Orthopaedic Surgeon, Dr B

Opinion – 98HDC15935/VC

Complaint

The Commissioner received a complaint from Mr A about treatment he received from Dr B. The complaint is that:

- *On 27 February 1997 Mr A had an operation for right hip revision at a public hospital. The surgeon was Dr B. During the surgery Mr A's femur was broken. Remedial action was taken to fix the femur while still in theatre.*
- *Subsequent x-ray revealed the femur angulated by 28°. Dr B instructed Mr A be fitted with a hip spica cast but the fracture was not re-aligned and is now reunited in this position.*
- *Mr A asked Dr B why the fracture had not been re-aligned. Mr A feels he was not given a satisfactory answer by Dr B. Mr A continued to have pain.*
- *Mr A visited Dr B on 25 November 1997. Mr A informed Dr B of his meeting with a Health and Disability advocate, to discuss his concerns regarding the hip operation. Dr B was rude and stated he did not wish to have anything further to do with Mr A.*
- *Mr A complained in writing to the public hospital. Mr A was not happy with the response he received.*
- *Dr B's health was deteriorating and at a meeting on 5 January 1998 with Dr C, it was agreed that the senior manager of the orthopaedic department would see Mr A.*
- *On 12 January 1998 Mr A was referred by his GP to the emergency ward at the public hospital because of pain and problems at the fracture site and hip joint. Dr B was the duty surgeon that day. Dr B informed Mr A that he would not treat him and that Mr A had to choose another surgeon for further treatment. Mr A was referred to Dr D.*
- *On 3 February 1998, Mr A received a report from Dr B in reply to a letter written by a customer relations officer at the public hospital on 18 December 1997. Dr B stated there were several changes of plaster and that the fracture was realigned on at least two occasions subsequent to the spica cast. Mr A says that theatre records would indicate that no such procedures took place.*
- *Mr A has not been in pain since Dr D operated on his right hip on 27 June 1998.*

Orthopaedic Surgeon, Dr B

Investigation Process

The complaint was received by the Commissioner on 6 July 1998 and an investigation was commenced. Information was obtained from:

Mr A	Consumer
Dr B	Provider / Orthopaedic Surgeon

Relevant medical records and x-rays were reviewed. The Commissioner obtained independent advice from an orthopaedic surgeon.

Information Gathered During Investigation

Background: Pre 1 July 1996

On 31 July 1985, orthopaedic surgeon, Dr B, performed a Charnley right hip replacement on Mr A. On 24 September 1994, Mr A presented at a public hospital complaining of clicking in his right hip with associated discomfort down his right side. There was no radiological evidence of loosening of his prosthetic right hip but x-rays demonstrated progressive deterioration in his left hip. As a result Mr A was placed on Dr B's waiting list for a left hip replacement. There was no loosening of the right hip joint replacement at this time.

Dr B next saw Mr A on 8 November 1995 and fresh x-rays confirmed the presence of bony deterioration at the tip of the right hip prosthesis. Dr B decided that in order for Mr A to mobilise appropriately after any surgery on his right hip, he needed to have his left hip replaced first. The left hip needed to be replaced urgently and this was done on 29 February 1996.

Post 1 July 1996

On 27 February 1997 Dr B performed a revision of Mr A's loose right hip prosthesis using an impaction allograft technique (bone packed down the femur to strengthen for the prosthesis).

During the course of this surgery Mr A said his femur (thighbone) was broken. Mr A said Dr B took remedial action in theatre to fix the femur but subsequent x-rays revealed the femur was angulated at 28 degrees. Dr B instructed that a hip spica cast (cast encircling the waist and leg) be fitted but the fracture was not realigned and is now apparently reunited in this position. Mr A said that when he asked Dr B why the fracture had not been realigned he was not given a satisfactory answer and has continued to experience pain.

Dr B explained to the Commissioner that it is not uncommon during a revision for a lateral window of the femur shaft to be fashioned in order to gain full clearance of cement from the previous replacement. This is what happened in Mr A's case. During the cement removal a small longitudinal

crack appeared in the femur shaft spreading down from the level of the bone window. This crack was prophylactically wired prior to insertion of the allograft cement and prosthesis. Dr B said that otherwise the procedure was uneventful.

The operation note for 27 February 1997 records: "*A bone window was made to remove the distal cement. Whilst in the process of removing the cement, a small longitudinal crack appeared in the femur. This was prophylactically wired. Operation continued with replacement and of the bone window and application of mesh graft. This graft was also wired into place*".

