or her practice is consistent with the requirements above (a–c).

In my view, District Health Boards and other health service providers also have responsibilities to ensure that patients' rights are protected in this situation of mixed public and private care.

It may be more straightforward for medical practitioners to restrict their services to an individual patient to either their public or private practice, and indeed many practitioners do adopt this approach. However in my view the individual patient should have the final choice of whether they opt for private care or public care, or a mixture of both if this is available, and to exercise or change that choice at any time. Irrespective of which they choose, the care should be provided in a manner which protects the patient's rights, under the Code of Health and Disability Services Consumers' Rights and otherwise, even though this may be more challenging in the mixed option of care.

The mixed public–private model of care raises another issue, not of the rights of the specific patient, such as [Mrs B], but of the rights of other patients. When a

specialist provides a patient, who has consulted them in a private capacity, access to public hospital surgery, it is important that the specialist does not give their patient an unfair advantage over others. A doctor needs not only to provide access to available options but also should only be able to shift patients from his or her private practice to the public system if those patients are subject to the same priority assessment criteria and are not seen before more needy patients in the public booking system. (Refer paragraph 17 of 'Statement on safe practice in an environment of resource limitation', Medical Council of New Zealand, October 2005).

I hope these comments are of assistance. While I offer these in my role as Clinical Director of the Elective Services programme and from my professional experience as a medical specialist, this opinion is not necessarily the position of the Ministry of Health."

Response from Southland District Health Board

On 18 August 2005, SDHB received Mrs A's complaint that a patient was charged for preoperative and postoperative visits for public cataract surgery. Mrs B's identity was subsequently disclosed to SDHB by this Office on 20 September 2005.

In response, SDHB advised Mrs A (on 19 December 2005) that Mrs B was a private patient of Dr C and it was therefore unable to take the matter further. SDHB also advised that it did not hold any ophthalmology notes for Mrs B. SDHB was unaware that Mrs B had received publicly funded cataract surgery until after the investigation was commenced (on 9 March 2006) — apparently due to an administrative oversight. SDHB further advised this Office (on 14 July 2006) that it had been unable to deal with the complaint any further, as investigation established that Mrs B had been a private patient of Dr C.

Ms G, Chief Operating Officer, SDHB, explained that SDHB became aware of Dr C's practice of charging patients accepted for public cataract surgery for preoperative and postoperative appointments when looking into a complaint (involving another patient) in March 2006. As a result, Dr C was made aware of the need to see these patients at the hospital, unless the patient specifically requested to be seen at his private rooms. In her letter dated 24 March 2006 to Dr C, Ms G stated:

"… [O]ne of the issues [I] have a concern with is that she [another patient] appears to have been called to see you privately in your rooms after she had been referred and placed (at her request) onto the public list for surgery. To my mind, the moment she is referred, she becomes a public patient and ought not to be seeing you in your private rooms. Any further consultations unless specifically requested by the patient should be within the public sector."

On 18 April 2006, Dr C responded:

"You state in your letter that you have a concern about her [the other patient] being seen privately after her referral to the public system. I can assure you this did not

> occur. She was referred to me by her GP but she elected to be seen publicly thereafter. There was a minor misdemeanour in my secretary inadvertently sending a letter to [the patient] but that did not result in any appointment.
>
> You also state that a private patient once referred becomes a public patient and any further consultations should, *unless specifically requested by the patient,* be conducted in the public sector. I agree, and confirm this has been my practice for some time. It may reassure you however to know that I am no longer willing to see patients who wish to see me privately for pre and postoperative care but wish to have the surgery publicly. Once a private patient elects to be treated in the public system then the patient is advised that I cannot see them privately thereafter."

Ms G explained that cataract surgery is funded under the generic national service specification contract and an electronic record of referral sources is kept. There is no requirement or capacity for SDHB to monitor the actions of individual consultants — although there have been reviews at the departmental level which did not reveal any cause for concern. SDHB places a level of trust in its employees to conduct themselves appropriately. Ms G stated:

> "SDHB relies upon cooperation and trust from its consultants that have private practices. The management of waiting lists and public/private referrals is a partnership between the DHB and the consultant. The only way of putting systems in place to prevent abuses of the partnership would be to exclude the consultant from the management process which is neither practicable nor in our view necessary when in the vast majority of cases there are no issues with the public/private partnership.
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> …
>
> We have in the past run a report to ascertain referral source in order to ensure both public and private referred patients were getting access to public treatment. This report was run for all Southland District Health Board specialities and there was at that time certainly no cause for concern."

Dr F stated that the waiting time in early 2006 for FSA for public patients waiting to see an ophthalmologist was 24 months for routine cases. Dr F explained that following the employment of locum ophthalmologists earlier this year, and a new full-time ophthalmologist, it is expected that the waiting times and backlog for FSAs will be reduced to six months.

Independent advice to Commissioner

The following expert advice was obtained from ophthalmologist Dr Peter Haddad:

"Thank you for asking me to provide expert advice/opinion to the Health and Disability Commissioner on case 05HDC12122.

