Dr B

Health New Zealand | Te Whatu Ora

A Report by the
Health and Disability Commissioner

(Case 22HDC02421)

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Contents

Complaint and investigation

1. On 29 September 2022 the Health and Disability Commissioner (HDC) received a complaint from Ms A about the services provided to her on 9 April 2018 by Dr B at Middlemore Hospital (Health New Zealand|Te Whatu Ora (Health NZ) Counties Manukau).[1] The following issues were identified for investigation:

- *Whether [Dr B] provided [Ms A] with an appropriate standard of care in 2018.*
- *Whether Health New Zealand|Te Whatu Ora provided [Ms A] with an appropriate standard of care in 2018.*

2. The parties directly involved in the investigation were:

Ms A	Consumer
Dr B	Provider/plastic surgeon
Health NZ Counties Manukau	Provider

3. Further information was received from:

Dr C	Provider/registrar
Dr D	Provider/registrar
Dr E	Provider/fellow
ACC	

Information gathered during investigation

Background

4. This opinion relates to Ms A's concerns about breast reduction surgery performed by plastic surgeon Dr B at Middlemore Hospital on 9 April 2018. The primary issues in Ms A's complaint relate to her concern that she did not consent to junior doctors operating on her and that this was a 'teaching exercise'. Her belief was that Dr B would be the operating surgeon for both breasts. Ms A is deeply unhappy with the results of the surgery. This opinion is focused on the informed consent process, rather than the outcome of the surgery.

5. On 24 February 2015[2] Dr B examined Ms A and recorded that she had moderately large and heavy breasts bilaterally, with the right breast larger than the left breast. She described significant problems around her shoulders with back pain, and difficulties with both sleep

[1] On 1 July 2022 the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all district health boards. Their functions and liabilities were merged into Te Whatu Ora|Health New Zealand (now Health New Zealand|Te Whatu Ora). All references in this report to Counties Manukau DHB now refer to Health NZ Counties Manukau.

[2] Ms A had been referred by her GP on 20 October 2014, with reference to 'moderate' functional impairment described as back pain so severe that she could not work long hours, and she had 'major' social impairment.

and exercise. Dr B diagnosed asymmetrical macromastia (abnormal enlargement of breast tissue).

6. Ms A saw Dr B on several occasions in the years following. The consultations occurred at a medical centre on 17 May 2016, 29 November 2016, and 22 August 2017. Dr B told HDC that it was uncommon to meet so many times with a patient preoperatively, and the consultations occurred because Ms A had other medical conditions that needed to be addressed, and concerns regarding the sequalae of previous surgical interventions that had had ongoing effects on her life with unresolved medical issues.

7. On 17 May 2016 Dr B reported that Ms A remained quite conflicted because of her very significant fears about the surgery and attendant complications versus her desire for breast reduction. On 29 November 2016 Dr B recorded that they had a lengthy discussion around her expectations of surgery and the fact that it was unlikely to have any positive impact on her breathing dynamics or her back pain.

8. Ms A told HDC that she spent many months considering whether to proceed with the surgery. She said that she was a size 14 with HH cup sized breasts, and she and Dr B decided that a reduction to a DD cup size would suit her frame. She said that she had huge anxieties and concerns about surgery, and Dr B put her at ease during their meetings in clinic before she decided to proceed. She said that she was aware of, and accepted the risks of, asymmetry, wound healing, and sensory changes, and, as she knew that Dr B was a very experienced surgeon, she was comfortable to proceed.

9. In response to the provisional opinion, Dr B submitted that during the period 2015–2017 Ms A did not raise concerns about a surgeon other than him operating on her.

Pre-admission assessments — June–September 2017

10. On 2 June 2017 Ms A was seen at the pre-admission clinic by a house officer. Ms A told the house officer that she had significant anxiety related to the surgery and previous experiences of anaesthesia. It was recorded that Ms A was unsure whether she wanted to go ahead and thought she would be seeing Dr B that day. Ms A also wished to speak to the anaesthetist who would be performing her anaesthesia. The house officer noted: 'I have explained to her that this will not be possible, however, I will arrange for her to be seen in anaesthetic clinic.'

11. It appears that the house officer discussed this with Dr B, who suggested that the surgery be postponed and said that he would review Ms A at a routine follow-up clinic.

12. Ms A was next seen by Dr B on 22 August 2017, as she was keen to proceed with surgery, and that day he completed a booking form for her procedure.

13. On 23 August 2017 the anaesthetist recorded that Ms A was 'anxious ++' and would be better managed if seen in clinic.

Anaesthetic pre-assessment clinic — 8 September 2017

Ms A attended an anaesthetic pre-assessment clinic on 8 September 2017 with resident medical officer (RMO)[3] Dr F. Dr F noted that Ms A was very anxious about the upcoming anaesthesia and had requested that anaesthesia registrars not be involved in her care. The records state: 'I explained in detail why this is not possible in the public health system.' The specific details of what he told Ms A are not recorded. Ms A stated in response to the provisional opinion that Dr F was aware of her reasons for requesting that no registrars be involved in her care and, although he did not record the details of the conversation, that was discussed with him fully.

14. In response to the provisional opinion, Dr B submitted that he was not aware of what had been said in the preadmission clinic. However, as stated above, Ms A's request not to have anaesthetic registrars involved in her care is recorded in her clinical notes. Health NZ Counties Manukau told HDC that it is likely that Dr F explained to Ms A that registrars would be involved in her care because Counties Manukau is a teaching/training healthcare provider. Health NZ stated: 'As such, Counties Manukau believe that [Ms A] was aware prior to her surgery, that RMOs (junior doctors) would be involved in her care.' In response to the provisional opinion, Ms A stated that she was not informed that RMOs (junior doctors) would be involved in her surgery, and she became aware of the role of an 'RMO' only after receiving HDC's provisional opinion.

15. Health NZ said that the clinic rooms where Ms A was seen preoperatively on multiple occasions display a poster informing patients that students may participate in their care, and that patients have the right to decline student involvement. However, there is no specific mention of RMOs on the posters because RMOs are providing clinically necessary services. Health NZ said that all staff are expected to introduce themselves to their patients and explain their roles. Ms A stated that all staff did not introduce themselves to her and explain their individual roles.

16. It appears that Ms A was on the waiting list as at late 2017 but was removed at her request, as she wanted to defer the surgery again until 2018 due to personal circumstances. Ms A was scheduled for her procedure on 9 April 2018.

Consent process — 9 April 2018

Preoperative discussion and consent form

17. On 9 April 2018 Ms A, then aged 46 years, presented to Middlemore Hospital at 8.30am for the breast reduction surgery. She told HDC that she understood the risks and expectations clearly. She said that first she met with the anaesthetist, then she was shown into a room to change into a gown and wait for Dr B.

18. Dr B told HDC that he is a consultant for Middlemore Hospital.

[3] An RMO is a qualified doctor and includes house officers and registrars. RMOs are sometimes referred to as junior doctors.

19. Dr B said that on 9 April 2018 he met with Ms A in the preoperative area along with members of his team, senior registrar Dr C ,[4] and Dr E,[5] a recently qualified plastic surgeon.[6] There is conflicting and limited evidence as to the extent to which the surgeons' roles were discussed with Ms A. Dr B said that in accordance with usual practice, the team is introduced 'as a matter of course but most pointedly when a patient is marked up in an exposed state such as with breast reduction'.

