Waikato District Health Board

A Report by the

Health and Disability Commissioner

(Case 15HDC01280)

Table of contents

Executive summary 1

Complaint and investigation 3

Information gathered during investigation 4

Opinion: Waikato District Health Board — breach 15

Recommendations 20

Follow-up action 21

Appendix A: Independent advice to the Commissioner 22

Executive summary

1. The Health and Disability Commissioner (HDC) received a complaint from Ms A regarding the care she received from Dr B at Waikato District Health Board (WDHB) during 2014 and 2015. Following correspondence with WDHB, HDC found that WDHB had commenced a disciplinary investigation into Dr B owing to concerns raised by another orthopaedic surgeon at WDHB. An external review of Dr B's practice was also commissioned focusing on the care he had provided to five other patients.

2. While the external review process was being undertaken, Dr B resigned and left New Zealand. HDC has been unable to obtain a response from Dr B throughout the investigation.

3. The WDHB external review report found that before moving to New Zealand Dr B had received complaints while working overseas. It was found that the Head of Surgery and the Chief Medical Advisor, amongst others at WDHB, were aware of these complaints. Accordingly, a decision was made to investigate the adequacy and appropriateness of the steps taken by WDHB to ensure that Dr B was competent to practise.

4. The recruitment policy at WDHB required at least two references, at least one of which needed to be from a previous manager. Dr B provided WDHB with three written references from orthopaedic surgeons with whom he had worked overseas more than two years previously. These references alluded to communication difficulties, and noted concerns regarding demeanour and personality. Contrary to the recruitment policy, Dr B was not asked to provide any references from his most recent workplace.

5. WDHB's Clinical Leader of Orthopaedics, Dr C, acted as Dr B's supervisor. WDHB had no guidelines or policies in relation to supervision requirements, and relied on clinicians adhering to the Medical Council of New Zealand (MCNZ) supervision guidelines. Dr C advised HDC that he was not given enough time for supervision, and that in order to do the job properly he would have needed to drop clinical time.

6. During Dr B's time at WDHB, complaints management was a manual process. An administrator received and acknowledged complaints before passing the complaint to the Service Manager or Business Manager for response. Written complaints regarding Dr B's manner of communication, personality, and demeanour were received on 17 September 2012, 22 October 2013, and 13 November 2013. These complaints were dealt with in writing by a Business Manager, who reports discussing two of the responses with Dr B. Dr C was not made aware of the complaints.

7. When a new Business Manager took over in February 2014, she was not advised of any concerns regarding Dr B. Further, the complaints database did not name clinicians at the time, and an emerging pattern of concerns was not evident.

8. No complaints were forwarded to the Human Resources Department, and the complaints policy did not provide guidance on situations where there were multiple complaints against one individual.

9. In September 2014, a fourth patient complained about Dr B regarding communication issues and a failure to recommend appropriate surgery. When a new Clinical Director

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started in September 2014, he was not made aware of this complaint, and Dr B was no longer under supervision.

10. Later that month, a fifth complaint was made, where the care Dr B had provided to a patient had resulted in the patient requiring revision surgery. No performance issues were identified in relation to this complaint. However, by late 2014/early 2015 the new Business Manager had identified that Dr B was receiving more complaints than his orthopaedic colleagues, and this was raised with senior management.

11. In February 2015, one of Dr B's orthopaedic colleagues sent a formal letter of complaint to WDHB management stating that he would resign if his concerns regarding Dr B were not dealt with. As a result, the Business Manager, Head of Surgery, and the Chief Medical Advisor decided that an external review of Dr B's practice was required, and an extension to his contract was cancelled.

Findings

12. WDHB was found to have breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code)[1] for failing to have in place appropriate systems relating to recruitment and complaints management, which amounted to a failure in its duty of care. This is evidenced by its lack of care in how it employed Dr B, most notably for failing to secure a recent reference, and by failing to have in place adequate systems to identify an emerging pattern of concerns about Dr B, and to enable the appropriate staff to be aware of, and ultimately respond to, that emerging pattern.

13. Further criticism was made in relation to WDHB's supervision and monitoring process and its processes around induction and orientation.

Recommendations

14. It was recommended that WDHB complete the following actions:

a) Ensure that policies on recruitment are understood and followed, particularly in relation to the necessity of current referees, and of verbal reference checking — the content of which is fully documented. Clinical leaders, management, and human resources should share the accountability for this. The position descriptions of the Service Manager and the Clinical Leader are to be reviewed to ensure that both parties understand their responsibilities in respect of recruitment of senior medical officers (SMOs), and in particular in respect of international medical graduates (IMGs).

b) The supervision requirements for IMG locum tenens are outlined clearly in the MCNZ guidelines. WDHB should ensure that all supervisors are aware of their responsibilities. Particular care should be taken in respect of any pre-employment concerns such as those indicated in reference checking.

c) Complaints regarding clinical staff should be shared with relevant professional clinical leaders, who in turn should contribute to the response.

[1] "Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."

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d) Data regarding numbers of complaints by individual practitioners should be monitored and, where there are more than two complaints in one year, or three in total, then consideration should be given to further investigation and, as appropriate, performance management.

e) Complaints should be linked to adverse events in the incident reporting system, and reports provided to clinical leaders and management, who in turn should take joint responsibility for the review and resultant actions.

f) WDHB should consider a formal policy for annual performance appraisal/professional development for all SMOs, and should develop a process whereby anonymous multisource feedback can be used in providing feedback about performance.

g) Peer support/mentoring, independent of clinical supervision, could be considered for all IMGs in their first year of employment.

h) Clinical leadership training should be provided for all clinicians in responsible roles, and could involve skills training in conflict resolution, clinical governance, and SMO performance assessment and management.

i) Consideration should be given to performing yearly review of credentials for all IMG SMO appointments.

Complaint and investigation

15. The Health and Disability Commissioner received a complaint from Ms A about the care provided to her by Dr B and Waikato District Health Board (WDHB). After completing a preliminary assessment of the complaint, the Commissioner decided to commence an investigation on his own initiative into the care provided to consumers by WDHB, pursuant to section 40(3) of the Health and Disability Commissioner Act 1994. The following issue was identified for investigation:

- *The adequacy and appropriateness of the steps taken by Waikato District Health Board to ensure that Dr B was competent to practise, including the steps taken to credential and supervise his practice, and the steps taken when concerns were raised about his practice.*

16. WDHB was directly involved in the investigation, and information was also reviewed from several other organisations.

Parties mentioned in this report:

Ms A	Consumer
Dr B	Orthopaedic surgeon
Dr C	Orthopaedic surgeon
Dr E	Orthopaedic surgeon
Ms D	Business Manager

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Ms F	Business Manager
Mr G	Executive Director
Dr H	Emergency physician
Dr I	Clinical director

17. Independent expert advice was obtained from a medical administrator, Chief Medical Officer Margaret Wilsher (Appendix A).

Information gathered during investigation

Complaint regarding Dr B received by HDC

18. HDC received a complaint from Ms A about the care she received from an overseas-trained orthopaedic surgeon Dr B at WDHB. On 13 December 2014, Ms A had spinal surgery carried out at WDHB. Her discharge summary stated: "Avoid bending backwards."

19. On 20 January 2015, Ms A had a follow-up appointment with Dr B, during which he instructed her to carry out manoeuvres — including having to bend over — that caused her pain. Dr B discharged Ms A with no follow-up planned or physiotherapy put in place. Ms A developed further pain, which later was attributed to the manoeuvres Dr B had instructed her to do, and she had to undergo revision surgery.

20. HDC obtained expert advice from an orthopaedic spinal surgeon, Dr Thomas Geddes, regarding the care provided to Ms A. Dr Geddes advised that the induction of the pain caused to Ms A by the manoeuvres carried out during Dr B's examination was a significant departure from an acceptable standard of care, and that the decision to discharge Ms A without further follow-up was a moderate departure. Dr Geddes also advised that not referring her to physiotherapy was a mild departure.

21. WDHB told HDC that following receipt of Ms A's complaint, broad concerns about Dr B's clinical skills were raised verbally by another orthopaedic surgeon at WDHB, Dr E, and a disciplinary investigation was commenced. In addition, an external review of Dr B's practice was commissioned, which focused on the care he had provided to five other patients. The review report, completed in May 2015, was critical of Dr B's technical expertise, clinical decision-making, professionalism, and communication.

22. During the external review process, Dr B resigned and left New Zealand. Despite numerous attempts by HDC (including contacting customs, Interpol, the NZ Police, and overseas licensing boards, as well as trying to contact Dr B via email (all of which went un-replied)), HDC has been unable to obtain a response from Dr B throughout the investigation.

23. WDHB's external review report was provided to HDC. The report noted that Dr B had received complaints while working overseas prior to moving to New Zealand. It was noted that the Head of Surgery and the Chief Medical Advisor, amongst others at WDHB, were aware of these complaints. Accordingly, with the information HDC had to date, the Commissioner decided to initiate an investigation into the adequacy and appropriateness of the steps taken by WDHB to ensure that Dr B was competent to practise, including the steps

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taken to credential and supervise his practice, and the steps taken when concerns were raised about his practice. As HDC has been unable to locate Dr B, the investigation has focused on WDHB, as opposed to Dr B's standard of care.

WDHB's recruitment process

Interview and reference checking

24. When WDHB advertised for a senior orthopaedic surgeon in 2011, it received Dr B's curriculum vitae (CV) and certificates of good standing.

25. WDHB had two relevant policies in place at the time relating to recruitment: "Policy Recruitment (2006)" and "Credentialing of Health Practitioners (2012)". There was also a WDHB credentialling checklist.

26. The practice at the time at WDHB regarding recruitment, in line with its recruitment policy, was that the relevant Business Unit Manager, Clinical Director, and Human Resources (HR) Department would manage the process. Shortlisting, interviewing, and obtaining and verifying references were co-ordinated by the Business Unit Manager.