I confirm that I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

My qualifications, training and experience are as follows:

- BSc (Med), MB.ChB (Cape Town), DO.(London), FRCSE., FRANZCO.
- I have held a full time post as Consultant and Lecturer at Dunedin Hospital.
- I have had a private practice in Dunedin.
- I have been in public and private practice in Tauranga for 21 years.
- I have been Secretary of the Ophthalmological Society of New Zealand.
- I am currently the Vice Chairman Elect of the NZ Branch of RANZCO.
- I am currently Chairman of the Joint RANZCO and MOH Committee revising the National Cataract CPAC tool.
- I am currently on a NZMC Practice Assessment Committee (PAC).
- I have done an External Review of the Wanganui Ophthalmology Department
- I have been asked to be the external assessor on the Otago District Health Board's Credentialing committee for the Senior Medical Officers.

Purpose:

To provide independent expert advice about whether [Dr C] and Southland District Health Board (SDHB) provided an appropriate standard of care to [Mrs B].

Expert Advice Required:

1. In your professional opinion were the services provided to [Mrs B] by [Dr C] and SDHB appropriate?
2. What standards apply in this case?
3. Were those standards complied with?

If not covered above, please answer the following:

1. Was [Dr C's] clinical assessment and treatment of [Mrs B] appropriate?
2. Did [Dr C] provide [Mrs B] with appropriate information about her treatment options and the associated costs?
3. Was it appropriate for [Dr C] to score [Mrs B] in his private rooms?
4. Was [Dr C's] referral of [Mrs B] to Kew hospital for cataract surgery appropriate?

5. Was it appropriate for [Dr C] to charge [Mrs B] for pre and postoperative appointments?
6. Did SDHB take adequate steps to ensure that [Mrs B] was appropriately managed.

Complaint:

Dr C

- *Whether [Dr C] provided [Mrs B] with adequate information about her treatment options, including the cost of those options*
- *The appropriateness of [Dr C's] management of [Mrs B's] treatment in both the public and private sector.*

Southland District Health Board

- *Whether SDHB took adequate steps to ensure that [Mrs B] was appropriately managed following her referral to the Southland Hospital waiting list for cataract surgery.*

Report:

[Mrs B] consulted [Dr C] on 3 Dec[ember] 2003 at his private rooms following a referral from a local optometrist for a watery eye. At that consultation he noted her to have cataracts and arranged to see her in a year's time. This was entirely appropriate.

He again reviewed her condition on 9 Dec[ember] 2004. At that consultation he again diagnosed cataracts and in his opinion these had advanced to the point where she would benefit from cataract surgery. As she was unable to afford private surgery she opted to have her cataract done through the public system at Kew Hospital. [Dr C] states that he gave her the option of going straight onto the public hospital surgery waiting list if she scored sufficient points to reach the threshold for surgery or to be referred to Kew Hospital outpatients for a First Specialist Assessment (FSA) — an option that would result in considerable delay. I have no reason to believe that this offer was not presented as such. In my opinion this was entirely acceptable and appropriate.

It is customary around New Zealand for specialists who work in both the public and private sectors to put private patients on public hospital waiting lists. This is a way of jumping the queue to get onto the surgery waiting list. Whilst it favours those patients who are able and are prepared to pay for a private consultation it does disadvantage those patients who cannot afford the private consultation (as they have to first wait to get an FSA before being waitlisted). On the other hand it saves the Government a huge cost as all those patients who get listed for public surgery via a private consultation (in some areas 50% of the patients waitlisted for public surgery get onto the list via the private sector) would otherwise have to be seen in the public outpatients thereby dramatically increasing the outpatient FSA

numbers and/or waiting times. This practice is well known to the Ministry of Health and has been in use for decades.

[Dr C] then scored her using the Cataract Clinical Priority Access Criteria (CPAC) tool. This tool is in national use across the country. Its manner of use varies from area to area but it was again entirely appropriate that he score her in his rooms at that visit. This allowed [Dr C] and [Mrs B] to ascertain that she had sufficient points to go onto the public surgical waiting list for cataract surgery.

Her name was forwarded to Kew Hospital and she was waitlisted for cataract surgery. I note a letter to [Mrs B] from the Ophthalmology Department dated 24 Dec 2004 stating that she had had a recent visit to the [local Eye Clinic]. I assume that this is a form letter sent out to all patients who are put on the waiting list and that it refers in fact to her visit to [Dr C's] private rooms on 9 Dec and that she did not actually attend the Eye Clinic as stated.

I note that [Mrs B] attended a cataract nurse's clinic on 13 May 2005 and was scored using the CPAC scoring tool for cataracts. She was given 38 points which was very similar to the 35 points [Dr C] had given her. The purpose of this visit escapes me.

[Mrs B] was then booked for day stay cataract surgery to be done on 27 June 2005 at Kew Hospital. She again visited [Dr C] in his private rooms on 7 June 2005. At this visit her Biometry (ultrasound measurement to determine the strength of her intraocular lens implant) was done.

She underwent uncomplicated day stay cataract surgery to the right eye on 27 June 2005 at Kew Hospital.

[Mrs B] then attended [Dr C] at his private rooms for two postoperative visits on 29 June and 13 July 2005. Her postoperative visual result was very good.