20. Ms A said that a female and a male accompanied Dr B into the room, and Dr B simply said, 'These are students,' with no discussion of their roles. In response to the provisional opinion, Ms A stated that introductions were not made. She said that the two 'students' accompanying Dr B remained standing by the door, and Dr B sat with her at the desk. She stated that specific introductions of each did not take place, and their roles were not discussed.

21. In response to the provisional opinion, Dr B stated that he did not introduce, and would never have introduced, Dr C and Dr E to Ms A as 'students'. Dr B noted that they were integral members of the surgical team and working within their scopes of practice. Similarly, Health NZ stated that it is inconceivable that Dr B would have introduced them as students.

22. Dr C told HDC that she believes she introduced herself to Ms A clearly in the preoperative area. Dr C said that she has a very standard way of introducing herself to patients, which she would have used to introduce herself to Ms A. Dr C said that she starts by stating her name and role, explaining that she is a senior registrar in the plastic surgery training program. She would then have outlined her level of participation in Ms A's care and told Ms A that she was part of the team who would be 'helping' Dr B with Ms A's operation. Dr C believed that Ms A understood that she would be one of the surgeons operating on her, and that Ms A consented to surgery on this basis. In response to the provisional opinion, Ms A stated:

> 'While [Dr C] "believes" she introduced herself and explained her role in depth — this did not occur. There was no discussion in relation to [Dr C] having an active role in my surgery. I cannot understand how she came to the belief that this had occurred.'

23. Dr C said that she then continued with discussion of the surgical consent process, describing the operation in detail and the expected recovery and potential risks, as are recorded in the consent form. She said that her standard practice for breast reduction consent is to discuss the phenomenon that the abdomen can seem subjectively larger after the breasts are made smaller, and that symmetry and cup size are something to aim for but cannot be guaranteed. Ms A said that Dr C did not have that discussion with her, and the only person who spoke to her about the surgery was Dr B, which was what she expected.

[4] Further details of her qualifications are noted under the heading 'Surgical team' below.
[5] His identity was not documented but this appears to be most likely.
[6] As covered later in this opinion, apparently Ms A suffered a diathermy burn during the surgery. Ms A said that she was informed of her burn in the ward (see 'Diathermy burn' section below). As this is documented as having been Dr E, in the absence of other documentation from this consultation or any other recollection of this staff member, it is inferred that Dr E was present at the 9 April consultation with Ms A.

24. Ms A said that Dr B gave her the consent form, which she read carefully.

25. The consent form included the following standard wording:

> 'I have had the opportunity to ask questions and I have received all the information that I want. …
>
> I understand that I may withdraw my consent in the future (provided that it is before having this procedure(s)) and that I have the right to refuse to have the procedure(s).
>
> I acknowledge that no assurance has been given that the operation(s)/procedure(s) will be performed by any particular doctor.'

26. Ms A stated that she signed the form and gave it back to Dr B. The consent was for 'bilateral breast reduction +/- liposuction and shave excision of skin lesions x 4'. The risks noted on the form are scar, infection, bleeding, asymmetry, nipple sensory change, nipple areolar necrosis,[7] wound healing issues, seroma,[8] and further surgery.

27. The form was countersigned by Dr C, and a note on the form states: 'With [Dr B] providing discussion.'

28. Ms A said that she noted that the form stated that if Dr B was absent, another surgeon would perform the operation, but as he was in front of her, she thought that this was not an issue.

29. Ms A's breasts were then marked and mapped by both Dr B and Dr C (see discussion below). Ms A said that once that had occurred, she asked Dr B, 'You're doing the surgery right [Dr B]?' and he replied 'Yes'.

30. Ms A said:

> 'At no point did [Dr B] say they were assisting him. There was no mention of them being present in the operation room or any discussion about this … I had zero reason to query this as I'd just verbally checked with [Dr B] that he was performing my surgery. I did not see him sign my consent form as I was told to sit on the table. The student … did not sign the form in front of me. To my dismay I found out 18 months after that the student had signed my form. If they had signed in front of me I could have had the chance to ask why.'

31. Ms A said that just because the other two people were in the room, that did not automatically indicate to her that they would be operating or touching her body. Contrary to Dr C's statement, Ms A said that they did not tell her that they would be involved in her

[7] Death of a nipple caused by lack of blood supply.
[8] Build-up or collection of fluid where tissue has been removed.

surgery, and if they had sought her consent to perform the surgery, the answer would have been a firm 'No'.

32. Ms A said that she would not have gone ahead had she known that they would be operating on her and, due to the concerns she had going into this procedure, she felt relieved that it was to be performed only by Dr B.

33. Dr B told HDC:

> 'I do not routinely discuss the involvement of all other medical staff at clinic and do not believe this to be standard practice among surgeons in New Zealand. If patients enquire after the involvement of medical students, registrars or other staff I disclose with absolute clarity. That is, that any surgeries I perform in the public hospital will include surgical staff other than myself, typically registrars, occasionally another specialist from the same or other specialties. Their role will include any aspect of the procedure they are competent to perform, under my direct supervision if I am present. Many surgeries booked will not be performed at all by the doctor scheduling the procedure.'

34. Dr C noted:

> '[Ms A] was aware that Middlemore Hospital is a public hospital and as such operates with doctors at all levels of training. I believe [Ms A] was familiar with how public hospitals function and when I introduced myself, she would have had the opportunity to ask questions about the level of my involvement, if she had any concerns. At no point did [Ms A] express concern about having registrars involved in her surgery.'

35. In response to the provisional opinion, Ms A stated that she does not understand how Dr C formed that belief, as there was certainly no conversation with her about it. Ms A said that she was not informed that she needed to ask about the specific involvement of other staff such as registrars.

36. In response to the provisional opinion, Dr B submitted that Ms A had substantial prior personal experience of the public hospital system, including surgeries. He said that she signed a consent form that she had 'read carefully', which clearly stated that procedures would not be performed by any particular doctor. Dr B asserted that the wording of the consent form signed by Ms A also recognised that during a surgery there might be an unanticipated need to call in additional assistance or particular expertise, and in long surgeries to give team members scheduled and unscheduled breaks.

37. Health NZ said that it is never able to assure a patient that their surgery will be performed by one particular surgeon, as surgical procedures are based on a team approach, and often, depending on the surgery, more than one person is required. Health NZ noted that it states on the consent form: 'I acknowledge that no assurance has been given that the operation(s)/ procedure(s) will be performed by any particular doctor.' Health NZ also said that the team works under the supervision of the senior medical officer, which allows 'junior doctors' to

develop the necessary skills in order to become a senior medical officer over the course of their training programme.

38. Health NZ told HDC that Ms A did not make a request that no surgical registrar be involved in her operation, and if she had requested clarification regarding who would be undertaking the operation, Dr B would have explained the team-based approach to providing surgical care in detail and would not have provided the operation to Ms A if she was unhappy with the involvement of RMOs.

39. Health NZ stated that Ms A did not make any specific requests or seek any clarification from either Dr B or Dr C regarding who would be undertaking what aspects of her surgery. Health NZ noted that Dr C undertook the surgical consenting process, including the signing of the consent forms, and Ms A signed to confirm the following: '[I have had] the opportunity to ask questions and I have received all the information that I want.' In response to the provisional opinion, Ms A stated that the team-based approach was not explained to her. She reiterated that Dr C did not undertake the consenting process or have any discussion directly with her as stated.

40. The consent form does not mention that Middlemore Hospital is a teaching hospital, or the significance of this, or that RMOs/registrars may be involved in the surgery.