Because of the small crack in the femur shaft Mr A was mobilised touch weight bearing only and discharged home in mid March. By 26 March 1997 when he attended an outpatient appointment Dr B said Mr A was able to take some weight on his right leg and stand without crutches. An x-ray at that time showed no change in position of the right hip joint.

On 4 April 1997 Mr A presented at the Emergency Department at the public hospital complaining of pain, swelling and a feeling of tightness in the operation area. When Mr A tried to get up he experienced pain in the right hip and experienced difficulty lifting his leg up. A haematoma (collection of blood) adjacent to the tip of the prosthesis was suspected and a CT scan was carried out from mid shaft to the tip of the femur prosthesis. The CT scan described a discrepancy in the width of the soft tissues on the right hip but no discrete mass, collection or haematoma was identified. No other abnormalities and, in particular, no fracture was reported.

On 9 April 1997 Dr B examined Mr A at an outpatient clinic. The notes record that the swelling on the lateral aspect of his thigh had largely settled but that he still had marked weakness of hip flexion which was of no great concern at that time. A follow up appointment was arranged for one month later to commence full weight bearing and also for an x-ray and lateral views of the right hip to be taken.

Dr B informed the Commissioner that:

> "*Unfortunately before that appointment [Mr A] was readmitted on 23 April when he woke up with an aching knee and hip and had noticed a bulge out the lateral side of his right thigh whilst showering. X-rays confirmed a transverse fracture of the femur at the level of the window. A socket was prepared for a cast brace, and when the socket was ready a cast brace was applied under anaesthesia on 29 April. An attempt was made under general anaesthesia to correct the angle deformity at the femur fracture shaft. Although largely corrected, there was considerable resistance to the correcting force. I took the decision not*

> *to exert greater force since the result could have been a calamity in terms of loss of end to end apposition of bone at this level. Unfortunately, there was subsequently a loss of position and [Mr A] was readmitted on 6 May and returned to theatre for re-manipulation and application of a fresh cast brace on 13 May. Again, good reduction was obtained but excessive force was avoided.*"

The operation note of the 29 April 1997 recorded:

> "*An attempt was made under general anaesthesia to correct the angle deformity at the femoral shaft fracture site. This was only partially successful but it was decided to accept the position. Cast brace then applied. It was remarkable how little movement there was available at the fracture site and how resistant it was to correction.*"

At a conference in June 1997 Dr B said he discussed Mr A's case with Dr E, an acknowledged world authority in the field of impaction allograft revision surgery for loose prosthetic hips. Dr B said Dr E agreed with the management of Dr B's femur fracture to date and recommended avoidance of surgical intervention if at all possible. There is no record in the clinical notes of this discussion.

Dr B informed the Commissioner that:

> "[*Mr A] was next seen in the outpatients department on 2 July when he gave a history of having tripped over the track of a sliding door and fallen two weeks previously; it was evident radiologically that he had re-angulated his right femur fracture measured on that occasion as just under 32 degrees. I stated my policy at that time that in view of the abundant new bone formation seen immediately adjacent to [Mr A's] fracture with some also appearing laterally as well as anteriorly, it would be acceptable to exchange his cast brace for a plaster spica for eight weeks, with correction of the fracture angulation prior to application of the spica. I stated that I considered that all things being equal he would proceed quite rapidly to full union over this period of time.*"

The outpatient record of 2 July 1997 noted:

> "*Orthopaedic Clinic: Had a fall about two weeks ago. He tripped over the track of a sliding door and has re-angulated his right femoral fracture measured today at just under 30 degrees. Policy: In view of the abundant new bone formation seen immediately adjacent to this man's fracture and there is also some appearing laterally as well as anteriorly, I would consider it acceptable to exchange his cast brace for a plaster spica for eight weeks with correction of the fracture*

> *angulation prior to application of the spica. I would consider that all things being equal he would proceed quite rapidly to full union over this period of time.*"

The hip spica cast was applied on 4 July 1997. At an outpatient visit on 6 August 1997 there was no increase in the angulation of Mr A's femur fracture. There was abundant new bone formation although there was some inhibition of new bone formation laterally over the wire mesh that had been applied to close the site of the window.

The plaster spica was removed on 20 August 1997, since Mr A found it quite uncomfortable. On 8 October 1997 it was noted that the x-ray showed a minimal increase in his angulation but more new bone formation had appeared medially.