In my opinion all these services provided by [Dr C] and SDHB were entirely appropriate and of an acceptable standard. The standard applying in this case would be the standard of preoperative, operative and postoperative care for cataract surgery found across New Zealand. I can find no cause at all to criticise the care given to [Mrs B] and indeed I find no criticism about the standard of care or the outcome of the operation from [Mrs B].

As I read it, this complaint arises out of the fact that [Mrs B] was charged for pre- and postoperative visits which she had not expected to pay for as her surgery was undertaken in the public sector. I have not found any evidence from [Mrs B] stating that she was not told that she would be charged for the pre and postoperative visits however the nature of the complaint leads me to conclude that this was indeed the case. [Mrs B] stated in a telephone interview that she was surprised at being charged for her postoperative visits as her friends who had had

similar surgery had not had to pay. She felt somewhat intimidated and therefore did not broach the subject with [Dr C].

The nature of public sector cataract surgery is such that it is free to the patient. That free service would normally include preoperative biometry, the operation itself, any inpatient time and postoperative follow up visits (for uncomplicated cataract surgery generally considered being two or three visits over a 2 to 4 week period). My understanding is that a District Health Board gets a set fee for cataract surgery from its funder arm (or the MOH) and included in that fee is the cost of preoperative biometry, surgery and any inpatient time. Postoperative follow up visits are funded via the outpatient contract. Once [Mrs B] went onto the public cataract surgery list she became a public patient for that episode and her treatment from then onwards should be free. That being the case it would be inappropriate for [Mrs B] to pay for her biometry appointment and her postoperative follow-up visits because they had already been paid for in the fee SDHB received for the cataract surgery and as provided for in the outpatient contract. If [Dr C] were to charge for those visits in his private rooms (and I think it is appropriate that he does) then the charge should be to the SDHB. If this is to be a continuing practice then the two parties should enter into some kind of contractual agreement. It is inappropriate for the patient to pick up the cost in these circumstances.

Across the country it would generally be expected that, if you have your cataract surgery in the public sector, then your biometry and postoperative visits would be free wherever they are undertaken. I believe that that would be the patient's expectation and if there were to be a departure from that practice it would need to be specifically explained to the patient preferably in verbal and written form.

In charging a public patient for their biometry and postoperative care I find [Dr C] in breach of his duties to his patient.

SDHB is aware of its need to provide pre- and post cataract surgery assessment (letter Dr F to HDC 13 April 2006) indicating therefore that the practice undertaken by [Dr C] (whereby patients were charged) was inappropriate. SDHB was unaware at the time that this practice was occurring. Unless someone had brought it to their notice it would be extremely unlikely that they would have knowledge of it. It is reasonable for SDHB to expect that cataract surgery undertaken in the public hospital would be followed up in the public system (despite the fact that it may clog up the public clinics). I would not expect that there would be systems in place to monitor this. SDHB brought this matter to [Dr C's] attention as soon as they became aware of it. As a consequence, [Dr C] has altered his practice and no longer sees public patients for postoperative follow up in private. That is clearly appropriate and good. In view of this I find that the SDHB did not breach the patients' code of rights in this case.

I find the breach in patient care that has occurred by [Dr C] mild."

Arrangements between Dr C and Southland DHB

During the course of the investigation, conflicting evidence was presented about the arrangements between Dr C and Southland District Health Board (and its predecessors Southland Area Health Board and Southern Health Crown Health Enterprise). The account of both parties is set out below.

Dr C
On behalf of Dr C, his lawyer submitted that the system of charging Mrs B was established, and had been condoned, by Dr C's employer. The lawyer provided a letter from Mr E, Group Manager of Surgical Services, Southland Hospital — written to a patient transferring to Dr C's private care, from the private care of ophthalmologist Dr D. (The letter was apparently written in 1996, around the time that Dr D left Southland Hospital.) Mr E stated:

> "You could make a private appointment to see [Dr C] at his private rooms … [Dr C] would reassess your eye condition and if he is in agreement with the decision for eye surgery, he will arrange to perform measurements on your eye and would perform postoperative follow up visits at his private rooms after you had your surgery at Southland Hospital. As with [Dr D], these preoperative consultations and follow up visits would be at your own expense."

The lawyer also stated:

> "[Dr C] was complying with a regime that had been set up, and which he understood was accepted, both historically and at the time that he was seeing [Mrs B]."

Southland District Health Board
Southland District Health Board (SDHB) was provided with the opportunity to respond to the lawyer's submission that charging for patients such as Mrs B had been supported by the previous administration, the Southland Area Health Board (SAHB).

Dr F informed me that the SDHB could not find any record of the letter written by Mr E, which he noted "appears undated and not addressed to anyone". Dr F confirmed that Dr D resigned on 7 January 1996. The letter the lawyer provided was likely to have been sent shortly afterwards. However, the Board disputed that the letter shows an acceptance by SAHB of Dr C's practice of charging public patients privately. The Board commented that this suggestion was "clearly mischievous".

The Board advised that SAHB management had significant difficulties with its eye department in 1995, including in relation to equipment, workloads, ongoing conflict between Dr D and Dr C, and dealing with a significant backlog of cataract operations.