41. Ms A said that while she was reading the consent form, Dr B asked her, 'Do you want to keep your breast tissue?' and she said 'Yes'. She stated that he sighed, and half rolled his eyes, and said: 'Really? [I]t's a lot of work to get tested and processed,' so, not wanting to be a hassle just before the surgery, she said, 'Never mind then.' In response to the provisional opinion, Dr B stated that he understands that consumers have the right to make a decision on return or disposal of body parts. However, it is poorly appreciated by consumers that tissue requiring pathological examination (as breast cancer must be excluded from the removed tissue) is formaldehyde fixed and therefore toxic. Dr B stated that he informs patients of that, and, if their reasons are not strongly held, then return of tissue ought to be considered carefully, including safe storage and anticipated eventual disposal.

Mapping

42. Ms A said that immediately after she signed the form, Dr B told her to sit on the table and asked her whether 'the female student' (Dr C) could map her, and she agreed. However, there is no documentation in the notes relating to Ms A consenting to this mapping, or of her consenting to Dr E observing the procedure.

43. Dr B stated that marking incisions on the breasts is almost always done by the SET (Surgical Education and Training Program)[9] registrar, who, in that case, was Dr C, and he modifies the markings while discussing them.

[9] Training program for surgical trainees to gain clinical and operative experience.

44. Ms A said that 'the other student', Dr E, watched as Dr C drew lines on her. Ms A stated that Dr B was watching Dr C, and he got up and said, 'No that's not right,' and he corrected the mapping and showed Dr C how to measure correctly.

45. As noted above, Ms A said that she then raised her hand in a stop position and asked Dr B, 'You're doing the surgery right [Dr B]?' and he replied 'Yes'. She recalled that Dr B completed her mapping and then he and the others left the room.

Surgical team

46. Dr B said that in addition to himself, the surgical team included Dr E, Dr C, and Dr D.

47. The qualifications of these providers at the time was as follows:

- Dr E was an FRACS (Fellow of the Royal Australasian College of Surgeons). Dr B said that Dr E was a recently qualified specialist plastic surgeon on overseas placement.
- Dr C was a specialist registrar in advanced training in plastic and reconstructive surgery. Dr C told HDC that at the time of Ms A's surgery, she had already been passed as competent in breast reduction surgery (as per the NZAPS training curriculum) and she had already been deemed competent to perform bilateral breast reduction.
- Dr D was a registrar. He obtained his medical degree overseas and was awarded a general scope of practice in New Zealand.

48. Dr B stated that his surgical team at Ms A's operation could not be described as 'junior'. He said that, typically, registrars have between three and seven years of postgraduate experience as a doctor before being selected into SET training. He stated that it would be expected to be well within the experience level of either Dr E or Dr C that they could consult, plan, and execute breast reduction surgery entirely independently.

49. Health NZ told HDC that Dr D and Dr E no longer work at Counties Manukau, but they confirmed their involvement in Ms A's surgery. Dr E reported that he has limited recollection of the surgery, and Dr D had no recollection of the surgery.

50. Similarly, Dr C told HDC that as it is now some time since these events, her response to HDC is based on her review of the notes provided to her, her memory of this case, and what would have been her normal practice at that time.

Surgery

51. Ms A's surgery commenced at 10.48am and ended at 1.14pm.

People in theatre

52. Ms A was concerned about the number of people present in the theatre during a sensitive procedure in which her body was exposed. She said that they were not introduced to her, nor were their roles explained. Ms A feels that this was an invasion of privacy, and she was not aware of, and did not consent to, having her procedure treated as a teaching exercise.

53. Health NZ said that the surgical team that operated on Ms A was the standard-sized team for a bilateral breast reduction procedure. Health NZ identified that the following 12 people were present during the surgery: Dr B; three registered medical officers (one plastic surgery fellow (a newly qualified plastic surgeon) and two registrars); two anaesthetists; one anaesthetic technician; one anaesthetic nurse; and four registered nurses.

54. Regarding staff introducing themselves, Health NZ stated that a significant number of staff can be involved, directly and indirectly, in surgical procedures. Those primarily responsible for the patient's care will engage with the patient and ensure that they receive the information that a reasonable patient in their position would expect to receive, but it is not possible, common practice, or expectation, that all staff involved in the procedure will individually introduce themselves and their role to the patient preoperatively.

55. Dr B told HDC that the standard procedure is that a team briefing is carried out with theatre staff before the patient is brought into the operating room. This involves a team introduction, a brief patient summary and surgical plan, an equipment check, and a call for any concerns from surgical, anaesthetic, and nursing teams. Following the check-in process completed by nursing and anaesthetic staff and administration of general anaesthesia, a 'time out' is completed for every patient, in which the patient detail is confirmed and the surgery to be performed is double checked along with signed consent. Intravenous antibiotics are given at that stage.

56. Dr C told HDC that Ms A was positioned lying on her back on the operating table with exposure from collarbone to umbilicus, as is the standard manner for breast surgery.

57. Dr B told HDC that most of the surgical steps that occurred took place at the same time on both breasts, with him and an assistant (Dr D) on one side, and the second surgeon (Dr C) with an assistant (Dr E) on the other side. Dr B said that pauses are taken at the completion of a step, in order to remain 'in-sync' and confirm the symmetry of the tissue removal and positioning. He stated that the roles among the surgical staff at the operating table are fluid, with him (as the senior surgeon) taking responsibility for overall decision-making.

58. Dr C told HDC that Dr B operated on one side, and she operated on the other side with Dr E. She said that she had already reached competency in breast reduction surgery prior to the operation, and any 'teaching' that occurred in this operation would have been a collegial discussion reinforcing the methods required to achieve the best possible symmetry for the patient with significantly asymmetrical breasts prior to surgery. She does not recall exactly what components of the breast reduction she performed personally, but she said that any that she did were made in a step-by-step fashion to match Dr B's side and under his direct supervision.

59. Dr B told HDC that Ms A had requested that several seborrheic keratoses (benign pigmented skin lesions) be removed. This was done by shaving their surface and sending the tissue for confirmatory pathology, and diathermy to the cut face of the skin, leaving a small raw burn that healed spontaneously.

60. Dr B stated that he was scrubbed for the entire case, and some portion of the incision, tissue removal, tissue retraction, haemostasis, irrigation, swabbing, suturing, cutting sutures, and dressing was performed by each of the surgical staff there (himself, Dr E, Dr C, and Dr D). Both the handwritten operation note (unknown author but not Dr B) and typed operation note by Dr B recorded that the surgical staff present were Dr B, Dr E, Dr C, and Dr D. The perioperative record completed by nursing staff documented the attending surgeons as Dr B and Dr E.[10] In response to the provisional opinion, Ms A said that Dr D was not mentioned to her, he was not present in the preoperative room, and he was not introduced to her. She stated: 'I have only become aware he was present after reading this report.'

Postoperative care

Recovery

61. Ms A was transferred to the Post Anaesthetic Care Unit (PACU) at 1.25pm. Ms A told HDC that when she woke up in recovery she was jerking, and her breathing was abnormal. She said that she was in recovery for a long time. The records indicate that she experienced pain and nausea, which were treated, and she was transferred to the ward at 5pm.

Diathermy burn

62. Ms A said that once she was in the ward, Dr E[11] came in and told her that they had burnt her slightly with an instrument while removing a mole.

63. Dr E's clinical notes record that he reviewed Ms A on the ward on the day after surgery (10 April 2018). The clinical notes state that he explained the operation findings to Ms A and 'explained accidental diathermy burn'. This was also recorded in the discharge summary, which states: '[A]ccidental diathermy burn — explained to patient.'