27. Dr B was interviewed over the telephone by the Business Unit Manager, Surgical Services, Ms D and the Clinical Leader Orthopaedics, Dr C. WDHB was unable to provide HDC with a copy of the interview questions, interview transcripts, or any notes in relation to the interview, as it stated that they were not kept, but WDHB told HDC that, at the time, a standard interview template with eight questions was used.

28. Ms D and Dr C told HDC that they recall Dr B disclosing verbally, and subsequently in writing, previous patient-related incidents, and Dr C told HDC that he also recalls that Dr B's references indicated that he could be forthright in his opinions. However, they did not consider the issues to be evidence of any professional or clinical deficit.

29. There is no documented evidence that during the recruitment process an internet search of Dr B was undertaken. Ms D told HDC that this was not common practice; however, Dr C told HDC that he did undertake a "Google" search and found "a couple of isolated complaints". Dr C stated: "These seemed to revolve around the non-provision of medications for the prescriptions of pain and I felt this fitted in with [Dr B's] description of events at interview."

30. WDHB's recruitment policy required at least two references. Dr B provided three written references — all three were from orthopaedic surgeons with whom Dr B had worked over two years previously (between 2001 and 2009). All spoke highly of him but alluded to communication difficulties, noting some concerns about Dr B's demeanour and personality.

31. The recruitment policy stated that at least one of the references must be from a previous manager, preferably the current or most recent manager. Contrary to its recruitment policy, Dr B was not asked to provide any references from his most recent work.

32. The Medical Council of New Zealand (MCNZ) supplied HDC with four written references that had been provided to MCNZ. Three were from the same three individuals from whom Dr B had provided written references to WDHB. The fourth was from an emergency physician from a location where Dr B had worked from 2009 until August 2011. Dr H's

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reference stated that "[Dr B] seemed to have difficulty communicating effectively with his orthopaedic colleagues", and that this led to friction.

33. WDHB told HDC that it was not provided with this reference, and that "no written or verbal references were provided by colleagues of [Dr B's] last employer".

Credentialling of Dr B

34. Credentialling is a formal process used to assign specific clinical responsibilities to health professionals through verification of their training, qualifications, experience, and current practice within an organisational context.

35. WDHB's policy "Credentialing of Health Practitioners" indicated that credentialling was to be undertaken on employment and formally 5–6 yearly, with issue-based credentialling as required. The policy further indicated that annual review was to be undertaken.

36. WDHB's credentialling checklist stated that written references from current or recent colleagues (within the last 12 months) were required as supporting documents, and written references were to be verified by verbal references. It further stated that interview notes of all panel members were to be considered supporting documents, as were certified copies of original qualifications.

37. The practice at WDHB was that clinical credentialling was undertaken by the Chief Medical Advisor on the advice of the SMO[2] Credentialing Committee. Information on candidates was presented to the committee by the relevant Clinical Director and Business Unit Manager.

38. The credentialling document for Dr B indicated that verbal reference checks were undertaken by WDHB, but there was no documentation regarding the verbal references. There is no record of how many or which referees were contacted, or by whom.

39. The credentialling document was signed off by Ms D, Dr C, and the Chief Medical Advisor (CMO). Mr G, the Executive Director of Hospital Services, told HDC that verbal reference checks were completed by two other orthopaedic surgeons. Mr G provided HDC with the three references that he stated formed part of the credentialling committee supporting documents. Contrary to WDHB's credentialling checklist, a more recent reference was not included.

40. The CMO told HDC that while the credentialling committee "was aware that there were no referee reports from [Dr B's] most recent place of employment, there were referee reports from peers who had recently worked with him, and for a significant period of time. It was felt these referees would know if there were issues with the clinical practice of [Dr B]."

41. Furthermore, WDHB told HDC: "[Dr B] had not worked actively since 2011. Therefore, there were no references provided from current or recent colleagues in the 12 months prior to commencement of his role at WDHB."

42. The CMO told HDC: "No complaints or proceedings relating to [Dr B's] work overseas were provided to the Credentialing committee during the recruitment process."

[2] Senior Medical Officer.

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43. Dr B's credentials were discussed at a Senior Medical Officer Electoral Committee (credentialling committee) meeting on 26 January 2012.

44. The minutes of the meeting noted that Dr B's references were discussed (the names of the referees are not documented). It was noted that, on the whole, the referees spoke highly of Dr B, but that one referee had commented negatively on Dr B's personality/demeanour. In relation to this comment, the minutes note: "[T]his being an employment related matter, the service will need to work through this." Dr C told HDC that he recalls that during the meeting, note was made of potential problems with interpersonal skills, and that these were attributed to frustrations with organisational situations where patient care was compromised.

45. Following the WDHB credentialling processes, on 27 January 2012 Dr B was sent a letter by WDHB advising him of the outcome. The letter stated that he had been credentialled to work as a locum consultant orthopaedic surgeon. The letter does not state any limitations on his practice, but says that his nominated supervisor would be Dr C. Dr B was offered a fixed-term role.

46. The certified copies of Dr B's qualifications were provided to MCNZ along with relevant certificates of good standing[3] (now known in New Zealand as Certificates of Professional Status). These were provided by the recruitment agency working for Dr B. In addition, Dr B's surgical log books detailing surgical activity in both his previous positions were provided.

47. Dr B was given Special Purpose (Locum Tenens) registration by MCNZ between 24 February 2012 and 28 February 2013, and then provisional vocational registration to work as an orthopaedic surgeon under supervision until he was granted full vocational registration by MCNZ on 12 June 2014.

WDHB's induction and orientation of Dr B

48. Dr B's letter of appointment from WDHB stated that on commencement of employment he would be given a WDHB Orientation Manual, and that it was his responsibility to read it. It also stated that Dr B would be required to attend a full-day organisation orientation session, and that additional orientation compliance components would need to be completed. There is no record of which of these components Dr B completed.

49. There was an orientation plan as part of the supervision plan for Dr B. A letter from WDHB to MCNZ (dated 13 January 2012) outlined that the plan[4] included orientation to departmental protocols, overview of the department and wider hospital, cultural aspects of care, and Clinical Director-led informal contact on a daily, then weekly, then three-monthly basis, with formal review every three months and an audit of all cases performed for morbidity and mortality. WDHB told HDC that the morbidity and mortality meeting is a formal meeting attended by all orthopaedic medical staff.

[3] These certificates confirm a doctor's registration and note whether there have been any complaints, investigations, or disciplinary action in the time of the doctor's registration. Doctors who have worked overseas applying to work in New Zealand must produce these from each relevant medical board with which they were registered or licensed within the last five years.

[4] The original plan cannot now be located.

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50. MCNZ provides best practice guidelines for the orientation, induction, and supervision of international medical graduates (IMGs). "Orientation" is described in the guidelines as an introduction and overview to medical practice in New Zealand. "Induction" is described as the familiarisation of systems and processes of the worksite and the individual service of departments.

51. Dr C was the clinician responsible for the supervision of Dr B. Dr C told HDC that Dr B's induction and orientation was organised by Ms D. Dr C can recall meeting, welcoming, and introducing Dr B to the department and discussing the nature of medical practice in New Zealand, including differences with Dr B's home country.

52. Dr C further recalls discussing the "Code of Patient Rights" (the Code of Health and Disability Services Consumers' Rights), the Health and Disability Commissioner, and Treaty of Waitangi obligations. He said:

> "I also would have discussed the various specialty interests of the Department members and the general tenor of the Department … My expectations would have been that he be communicative, hand over or discuss difficult cases and those outside his skill set and do the best he can within the resource constraints."

53. There is no documented evidence of Dr B having been given any formal induction into clinical and professional practice.

WDHB's supervision of Dr B

54. WDHB had no guidelines or policies in relation to supervision — it relied on clinicians adhering to the MCNZ guidelines. Dr C told HDC that he was given no guidance or instruction regarding what criteria WDHB would set regarding IMGs in terms of induction, orientation or supervision, and in particular the need for protected formal meetings or reviews outside the discussions in relation to supervision reports.

55. According to the MCNZ supervision requirements, Dr C, as Dr B's supervisor, was responsible for providing quarterly supervisor's reports to MCNZ while Dr B was under supervision. MCNZ's best practice guidelines provided guidance to supervisors in relation to how this should be carried out. Seven supervisor reports were provided to MCNZ during the supervision period (February 2012 to June 2014).

56. MCNZ's best practice guidelines describe formal supervision as "regular protected time, specifically scheduled … to enable facilitated in-depth reflection on clinical practice". The guidelines further state:

> "For supervision to work appropriately, the supervisor and IMG need to agree on the frequency, duration, and content of formal supervision sessions. This should be recorded in a formal written agreement."

57. The guidelines describe the frequency of meetings that may be necessary as depending on the experience of the doctor and the nature of the information that may be discussed.

58. Dr C told HDC that he met with Dr B regularly in the course of meetings in clinic, but that no formal meetings were organised. Dr C stated that he discussed Dr B's performance with

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members of his surgical team, and that they considered his surgical skills to be more than adequate. Dr C said that he was able to observe Dr B in the clinical setting and overhear Dr B's interactions with his patients, as he worked in close proximity in the outpatients department.

59. WDHB also stated that no formal meetings took place regarding the supervision of Dr B. However, in a later statement to HDC, Dr C said that he did undertake formal review meetings as part of producing his supervision reports. He said that these were "formal meetings where performance was discussed", and that he sought feedback from senior clinicians who worked with Dr B. Dr C acknowledged, however, that "outside the supervision report context, no formal meetings were organised".

60. Dr C said that no particular issues were raised, "as can be seen by the reports".

61. Dr C told HDC that he was subject to considerable management pressure to deliver elective targets and manage acute flow in the face of workforce challenges. He was juggling his own clinical work and his Clinical Director responsibilities as well as his supervision role. He said that "to do the job [of supervision] properly he would [have] need[ed] to drop clinical time".

62. Dr C further told HDC that in hindsight he feels that "the supervision of [Dr B] could have been better". Dr C added:

> "However, at the time and with the issues that the Hospital and the Department were dealing with (new build, ESPI compliance, driving theatre efficiency, expanding departmental workload), I felt I did the best job that I could."