The Board provided a letter dated 30 January 1996 (after Dr D's resignation) in which Dr C wrote to Mr E:

> "I confirm that I am prepared to perform the extra 32 or so of [Dr D's] cataracts required to complete the base volumes for the year … This will have to be done in my private time and I would charge my normal private rates for a new patient examination ($80) and a reduced fee for biometry ($70), a total of $150 per patient over and above the surgical fee.
>
> …
>
> Private patients of [Dr D's] on whom I operate at Southland Hospital should have their care transferred to my private rooms rather than their suddenly becoming a public hospital patient by default."

The Board advised me:

> "You will note then that given the circumstances it would appear that the Southland Area Health Board (SAHB) had little choice but to accede to [Dr C's] proposal amongst a host of further demands for the extra cataract surgery. This was clearly not the SAHB usual practice, but a specific arrangement in relation to specific circumstances following the departure of [Dr D]."

The Board also provided correspondence showing that, in November 1997, when SAHB became aware that Dr C had charged public patients for consultation held in his private rooms, it took disciplinary action against him as a result. SAHB considered the matter was a "very serious breach of trust". On 25 November 1997, the then Southern Health Chief Executive Officer directed Dr C that "under no circumstances" was he to engage in any work without having an "absolutely clear contract and understanding" of the arrangements around such work, "be it within the employment contract or outside the employment contract".

In response, Dr C agreed to pay back money to patients he charged (for public cataract surgery related appointments).[9]

The Board submitted that there is no indication that it was aware or condoned Dr C's practice of charging patients. The Board noted that in his letter dated 18 April 2006 (see above, pages 10, 11) Dr C agreed that once a private patient was referred publicly, all future treatment should be public unless specifically requested. Dr F observed that Dr C did not attempt to argue that his conduct had been condoned by the previous administration. He stated:

> "I would suggest that even if you were to conclude that the SAHB did condone [Dr C's] practice circa 1996, there is more than enough evidence by the time of

[9] On 28 November 1997, Dr C advised SAHB that he "genuinely and honestly believed" under the terms of his agreement with SAHB that he was "entitled to charge the patients that he did". Dr C agreed to refund the patients he charged, without any admission of liability.

> [Mrs B's] treatment [that] [Dr C] was under no illusion in relation to the public/private rules."

Dr C's response

The lawyer disagreed with Dr F's comment that SAHB had "little choice to accede to Dr C's demands" in relation to the agreement about the extra cataract surgery patients following the departure of Dr D. At the relevant time, the outpatient clinic could not keep up with demand and was subject to "severe criticisms" from general practitioners and the public. Management support was given to Dr C as the senior ophthalmologist, and he conducted additional clinics without payment in 1994. The lawyer stated:

> "What Dr F has failed to emphasise, is that for a significant portion of that time, [Dr C] was the only ophthalmologist in the whole of Southland. [Dr C] has long been committed to providing the ophthalmological service to Southland Hospital.
>
> …
>
> [Dr C] instructs that at the beginning of 1996, he found himself in a position where Southern Health was already under resourced, and he was, in January 1996 the sole ophthalmologist as [Dr D] had resigned.
>
> …
>
> That [Dr C] agreed that [Dr D's] patients should have their care transferred to his private care in that situation can, with respect, hardly be construed as a 'demand' by [Dr C]. I am instructed that [Dr C] held one clinic each week at the public hospital. [Dr C] recalls that there were about 60 such private patients of [Dr D's] and [Mr E] was aware that if 60 such patients were to suddenly transfer to Southland Hospital as a bolus it would take [Dr C] two months just to see these patients and perform biometry, at his weekly clinics. [Dr C] was also expecting to inherit all of [Dr D's] public clinic patients, as well as managing his own. [Dr C] recalls that as being the essence of [Mr E's] concern, and [Dr C] agreed to see those patients at his rooms when asked by [Mr E], as outlined in [Mr E's] letter to the patients.
>
> [Dr C] has instructed that there was a clear distinction between routine operating list patients and extra surgery patients and that, when referring in that letter to the 'extra 32' patients [see page 16 above] that [Mr E] had asked him to operate on for a fee, the $150 mentioned was a fee invoiced to and which was paid by [Southern Health], not the patients, as these were not [Dr C's] private patients."

The lawyer submitted that the issues around the waiting times fund contract that arose between Southern Health and Dr C in November 1997 have no relevance to Dr C's management of his normal patient load (those not included in the waiting times fund contract), and the waiting times fund contract work was performed outside Dr C's employment contract. She stated:

> "[Dr C] has instructed that the waiting times fund surgery was a discrete contract, was put out to tender, and [Dr C's] tender was accepted for that extra surgery. [Dr C's] tender stated that patients from his private rooms were to be followed up at his rooms; 'Private patients will, as at present, have their preoperative and postoperative assessments [at my rooms].' In that tender, [Dr C's] use of the term 'as at present' (referring to the non-WTF cataract surgery) supports his understanding that [Southern Health] management were aware of that practice.
>
> …
>
> You will note that the letter of complaint written by Southern Health on 25 November 1997 … was written by the then CEO. The hospital's concern at that time was that as [Southern Health's] waiting times fund contract with the [Health Funding Authority] apparently included a payment for postoperative visits that should apply to the contract that [Southern Health] had with [Dr C]. [Dr C's] position was that that was unclear from the separate tender between him and [Southern Health]; that was accepted by [Southern Health].
>
> …
>
> Dr F states that '[Dr C] agreed to pay back the money to patient so charged once SAHB became aware'. That is not the case and [Dr C] does not accept that … [Dr C] refunded money to his private patients 'without prejudice'. This had nothing to do with the contract but represented an expression of good will to end an elongated and public dispute."