64. Dr B stated that 'Accidental diathermy burn — explained to patient' was recorded in the ward notes following the surgery but not in the written or dictated operation notes. He cannot specifically recall such an event and thinks it possible that it was a misunderstanding on the part of the recording house officer (who also wrote the same in the discharge summary).

65. Health NZ told HDC that if an accidental diathermy burn had occurred, it would have expected the nursing staff in the theatre to complete an Incident Form and for there to be open disclosure to the patient. There is no incident form relating to this surgery.

66. Dr B stated that Ms A had several intentional superficial diathermy burns at the sites of the shave excisions that she had wanted, and to which she had consented. He said that at one early postoperative consultation, Ms A pointed to one of the sites of diathermy burn and he explained that these were the sites at which the seborrheic keratoses had been excised and the skin had been cauterised at the base (ie, an intended diathermy burn to the skin). Dr B

[10] The nursing notes also included the name of a third person, which appears to be an error.

[11] She did not state the name of this person, but said he was the male who had been in the preoperative room — most likely to have been Dr E.

told HDC: 'It is also possible that there was an additional small diathermy injury to the skin that was noted by the team that I do not specifically recall.'

Discharge

67. Ms A was discharged home from hospital on 11 April 2018. She said that at that stage she was dismayed at the small size of her breasts, but they were dressed, and she knew she had to wait to heal.

68. An outpatient clinic appointment was planned for one week after the surgery so that the wounds could be checked, and a follow-up appointment was to be arranged with Dr B in six weeks' time.

Follow-up

69. Dr C telephoned Ms A on 13 April 2018, as Ms A had contacted their department with some concerns following her operation. Dr C wrote a detailed note of their conversation.

70. Ms A said that she told Dr C that she was concerned about the small size of her breasts. The clinical notes record that Ms A was considerably upset and crying during the call, not just about the size of her breasts but because they did not suit the size of her frame. Dr C recorded that she reiterated to Ms A the preoperative discussions that cup size could not be guaranteed, and the significant preoperative asymmetry that Ms A had started with, her request to be similar on both sides, and the need for the surgeons to match the breasts.

71. Ms A said that Dr C then told her that she had operated on one breast and Dr B had operated on the other breast. Ms A stated that she told Dr C that she did not give permission for that and did not know it was going to happen. Dr C reassured Ms A that all had gone well and advised her to raise her concerns with Dr B at the six-week checkup.

72. Dr C documented:

> '[Ms A] specifically asked who has performed the operation and I have explained to her that [Dr B] is the surgeon in charge and that to shorten the duration of the surgery, [Dr B], our fellow and myself all work together. She had concerns about the plan being changed inter-operatively and I reassured her that the marking we made pre-operatively which we talked her through at the time were not changed inter-operatively …
>
> [Ms A] seemed somewhat reassured at this point and reiterated to me that she thinks we have done a great job but it was not quite the job that was right for her …
>
> [Ms A] seemed reassured by our conversation, she had no further concerns she wished to discuss and she stated that she thinks she will have a good functional benefit from this reduction despite not being happy with the appearance. I once again apologised to [Ms A] for her disappointment in the outcome.'

73. In response to the provisional opinion, Ms A stated that she was very upset during this conversation, and although Dr C noted that she seemed reassured, she certainly was not. She stated:

> 'I was in disbelief. I simply was not going to discuss my situation with a student who had touched me without consent. It was during this conversation that I said to her "I did not give permission for a student to operate on me" and it was at this time she said she was not a student but was nearly finished her training.'

74. Ms A said that Dr C told her that Middlemore Hospital was a teaching hospital. Ms A said she told Dr C that she did not know that Dr C was going to be doing her surgery.

75. On 17 April 2018 Ms A was reviewed by Dr B, and they discussed the surgery. Ms A said that Dr B told her that she needed to wait for at least 12 months for her breasts to settle. She said that she showed him her stomach distension and he replied: 'Well you're quite fat and now you'll be able to exercise.' She stated that she was insulted and embarrassed and said that it had not been like that before the surgery, to which he replied: 'You can now see your stomach so it will look larger.'

76. The clinical notes state:

> '[Patient] not happy [with] size, feels they are small. She agrees they look amazing, but they are small for the rest of her body … [Dr B] has explained that the surgery went really well and the result is exactly what he had aimed for, but he is sorry that she feels upset [and] disappointed. Have also explained that this can also be taken as an opportunity to lose weight with a smaller bust, now that she doesn't have the additional upper body weight. He has provided her insight in that she would benefit from a bit of weight loss, for her health and her self-esteem. He has also explained for her to give it some time for everything to settle …
>
> [Dr B] has reiterated that the surgery is exactly what he had wanted and [Ms A] is happier that [Dr B] had time to see her today. She is brighter at the end of the consult.'

77. Dr B told HDC that the most frequent cause for abdominal distension in adults is weight gain. He said that he did not call Ms A 'fat', but they looked at one of her abdominal CT scans together, which visually demonstrated her intra-abdominal (around the organs) and extra-abdominal (under the skin) fat deposits. Dr B said: 'I am sorry that she misconstrued this conversation and thought I called her fat.'

78. A fortnight later, Ms A presented to Middlemore Hospital's Theatre Admission and Discharge Unit (TADU) because of her concerns about wound healing, and her surgical site was assessed and treated.

Follow-up appointment with Dr B

79. On 15 August 2018 Ms A attended a further check-up with Dr B. The reporting letter states:

> 'She had several concerns around the shape of her nipples, the role of various personnel involved in her surgery, delayed healing and hopefully I have clarified these for her in detail.'

80. Ms A said that when she saw Dr B, he was alone. She was still strapped but she expressed her concerns about the size difference of her breasts and that there was a pucker that had caused her cleavage to be crooked. She said that before the surgery she had specifically asked Dr B not to touch the area in between the breasts.

81. Ms A said she told Dr B that she was not aware that the 'students' would be operating on her, and he replied that Middlemore Hospital is a teaching hospital.

82. Dr B told HDC that from the first day following surgery, Ms A had the perception that her breasts had been severely distorted by the surgery, and she stated this at each medical visit following the surgery. He said that the shape and appearance of Ms A's nipples were minimally distorted by the scarring surgery. He stated that it is not uncommon for nipples to be dragged downward by scar tension, and they look 'correct in position'.

Second opinion

83. On 6 September 2018 Ms A wrote to request a second opinion. In her letter she stated that at her review with Dr B 'four weeks' after the surgery:

> 'I asked who did the breasts and was told he did the right and the registrars did the left. I was shocked at the fact that two different people did it but more shocked at the result once I removed the dressings to discover the right breast's nipple had a hole in it and the shape of the nipple was deformed. The size is a C cup. The scarring is lumpy and the burn mark is unsightly. It oozed blood for 8 weeks and I was put on antibiotics. One nipple is up and one is down, one is large, one is small.'

84. On 4 October 2018 Dr B requested a second opinion from a plastic and reconstructive surgeon at Middlemore Hospital.

85. The surgeon reviewed Ms A on 14 December 2018. Following the review, the surgeon proposed volume augmentation to the right breast by way of a fat transfer, and her opinion was that nothing further was required.

Further comment — Ms A

86. Ms A told HDC:

> 'This has changed my life. I have severe PTSD. I'm exhausted in fighting and searching for answers and accountability. Every day I despise my body and my self-esteem is destroyed. It's hard to shower or leave the house. I've lost my relationship and no confidence to try again. My children are affected. Please don't underestimate the impact. I have physical pain and costs continue. To fix the physical will go a long way to healing my emotional state. If I don't have the reminders there, I can begin to move forward.'