> Dr B informed the Commissioner that: "*[O]n 19 November when I saw [Mr A] he was very unhappy with his hip. Flexion at his knee had increased from 30 degrees to 70 degrees. Hip movements remained weak, but he did demonstrate straight leg raise against gravity. There was no tenderness over his fracture side and the fracture felt solid*".
>
> Mr A informed the Commissioner that: "[*Dr B] asserted that I had been offered and declined further surgery at his clinic on 19 November 1997. No such discussion took place and obviously is not recorded in the clinical notes. He then informed me that I had to choose another surgeon for further treatment. The choice being [Dr F] or [Dr D]*"

The outpatient record of 19 November 1997 recorded:

> "*Is very unhappy with his hip. Currently has 70 degree flexion at the knee. All movements at the hip are weak but he does have straight leg raise against gravity. There is no tenderness over his fracture site and it feels solid. There was no movement there. However [Mr A] is most unhappy with the situation and has through the Health & Disabilities Commissioner sought a second opinion who I understand is [Dr G] and he wishes that further treatment be left in the hands of [Dr G].*"

Mr A said no such suggestion was made and that Dr B told the nurse that there would be no further appointments.

Mr A visited Dr B on 25 November 1997 and informed him of his contact with a health and disability services consumer advocate. Mr A said Dr B was extremely rude and stated that he did not wish to have anything further to do with Mr A. Mr A then put his concerns in writing to the public hospital and was not happy with the response he received.

In his response to the Commissioner, Dr B said Mr A informed him that he had complained to the Health and Disability Commissioner and that a second opinion was to be supplied by Dr G.

On 12 January 1998, Mr A was referred by his general practitioner to the emergency ward at the public hospital because of pain and other problems at the fracture site and hip joint. Dr B was the duty surgeon that day, but informed Mr A that he would not treat him and that he had to choose another surgeon for further treatment. Mr A chose Dr D who took over his treatment. Mr A said he was admitted to hospital under the care of Dr D for further examination, treatment and eventually correction surgery on 27 June 1998. Mr A said that the corrective surgery "*restored his leg to the correct length, gave him back his life, plus an 80% abatement of the pain he had been experiencing*".

Dr B informed the Commissioner that:

> "*In the course of an extensive discussion with [Mr A] and his wife I explained with complaints against me outstanding it was in [Dr B's] best interests for further treatment to be transferred to another orthopaedic surgeon. I explained that the surgeons available at that time to take over his treatment (it was holiday time) were [Dr D] or [Dr F] and [Mr A] chose [Dr D]. At a meeting that evening I discussed his case with [Dr D] who agreed to take over further care. I had hoped to be able to scrub in with Dr D at the performance of the necessary surgery but in the event was unable to.*"

Mr A said that as his health was deteriorating he requested a meeting with Dr C, Acting Chief Executive Officer of the public hospital. This occurred on 5 January 1998 and it was agreed that the senior manager of Orthopaedic Department would see Mr A and that the public hospital would meet his costs for massage, as the costs were a result of the break in his femur during the revision operation.

On 3 February 1998 Mr A received a report from Dr B in which he stated that there had been several changes of plaster. Dr B stated that the fracture was realigned on at least two occasions subsequent to the spica cast. Mr A noted that theatre records would surely indicate that no such procedures took place.

In his letter of 3 February 1998 Dr B stated:

> "[*Mr A] asks why the cast was not replaced after shrinkage between the leg and the cast was evident, as pointed out to [Mr A]. I am afraid I do not fully understand the question; as outlined above there were several changes of plaster. I regret I am unable to recall the event complained of by [Mr A] here and I cannot make a sensible reply.*"

In his response to the Commissioner, Dr B said that he was unaware of any rudeness on his part to Mr A but said that the mere fact that Mr A felt he was rude is regrettable in the extreme and to this end he offered Mr A his unreserved apology for any rudeness as it was not and has never been his intention to be rude to Mr A.

Dr B said that it was unfortunate that Mr A suffered a transverse fracture of a femur shaft but this is an acknowledged potential complication of hip revision surgery and is not unknown even during primary replacement surgery. Management of the fracture failed to produce an ideal result and eventually resulted in open reduction and surgical fixation. However, Dr B maintains it was reasonable in the circumstances to continue with attempted conservative treatment of the fracture, particularly as he had support and advice from Dr E.

Dr B said that in every consultation he had with Mr A he was at pains to explain clearly what was happening and the pros and cons of various treatment, particularly surgical versus conservative. Dr B regrets that Mr A felt he was not given a satisfactory answer, particularly where things have not gone as well as they otherwise might. Dr B said he takes particular care to explain details carefully to patients and regretted that Mr A continued to have pain that they were doing their best to alleviate.