The lawyer provided copies of correspondence in relation to three cataract surgery patients which she submitted "were supportive of the understanding" between Dr C and Southern Health of "what was considered accepted practice between him and his patients and the hospital".

First, the lawyer provided a copy of a letter from the Southern Health CEO to a public cataract surgery patient dated 9 April 1998. The patient had written to Southland Hospital querying an invoice for $85 from Dr C dated 21 April 1997. In her letter of response, the CEO stated:

> "Surgery performed during this time [28 July 1997] was not part of the waiting times fund contract, and therefore the cost of any private consultations will not be covered by this contract."

The lawyer also provided a note (in relation to the patient above) from the then surgical services manager advising the CEO (by handwritten note on Dr C's invoice) that Dr C was legitimate in claiming "for this". The lawyer stated:

> "There is, it is submitted a clear distinction drawn by [the CEO], between the waiting times fund cataract surgery … and [Dr C's] usual practice of which Southern Health were aware. It is clear, it is submitted, that Southland Hospital

> knew of and accepted, the charging for private consultations that occurred outside of the waiting times fund."

Secondly, the lawyer provided a letter from the CEO (to another patient) dated 3 October 1996 in which the CEO confirmed to the patient that, as he was Dr C's private patient, he should attend Dr C for a further assessment. (The patient had apparently written to the CEO querying when he would receive his cataract surgery.) The lawyer noted that the CEO was clearly aware that the patient was on the waiting list for cataract surgery at Southland Hospital. The CEO's letter states:

> "As you consult privately with [Dr C] your request was discussed with him.
>
> …
>
> If your eyesight is deteriorating can I suggest that you return to [Dr C] so a further assessment can be undertaken, as this may demonstrate that you need to be moved further up the waiting list."

Thirdly, the lawyer provided correspondence in relation to a patient who had been referred by Dr C to Southland Hospital for a first specialist assessment (FSA) in April 1997. In early February 1998, the patient wrote to the CEO querying when he would be seen. The patient stated: "I had the option to go to Kew or pay him [Dr C] $80.00 at his house." The lawyer commented that the patient's letter indicates he clearly understood that he was given the option of private or public treatment by Dr C. The lawyer then provided correspondence from Southern Health to Dr C (dated February and April 1998) requesting clarification whether the patient had already been seen in Dr C's private rooms and whether he needed to be seen in the outpatient clinic, prior to his name being added to the surgical waiting list. (According to the lawyer, the referral information had been sent by Dr C but could not be located by Southern Health.)

Dr C also informed me that it was agreed "over 15 years" ago by "sympathetic management" that he could see acute public hospital patients at his private rooms to assist with patient volumes. He invoiced these consultations as a "nil" charge which were then forwarded to Southern Health to be included in its figures.[10] Dr C explained that the arrangement was that he would get the equivalent time off in leave in recompense, although this rarely eventuated. He stated:

> "Emergencies were seen immediately but most acute patients did not fit into that category and did not need always to be seen the same day. Most acute GP calls occurred when I was outside the hospital, either at my private rooms performing a private clinic, or at home in the evening with my family. It was often more convenient for both the patient and for me for them to be seen at my private rooms yet still as a public patient, especially if I was in the middle of a busy private clinic

[10] SDHB provided this Office with a list of 17 zero balance invoices forwarded to Ms G by Dr C for the financial year ending June 2001.

and especially if they presented in the second half of the week, after my weekly Wednesday public clinic.

Some, especially those presenting on Monday or Tuesday could often reasonably wait until my Wednesday morning clinic. An alternative would be for them to have been seen at the end of the day at Southland Hospital. Both tended to happen, so not infrequently a patient was seen at my private address for either their or my convenience (usually both), during the middle of an all-day private clinic.

This did not at all imply that the patient was in any way considered a 'private' patient, however. Unless a record was kept of that consultation, [Southern Health] would not be able to add the figure to its contractual volumes each year, and if [Southern Health] did not reach its funded numbers, its funding would be reduced. For that reason, to suit [Southern Health], it was a simple matter to document the consultation by means of a 'nil' invoice simply as a record for [Southern Health] and my understanding was that [Southern Health] then added those patients. [Southern Health] (but not I) claimed extra monetary compensation (from the RHA) for those public patients seen at my private rooms.

There was never any suggestion that I would gain financially from that: it was simply the most practical way to deal with the situation of an overworked, busy sole specialist providing an unreasonably heavy on-call roster, with no junior assistance."

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 2
Right to Freedom from Discrimination, Coercion, Harassment and Exploitation

Every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial or other exploitation.