Concerns raised about Dr B, and WDHB's response

63. As referred to above, during the course of Dr B's employment, WDHB received a number of complaints relating to his manner of communication and in relation to the care provided by him.

64. During the time of these events, complaints management at WDHB was a manual process of an administrator receiving and acknowledging complaints, before passing the complaint to the Service Manager or Business Manager for response. There was no opportunity to search the complaints received for themes, specific staff names, or other features, other than manually.

Patient complaints

65. On 17 September 2012, 22 October 2013, and 13 November 2013, WDHB received written complaints in relation to Dr B's manner of communication, personality, and demeanour. All three complaints were responded to in writing by Ms D. She wrote in two of the responses that she had discussed the complaint with Dr B.

66. There is no evidence that the complaints relating to Dr B's manner of communication, personality, or demeanour were considered together as a whole.

67. Ms D told HDC that she does not now recall these complaints.

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68. Dr C told HDC that he was not made aware of the complaints. He further said that no comments were provided to him that alluded to any complaints or difficulties with Dr B's communication.

69. Dr C's supervisor reports submitted to MCNZ through to June 2014 indicate that Dr B was meeting the standard or exceeding it in all domains, including communication.

70. Business Manager Ms F (having taken over from Ms D) told HDC that when she became Business Manager in February 2014, she was not advised of any concerns regarding Dr B. Furthermore, she said that at the time of events the complaints database did not name clinicians.

71. Ms F said that when receiving complaints, her standard practice would be "to give a copy of these to the clinician concerned for review and for them to provide comment". Ms F stated:

> "I also read and reviewed the clinical record and discussed [the matter] with any other relevant clinicians involved in the patients care. If any significant concerns were raised I discussed these with the service management and/or the Quality and Patient Safety Department."

72. On 4 September 2014, a fourth patient complained about Dr B concerning a lack of communication and a failure to recommend appropriate surgery. Ms F responded to the complaint. By this time, Dr B was no longer under supervision (which had ceased in June 2014). In addition, in September 2014 Dr I had taken over from Dr C as the Clinical Director. Dr I told HDC that he was not made aware of this complaint.

73. Later in September 2014, Ms F conducted a family meeting to discuss a serious event review that had been carried out in relation to the care Dr B had provided to a patient where the procedure had resulted in the patient requiring revision surgery. A formal complaint by the patient's family followed this meeting (the fifth complaint about Dr B). Overall, the review found that there were differences of opinion between surgeons, and it was stated that when complexity is involved it is vital that colleagues with expert knowledge and experience be consulted. No performance issues were identified. Dr C told HDC that he was aware of this complaint, and that at the time he "did not consider it to be part of a wider performance concern".[5] On 26 November 2014, a further sixth patient complaint was received, stating that Dr B's manner had left the patient feeling embarrassed and humiliated. Ms F responded to the complaint. Dr I told HDC that he was not made aware of this complaint.

74. Ms F told HDC that by late 2014/early 2015 she "had identified that [Dr B] was receiving more complaints than his other orthopaedic colleagues", and she raised this with her manager, the Assistant Group Manager of Surgery and Cardiology, Cardiothoracic and Vascular Services. He told HDC that he recalls a few complaints that were all investigated by the Business Manager, and that action was taken to bring these to the attention of Dr B, the Clinical Director, and the department's quality committee ("where appropriate"). However, he said that by 2015 he was aware of more complaints than would be expected.

[5] Subsequent external peer review found, however, that Dr B's care of this patient fell well below that expected of an orthopaedic surgeon in New Zealand.

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External complaints

75. In April 2014, an MP contacted WDHB and provided two negative reviews found on the internet in relation to complaints written by former patients of Dr B from overseas. WDHB's Executive Director for Community and Clinical Support told HDC that the Chief Medical Advisor and the Clinical Director were advised of the articles, and they confirmed that they had no concerns about the standard of Dr B's practice.

76. WDHB replied to the MP stating that WDHB had investigated the negative reviews and that no basis for the concerns had been found (the two overseas complaints had been dropped when they went to discovery). The letter documented that the Chief Medical Advisor and the Clinical Unit Leader were happy with the standard of care being provided by Dr B.

WDHB's complaints policy

77. At the time of these events, WDHB had the following complaints policies: "Compliments and Complaints" (issued 1 July 2011) and then "Feedback and Complaints" (Issued 1 January 2015).[6]

78. WDHB's policy "Compliments and Complaints" stated that all complaints were to be logged on the central Waikato DHB Quality and Risk complaints database. All complaints were to be sent to the Quality and Risk Administration Support and acknowledged within three days. The complaints were also to be forwarded to the manager of the service. If the complaint were considered serious, the Manager of the service was required to complete an incident report and inform his or her manager.

79. The policy did not mandate that the manager who addressed the complaint should also discuss the complaint with the relevant clinical leader. The policy stated that where performance issues were addressed as part of the complaint investigation, the information should be held in the Human Resources file.

80. None of the complaints made against Dr B were forwarded to Human Resources. Ms F told HDC that during her time as Business Manager she did not forward any complaints to Human Resources as the complaints policy did not provide instruction on when this was to occur other than if a person was being performance managed.

81. The policies did not provide guidance on what to do if there were multiple complaints against one individual.

Internal concerns raised in relation to Dr B's clinical practice

82. Dr E had concerns about the clinical practice of Dr B from 27 April 2013. Dr E told HDC that he did not elevate these beyond peer discussion at the departmental level until February 2015.

83. On 27 April 2013, Dr B and Dr E had a difference of opinion in relation to a patient's treatment. Dr E took over the care of the patient.

[6] The policies did not apply to staff complaints. Complaints made by other staff members were to be made in writing to the staff member's manager.

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84. In October 2013, there was a further incident where Dr B had a difference of opinion with Dr E and another orthopaedic surgeon regarding another patient's treatment. The other surgeons eventually took over the care of the patient.

85. Dr E told HDC that with each incident he informed Dr C, who discussed the situation with Dr B.

86. Dr C told HDC that he was made aware of the "difficulties in relationship between [Dr E] and [Dr B]". Dr C stated that he discussed the issue with the Business Unit Manager. In Dr C's view the issue was a "difference of opinion" and not evidence of concerns regarding Dr B's clinical care.

87. Dr C told HDC that he "sought advice from [his] senior colleagues in the department" and concluded that the issues were in relation to differences of opinion.

88. In December 2014, and again in January 2015, Dr B and Dr E had further differences of opinion in relation to a patient's care. Dr E brought these to the attention of Dr I, who was the Clinical Director at the time.

89. In December 2014, Dr E told Dr I, via text, about concerns he had with Dr B's clinical practice in relation to a patient. Dr I told HDC that he discussed these concerns with Dr E but that as Dr E did not make a formal complaint, no further action was taken. Dr I then became aware of differences of opinion between Dr B and Dr E in relation to another patient's care (in January 2015). Dr I met the patient and managed to resolve the issue.

90. Dr I told HDC that he considered that these situations involved "divergent views" that could be expressed between professional colleagues in relation to the best treatment for the patient. He further said: "Neither option was necessarily wrong on the information that was available at the time the discussion was had."

91. Dr I told HDC that he had not been made aware of any earlier complaints regarding Dr B's practice, and that it was not until Dr E approached him at this time that he became aware of any issues.

92. In February 2015, Dr E also approached Business Manager Ms F. Dr E told HDC that Ms F told him that she too had concerns, but that she had been told that such concerns were for clinicians to deal with, not management. Contrary to this, Ms F told HDC that the "first concerns raised with her were those of [Dr E] on 11 February 2015". As discussed above, she acknowledged that she was aware of earlier complaints (received during September and November 2014). She said that it was not unusual to receive two complaints in a month in the context of the volume of patients being seen by Dr B, but that on the third complaint in three months she discussed it briefly with her manager and the Clinical Director. She said that because concerns were not raised regarding Dr B's clinical care, as per "standard practice" the complaint was forwarded to Dr B to apologise to the consumer. She said that initially when she escalated the communication concerns raised in complaints to management, the response was that Dr B was an older clinician who was probably a little too direct.

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93. Ms F also told HDC that complaint themes discussed at the Orthopaedic quality meetings included communication and interaction with patients, "so that staff were aware of the themes and learnings".

94. Ms F had also been aware of the fifth complaint referred above, but stated that "[a]t no stage were any performance or clinical concerns regarding [Dr B] raised".

95. Ms F told HDC that following Dr E's conversation with her in February 2015, she elevated his concerns to senior management. She asked Dr E to draft a statement outlining his concerns and, on the evening of 11 February 2015, Dr E sent a formal letter of complaint to WDHB management stating that the situation had become untenable and that he would have no choice but to resign unless the matter was dealt with.

96. A meeting was arranged with the Business Manager, the Head of Surgery, and the Chief Medical Advisor, and it was decided at the meeting to restrict Dr B's practice and to commission an external review of his practice (discussed above). It was mutually agreed to cancel the recent extension to Dr B's contract and, as mentioned above, Dr B resigned. Following the review, MCNZ was advised of the review's findings, which indicated significant performance issues.

WDHB's monitoring and auditing of Dr B

97. WDHB told HDC: "WDHB SMOs normally have an annual performance review, completed with their Clinical Director and in some circumstances including other relevant personnel (such as Manager or peer)."

98. As stated above in relation to supervision, Dr C met with Dr B regularly in the course of meetings in clinic, and discussed Dr B's performance with members of his surgical team. Dr C also observed Dr B in the clinical setting and overheard Dr B's interactions with his patients. Dr C said that he undertook formal review meetings as part of producing his supervision reports, and stated that these were "formal meetings where performance was discussed". In addition, he sought feedback from senior clinicians who worked with Dr B.

99. WDHB told HDC that because Dr B, as an IMG, was under formal MCNZ supervision for the duration of his locum tenens position, no formal performance reviews of Dr B's practice were undertaken during his employment (other than the quarterly reports on his performance that were supplied to MCNZ).