Dr B advised the Commissioner that the orthopaedic surgeons at the public hospital have a meeting every Friday morning where they discuss difficult cases and that Dr B's case was discussed at these meetings. Dr B added that these consultations were not recorded due to the fact that there were no dictation recording facilities available in the staff education unit where the meetings are held. Dr B informed the Commissioner that he has asked the hospital management to provide recording facilities in order that the advice or criticisms of colleagues can be immediately recorded.

Orthopaedic Surgeon, Dr B

Independent Advice to Commissioner

The advisor informed the Commissioner that:

"*The Charnley replacement introduced in 1962 has been described as 'the gold standard'. It was one of the first cemented total hip replacements. The prosthesis consists of a plastic socket, which is fixed, using acrylic cement, into the bone of the pelvis, after reaming out the arthritic socket to the appropriate size. A further component is inserted into the thigh bone (the femur component) after removal of the arthritic femur head and preparing the shaft of the femur. This component has a rounded head which articulates with the plastic socket. The femur component is also cemented in place. Although satisfactory long-term results are obtained in a high proportion of cases, one or both components may loosen with the passage of time. An excepted figure for the loosening rate is 1% per year, that is at 10 years about 10% will have loosened and at 20 years 20%. Although the loosening may be apparent on x-rays this does not inevitably give rise to symptoms and on occasions symptoms are intermittent. The decision, as to when the time has come to revise the hip replacement, depends in part on the symptoms experienced and also in the x-ray appearances. With progressive loosening there is loss of the bone of the pelvis if the socket loosens and of the bone of the femur if the femur component loosens. The loss of the bone is described as the loss of bone stock and in some cases the new components are again cemented in place but [if] there has been significant absorption of bone, bone grafting is required. In a revision operation the loose component is removed usually without much difficulty, but in addition removal of all previously inserted cement is required.*"

The advisor further informed the Commissioner that:

"*To facilitate this it is usual to cut out a piece of bone (a window), part way down the shaft of the femur. This means that the cement can be removed from the top of the femur and also further down the shaft. The window is used in part to facilitate removal of the cement, and also to check the position of the instrument being inserted down the femur from the top. The size of the window varies depending on the difficulty experienced in removing the cement but it is not of such a size as to weaken the femur. However, the presence of the window gives rise to what is described as a stress riser, which concentrates stress at that point and makes the femur more likely to fracture. A technique which has been developed in recent years is that of impaction bone grafting. The bone may be taken from the patient's pelvis (an autograft) or banked bone used (an allograft). The bone is cut up*

> *into small fragments and then very firmly packed or impacted down the femur, using shaped punches of different sizes which allow space for the femoral component to be inserted, after the bone graft has been impacted. Acrylic cement is then inserted followed by the femur component. Part of the operative technique is to ensure that the bone graft is packed in place very firmly.*"
>
> "*On occasion a crack may occur extending from a corner of the window. In order to prevent the crack extending further several techniques are used one of which is to place an encircling wire or wires around the femur and tightening these firmly. The bone, which has been removed as a window, is ordinarily replaced. A piece of metal gauze may also be wired under the window to prevent extrusion of bone graft or cement through the window. In most cases where there has been a crack or incomplete fracture, the use of wires or encircling bands combined with partial weight bearing on crutches is sufficient to prevent the fracture propagating and becoming complete. However on occasions sometimes after a stumble or fall and sometimes for no apparent reason the fracture becomes complete. A decision then has to be made by the surgeon as to whether a further operation with more extensive fixation on the fracture is undertaken or the fracture is mobilised to allow union to occur. Operative treatment is difficult and the advantages have to be weighed against the risks of the fixation failing and the bone graft (which is essential for the fixation of the femoral component) not incorporating and the replacement again loosening. Non operative treatment may be by means of a cast brace.*"

The advisor informed the Commissioner that one technique for a cast brace uses a pre-formed plastic socket enclosing the upper part of the thigh incorporated in a cast extending down to the ankle and usually with hinges at the knee. Another method is to use a spica cast that is a cast that encircles the waist and includes the leg:

> *"[S]ometimes in order to allow knee movement the spica is hinged at the knee and the foot is left free. If there is angulation or displacement at the fracture site attempts are made to correct this. However if full correction cannot be maintained it is usually prudent to allow the fracture to unite in the angulated position knowing that this can be corrected later. A modular component may be useful for the revision and it was in this case. This means that the head and shaft are separate which allows head with different length of neck to be used in order to establish stability and to reduce the risk of dislocation. A Multilock replacement is a particular brand of uncemented component that has a roughened*

surface to allow bony ingrowth to anchor the component. Such component was used in the other hip in this case."