RIGHT 4
Right to Services of an Appropriate Standard

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

RIGHT 6
Right to be Fully Informed

(1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including —

…

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

Opinion: Breach — Dr C

Information about public/private treatment options and costs
Right 6(1)(b) of the Code states that a patient has the right to information about the options available, including the expected costs of each option. In my view, Dr C failed to ensure that Mrs B understood the options of fully public or part public/part private treatment and that there would be additional costs (for which she would be personally liable) for any private consultations associated with her public cataract surgery.

Mrs B can no longer recall the details of what was discussed. What is clear is that, after the initial consultation, Mrs B understood that any associated treatment would be free after she requested public cataract surgery rather than private. She was distressed to be burdened with unexpected additional costs but was reluctant to question Dr C.

Support person Mrs A accompanied Mrs B to her initial postoperative appointment on 29 June 2005. Mrs A informed me that Mrs B was "quite indignant" and "immensely" surprised that Dr C had charged her for preoperative and postoperative appointments. Mrs A forwarded a letter of complaint dated 15 August 2005 on behalf of Mrs B. The letter was addressed to the Board and copied to the Health and Disability Commissioner and the Minister of Health.

Dr C claims that he would have discussed the two broad alternatives of public and private treatment with Mrs B. He does not "specifically explain" to all private patients that any future private appointments will incur a fee, because "the average person realises" this, with the "implication" that a private fee is to be expected.

Mrs B does not recall any discussion of options. There is no documentation to support Dr C's claim that he discussed the public or private treatment options with Mrs B.

My expert advisor, Dr Haddad, observed that the nature of public cataract surgery is that there is no cost to the patient. The patient should be informed if there is to be a charge. Dr Haddad stated:

> "[I]t would generally be expected that, if you have your cataract surgery in the public sector, then your biometry and postoperative visits would be free wherever they are undertaken. I believe that that would be the patient's expectation and if there were to be a departure from that practice it would need to be specifically explained to the patient preferably in verbal and written form."

Dr Ray Naden, Clinical Director, Elective Services, Ministry of Health, also noted the need for "great care" by a practitioner providing a patient with a mixture of public and private care, to avoid the patient feeling misinformed.

Given that Dr C has only a general recollection; Mrs B has no recollection of being told about the charges she would incur personally, and was surprised and indignant to be billed; and Dr C failed to document that he had told Mrs B about the unusual arrangement, I conclude on the balance of probabilities that Dr C did not properly inform Mrs B about the options of fully public or part public /part private treatment and the expected costs of the latter.

Dr C's lawyer noted that there is no record of Mrs B expressing concern about her associated treatment occurring at Dr C's private rooms — which was apparently discussed with her by hospital staff on two occasions (27 and 28 June 2005). Mrs B also received a letter advising her that her preoperative and postoperative appointments would be at Dr C's room. However, Mrs B's lack of concern is consistent with her believing that all her treatment (whatever the location of the service provision) was being publicly funded, and there is no indication that any of the communications she received from the ophthalmology department referred to additional costs.

The onus was upon Dr C to ensure that Mrs B understood the situation — rather than waiting for any expression of concern from Mrs B. The legal test for informed consent is not, as Dr C suggests, what the average person would realise by implication. The practitioner is required to volunteer the information that a reasonable patient in the *particular patient's circumstances* would expect to receive. I do not consider it is reasonable to expect Mrs B (aged 82) to understand the costs involved in being, in effect, a hybrid private/public patient.

In my view, Mrs B had a reasonable expectation that her public cataract surgery would be free, and there is no evidence that she was given explicit advice to the contrary. In these circumstances Mrs B was understandably confused about the reason for the further charges she incurred. It appears that being seen in Dr C's private rooms only added to her confusion. Unfortunately, she felt unable to question the situation at the time. Although Dr C's standard appointment letter contains a reminder that payment is expected on the day of the consultation, there was no specific mention on any of the associated documentation of the cost of her preoperative and postoperative

appointments. In any event, such a reminder could not remedy an earlier failure to provide information about costs.

Dr C's responsibility was to ensure that Mrs B understood that there would be further costs after she had been placed on the waiting list, if she saw him for private consultations in relation to her surgery. The discussion should have been documented. In my opinion, Mrs B was not adequately informed about her treatment options and the likely costs. Accordingly, Dr C breached Right 6(1)(b) of the Code.

Charges in relation to public cataract treatment
Under Right 2 of the Code of Health and Disability Services Consumers' Rights (the Code), Mrs B had the right to be free from financial exploitation. "Exploitation" is defined in clause 4 of the Code to include "any abuse of a position of trust, breach of fiduciary duty, or exercise of undue influence". Dr C was also obliged to comply with ethical standards, under Right 4(2) of the Code.

On 3 December, Dr C saw Mrs B at his private rooms, having been referred to him by her optometrist. At that point she was clearly a private patient. Mrs B (and her daughter) expected to pay for the private treatment she received from Dr C. Dr C reviewed Mrs B on 9 December 2004 and formed the view that she was a suitable candidate for cataract surgery. Mrs B chose to have cataract surgery in the public system.