100. The supervision reports were positive, and no issues of concern were documented on them. The reports were not forwarded to the Business Manager.

101. Dr C told HDC that the cases of concern (outlined above) would have likely been discussed at quarterly morbidity and mortality meetings. However, because the outcomes of those meetings are privileged under Protected Quality Assurance Activity (PQAA) guidelines, HDC is unable to obtain the information. However, Dr C said that whilst "no individual formal audits or surgical outcome assessments were undertaken in relation to Dr B's practice, [Dr B] was an active participant in the audit meetings of the Waikato Department and complications were reviewed as appropriate in that forum". Dr C further said that although "complications" were raised and discussed in relation to Dr B, he (Dr C) "did not

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recall detecting a pattern of events that would trigger a need for peer review or performance management".

102. WDHB told HDC:

> "Standard practice within a surgical team is to have an open and collegial conversation around difficult clinical problems … Where there is ongoing disagreement about the best way to treat a patient, then there would be an expectation that both sides of the disagreement would be presented to a senior colleague, often the Clinical Director, or a respected external SMO.
>
> …
>
> [Dr C] did, on several occasions, appropriately intervene in these treatment debates between [Dr B] and other WDHB orthopaedic SMOs."

103. Dr C told HDC that "with hindsight it might be said there was a concerning pattern of events"; however, he further said that he did not notice a pattern with Dr B's manner or performance, and that "[w]hen a pattern became apparent, the matter was attended to and dealt with appropriately".

104. Dr C said that were he to perform the role of Dr B's supervisor again, he would hold more formal meetings, record all complaints and possible outcome audits of Dr B's work, and drop clinical time in order to perform the duties adequately.

Changes made by WDHB

105. Following these events, WDHB updated its relevant policies (credentialling, recruitment, and complaints) and undertook both an internal audit of its recruitment process involving Dr B, and a more general review into its recruitment processes as a whole. Several recommendations were made, which are either now in place or are currently being implemented.

106. A supporting guide for managers has been developed to assist with recruitment and selection, and more timely responses to complaints are now undertaken, with weekly monitoring by senior management.

107. WDHB has since utilised a software programme that allows searchable, detailed records to be kept of complaints, management of complaints, and investigations and outcomes/learnings to be used for quality improvement. A reporting process is being instituted whereby complaints relating to one practitioner will be identified and acted upon when recorded in the above complaints system.

108. WDHB has strengthened its clinical leadership infrastructure to ensure that there is one point of accountability for management of medical staff within the surgical division, and that the function is well supported. The person appointed to the role is required to undertake the annual performance reviews of its medical staff. There is now an explicit requirement for all medical staff to have an annual performance review.

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109. In addition, the Orthopaedic Department has implemented a surgical safety checklist to increase the safety of surgical interventions, and is in the process of implementing other recommendations made as a result of the external review into Dr B's care.

Responses to provisional opinion

110. WDHB was given the opportunity to respond to the provisional opinion, and advised that it considers the findings and recommendations to be reasonable. It further said: "[W]e stress once again Waikato DHB's commitment to addressing the obvious deficiencies that have been identified in the unedifying series of events."

Opinion: Waikato District Health Board — breach

Introduction

111. WDHB is subject to a legal duty to provide health services with reasonable care and skill. As part of this, WDHB has an obligation to take reasonable steps to ensure that its clinical staff are competent and fit to practise, in order to protect its patients. It has an obligation to select competent staff and monitor their continued competence; provide proper orientation and supervision of its staff; and establish systems necessary for the safe operation of its hospitals.

112. District health boards' organisational duty of care has been considered in several Health and Disability Commissioner reports.[7] The present inquiry seeks to determine whether WDHB took adequate steps to identify and respond to concerns about Dr B and ensure that he was competent to practise.

WDHB's recruitment process: interviewing, reference checking, and credentialling — breach

113. This Office has stated previously that a DHB has a duty to exercise reasonable care and skill when employing staff. This involves establishing clear and appropriate recruitment processes, and supporting staff to comply with them.[8] WDHB failed to fulfil all its responsibilities as an employer in the following respects.

114. WDHB's recruitment policy required at least two references, one of which was to be from a previous manager (preferably the current or most recent manager). WDHB's credentialling checklist also required a written reference from colleagues within the last 12 months.

115. WDHB told HDC that Dr B had not worked actively since 2011, and that therefore no references from current or recent colleagues in the 12 months were provided prior to commencement of his role at WDHB. I note, however, that according to his CV, he had actually worked up to August 2011 (five months prior to his appointment at WDHB), and therefore that response is not correct. WDHB failed to secure a reference from a colleague with whom Dr B had worked within the past 12 months.

[7] Including Dr Roman Hasil and Whanganui District Health Board 2005–2006, Opinion 07HDC03504.
[8] See Opinion 07HDC03504.

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116. I find that WDHB had an appropriate policy on credentialling, but am critical that in reference checking and credentialling Dr B, WDHB did not follow its own policy by failing to secure a current reference.

Adverse comment

117. I further note that although patient-related incidents were raised during the interview with Dr B, they were not passed on to the Credentialing Committee. In addition, interview notes were not kept, despite these being considered suitable supporting documentation for the credentialling process. I am critical of this.

118. In addition, the credentialling document for Dr B indicates that verbal reference checks were undertaken by WDHB, but there is no documentation regarding the verbal references. It is not stated how many or which referees were contacted, or by whom. During this investigation, independent expert advice was obtained from Chief Medical Officer Margaret Wilsher. Dr Wilsher advised that given the critical comments (regarding demeanour and personality) made on the written references, in these circumstances "the verbal references are of particular relevance and the content of those conversations should have been documented".

119. Dr Wilsher further advised that had the concerns been confirmed, they should have been reflected in the supervision plan. If not, then the assurance provided by those referees should have been documented. I agree.

WDHB's systems to deal with performance issues, complaints, and incidents — breach

120. District health board hospitals should have a culture that supports safe care, identifies risks to patient safety promptly, and responds appropriately. There should be effective systems for clinical supervision, performance management, incident reporting, complaints management, and credentialling, together with traditional audits of morbidity and mortality within specialities. DHBs are responsible for ensuring that such systems are in place and that staff are supported to comply with them.

121. WDHB's "Compliments and Complaints" policy stated that all complaints were to be logged on the central WDHB Quality and Risk complaints database and forwarded to the manager of the relevant service, and that, if considered serious, the manager of the service was to complete an incident report and inform his or her manager.

122. The complaints relating to Dr B were logged and forwarded to the manager of the Orthopaedic Service.

123. As early as September 2012 and October and November 2013, WDHB had received complaints in relation to Dr B. While unlikely to be considered serious (for the purposes of requiring further escalation and an incident form as per the complaints policy process), they related to Dr B's manner of communication, personality, and demeanour (similar issues to those identified by Dr B's referees). All three complaints were logged and responded to in writing by Ms D, the Business Unit Manager at the time, as per WDHB's complaints policy, and at least some of them were discussed with Dr B.

124. It is noted that there was a change in management during the time of Dr B's employment, and that Ms F told HDC that when she commenced as the Business Unit Manager for the

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Orthopaedic Service in February 2014, she had not been informed by Ms D about the above complaints.

125. However, WDHB's complaints policy did not state that the Clinical Leader (who in this case was also supervising Dr B up until June 2014) was to be forwarded any complaints. No comments were provided to Dr C that alluded to any complaints or difficulties with Dr B's communication while he was under supervision at WDHB; therefore, Dr C's supervisor reports submitted to MCNZ through to June 2014 indicate that Dr B was meeting the standard (or exceeding it) in all domains, including communication.

126. I note that it was implied in Dr B's referee reports that communication issues had been encountered in previous employment settings, and that Dr C was aware of these. Once complaints about communication had been received at WDHB, then the Business Unit Manager should have shared those with Dr C, as the supervisor.

127. Dr Wilsher advised:

> "That an IMG locum tenens under MCNZ supervision could have 5 written complaints within three years and the supervisor, and head of department, not be notified or engaged in the management of those complaints represents a major departure from standard hospital management practice."

128. I accept this advice.

129. WDHB acknowledged that there was no opportunity to search its complaints database for themes, specific staff names, or other features, other than manually. There was also no system in place to review individual surgical outcomes or complaints regularly. In relation to Dr B, it is also noted that there were no individual formal audits or surgical outcome assessments undertaken in relation to his practice.

130. WDHB had no system for recognising and/or acting upon multiple complaints involving a single individual. In addition, I note that the relevant policies in relation to complaint management gave no guidance on what to do when multiple complaints were made about an individual clinician, and that complaints were forwarded to Human Resources only if the individual was being performance managed.

131. Dr Wilsher advised that management and clinical leadership need to work in close alignment in respect of monitoring and managing SMO performance. I am critical that this aspect was missing from WDHB's complaints process in place at the time.

132. I am critical that WDHB did not have a system to enable complaints about Dr B to be considered together. This hindered any identification of a pattern of conduct or a common theme that required training or other action. Therefore, WDHB failed to consider the combined significance of the concerns raised about Dr B.

133. Furthermore, DHBs have a duty to monitor the performance of its employed doctors. Dr B did not have a formal annual performance appraisal during his time at WDHB. Although WDHB has stated that this was because he was being supervised at the time, I note Dr Wilsher's advice that WDHB should consider a formal policy for annual performance

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appraisal/professional development for all SMOs. I agree, and consider that clinicians should be subject to a separate formal annual performance appraisal (or equivalent) even if currently under supervision. I note that WDHB has acknowledged this, and that there is now an explicit requirement for all its medical staff to have an annual performance review.

134. When it became clear that there were significant concerns about Dr B's performance (following Ms A's complaint in January 2015 and Dr E elevating his concerns at a management level), as discussed above, WDHB arranged for an external review into Dr B's care. Following this, WDHB took timely and appropriate steps to elevate the concerns to senior clinical leadership and management, and to address the concerns by restricting Dr B's practice.