Further comment — Dr B

87. In a clinic letter to Ms A in March 2021, Dr B stated:

> 'As with almost all significant operations in the public hospital, my surgical assistants work concurrently with me as the primary surgeon, and intraoperative assessments and decision-making are mine as the senior surgeon. In retrospect, I did not explain this in enough detail and a lingering concern for you is that your resultant asymmetry is "the result of different surgeons working on each side".'

88. In response to the provisional opinion, Dr B said that his statement that 'in retrospect I did not explain this in enough detail' was a poorly worded attempt at an apology that Ms A's experience had been so difficult for her, from a clinician unaccustomed to seeing patients as adversarial.

89. Dr B told HDC that he has reflected deeply on the learnings from this case and whether there are aspects of his public practice working within a teaching hospital that he could alter to avoid 'incidents' such as have unfolded for Ms A.

90. Dr B said that he has considered whether insistence on a completed psychological assessment should be mandatory for any patient for whom he thinks it might be helpful. He stated that he had recommended this to Ms A in May 2016 when they decided not to proceed at that time, owing to her 'very significant fears about the surgery and attendant complications'. However, this would present a barrier to care both financially and logistically for some of the most challenged patients, given the extremely limited access to these services in public. He stated that on balance he will continue to rely on his judgement in this regard, knowing that it can be fallible.

91. Dr B believes that the care he provided to Ms A was in accordance with best practice and the Code of Health and Disability Services Consumers' Rights (the Code). He stated: 'Overall I would not make any significant changes to my practice but I am open and receptive to any recommendations to inform and enhance my surgical practice.'

Further comment — Health NZ

92. Health NZ stated that it was sorry to learn that the surgery did not result in the outcome Ms A expected and that this is having an ongoing effect in terms of her psychological and emotional wellbeing.

93. Health NZ believes that the care provided to Ms A was appropriate and of a good standard, and that informed consent was obtained for the procedure.

94. Health NZ said that no public hospital, and certainly not one as large and as complex as Counties Manukau, can function at a service level without RMOs. It noted that RMOs are registered medical practitioners, competent to practise in their own right and employed to provide services and do so within their scope of practice and at a level appropriate to their expertise and experience. Health NZ said that it practises within teams, and the nature of oversight or direct supervision depends on circumstances; registrars are engaged in

specialist training programmes and may be competent to undertake various surgical procedures independently.

95. Health NZ stated that Counties Manukau's approach to informing patients that RMOs may be involved in their care and part of the operating team does not differ from the approach across all public hospitals in New Zealand. It said that considerable information is presented to all patients attesting to the fact that they have students as well as other staff involved in the care of patients.

96. Health NZ stated:

> '[W]e acknowledge and affirm that all patients have the right to decline the involvement of students in their care. However, while patients are entitled to express a preference as to who will provide care, it is generally not feasible in a large public hospital to routinely offer patients the opportunity to choose which staff will provide their care.'

Responses to provisional opinion

Ms A

97. Ms A's responses have been incorporated into the 'information gathered' section as appropriate. In addition, she submitted as follows.

98. She said that had she been adequately informed, she would have cancelled the operation. She stated: 'It is infuriating to know that this could have been avoided by simply telling me a) themselves or b) when I asked for clarification.' She said that there were three doctors who did not inform her that they would be involved in her surgery.

99. Ms A stated that her rights to make an informed choice and give informed consent were removed from her. She said that she was not given the information she needed to make an informed decision.

100. Ms A stated that since this time she has had to deal with physical issues, with more surgeries and tests, and also the experience of going positively into an operation then finding out that she had been misled. She said that the mental and emotional scars are huge.

Dr B

101. Counsel for Dr B submitted a response on his behalf, and this has been incorporated into the 'information gathered' section of this report as appropriate. In addition, Health NZ submitted as follows.

102. Where a team of surgeons will be operating, it can provide patients with an explanation of the expected roles the members of the team will play in an operation. However, it is not possible or feasible to guarantee that each team member will only be involved in those parts of the surgery described during the consenting process.

103. Health NZ considers that having to adhere rigidly to the roles described during the consenting process will lead to the risk of adverse outcomes. It may also lead to patients having to return to theatre multiple times if a surgeon cannot carry out the particular role

that the patient consented to them playing. Some flexibility to address unexpected situations that arise during surgery must be allowed to enable operations to be undertaken safely and efficiently, and to avoid the risk for patients of repeated anaesthetics, surgeries, or prolonged periods in surgery, as an individual surgeon undertaking a surgery will increase the duration of surgery.

104. Health NZ stated that a requirement to specify precisely the roles that the surgical team will undertake is impractical, and if this approach is confirmed by HDC, it must be qualified to allow flexibility to address unexpected issues as they emerge. Counties Manukau believes that the requirement should be to describe the roles with reasonable precision but provide some flexibility to address unexpected events during procedures.

105. Health NZ accepts that the right to express a preference as to who provides care under Right 7(8) is not at issue in Ms A's case, but it stated that the case highlights the risks that patients will default to choosing consultants over registrars if given a choice, and the impact this would have on the delivery of health care.

106. Health NZ submitted that the standards seven years ago did not require the level of notification and clarification of roles during the informed consent process that the Commissioner now appears to be holding out as required. The Commissioner's opinion appears to have been made in the light of Case 19HDC01260 rather than in the light of the standards applicable at the time Ms A was consented in 2018.

107. Health NZ stated that it is unreasonable to conclude that Dr B was aware that Ms A was extremely anxious about the surgery and possible complications. Dr B reviewed Ms A on multiple occasions between 2015 and 2017. However, the number of consultations was due to Ms A having other medical conditions that needed to be addressed, concerns about the sequelae of previous surgical interventions, and the deferral of her surgery at her request due to a family crisis, not to Ms A showing a high degree of concern or anxiety about the procedure.

108. Health NZ stated that it accepts that patients are entitled to the information that a reasonable patient in their circumstances would expect to receive in order to give informed consent, regardless of whether they ask for that information. However, it noted that Ms A did not request that only Dr B undertake the procedure, nor did she state any specific concerns about registrars being involved in her surgery at any stage. Health NZ submitted that a reasonable consumer provided with the same introduction, explanation, and actions would conclude that Dr C would be providing them with intraoperative surgical care.

109. Health NZ considers that insufficient weight has been given to Dr B's knowledge that Ms A was an experienced consumer of hospital services, having undergone several surgeries in the past, and it was reasonable for Dr B to expect Ms A to have a general understanding of the way in which operations are undertaken, and the roles that registrars play in theatre.

110. Health NZ submitted that it is unreasonable to expect either Dr B or Counties Manukau to have been aware that Ms A required information about precisely who would be involved in

her surgery, whether or not the people involved were registrars, and exactly what part they would play in her surgery, and to have provided information about those matters, given that Dr B was not aware that Ms A had specific concerns about registrars being involved in her surgery or that she wanted to know exactly what part of the surgery each surgeon would undertake.

111. Health NZ submitted that neither Dr B nor Counties Manukau should be held in breach of the Code. However, it said that if breach findings are made, they should be against Counties Manukau, as it was responsible for setting the standards for obtaining informed consent for its staff and did so by issuing policies in relation to informed consent. Those policies did not require staff to provide precise details of how an operation would be undertaken and the exact roles each surgeon would play in it. In advising Ms A that Dr C and Dr E would be involved in her surgery, Dr B met Counties Manukau's standards for obtaining informed consent and was meeting the standard set by the Medical Council of New Zealand. Any failure on his part to meet the requirements of Rights 6 and 7 therefore reflects deficits in the standards set by Counties Manukau.