Dr C referred Mrs B onto the waiting list for public cataract surgery, after scoring her using the Cataract Clinical Priority Access Criteria (CPAC). This negated the need to wait for a public first specialist assessment appointment (FSA), since Mrs B had effectively had a private FSA. Dr Haddad advised that referring patients directly onto the hospital waiting list after a private FSA is "entirely acceptable and appropriate".

I note, in passing, that this widespread practice raises ethical issues, since it results in differential access for the public by giving preferential access to the booking system for elective services, to patients who can afford to pay for a private FSA. It may, however, be countered that the practice prevents the public FSA system from becoming clogged up, and in that sense ensures greater access to elective services within the public system.

Mrs B was seen by Dr C for a preoperative assessment on 7 June 2005. She underwent uneventful cataract surgery on 27 June 2005, with postoperative reviews on 29 June and 13 July 2005.

My expert advisor, Dr Haddad, stated:

> "In my opinion all these services provided by [Dr C] and SDHB were entirely appropriate and of an acceptable standard. The standard applying in this case would be the standard of preoperative, operative and postoperative care for cataract surgery found across New Zealand. I can find no cause at all to criticise the care

> given to [Mrs B] and indeed I find no criticism about the standard of care or the outcome of the operation from [Mrs B]."

It is common ground that Dr C charged Mrs B for her preoperative and postoperative assessments. Dr Haddad considered that this should not have occurred, since "the nature of public sector cataract surgery is … that it is free to the patient". He stated:

> "Once [Mrs B] went onto the public cataract surgery list she became a public patient for that episode and her treatment from then onwards should be free. That being the case it would be inappropriate for [Mrs B] to pay for her biometry appointment and her postoperative follow up visits because they had already been paid for in the fee SDHB received for the cataract surgery and as provided for in the outpatient contract."

Nevertheless, Dr Haddad accepted that [Dr C] could properly charge for patients seen at his private rooms, but that (1) the reasons for the charges (if the patient is to be billed directly) would need to be "specifically explained to the patient preferably in verbal and written form"; or (2) there should be an arrangement for the cost to be passed to the district health board.

Dr David Geddis, Chief Medical Advisor, Ministry of Health, confirmed that all care following a first specialist assessment is covered for public surgery patients. Dr Ray Naden, Clinical Director, Elective Services, Ministry of Health, advised that there is "nothing inherently unethical or inappropriate" about specialists providing a patient with "a mixture of public and private care", but "great care" is needed to avoid the risk of misinformation, discrimination or coercion.

There is no evidence that Dr C intended to financially exploit Mrs B, although he would have been well aware that Mrs B was entitled to free treatment. Dr C's lawyer stated:

> "I am instructed by [Dr C] that if he inadvertently did not, on that particular occasion make [Mrs B's] options sufficiently clear, that was neither intentional nor an attempt to exploit [Mrs B]."

I also acknowledge that Dr C was operating under significant resource pressures at Southland Hospital — which had at times required specific arrangements to clear the backlog of cataract operations. The lawyer submitted that Dr C's practice of undertaking private preoperative and postoperative assessments for those private patients referred directly onto the public waiting lists relieved pressure on the outpatient clinic and avoided delays to those patients awaiting a public FSA.

Exploitation may occur in the absence of any intention to exploit. Dr C was in a position of trust vis-à-vis Mrs B. The onus is on Dr C to show that he did not abuse his position of trust when he charged Mrs B for preoperative and postoperative services she was entitled to receive free of charge. In my view, that onus has not been discharged. I am not satisfied that Mrs B made an informed choice to pay for the

convenience of private consultations pre- and post-surgery. Nor can Mrs B's position be affected by any arguments that Dr C's practice was implicitly condoned by the current or previous administration (see below).

Particular care is needed because of the potential conflict between a doctor's duty (including the duty to explain that all the necessary treatment is available in the public system) and self-interest (for example, in bolstering his private income). Scrupulous disclosure is especially important when a doctor has responsibility for a patient's position on the public waiting list *and* has a private practice.

In my view, the effect of Dr C's conduct was to exploit Mrs B and to fail to comply with ethical standards, as a result of the failure to explain her options and the extra costs for private consultations. In these circumstances, Dr C breached Rights 2 and 4(2) of the Code.

Opinion: No Breach — Southland District Health Board

As a provider of publicly funded cataract services, SDHB had an obligation to ensure that patients waiting for elective cataract surgery were adequately informed about their treatment options, including the option of private (or partly private) treatment, and the estimated costs.

The information disclosure obligations of a district health board in relation to "elective" services and its waiting list/booking system are discussed in the Southland District Health Board urology case (04HDC13909, 4 April 2006).

In the present case, SDHB relied on Dr C to provide the required information to patients in fulfillment of both his own obligation (as an individual doctor) and the obligation of the district health board (as the corporate health care provider). For the reasons set out below, with some slight misgivings, I conclude that SDHB's reliance on proper disclosure by Dr C was reasonable in the circumstances, and that SDHB is not directly liable for his failure to provide adequate information.