Conclusion

135. While I note the changes that WDHB has already made in respect of this investigation, I am critical of the inadequacies of the systems at the time in relation to WDHB's recruitment and complaint processes (as identified above).

136. This investigation highlighted gaps in WDHB's systems in place at the time. Overall, for failing to have in place appropriate systems relating to recruitment and complaints management, WDHB failed in its duty of care. This is evidenced by its lack of care in how it employed Dr B, most notably for failing to secure a recent reference, and by failing to have in place adequate systems to identify an emerging pattern of concerns about Dr B, and to enable the appropriate staff to be aware of, and ultimately respond to, that emerging pattern. I find that WDHB breached Right 4(1) of the Code.

WDHB's supervision and monitoring process — adverse comment

137. The deficiencies identified above in relation to WDHB's recruitment process and its systems to deal with performance issues, complaints, and incidents in turn affected the supervision and monitoring of Dr B at WDHB.

Supervision

138. Dr B, as an IMG, was under formal MCNZ supervision for the duration of his locum tenens position. While no formal performance reviews were undertaken of Dr B's practice during his employment, quarterly supervision reports were supplied to MCNZ.

139. WDHB had no guidelines or policies in relation to supervision — it relied on clinicians adhering to MCNZ guidelines.

140. MCNZ's best practice guidelines described formal supervision as "regular protected time, specifically scheduled … to enable facilitated in-depth reflection on clinical practice". The guidelines further stated: "For supervision to work appropriately, the supervisor and IMG need to agree on the frequency, duration, and content of formal supervision sessions. This should be recorded in a formal written agreement." The guidelines describe the frequency of meetings that may be necessary as depending on the experience of the doctor and the nature of the information that may be discussed.

141. Dr C provided HDC with conflicting accounts about whether he had formal meetings with Dr B. I consider that although meetings did occur, there is no evidence of those meetings having been "regular protected time, specifically scheduled … to enable facilitated in-depth

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reflection on clinical practice", as outlined in the MCNZ guidelines, or of there having been any formal written agreement in relation to the supervision process between Dr C and Dr B.

142. MCNZ's best practice guidelines provide very clear guidance for the supervisor. Dr Wilsher advised that MCNZ is very clear on the standard required regarding supervision. She said that at the very least, scheduled meetings should have taken place. She advised that this responsibility lay primarily with the supervisor who was accountable to MCNZ for the reports — in this case, Dr C. Dr Wilsher advised: "Whilst a supervisor working in close clinical contact will be able to witness performance first hand, it is only with a formal structure that feedback can be appropriately given." I agree. While I note that Dr C met his requirements in relation to providing his quarterly supervision reports, in line with the MCNZ best practice guidelines, the meetings should have been structured in a more formal manner, with scheduling of the meetings and a detailed agreement outlining the structure and frequency of the meetings.

143. Although Dr C has acknowledged that his supervision of Dr B could have been better, I note his comment that he was subject to considerable management pressure to deliver elective targets and manage acute flow in the face of workforce challenges. He was juggling his own clinical work and his Clinical Director responsibilities as well as his supervision role. He told HDC that "to do the job properly he would [have] need[ed] to drop clinical time".

144. Dr Wilsher advised: "It would not be an uncommon scenario in New Zealand for a new clinical director to find himself in the role with little in the way of formal leadership or management training, and at times with limited support."

145. Dr Wilsher further advised:

> "[Dr C] was subject to considerable management pressure to deliver elective targets and manage acute flow in the face of workforce challenges and his priority would have been his own clinical work plus the essential clinical director responsibilities — not searching through the policies and procedures library for supervision guidelines. He makes a telling point in the final paragraph of his response in that to do the job properly he would need to drop clinical time. All too often clinical leadership is not afforded sufficient time."

146. Dr Wilsher considers that "[the DHB] is partly responsible for not ensuring that supervision standards [were] adhered to". DHBs have a responsibility to ensure that appropriate procedures are in place to enable its clinicians and clinical leaders to do their jobs well — in particular in respect of the induction, orientation, and supervision of IMGs to ensure the safe employment of such doctors. While Dr Wilsher advised that "[W]DHB would ordinarily presume that supervision of all doctors for whom the MCNZ requires such would be of the necessary standard", I find that WDHB did not ensure that supervision was provided in accordance with the MCNZ standards for supervision of a locum tenens IMG.

147. WDHB did not provide Dr C with any guidelines or policy on supervision, and Dr C advised that he was not given sufficient time to devote to supervision. Clinicians who have such responsibilities require protected time to recognise and respond to problems. I find that Dr C took all reasonable steps in the circumstances and, while noting that ideally his

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supervision would have been carried out in a more structured manner, I am not critical of Dr C in relation to how he conducted his supervision of Dr B. I consider that it is the DHB's role to facilitate the supervision process by ensuring that enough time and resources are set aside for this to happen. This requires DHBs to size jobs appropriately to allow sufficient time for this activity and to provide appropriate technical support.

WDHB's induction and orientation process — adverse comment

148. Dr C told HDC that Dr B's induction and orientation was organised by the Business Unit Manager, Ms D. While he can recall meeting, welcoming, and introducing Dr B to the department, and discussing the nature of medical practice in New Zealand, Dr C did not give Dr B any formal induction into clinical and professional practice. As there is no evidence of any formal induction into such matters, the extent of the formality of Dr B's orientation is not known.

149. Dr Wilsher advised:

> "Given the referees' comments and the apparent discussion of interpersonal skills at the credentialing committee meeting [regarding the 'service needing to work through this' in relation to issues identified around [Dr B's] personality and demeanour], it would have been appropriate to consider more substantive orientation including a graduated work programme for this IMG to provide assurance about clinical and professional competency."

150. I agree. There is no evidence that this occurred, and I consider this to have been a missed opportunity.

151. In this situation there was a separation between management and clinical leadership. Dr Wilsher advised:

> "In delegating the orientation of [Dr B] to the Business Unit Manager, there is a risk that organisation compliance matters, such as health and safety, will be covered but not the clinical and professional context in which the employee will be working."

152. I agree, and suggest that WDHB turn its mind to the learnings from this case in relation to this point.

Recommendations

153. I recommend that Waikato District Health Board consider Dr Wilsher's recommendations (largely reproduced below) and report back to HDC regarding the outcome of that consideration, within six months of receipt of this report. Dr Wilsher's recommendations include the following:

1. Ensure that policies on recruitment are understood and followed, particularly in relation to the necessity of current referees, and of verbal reference checking — the content of

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which is fully documented. Clinical leaders, management, and human resources should share the accountability for this.

2. The position descriptions of the service manager and clinical leader are reviewed to ensure that both parties understand their responsibilities in respect of recruitment of SMOs, and in particular in respect of IMGs.

3. The supervision requirements for IMG locum tenens are clearly outlined in the MCNZ guidelines. WDHB should ensure that all supervisors are aware of their responsibilities. Particular care should be taken in respect of any pre-employment concerns such as those indicated in reference checking.

4. Complaints regarding clinical staff should be shared with relevant professional clinical leaders, who in turn should contribute to the response.

5. Data regarding numbers of complaints by individual practitioners should be monitored and, where there are more than two complaints in one year, or three in total, then consideration should be given to further investigation and, as appropriate, performance management.

6. Complaints should be linked to adverse events in the incident reporting system, and reports provided to clinical leaders and management, who in turn should take joint responsibility for the review and resultant actions.

7. WDHB should consider a formal policy for annual performance appraisal/professional development for all SMOs, and should develop a process whereby anonymous multisource feedback can be used in providing feedback about performance.

8. Peer support/mentoring, independent of clinical supervision, could be considered for all IMGs in their first year of employment.

9. Clinical leadership training should be provided for all clinicians in responsible roles, and could involve skills training in conflict resolution, clinical governance, and SMO performance assessment and management.

10. Consideration should be given to performing yearly review of credentials for all IMG SMO appointments.

Follow-up action

154. A copy of this report with details identifying the parties removed, except WDHB and the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from Chief Medical Officer, Dr Margaret Wilsher:

"**Report for Commissioner Initiated Investigation**

Ref: 15HDC01280

1) I have been asked to provide an opinion to the Commissioner on case number 15HDC01280 and I have read and followed the Commissioner's Guidelines for Independent Advisors.

2) My qualifications are as follows: MB ChB, University of Otago; MD, University of Otago; Fellow, Royal Australasian College of Physicians; Distinguished Fellow, Royal Australasian College of Medical Administrators. I am currently the Chief Medical Officer for Auckland District Health Board and an Honorary Professor of Medicine, Faculty of Medical and Health Sciences, University of Auckland. I am accountable for the clinical practice and professional standards of nearly 1500 doctors employed by ADHB and have been involved in medical leadership and health management for over 15 years. I am a practising physician in public and private sectors, a clinical researcher and teacher. I also hold membership of the New Zealand Institute of Directors and sit on a number of external health related governance and advisory committees and boards.

3) My referral instructions from the Commissioner are to provide an opinion on the adequacy and appropriateness of the steps taken by Waikato District Health Board (Waikato DHB) to ensure that [Dr B] was competent to practise, including the steps taken to credential and supervise his practice, and the steps taken when concerns were raised about his practice.

4) I have read and considered the following material supplied by the Commissioner:

a. Waikato DHB's response dated 18 September 2015, including external review;
b. Waikato DHB's response dated 13 July 2016, including attachments;
c. Information provided by MCNZ to HDC dated 15 July 2016, including attachments;
d. Information provided by MCNZ to HDC dated 29 July 2016, including attachments;
e. Waikato DHB's response dated 15 August 2016, including attachments;
f. Further information emailed from Waikato DHB to HDC dated 18 August 2016;
g. Waikato DHB's response dated 29 August 2016;
h. Waikato DHB's response dated 25 October 2016, including attachments;
i. Waikato DHB's response dated 12 December 2016;
j. Individual statements from clinicians and individuals at Waikato DHB (X 12);
k. Waikato DHB's audit sent 16 June 2017; and
l. Waikato DHB's notes regarding HDC Investigation sent 24 July 2017.