112. Health NZ outlined its concern that the requirement to inform patients of the precise role registrars will play in their procedures in the manner envisaged by the provisional decision will significantly impact its ability to train registrars. Consultant surgeons will not be able to allow registrars to learn new skills as suitable opportunities arise during procedures unless the patient has specifically consented to the registrar doing so. It is impossible to predict in advance when such opportunities will arise and to obtain consent for them. These expectations will slow the completion of training requirements by registrars and lead to the prolongation of training programmes.

Opinion: Introduction

113. The rights relevant to Ms A's complaint are as follows.

114. Right 6(2) of the Code states:

> 'Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent.'

115. Right 6(3) of the Code states that every consumer has the right to honest and accurate answers to questions regarding the identity and qualifications of the provider.

116. Right 9 of the Code extends the rights in the Code to those occasions when a consumer is participating in, or it is proposed that a consumer participate in, teaching.

117. The first issue I must determine is whether Ms A's surgery was a teaching situation that would have necessitated her explicit consent to that teaching.

118. Certainly, Ms A believed her surgery was a teaching exercise to which she had not consented. This is hardly surprising noting Ms A's evidence that she believed Dr C and Dr E to be 'students', as, according to her, this is how they were introduced. She said that she was not aware that Dr C was not a student until their conversation on 13 April 2018. However, Dr B has denied having said that they were students. I am unable to make a finding about which account is correct, but I note that Ms A states that she did not know the meaning of the term RMO, which may have contributed to some confusion.

119. On the evidence before me, I accept that none of the surgical team who performed Ms A's operation were students. All medical personnel were fully qualified doctors and appear to have been working within their scope of practice. Dr E was a recently qualified specialist plastic surgeon. Dr C was a specialist registrar, one year away from qualifying as a specialist plastic surgeon, and I accept that it was within the experience level of both Dr E and Dr C to consult, plan, and execute breast reduction surgery independently. I note further that Dr D was a non-SET registrar of several years' postgraduate experience directly assisting Dr B.

120. I am also satisfied that given the qualifications of the medical professionals, the surgery, including the preoperative mark-up of Ms A's breasts, was not intended as a teaching exercise and did not involve direct and active teaching such as to activate the relevant Code rights in relation to teaching. I further accept that Dr E, Dr C, and Dr D were involved in the surgery as part of the team in the provision of a surgical service.

121. Accordingly, the key issue becomes whether Ms A was advised adequately about who would be performing her surgery.

122. In this respect, Ms A's evidence is that she was not informed of the role that the registrars and fellow would have in her surgery, the team-based approach was not explained, and she believed that Dr B alone would operate on her. Ms A has been dissatisfied with the outcome of the surgery and believes that having different surgeons operating on each breast contributed to the asymmetry.

123. Previously this Office has found that information regarding who will be performing a consumer's surgery is information that a reasonable consumer would expect to receive. Health NZ submitted that this was not the case prior to my decision on 21 June 2024,[12] rather than being the standard applicable at the time Ms A gave consent in 2018. I disagree — that issue had been considered in several earlier HDC decisions.[13]

124. Furthermore, under Right 6, it is also important to take into account the particular characteristics of the consumer, as is discussed below.

[12] Opinion 19HDC01260 available on www.hdc.org.nz.
[13] For example, 13HDC01345 (16 June 2015) and 09HDC01565 (5 September 2012).

Opinion: Dr B — breach

125. On 24 February 2015 Dr B diagnosed Ms A with asymmetrical macromastia. Subsequently he reviewed her on several occasions in 2016 and 2017. Ms A spent many months considering whether to proceed with the surgery. She said that she had anxieties and concerns, and Dr B put her at ease during their meetings in clinic. She accepted the risks of the surgery and, as she knew that Dr B was a very experienced surgeon, she was comfortable to proceed. In response to the provisional opinion, Dr B submitted that during the period 2015–2017 Ms A did not raise concerns about a surgeon other than him operating on her. That is not surprising, as that possibility was not discussed with her, and I am satisfied that she believed that Dr B would perform her surgery.

126. On 9 April 2018 Ms A presented at Middlemore Hospital for breast reduction surgery. As the doctor undertaking the treatment, Dr B was responsible for the overall informed consent process.

127. I am not persuaded by Health NZ's submissions that it, as opposed to Dr B, should be held accountable for any failures to meet the informed consent provisions of the Code, given that, in its view, he met Counties Manukau's standards for obtaining informed consent.

128. I remain of the view that in the circumstances of this case, the information provided to Ms A was inadequate, as discussed below, and that ultimately Dr B was the one possessed of the specific knowledge about Ms A's situation — circumstances that are directly relevant to the application of Right 6 of the Code.

Information about who would operate

129. Ms A was shown into the preoperative area to wait for Dr B, who arrived with Dr C and Dr E. Ms A said that Dr B did not introduce Dr C and Dr E or explain their roles other than to refer to them as 'students'. Dr B denies referring to them as students. As stated, Health NZ submitted that Dr B told Ms A that Dr C and Dr E would be involved in her surgery. The evidence provided is that it was Dr C who said that she would be involved in the surgery, but Ms A denies being provided with this information by Dr C. While there are conflicts in the evidence on this point, I am nevertheless satisfied (from the totality of evidence and as discussed below) that Ms A did not understand that Dr C, Dr E, and Dr D would be operating on her.

130. Ms A said that just because there were two other people in the preoperative room with Dr B, this did not automatically indicate to her that they would be operating on her or touching her body. Ms A also said that had she been asked, she would have refused consent to their involvement.

131. In this respect, I note that Ms A's evidence regarding her lack of knowledge as to who would be performing her surgery is corroborated by evidence that during a phone call on 13 April (only four days after the operation), she became aware for the first time that Dr C and Dr E had operated on one of her breasts. Ms A said she told Dr C that 'she did not give permission for that and did not know it was going to happen'. Dr C recorded:

> '[Ms A] specifically asked who has performed the operation and I have explained to her that [Dr B] is the surgeon in charge and that to shorten the duration of the surgery, [Dr B], our fellow and myself all work together. She had concerns about the plan being changed inter-operatively and I reassured her that the marking we made pre-operatively which we talked her through at the time was not changed inter-operatively.'

132. Ms A's concerns about the 'students' operating on her (noted in the clinical record and in an email) were reiterated on 15 August and by letter on 6 September requesting a second opinion.

133. It is also relevant to note that Ms A had formerly expressed concerns about the involvement of an anaesthetic registrar in her surgery when she had become aware of this, and that this was noted in the clinical record. While Dr B has said that he was not aware of this, this evidence demonstrates Ms A's particular interest in knowing who would be involved in her surgery.

134. Dr B's evidence is that the team is introduced as a matter of course, and if patients enquire about the involvement of other staff, he discloses their roles with 'absolute clarity'.

135. Dr B said that he does not routinely discuss the involvement of all other medical staff at clinics, but if patients ask about the involvement of medical students, registrars, or other staff, he tells the patient that any surgery he performs in the public hospital will include other surgical staff such as registrars, and occasionally another specialist from the same or other specialties.

136. Dr C said that based on the way she usually introduced herself, she believes that she informed Ms A that she would be 'involved' in the surgery, that she was a senior registrar, and that Ms A consented to proceeding on that basis. She also said she told Ms A that she would be helping Dr B with the operation. Dr C said that understandably, her comments (given in 2024 — eight years after the events in question) were based on the notes, her memory of this case, and also what would have been her normal practice at that time.