The advisor informed the Commissioner that the development of a crack fracture during the revision operation is a well recognised complication of the procedure and there is simply no way of avoiding it. The crack may occur even if a window is not removed but in that case it is more commonly at the upper end of the femur shaft. There is no means of knowing, in any individual case, how much force is required to cause the crack and the method used by Dr B to minimise the chances of the fracture propagating and becoming complete would be that used by most if not all surgeons.

The post operative procedure of minimal weight bearing on the leg was appropriate. A further investigation, x-rays and CT scan when Mr A reported back for pain on 4 April 1997 were appropriate for the investigation of the pain. The decision to delay proceeding to full weight bearing on the leg was prudent in view of the pain, and it was unfortunate and disappointing that despite this the fracture became complete. The advisor noted that "*[t]he fracture was transferred, which means that angulation is likely, and may be difficult to control. The angulation occurs simply because of the pull of muscle*".

The advisor informed the Commissioner that in years past before hip replacement and the development of modern methods of internal fixation, transferred fractures of the femur shaft were usually treated by the application of traction and immobilisation in a splint for a minimum period of 12 weeks. The advisor could recall cases where immobilisation either in a splint or in a plaster spica was required for 24 weeks. This type of treatment would not now be considered appropriate in a person aged 73 years, as the likelihood of chest and other complications such as pressure areas is high. Alternative methods using a cast brace or hip spica are preferable.

The advisor commented that although initially the angulation seemed to be controlled satisfactorily it increased following the fall in June 1997. The measurement of angulation is approximate and depends on obtaining the same x-ray projection each time but this is not practicable. A variation of five degrees between x-rays is not significant. There will always be slight differences at different methods they used. In the early stages the new bone that forms, if the fracture is uniting, is pliable and can be moulded to a different position, but as union progresses it becomes firmer and ultimately rigid. The advisor stated that "*[t]here is always some movement under a cast and looseness does not necessarily mean that fixation is lost and I would not place much significance on that as a cause for the angulation*".

The advisor informed the Commissioner that:

> "*I am unable to reconcile the statement in the clinic note of 2 July 1997, that there was abundant new bone formation with the decision to manipulate the fracture to correct the angulation and to apply more extensive immobilisation in the hip spica. The abundant new bone formation and the fact that it was about ten weeks from the fracture makes it unlikely that the position could have been corrected without actually re-fracturing the femur and breaking down the commencing union. If this had occurred there is a real risk that an even more difficult problem would have been created. In my opinion the failure to manipulate was fortunate and did not disadvantage [Mr A].*"

The advisor noted that Dr B took the opportunity to discuss the problem with Mr E who was conducting a course in New Zealand. Dr E was a pioneer of the technique used having performed the first operation, using impaction, bone grafting and cement in Exeter, in England, in May 1997. Although Mr E agreed with the management to date and recommended avoidance of surgical intervention if at all possible, it is not noted whether he considered the position acceptable in the long term.

The advisor stated that he would have had concern that angulation of the degree present would be likely to produce an abnormal strain on the knee with the development of symptoms, which proved to be the case. Although Dr B says that a good reduction was obtained at the time of a new cast brace on 13 May 1997, there are no x-rays showing the position at that time. X-rays on 18 June 1997 show angulation of about 28° in the cast break. The advisor noted that it is possible that the angulation would have developed no matter how the fracture was treated. The advisor further commented:

> "*It is however my opinion that the chances of this would have been reduced by applying a hip spica initially as this would give a more complete and firmer immobilisation. In addition there would be the ability to correct the angulation by wedging the plaster, that is removing a segment, then closing the gap by moving the lower part of the leg to the corrected position.*"

The advisor noted that it is a matter of surgical opinion as to whether fractures of this type occurring as a complication of a hip replacement operation are treated non-operatively as in this case, or by open reduction and internal fixation as soon as the fracture has occurred.