I have also read and considered information from the Medical Council of New Zealand and the Royal Australasian College of Surgeons.

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5) Factual Summary
[Dr B], [an overseas]-trained orthopaedic surgeon, began working at Waikato DHB [in] 2012. A phone interview was conducted by the Clinical Director and Unit Manager. [Dr B] provided three written references to Waikato DHB, who were also his verbal referees. All three were from orthopaedic colleagues he had worked with in […] over two years previously. He did not provide any references from his most recent work in [...]. The three referees all noted some concerns about [Dr B's] demeanour/personality.

[Dr B] was discussed at a Senior Medical Officer Electoral Committee meeting and was credentialed to work as a locum consultant orthopaedic surgeon, under the supervision of the Clinical Director. [Dr B] remained under supervision until he was granted vocational registration by the Medical Council of New Zealand [in] 2014.

During the course of [Dr B's] employment, the Chief Medical Advisor became aware that [Dr B] had received a complaint about his practice in [his previous position], and discussed this with him.

In April 2013, an incident occurred where [Dr B] had a difference of opinion with another orthopaedic surgeon in relation to a patient's treatment, which resulted in the other surgeon taking over the care of the patient. The Clinical Director was informed and discussed the situation with [Dr B].

In October 2013, [Dr B] had a difference of opinion with two other orthopaedic surgeons regarding another patient's treatment. Those surgeons eventually took over the care of the patient.

In February 2014, [Dr B] carried out surgery while on-call, when the required equipment was not available. The surgery was inadequate and revision surgery was required. This case was discussed at an audit meeting and a Serious Incident Review was carried out following a complaint from the patient's family. Also in February 2014, an MP's office contacted Waikato DHB raising concerns about the care provided by [Dr B] to a constituent. It also noted that [Dr B] had bad reviews online from [previous positions], and that it knew of two other patients who [Dr B] had operated on unsuccessfully. The Chief Operating Officer replied, stating that the Chief Medical Advisor and the Clinical Unit Leader were happy with the standard of care provided by [Dr B] and that two overseas complaints had been dropped when they went to discovery.

Between September 2012 and November 2014, Waikato DHB received a further seven complaints about [Dr B].

In December 2014, [Dr B] carried out surgery which was inadequate. Revision surgery was required. A complaint was received from the patient's family.

In January 2015, [Dr B] had a difference of opinion with another orthopaedic surgeon. The Clinical Director had to intervene.

Also in January 2015, [Dr B] requested that a patient post-spinal surgery carry out exercises which caused them pain. The patient later had to have further surgery as a result of damage caused by the exercises. The patient complained to Waikato DHB.

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Following this incident, concerns were raised about [Dr B] by another member of the Orthopaedic Department. Waikato DHB commenced a disciplinary investigation and commissioned an external review. The external review was critical of [Dr B's] technical expertise, clinical decision-making, professionalism and communication. During the review process, [Dr B] resigned and [left NZ]. Despite numerous attempts, HDC has been unable to contact him.

No formal performance reviews were undertaken of [Dr B's] practice during his employment, as he was being supervised. No quality assurance or clinical audits were completed for him.

6) Glossary

Acronyms used in this report are as follows:

- SMO, Senior Medical Officer
- IMG, International Medical Graduate
- MCNZ, Medical Council of New Zealand
- RACS, Royal Australasian College of Surgeons
- CV, Curriculum Vitae
- DHB, District Health Board

7) Opinion

a. Waikato DHB's recruitment process, including in relation to the interview and reference checking.

Waikato DHB has two relevant policies relating to the recruitment of Senior Medical Officers (SMOs): Policy Recruitment (issued 2006), Recruitment and Selection Policy (Issued Oct 2015 and which appears to replace the 2006 Policy on Recruitment), Credentialing of Health Practitioners (Issued March 2012). There is also a credentialing check list.

The process of recruitment of [Dr B] comprised the following:

- Advertisement (not supplied).
- [Dr B's] details including CV and certificates of good standing were provided to Waikato DHB by [a recruitment agency].
- Application for employment dated […] 2012
- Interview
- Reference checks — as required by policy 3 referees were to be contacted.
- Medical Council completion of registration processes
- Credentialing
- Offer — Locum Orthopaedic Surgeon

[Dr B] was interviewed by phone by [Ms D], Business Unit Manager, Surgical Services and [Dr C], Clinical Leader Orthopaedics. No copy of interview questions, interview

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transcripts or notes were kept but the interviewers apparently used a standard interview template of 8 questions. [Ms D] recalls [Dr B] disclosing verbally and subsequently in writing, a patient related incident prior to being offered [his previous position]. The matter was not considered evidence of any professional or clinical deficit. No Google or other internet search was undertaken.

Verbal and written references were obtained from three orthopaedic surgeon peers all of whom had worked with [Dr B] [overseas] where [Dr B] had worked between 2001 and 2009 ([names]). All spoke highly of him but two alluded to communication difficulties. A fourth written reference was supplied by an emergency physician from […] where [Dr B] had worked from 2009 until August 2011. [Dr H], Emergency Physician, stated that she had known [Dr B] for 2.5 years (from August 09 until the date of writing, 9/12/2011). [Dr H] stated that '[Dr B] seemed to have difficulty communicating effectively with his orthopaedic colleagues, which led to the friction …'. All four references were supplied via the Medical Council of New Zealand.

Following the Waikato DHB credentialing processes, [Dr B] was offered a fixed term role as locum orthopaedic surgeon on 21 December 2011. He was vocationally registered by the MCNZ to work as an orthopaedic surgeon under supervision as required for an international medical graduate (IMG) locum tenens.

Only one reference was obtained from a peer/manager ([Dr H]) at the most recent place of employment. It is not clear if this was sighted by the appointing manager as it does not appear to be included in the credentialing supporting documentation (see below). This is not practice that is in accord with the DHB's recruitment policy.

b. Waikato DHB's credentialing of [Dr B], including in relation to the adequacy of the information he was credentialed on and whether further enquiries should have been made.

The policy Credentialing of Health Practitioners (issued March 2012) indicates that credentialing must be undertaken on employment and formally at 5–6 yearly with issue based credentialing as required. The policy indicates that annual review will be undertaken. The document is similar in content to the policy on credentialing at ADHB.

The credentialing checklist states that written references from current or recent colleagues (within last 12 months) are required as supporting documents. Written references are to be verified by verbal references. Interview notes of all panel members are considered supporting documents as are certified copies of original qualifications. The latter were provided by the recruitment agency to the MCNZ along with relevant certificates of good standing. The credentialing document for [Dr B] indicates that verbal reference checks were undertaken but it does not state how many or which referees were contacted, or by whom. The document is signed by [Ms D], [Dr C] and the Chief Medical Advisor]. In a letter to the HDC, 13 July 2016, [Mr G], Executive Director, Waikato Hospital Services indicates that verbal reference checks were completed by [two staff members][9]. [Mr G] encloses three references that formed part

[9] It is noted that one of these staff members has told HDC that he has no recollection of conducting this verbal reference check.

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of the credentialing committee supporting documents — the reference from [Dr H] is not included.

No police check appears to have been requested.

Surgical log books detailing surgical activity in both [previous positions] were provided.

Waikato DHB has an appropriate policy on credentialing and the policy indicates that a consumer should be party to the process. The minutes of the SMO Electoral Committee meeting, 26 January 2012, at which [Dr B's] credentials were discussed, indicates 8 attendees but roles are not detailed. The references were discussed and it was minuted that the referees spoke highly about [Dr B]. It was noted that one referee commented negatively on his personality/demeanour. Comment is made in reference to 'this being an employment related matter, the service will need to work through this' but it is not clear if the minute is in relation to the adverse referee comment. It is not clear whether the reference from [Dr H], the only current reference, was available as the names of the referees are not provided but as her reference is the most direct in stating that there were communication difficulties and friction between [Dr B] and his peers, then it seems likely it was tabled. Two of the other referees alluded to communication difficulties. It is unusual for medical peers to provide criticism in a written reference so the verbal references are of particular relevance and the content of those conversations should have been documented. [Dr C] recalls that during the meeting, note was made of potential problems with interpersonal skills but this appears to have been attributed to frustrations with organisational situations where patient care was compromised.

In credentialing [Dr B], the DHB appears not to have followed its own policies in that only one reference from the previous employer was made available to the appointing manager and the credentialing committee. Given the comments made on the written references, it would have perhaps been prudent to document the comments made by the referees on verbal interview. If the concerns were confirmed then this should have been reflected in the supervision plan. If not, then the assurance provided by those referees should have been documented.

The failure to secure three current references in line with policy, and to document verbal reference checks represents a departure from acceptable employment practice, particularly so in light of employment of an international medical graduate (IMG) who spent less than 3 years at his last job.

The letter to [Dr B] advising him of his credentials, dated 27 January, 2012 advises that he has been granted clinical privileges to work as a locum consultant orthopaedic surgeon. It does not state any limitation on clinical practice or that he will be required to work nominally under supervision as a locum tenens IMG. It is not clear if the credentialing committee considered [Dr B's] log book and whether it formed an opinion on whether he should be specifically credentialed to work as a spinal surgeon but the applicant details for credentialing indicated a special interest in spine, foot/ankle, trauma. Details regarding the scope of practice are not presented. In the external review, the reviewers commented on the apparent fact that [Dr B] worked

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outside of a strict scope of practice, particularly when it came to the management of cervical spine injuries.[10]

It appears that [Dr B] commenced employment [in] 2012.

c. Waikato DHB's induction and orientation of [Dr B].

The letter of appointment, dated […] 2011, states that on commencement of employment, [Dr B] will be given a Waikato DHB Orientation Manual and that it is his responsibility to read. It was stated that [Dr B] would be required to attend a full day organisation orientation session and that additional orientation compliance components would need to be completed. It is not clear which of these components [Dr B] completed. The letter of credentials makes no mention of clinical orientation. It is stated by Waikato DHB that an orientation plan as part of the supervision plan for [Dr B] was supplied to the MCNZ but that is not supplied. That plan apparently included orientation to departmental protocols, overview of the department and wider hospital, cultural aspects of care and Clinical Director led informal daily contact on a daily, then weekly, then three monthly basis with formal review every three months and an audit of all cases performed for morbidity and mortality.