137. In general, the passage of time makes it difficult to determine with certainty what may or may not have been said at any particular clinical consultation. In this respect, I note that there is value in evidence given by providers as to their 'usual' practice when seeking consent. However, in the present case there is also evidence recorded closer in time to the surgery — that is, between April and September 2018 — which on balance satisfies me that Ms A expected to have her breast reduction surgery performed by Dr B alone, and that she had no knowledge that Dr C and Dr E would be operating on one of her breasts.

138. In response to the provisional opinion, Dr B submitted that Ms A assumed unreasonably that he would be the sole surgeon as he was 'in the room', and yet she also assumed that the other doctors who were also present in the room would not participate in her care. I do not accept this submission. Ms A had contact with Dr B over several years, and he put her at ease during their meetings in clinic. Ms A said she knew that Dr B was a very experienced surgeon, so she was comfortable to proceed.

139. Dr B also stated that Ms A had substantial prior personal experience of the public hospital system, including surgeries, and she signed a consent form that she had 'read carefully' the information provided, which clearly stated that procedures would not be performed by any particular doctor.

140. On the basis of the evidence before me I am satisfied on the balance of probabilities that Ms A was not informed that her surgery would be undertaken by four doctors, with two operating concurrently on each breast. Ms A did not receive an adequate explanation of the roles that would be played by Dr C, Dr E, and Dr D in her operation.

141. I remain of the view that this is information that a reasonable consumer would expect to receive. This is particularly so in the case of surgery or procedures conducted involving intimate body parts, such as breasts. Right 6(2) also requires the provider to consider the particular circumstances of the consumer — that is, what information would the reasonable consumer *in that consumer's circumstances* expect to receive? I therefore take particular note of the characteristics and circumstances of Ms A. Dr B was aware that Ms A had spent several years considering whether to undergo the surgery, including that she had 'very significant fears about surgery and attending complications' (Dr B's letter of 17 May 2016).[14] Ms A had seen Dr B on 24 February 2015, 17 May 2016, 29 November 2016, and 22 August 2017. That is, he knew that Ms A was extremely anxious about the surgery. Considering all this, it is my view that Dr B should have provided Ms A with a clear explanation of who would be operating on her, and the roles of each of the surgeons, and therefore I consider that he failed to ensure that Ms A had sufficient information to consent to the surgery.

Conclusion

142. Patients may not necessarily be aware that the 'involvement' of RMOs in the treatment process or in 'helping' the surgeon will extend to actually performing the surgery.

143. Given Ms A's anxiety about the surgery, the appropriate course would have been to discuss with her the roles of the registrars and fellow.

144. Health NZ submitted that where a team of surgeons will be operating, it can provide patients with an explanation of the expected roles the members of the team will play in an operation. However, it is not possible or feasible to guarantee that each team member will be involved only in those parts of the surgery described during the consenting process.

145. I acknowledge that submission, noting that in the circumstances of this case the explanation was inadequate. In my view, there was ample opportunity to indicate in general terms how the team was to operate, and I consider that Dr B should have provided Ms A with that information to allow her to make an informed choice about whether to proceed. For the avoidance of doubt, the information about the roles of the surgeons does not necessitate specifying precisely the roles that each member of the surgical team will undertake. I acknowledge that some flexibility is required should unexpected situations arise during

[14] I reject Health NZ's submission that it is unreasonable to assume that Dr B had knowledge of Ms A's anxiety. There is explicit recognition of this by Dr B in the clinical record.

surgery. In my view, what was required was for Dr B to inform Ms A that he would not be operating alone, that he would be assisted by Dr C, Dr E, and Dr D, and that he and Dr D would operate on one breast while Dr C and Dr E operated on the other breast. This is not, in my view, unreasonable information to provide to a consumer undergoing breast surgery.

146. For the above reasons, I find that Dr B breached Right 6(2)[15] of the Code. It follows that Ms A was not in a position to provide informed consent, and I find that he also breached Right 7(1)[16] of the Code.

Other comment — observation of breast marking

147. Ms A said that immediately after she signed the consent form, Dr B told her to sit on the table and asked her whether Dr C could map her, and she agreed.

148. Although not recorded in the clinical notes, I accept that Ms A verbally consented to Dr C marking her breasts.

149. However, Dr E observed while Dr C drew markings on Ms A's breasts, and Dr B then amended the marking. This was an intimate procedure involving the exposure of Ms A's breasts, and there is no clear evidence that Ms A consented to Dr E observing. I take this opportunity to remind Dr B that such observation of an intimate examination requires consent and should be documented.

Other comment — tissue retention

150. Ms A was also concerned that when she indicated that she wished to retain her excised breast tissue Dr B sighed, rolled his eyes, and said, 'Really? [I]t's a lot of work to get tested and processed,' and, as a result, she did not take the matter further.

151. I have noted Dr B's submission that while consumers have the right to make a decision on return or disposal of body parts, it is poorly understood by consumers that tissue requiring pathological examination is formaldehyde fixed and therefore toxic. Dr B stated that he informs patients of that, and if their reasons for retaining the tissue are not strongly held, then return of tissue ought to be considered carefully, including safe storage and anticipated eventual disposal.

152. I take this opportunity to remind Dr B that Right 7(9) of the Code gives consumers the right to make a decision about the return or disposal of body parts, and I remain of the view that it is his responsibility to enable consumers to exercise their rights. As such, I consider that his response to Ms A was inappropriate.

[15] Right 6(2) of the Code states: 'Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent.'

[16] Right 7(1) of the Code states: 'Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent …'

Opinion: Health NZ — adverse comment

Consent to involvement of RMOs

153. As stated above, information regarding who will be performing a consumer's surgery is information that a reasonable consumer would expect to receive. Health NZ said that all staff are expected to introduce themselves and explain their roles to their patients. However, I am not satisfied that Ms A was made aware of the roles of the clinicians involved in her surgery.

154. Health NZ said that it is never able to assure a patient that their surgery will be performed by a particular surgeon and noted that the consent form states: 'I acknowledge that no assurance has been given that the operation(s)/procedure(s) will be performed by any particular doctor.' Health NZ also said that Ms A did not make any specific requests or seek any clarification from either Dr B or Dr C regarding who would be undertaking what aspects of her surgery.

155. I do not accept that the statement in the consent form, or that Ms A allegedly failed to seek clarification about who would be operating negated her right to the information that she needed to make an informed choice. As referred to in the previous section, Ms A's particular circumstances required that she be proactively provided with the information about who would be operating. For the sake of completeness, I note that Ms A said that she did specifically ask whether Dr B would be performing the surgery, and he responded 'yes'. This answer, while true, was not complete. I have treated Ms A's recollection of this statement with some caution (noting that evidence was provided several years after the event), but it is established on the evidence that she had developed a close and trusting relationship with Dr B in the years prior to the surgery, which appears to have provided her with some degree of reassurance and understanding that he would be her surgeon.

156. Health NZ said that generally it is not feasible in a large public hospital to routinely offer patients the opportunity to choose which staff will provide their care. However, that is not the point in this case. Ms A had a right to be informed of who would be performing the surgery in order to provide informed consent, and she was not. For the avoidance of doubt, that does not mean that a patient must be told in detail the various aspects of the surgery that each clinician may perform. What is required is that the patient is informed of who will operate on them, while acknowledging that that could change due to unforeseen circumstances.