SDHB confirmed that it is funded to provide preoperative and postoperative appointments in relation to cataract surgery performed at Kew Hospital by ophthalmology staff. There is no funding related requirement (or actual capacity) to monitor the actions of individual consultants, in whom SDHB places a level of reliance and trust. In addition, there have been reviews at the departmental level of referral sources and the effects on waiting times for publicly/privately funded patients, which did not give rise to cause for concern. SDHB advised that it was not aware of Dr C's practice of charging public cataract patients until March 2006, when looking into a complaint involving another patient.

The lawyer presented an undated letter indicating that the Southland Area Health Board (SAHB) had condoned the arrangement of charging public patients directly for preoperative and postoperative appointments. The patient was informed that payment would be required for preoperative and postoperative consultations. It appears that this patient may have been included in arrangements for clearing the backlog of cataract patients in 1996 following the resignation of the other ophthalmologist at Kew Hospital, Dr D — although Dr C informed me that his $150 charge for each of the extra 32 patients of Dr D was paid by his employers. The precise details of the arrangement reached between Dr C and SAHB (following the resignation of Dr D) in relation to the extra cataract patients are outside the scope of my report.

SAHB took disciplinary action in November 1997 against Dr C in relation to the charging of public cataract patients seen by him under the "waiting times fund" contract. This was regarded as a "very serious breach of trust". The lawyer has submitted that the dispute over the waiting times fund contract was a discrete issue and has no relevance to the manner in which Dr C managed his "normal" (public or private) patients. I accept that the waiting times fund contract issues were, technically, not related to Dr C's employment contract. However, Dr C was specifically requested not to engage in any further work (within or outside his employment contract) without having an "absolutely clear contract and understanding" of the arrangements around the work.

I do not accept the lawyer's submission that the correspondence provided in relation to three patients indicates that the system of charging patients such as Mrs B had been condoned by Dr C's employers. Rather, the correspondence confirms Dr C's practice of referring private patients directly onto the public waiting list at Kew Hospital. As noted above, this is common practice. It is an entirely different matter whether such patients should incur further charges in relation to their public cataract surgery.

My advisor, Dr Haddad, stated:

> "Unless someone had brought it to their [SDHB's] notice it would be extremely unlikely that they would have knowledge of it. It is reasonable for SDHB to expect that cataract surgery undertaken in the public hospital would be followed up in the public system (despite the fact that it may clog up the public clinics). I would not expect that there would be systems in place to monitor this. SDHB brought this matter to [Dr C's] attention as soon as they became aware of it. As a consequence, [Dr C] has altered his practice and no longer sees public patients for postoperative follow up in private."

It is not entirely clear whether, historically, Dr C's practice of charging patients for preoperative and postoperative visits for public cataract surgery was condoned (either explicitly or implicitly) by the previous administration (or by individuals within that administration). In any event, there is no information to suggest SDHB knew that Dr C had resumed charging patients seen at his private rooms in relation to public hospital cataract surgery. Southland Hospital ophthalmology department staff were obviously generally aware that Dr C was seeing public patients at his private rooms.

However, Dr C was one of two ophthalmologists at Southland Hospital and appeared to act with a considerable degree of autonomy. There is no evidence to suggest that SDHB was informed by ophthalmology department staff of Dr C's practice — or that ophthalmology department staff were aware of the specific nature of Dr C's charges to patients.

SDHB promptly advised Dr C that he should not continue his practice of charging public cataract patients for associated consultations, after being alerted to this practice in March 2006 when investigating a complaint concerning another patient. SDHB could not realistically be expected to have known about Dr C's practice — following the one-off arrangement in 1996, and disciplinary action in 1997, he had been specifically told not to bill public patients for preoperative and postoperative consultations (albeit in the context of the waiting times fund contract). In 2005, SDHB was not aware that Dr C was passing the cost of preoperative and postoperative consultations held at his rooms onto public patients, and there was no contractual obligation to monitor this aspect of Dr C's conduct.

It is unfortunate that Mrs A's complaint did not trigger action by SDHB after being advised of her identity by this Office in September 2005. Mrs B was initially a private patient of Dr C, but she became a public patient after she was placed on the waiting list for cataract surgery. Therefore, the complaint did potentially raise concerns about charging a public patient but this fact was obscured by an administrative oversight that led SDHB to believe erroneously that Mrs B was a private patient of Dr C.

Overall, I consider that SDHB is not liable for Dr C's breaches of the Code. I note that SDHB has achieved considerable improvement in waiting times for ophthalmology first specialist assessments since these events.

Recommendations

I recommend that Dr C:

- apologise to Mrs B for his breaches of the Code
- review his practice in light of my report
- refund Mrs B the cost of her preoperative and postoperative consultations.

I recommend that the National Ethics Advisory Committee be asked to advise the Minister of Health on the ethical issues raised by the current mix of public and private treatment options in relation to elective services and whether any guidelines are needed to clarify the limits of ethically acceptable practice.

Follow-up actions

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

- A copy of this report, with details identifying the parties removed (other than Southland District Health Board and Kew Hospital), will be sent to the Minister of Health, the Director-General of Health, the National Ethics Advisory Committee, the Commerce Commission, the New Zealand Medical Association, the Association of Salaried Medical Specialists and the Royal Australasian College of Surgeons, and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Names have been removed (except Kew Hospital/Southland DHB) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's name.