In his statement to the HDC dated 17 March 2017, [Dr C] confirms that he was the clinician responsible for the supervision of [Dr B], and hence responsible for providing quarterly supervisor's reports to the MCNZ. He states that he was involved in the interview but not the reference checking aspect of the recruitment process. [Dr C] did present the credentialing documentation to the Chief Medical Advisor for sign off. [Dr C] does recall that the references indicated that [Dr B] could be forthright in his opinions.

[Dr C] states that [Dr B's] induction and orientation was organised by [Ms D], the Unit Business Manager. He can recall meeting, welcoming and introducing [Dr B] to the department, discussing the nature of medical practice in New Zealand, including differences with [his home country].

Given the referees' comments and the apparent discussion of interpersonal skills at the credentialing committee meeting, it would have been appropriate to consider more substantive orientation including a graduated work programme for this IMG to provide assurance about clinical and professional competency. Particular care regarding obligations under the Code of Rights, the Treaty of Waitangi and the RACS professional standards including Operating with Respect (acknowledged as not in place in 2012) could all be considered as forming part of such orientation. The MCNZ provides best practice guidelines for the supervision of IMGs (Orientation, Induction and Supervision) which are published on the website. Orientation is described by the MCNZ as an introduction and overview to medical practice in New Zealand. Induction is the familiarisation of systems and processes of the worksite and the individual service of departments. In delegating the orientation of [Dr B] to the Business Unit Manager, there is a risk that organisation compliance matters, such as health and safety,

[10] There were no limits on Dr B's scope of practice until early 2017, when he was restricted from conducting spine or ankle surgery, and from participating in the after-hours roster.

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will be covered but not the clinical and professional context in which the employee will be working.

I consider this a departure from accepted standards for the orientation and induction of an IMG locums tenens.

d. Waikato DHB's supervision of [Dr B].

[Dr C], in his report to the HDC dated 17 March 2017, states that as MCNZ appointed supervisor he met with [Dr B] regularly in the course of meetings in clinic but no formal meetings were organised. He states that he was at pains to discuss his performance with members of his surgical team who considered that his surgical skills were more than adequate. It is also evident that [Dr C] was able to observe [Dr B] in the clinical setting as he worked in close proximity in the outpatients department and he states that he overheard his interactions with his patients.

The MCNZ, in its best practice guidelines for supervisors of IMGs states categorically that formal supervision time is regular protected time, specifically scheduled to enable facilitated in-depth reflection on clinical practice. For supervision to work appropriately, the supervisor and IMG will need to agree on the frequency, duration, and content of formal supervision sessions. This should be recorded in a formal written agreement. The MCNZ describes the frequency of meetings that might be necessary and the nature of information that might be discussed. The MCNZ sets out very clear guidelines for the supervisor.

The Royal Australasian College of Surgeons (RACS) provides guidelines for IMG surgeons undergoing assessment (Clinical Assessment of IMG Surgeons. A Guide for IMG Surgeons Undergoing Clinical Assessment by Supervision), in which it is stated that the IMG will be required to meet quarterly with clinical assessors for a performance review. Logbook data should be reviewed and 6 monthly multisource feedback (MSF) undertaken. These standards are intended for IMG surgeons intending to apply for Fellowship of the RACS which [Dr B] as a fixed term locum tenens was not proposing to do. However, the principles of supervision are similar to those outlined by the MCNZ, in particular the importance of meaningful feedback.

In acknowledging that no formal meetings took place, the DHB did not ensure that supervision was provided in accord with the MCNZ standards for supervision of a locum tenens IMG. It is not clear what standards Waikato DHB sets for the supervision of IMGs but as a provider of employment for Interns it will be credentialed by the MCNZ and as such meet those standards. The DHB would ordinarily presume that supervision of all doctors for whom the MCNZ requires such would be of the necessary standard. I consider the failure to provide appropriate supervision of [Dr B], of the MCNZ standard, or at the very least formal scheduled meetings to discuss performance, to represent a departure from usual supervision practice.

e. Waikato DHB's response to the concerns raised about [Dr B].

There are a number of patient complaints relating to care provided by [Dr B]. The first appears to be that made by [Complainant 1] in relation to the care of [her father], dated 17 September 2012. In that complaint she found [Dr B] to be rude and dismissive of her concerns. The next complaint was made on 22 October 2013 by [Complainant 2] in

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which she described [Dr B] as losing his temper and shouting at her and her husband, finding that he showed a lack of respect, failed to keep her informed and did not seem to care. A third complaint was made on 13 November 2013 by [Complainant 3] on behalf of [a consumer], stating that [the consumer] was not listened to or treated with respect. All three complaints were responded to in writing by [Ms D], Unit Business Manager. She does state, in two of the responses, that she has discussed the complaint with [Dr B]. It is not clear if the complaints taken together were considered as thematic and representative of a communication problem and it is not clear if the complaints were elevated to [Dr C], the clinical leader and MCNZ supervisor of [Dr B]. The supervisor reports submitted to the MCNZ from first quarter of employment through to June 2014 indicate that [Dr B] meets the standard or exceeds it in all domains including communication. No comments are provided by the supervisor that allude to any complaints or difficulties with communication.

[Ms D] in her statement to the HDC, 09 December 2016, writes that she does not recall any formal complaints (about [Dr B]) in 2013. [Dr C] states in his letter to the HDC, 17 March 2017, that he was not aware of the complaints regarding the care of [the three patients].

A fourth complaint was received on 4 September 2014 from [Complainant 4] in which he describes a lack of communication and failure to recommend appropriate surgery. That complaint was responded to by the Business Manager Surgery, [Ms F]. It is not clear if [Dr C] was made aware of this complaint. On 26 November 2014, [Complainant 5] complained that [Dr B] had left him feeling embarrassed and humiliated by his manner. That complaint, the fifth, was also responded to by [Ms F].

In September 2014, [Ms F] conducted a family meeting to discuss the serious event review of [Complainant 6] in relation to care provided by [Dr B] who had performed a procedure that required revision. That in turn resulted in a formal complaint by the family. A root cause and a number of contributory factors were identified but no performance issue. Subsequent external peer review found that [Dr B's] care of [Complainant 6] fell well below that expected of an orthopaedic surgeon in New Zealand.

In his statement to the HDC, 19 January 2017, [the] Assistant Group Manager Surgery and Cardiology, Cardiothoracic and Vascular Services states that he recalls *a few complaints* which were all investigated by the Business Manager for orthopaedics and action taken to bring these to the attention of [Dr B], the Clinical Director and the department's quality committee (where appropriate). By 2015, he was aware of more complaints than would be expected.

In relation to concerns about clinical practice, the new Clinical Director for Orthopaedic Surgery, [Dr I], states in his draft response to the HDC, dated 16 March 2017, that he first became aware of concerns when [Dr E] sent him a text, the contents of which he subsequently discussed with [Dr E]. This related to the care of [a patient]. As [Dr E] did not make a formal complaint, no further action was taken. The next concern related to the care of [another patient], in which there were differences of opinion between [Dr B] and [Dr E] which were resolved by [Dr I] meeting with the patient. After this, [Dr E] complained formally to hospital management. That resulted

HDC

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in a meeting with the Business Unit Manager, the Head of Surgery and the Chief Medical Advisor at which time it was decided to restrict [Dr B's] practice and commission an external review of his practice. [Dr I] states that prior to these concerns he had not been made aware of any problems regarding [Dr B's] practice or of any previous complaints.

The DHB had been made aware of external concerns about [Dr B] when, in February 2014, [an MP] raised a concern on behalf of a constituent who had not actually complained to the DHB. In April 2014, the same MP contacted the DHB with several internet articles written by former patients overseas. The DHB investigated that concern and found no basis for it. At the time, the [Executive Director for Community and Clinical Support] reports that the Chief Medical Advisor and the Clinical Director were advised and confirmed that they had no concerns about the standard of [Dr B's] practice.

The Waikato DHB policy on Consumer Feedback and Complaints (issued January 2011) does not mandate that the manager who addresses the complaint should also discuss the complaint with relevant clinical leadership. Where performance issues are addressed as part of the complaint investigation, then that information should be held in the Human Resources file. It is not clear if any information regarding the complaints made against [Dr B] were forwarded to Human Resources. An annual report of complaints is provided to the Board of Clinical Governance, Group Managers and executive groups. The policy does not provide instruction on multiple complaints against one individual.

[Dr E] had concerns about the clinical practice of [Dr B] from 27 April 2013 but did not elevate these beyond peer discussion at departmental level until February 2015 at which point he raised his concerns with [Dr I], advising that the situation was untenable and that he would have no choice but to resign unless the matter was dealt to. He then approached the Business Unit Manager, [Ms F], who advised that she too had concerns but that she had been told that such concerns were for clinicians to deal with not management. It was not clear which senior managers she had approached with her concerns. Following [Dr E's] conversation she apparently elevated his concern to her senior manager.

h. The systems that were in place at Waikato DHB to deal with performance issues, complaints and incidents regarding [Dr B].

Waikato DHB appears to have had no system for recognising and/or acting upon multiple complaints involving a single individual. There is no formal mechanism for ensuring that relevant clinical leadership is made aware of complaints against clinicians in their respective services. There appears to be no link between complaints and serious adverse events. Within three years of employment [Dr B] was the subject of 5 written complaints with a common theme of poor communication. He had also been subject to one serious adverse event review and despite the review finding that there were differences of opinion between surgeons, and the finding that when complexity is involved it is vital that colleagues with expert knowledge and experience be consulted, there was no finding of a performance issue. This is a somewhat different finding to that of the external reviewers and should perhaps provoke a review of the RCA process

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in relation to this case. There had been concerns articulated by a junior SMO about [Dr B's] clinical practice, in particular his care of spinal injury or infection, that had been unsatisfactorily resolved at service level. There appeared to be no process of peer review of individual surgical outcomes, no formal annual performance appraisal or equivalent for SMOs in the orthopaedics department and no identified pathway for a surgeon expressing concerns about a peer to ensure that those concerns could be heard. There appeared to be a degree of acceptance that clinical variation in practice was the result of different training and experience and could be accepted. Perhaps with leadership skill in conflict resolution, the clinical issues of concern could have been safely addressed by the orthopaedic peer group.