Knowledge of public health system

157. Both Health NZ and Dr C submitted that Ms A was aware that she was being treated in a public hospital and would have been familiar with how public hospitals function, and so she would have been aware that registrars or trainees might be involved. In response to the provisional opinion, Dr B also said that Ms A had substantial prior personal experience of the public hospital system, including surgeries. When Ms A attended an anaesthetic preassessment clinic on 8 September 2017, Dr F noted that she was very anxious and had asked that anaesthesia registrars not be involved in her care. Dr F recorded: 'I explained in

detail why this is not possible in the public health system.' Health NZ interpreted this as meaning that Ms A was aware that junior doctors would be involved in her care. In response to the provisional opinion, Dr B submitted that he was not aware of what had been said in the preadmission clinic despite Ms A's request not to have anaesthetic registrars involved in her care being recorded in her clinical notes.

158. Health NZ also stated that the clinic rooms where Ms A was seen preoperatively display a poster informing patients that students may participate in their care and that patients have the right to decline student involvement, but there is no specific mention of RMOs because RMOs are providing clinically necessary services. I have no difficulty accepting that RMOs are integral members of the clinical team. I also accept that in certain contexts their assisting senior doctors is a necessary part of their role and usually within their scope of practice. However, this does not in and of itself remove the requirement to inform patients who will be operating on them, and (in some cases) that there will be teaching, training, and supervision of the RMOs.

159. Dr C stated that Ms A could have asked questions about the level of Dr C's involvement but did not do so. I do not accept this submission. In my view, a consumer will not necessarily conclude that by attending a public hospital, RMOs will be involved in their surgery, and it is important that hospital staff recognise the significant knowledge gap that exists between consumers and health professionals, who largely understand how hospital systems operate. The presence of RMOs in the preoperative area would not necessarily alert the patient of the need to ask questions about their subsequent involvement, particularly in these circumstances, where Ms A's engagement about her surgery was primarily with the SMO with whom she had developed a rapport.

Conclusion

160. Providers of health and disability services must ensure that they have a robust system and culture for obtaining informed consent. Senior clinicians and teachers must lead from the top and ensure that they model good, transparent consent processes to their junior colleagues. Basic courtesy and respect for patients apply, and wherever practicable consumers should know who is to be providing their care and what their role will be. This is information that a reasonable consumer can expect to receive.

161. Ms A was, understandably, distressed by the services provided by Middlemore Hospital. She expected the procedure to be performed by Dr B and was not informed that her surgery would be performed by Dr B plus a recently qualified plastic surgeon and two registrars. She had not consented to their involvement, and her distress is entirely reasonable in the circumstances.

162. It was the responsibility of the relevant clinicians to obtain consent, not Ms A's responsibility to ask questions and request that no surgical registrar be involved in her operation. Accordingly, I am critical of Health NZ's response, which appears to suggest that this is the case. I remind Health NZ that the information a consumer can expect to receive is determined by the individual circumstances of the consumer. Here, with an anxious

consumer who understood that Dr B would be performing the surgery, Ms A was entitled to know who would in fact be performing it.

163. Health NZ submitted that this would significantly affect its ability to train registrars in that consultants need to allow registrars to learn new skills if suitable opportunities arise during procedures. However, that would not be possible unless the patient has specifically consented to the registrar doing so. Health NZ submitted that the expectations in this opinion would slow the completion of registrar training requirements and lead to the prolongation of training programmes.

164. I fully support the training of doctors and that there is a strong public interest for this. However, I do not accept that provision of general information in the circumstances discussed in this report will impede the training of registrars.

Diathermy burn — adverse comment

165. Ms A said that following her surgery she was informed that during the surgery she had been burnt with an instrument. This is supported by Dr E's clinical notes, which record that when he reviewed Ms A on the ward on 10 April 2018, he told her that there had been an accidental diathermy burn. This was also recorded in the discharge summary, which states: '[A]ccidental diathermy burn — explained to patient.'

166. There is no reference to an accidental diathermy burn in the written or dictated operation notes. Dr B does not specifically recall such an event and thinks it possible that it was a misunderstanding on the part of the recording house officer. Dr B told HDC: 'It is also possible that there was an additional small diathermy injury to the skin that was noted by the team that I do not specifically recall.'

167. Health NZ told HDC that if an accidental diathermy burn had occurred, it would have expected the nursing staff in the theatre to have completed an incident form and for there to have been open disclosure to the patient. However, there is no incident form relating to this surgery. Dr B stated that Ms A had several intentional superficial diathermy burns at the sites of the shave excisions. He said that at a postoperative consultation Ms A pointed to one of the sites of diathermy burn and he explained that these were the sites at which the seborrheic keratoses had been excised and the skin had been cauterised at the base (ie, these were intentional diathermy burns to the skin).

168. I consider that as Ms A's account is supported by the clinical records, it is more likely than not that she was told that she had been burned accidentally. However, I am unable to make a finding as to whether the burn was indeed an accident or whether it was part of the intentional superficial diathermy burns at the sites of the shave excisions. I agree with Health NZ that if Ms A had been burned accidentally, an incident form should have been completed. I am critical that either Ms A was given incorrect information (if in fact there was no accidental burn) or, if she was burned accidentally, that appropriate processes were not followed.

Changes made

169. Health NZ told HDC that since this event, no specific changes to the informed consent process have been identified, and no changes have occurred. Health NZ stated that the importance of good consenting practice is well understood, and this area continues to be addressed as part of routine credentialling, professional development, and quality improvement processes.

170. Health NZ Counties Manukau recently completed a detailed review of its tissue return policy and process. As part of this review, it identified that the information that it had been providing to patients about the safe storage, handling, and disposal of tissue did not provide sufficient advice about tissue stored in formalin. It has updated the pamphlet to include more specific advice on the storage and handling of tissue stored in formalin.

171. Health NZ Counties Manukau will stress to staff the need to advise patients undergoing bilateral breast reduction surgery and any other procedures that involve teams of surgeons operating simultaneously that more than one team of surgeons will be involved in the surgery and that registrars will be part of those teams.

172. Dr B has sought to ensure in his conversations with patients that there is absolutely no possibility of any misconception on the part of patients as to the meaning of 'lead surgeon' or of being on Dr B's 'operation list' or of having registrars or fellows 'operating alongside him'. This complaint continues to inform his practice and his interactions with patients.

Recommendations

Health NZ Counties Manukau

173. I recommend that Health NZ Counties Manukau:

a) Provide further training to clinical staff within the plastic surgery service regarding informed consent, and the requirement to record consent in the clinical records. Health NZ is to report back to HDC within 12 months of the date of this report, with details of the content of the training and evidence of it having been conducted. I remind Health NZ that HDC's e-learning module on informed consent may assist with that training.

b) Provide a written apology to Ms A for the criticisms identified in this report. The apology is to be sent to HDC, for forwarding to Ms A, within three weeks of the date of this report.

Dr B

174. I recommend that Dr B provide a written apology to Ms A for the breaches of the Code identified in this report. The apology is to be sent to HDC, for forwarding to Ms A, within three weeks of the date of this report.

Dr B has provided HDC with evidence that he completed HDC's online training module on informed consent on 14 February 2025 as was recommended in the provisional opinion.

Follow-up actions

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

176. A copy of this opinion with details identifying the parties removed, except the name of Health NZ Counties Manukau and Middlemore Hospital, will be sent to the Medical Council of New Zealand, the Chief Medical Officers group, the New Zealand Board of Plastic and Reconstructive Surgery, and Te Tāhū Hauora|Health Quality and Safety Commission and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.