Orthopaedic Surgeon, Dr B

The advisor noted his concern to the Commissioner that the records for Mr A did not include a treatment plan:

> *"In my opinion once the fracture had occurred it would have been appropriate to record a plan for the further management of the problem. If it becomes necessary to modify the plan this should be recorded."*

And added:

> "*There is no record of any consultation with Orthopaedic colleagues at [the public hospital]. In my opinion this would have been prudent in view of the difficulties experienced in control of the angulation.*"

The advisor further stated:

> "*There is no record of the discussion with [Dr E]. In my opinion this should have been recorded and I would have expected this to include comments as to whether [Dr B's] case had been discussed in general terms or in particular. I would also have expected some comment as to whether the degree of angulation present was acceptable in the long term.*"
>
> *"Although [Dr B] states that at every consultation it pays to explain clearly what was happening and the pros and cons of various treatments, particularly surgical versus conservative, this is not recorded in the notes. In my opinion my points of concern do not require detailed or time consuming notes to be made but are important. My view is that the notes should be such that another surgeon could take over the management of the case in the event that the treating surgeon was not available. This is very much facilitated if there is a treatment plan."*

Orthopaedic Surgeon, Dr B

Code of Health and Disability Services Consumers' Rights

RIGHT 1
Right to be Treated with Respect

1) Every consumer has the right to be treated with respect.
…

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.
…

Opinion: No Breach

Right 1(1)

Given the credibility both of Mr A and Dr B, in my opinion, there is insufficient evidence for me to conclude that Dr B treated Mr A with disrespect.

Right 4(2)

Fracture and management of fracture
The development of an incomplete fracture during hip revision surgery is a known complication of the procedure and there is no way of avoiding it. The method used by Dr B to minimise the chances of the fracture becoming complete was appropriate and a CT scan of 5 April 1997 showed no fracture.

Although the angulation seemed to be controlled satisfactorily, it increased after Mr A's fall in June 1997. On occasions after a stumble or a fall, or for no reason at all, a fracture can become complete. Dr B opted for a conservative approach and non-surgical intervention at this point. Based on the advice from my advisor, Dr B's decision not to manipulate the fracture to correct angulation on 2 July 1997 was reasonable.

In my opinion, in relation to his decision to opt for non-surgical intervention, Dr B complied with professional standards and therefore did not breach Right 4(2) of the Code.

Referral to another orthopaedic surgeon
In my opinion it was appropriate for Dr B to refer Mr A to Dr D when he knew there was a complaint against him. Where a competent alternative provider is available to treat a consumer who has lodged a complaint, it is appropriate for the provider complained against to refer the consumer to that alternative provider, to avoid any risk that conflict might compromise ongoing care.

Opinion: Breach

Right 4(2)

Record keeping
There was no record in the notes of any consultation with orthopaedic colleagues at the public hospital. In my opinion this would have been prudent in view of the difficulties experienced in controlling the angulation.

There is no record of Dr B's discussion with Dr E and whether Dr B's case was discussed in general terms or in particular. There is also no record that Dr B discussed the pros and cons of various treatments with Mr A particularly surgical versus conservative management of the fracture.

Once the small longitudinal crack occurred during the right hip revision on 27 February 1997, it would have been prudent and appropriate for Dr B to record a plan for the further management of this problem. Furthermore, if it subsequently became necessary to modify the treatment plan, this too should have been recorded.

Good record keeping is an essential requirement for good professional practice. Rule 4 of the NZMA Code of Ethics states that "*accurate records of fact must be kept*". Additionally, in the 1999 edition of the Medical Council of New Zealand's publication entitled 'Cole's Medical Practice in New Zealand' the Council advises that "*a doctor is expected as part of quality of service to maintain adequate records*".

Clinical notes should be of such a standard that another surgeon could take over the management of the case in the event of Dr B not being available. All treatment and advice should be recorded. In my opinion, by not recording a treatment plan concerning management of Dr B's fracture, his discussion with Mr E, and that he discussed surgical and non surgical options with Mr A, Dr B failed to comply with Rule 4 of the NZMA Code of Ethics and Medical Council guidelines. In this respect, Dr B breached Right 4(2) of the Code.

Orthopaedic Surgeon, Dr B

Actions

I recommend that Dr B takes the following actions:

- Amends his practice to ensure all discussions with other consultants are recorded including details of actions taken, advice given and decisions made by both the consumer and himself.

- Amends his practice in future to ensure that should problems such as a fracture occur during a hip replacement, that a treatment plan is drawn up to further manage the problem and to ensure that any modifications to such a plan are also recorded.

Other Actions

A copy of this opinion will be sent to the Medical Council of New Zealand and the Royal New Zealand College of Surgeons.