That an IMG locum tenens under MCNZ supervision could have 5 written complaints within three years and the supervisor, and head of department, not be notified or engaged in the management of those complaints represents a major departure from standard hospital management practice.

Once it became clear that there were significant concerns about [Dr B's] performance, the DHB arranged for external peer review of 5 cases. This seems to have been triggered by a major complaint ([Ms A], [2015]) that indicated a significant deviation from accepted clinical practice, and the concerns of [Dr E]. Following this, the DHB took timely and appropriate steps to elevate the concerns to senior clinical leadership and management, and address them by restricting [Dr B's] practice. In the course of the external review, [Dr B] resigned, the extension to his locum position having been cancelled by mutual agreement. The MCNZ was advised of the review findings which indicated significant performance issues.

i. Waikato DHB's monitoring and auditing of [Dr B's] performance.

[Dr B], as an IMG, was under formal MCNZ supervision for the duration of his locum tenens position, extended beyond the initial one year. Quarterly reports on his performance were supplied to the MCNZ and presumably to the Waikato DHB Human Resources file. It is not clear if the Business Manager was sent a copy. No formal supervision meetings were held contrary to the guidelines for supervisors published by the MCNZ. Whilst the supervisor took informal feedback from peers and colleagues, it is not clear if formal audit data of, for example, patient outcomes, was taken into consideration. No evidence has been provided of any audit performed or surgical outcome measurements relating to [Dr B's] practice.

Independent of the MCNZ supervision process, it is not clear if formal annual appraisals were held for [Dr B] or any of the SMOs in the orthopaedic department. It would appear that formal MSF was not employed in any assessment of [Dr B's] performance. It is not clear if the orthopaedic department regularly reviewed individual surgical outcomes or any other quality measures such as complaints but the department did hold quarterly morbidity and mortality meetings at which time difficult cases could be discussed. It is indicated by [Dr C] that the cases of concern would have been discussed but that the outcomes of those meetings are privileged under PQAA guidelines. If there were concerns about [Dr B's] practice then these did not translate into any formal process of either support or performance management.

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[Dr B] had three extension of employment offers made during his tenure at Waikato DHB. It appears that the employing manager was not aware of performance concerns including complaints and one serious adverse event review.

j. Any changes Waikato DHB has made to its practice following these events

Relevant policies (credentialing, recruitment, complaints) have been updated although it is not clear if this is in relation to [Dr B's] performance as policies are normally reviewed and updated every three years. Waikato DHB has undertaken an internal audit of the recruitment process involving [Dr B] and a more general review of recruitment processes. Several recommendations follow from that audit and are currently being implemented by management.

More timely responses to complaints are now in place with weekly monitoring by senior management.

The orthopaedic department has made changes in line with the recommendations of the external review. The surgical safety checklist has been implemented which increases the safety of surgical interventions.

k. Any other matters in this case that you consider warrant comment

[Dr C] and the two business unit managers employed during the tenure of [Dr B] apparently met weekly and complaints were discussed at these meetings. It seems that there was a clear separation of management and clinical leadership with [Ms D], the manager, assuming all responsibility for [Dr B's] recruitment and [Dr C] stating that he was not involved in reference checking. The induction and orientation was organised by management, despite the plan submitted to the MCNZ requiring regular meetings with the clinical director. It is not clear if [Dr C] was aware of that submitted plan. When it became clear that there were difficulties in the relationship between [Dr E] and [Dr B], it seems that [Dr C] sought to manage this with the assistance of his peers but it is not clear if he shared his concerns with his manager.

Where there is an effective working partnership between manager and clinical leader, then information relating to complaints, particularly where professional competencies rather than technical are the subject of complaint, and difficulties in interpersonal relations between SMOs in a department might be the subject of further discussion. [Dr C] alludes to the pressing concern of ESPI compliance at his weekly management meetings suggesting clinical governance matters did not receive due consideration. Whilst targets set by government and ministry naturally form the business of health management, the clinical quality and safety of a service is of paramount importance. Those metrics might usefully be considered with equal weight. By their very nature, morbidity and mortality meetings do not always uncover performance concerns. Junior SMOs, in particular, may find it difficult to speak out or voice concerns about the performance of a senior colleague. For that reason a formal appraisal process with appropriate anonymous multisource feedback should be considered.

In [Dr B's] case, there were indications in the referee reports that communication issues had been encountered in previous employment settings. The Waikato DHB supervisor was aware of such but quarterly feedback to the MCNZ did not reflect any

concerns about communication. Once complaints about communication had been received, then the manager should have shared those with the supervisor. Consideration of factors influencing communication and professionalism such as professional isolation, to which IMGs are susceptible, age ([Dr B] was over […] years at the time of review and still taking a full on call load) and workload should occur. Management and clinical leadership need to work in close alignment in respect of monitoring and managing SMO performance.

At the time of [Dr B's] recruitment, Waikato DHB had orthopaedic surgeon vacancies, particularly in the field of orthopaedic surgery. It is not clear how the pressures of SMO vacancies influenced matters pertaining to [Dr B's] recruitment, credentialing and oversight.

Any recommendations for improvement that may help prevent a similar occurrence in the future.

There are a number of improvements that Waikato DHB could consider:

- Ensure policies on recruitment are understood and followed, particularly in relation to the necessity of current referees, and of verbal reference checking the content of which is fully documented. Clinical leaders, management and human resources should share the accountability for this. It could be that the position descriptions of the service manager and clinical leader are reviewed to ensure that both parties understand their responsibilities in respect of recruitment of SMOs, and in particular in respect of IMGs.
- The supervision requirements for IMG locum tenens are clearly outlined in the MCNZ guidelines. Waikato DHB should ensure all supervisors are aware of their responsibilities. Particular care should be taken in respect of any pre-employment concerns such as those indicated in reference checking.
- Credentialling documentation for SMOs should specify the scope of practice and, in particular, any restrictions on scope.
- Complaints regarding clinical staff should be shared with relevant professional clinical leads, who in turn should contribute to the response. Data regarding numbers of complaints by individual practitioners should be monitored and where there are more than two complaints in one year, or three in total, then consideration given to further investigation and as appropriate, performance management.
- Complaints should be linked to adverse events in the incident reporting system, and reports provided to clinical leaders and management, who in turn should take joint responsibility for the review and resultant actions.
- Waikato DHB should consider a formal policy for annual performance appraisal/ professional development for all SMOs, and should develop a process whereby anonymous multisource feedback can be used in providing feedback about performance.
- Peer support/mentoring, independent of clinical supervision, could be considered for all IMGs in their first year of employment.

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- Clinical leadership training should be provided for all clinicians in responsible roles and could involve skill in conflict resolution, clinical governance, SMO performance assessment and management.
- Consideration could be given to one year review of credentials for all IMG SMO appointments.

Yours sincerely

Margaret Wilsher MD, FRACP, FRACMA
Chief Medical Officer

Enclosed document:
— Orientation Induction and Supervision for International Medical Graduates[11]"

Dr Wilsher's expert advice was provided to Waikato DHB and to the individual clinicians. Their responses to that advice was then also forwarded to Dr Wilsher. Dr Wilsher provided the following further advice on 28 February 2018:

"Thank you for the opportunity to comment on the responses from Waikato District Health Board.

I respond to each of the three respondents in turn:

1) [Ms F].

[Ms F] queries my statement 'she too had concerns but that she had been told that such concerns were for clinicians to deal with not management'. That was taken from the original submission to the HDC by [Dr E], 12 December 2016, page 7 paragraph 2. I acknowledge that the statement is not taken directly from [Ms F] but it was [Dr E's] understanding of her position.

2) [Dr C]

[Dr C] states that the review meetings in respect of the supervision reports were formal meetings where performance was discussed and that he sought feedback from senior clinicians who worked with [Dr B]. I cannot reconcile that statement with the one made in his original submission to the HDC on 17 March, 2017. In section 5 of that report he states that 'I met regularly with him in clinic but no formal meetings were organized as I felt that there was sufficient contact within the regular department meetings and informal interactions in clinic etc'.

What is clear in this latest response is that [Dr C] was given no guidelines or policy on supervision by the Waikato DHB. Of course in respect of IMG vocational applicants the supervision is provided for the purposes of the MCNZ, not the DHB, and the MCNZ does provide information to supervisors. It would not be an uncommon scenario

[11] Please note that this has not been appendixed to this report owing to its size but a copy can be located at: https://www.mcnz.org.nz/assets/News-and-Publications/Booklets/Orientation-Induction-and-Supervision-for-International-Medical-Graduates.pdf (published 2011).

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in New Zealand for a new clinical director to find himself in the role with little in the way of formal leadership or management training, and at times with limited support. [Dr C] was subject to considerable management pressure to deliver elective targets and manage acute flow in the face of workforce challenges and his priority would have been his own clinical work plus the essential clinical director responsibilities — not searching through the policies and procedures library for supervision guidelines. He makes a telling point in the final paragraph of his response in that to do the job properly he would need to drop clinical time. All too often clinical leadership is not afforded sufficient time. Ultimately it is for management to enable clinicians and clinician leaders to do their jobs well and in respect of the induction, orientation and supervision of IMGs then management should ensure that the appropriate procedures are in place for the safe employment of such doctors.

3) […]

I commend the changes that Waikato DHB has already made in respect of this investigation as outlined in the final paragraph of the response.

Yours sincerely

Margaret Wilsher MD, FRACP, FRACMA
Chief Medical Officer”

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