Breast and General Surgeon, Dr B

Breast and General Surgeon, Dr C

General Surgeon, Dr D

A Report by the

Health and Disability Commissioner

(Case 03HDC05435)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Consumer/Complainant
Mr A	Consumer's husband/Complainant
Dr B	Provider/Breast and general surgeon
Dr C	Provider/Breast and general surgeon
Dr D	Provider/General surgeon
Dr E	Breast surgeon
Dr F	Anaesthetist
Dr G	Breast surgeon
Dr H	General practitioner
Ms I	Breast care nurse
Ms J	Anaesthetic nurse
Ms K	Instrument nurse

Complaint

On 11 April 2003 the Commissioner received a complaint from Mr and Mrs A about the services provided by Dr B, Dr C, and Dr D of a city clinic. The following issues were identified for investigation:

Dr B

Surgeon Dr B did not provide services of an appropriate standard to Mrs A. In particular, Dr B:

- *incorrectly advised Mrs A that she was a suitable candidate for a liposuction procedure*
- *did not make accurate preoperative markings on Mrs A's breasts and stomach*
- *did not perform the bilateral breast reduction surgery and liposuction to an appropriate standard on 9 July 2002.*

Furthermore, Dr B did not provide Mrs A with adequate information. In particular, Dr B:

- *did not provide adequate information about the risks and complications of the surgery (including the complications associated with combining several surgical procedures)*
- *did not explain why Mrs A's care was to be transferred to another surgeon*
- *did not explain why Mrs A developed complications.*

Dr C

Dr C, surgeon, did not provide services of an appropriate standard to Mrs A. In particular, he did not perform an abdominoplasty to a satisfactory standard on 9 July 2002.

Furthermore, Dr C did not provide Mrs A with adequate information. In particular, Dr C did not provide adequate information about the risks and complications of the surgery (including the complications associated with combining several surgical procedures).

Dr D
Dr D, surgeon, did not provide services of an appropriate standard to Mrs A. In particular, he did not perform an abdominoplasty to a satisfactory standard on 9 July 2002.

Furthermore, Dr D did not provide Mrs A with adequate information. In particular, he did not provide adequate information about the risks and complications of the surgery (including the complications associated with combining several surgical procedures).

An investigation was commenced on 30 May 2003.

Information reviewed

Information was obtained from:

- Mr and Mrs A
- Dr B
- Dr C
- Dr D
- Dr E
- Dr F
- ACC Medical Misadventure Unit – including expert reports from Dr Tristan de Chalain and Dr Chris McEwan
- The current clinical manager, a private hospital
- The former clinical services manager, a private hospital
- Ms J and Ms K, nursing staff, a private hospital
- Medical Council of New Zealand
- The Royal Australasian College of Surgeons

Mrs A's medical records were obtained from the city clinic and the private hospital.

Independent expert advice was obtained from Dr Graeme Blake, a plastic and reconstructive surgeon (report dated 1 March 2004) and Dr John Simpson, a general surgeon (reports dated 6 April 2004 and 19 September 2005).

Introduction

This report concerns the provision of surgical services − a bilateral breast reduction ("mammoplasty"), an abdominoplasty with abdominal liposuction, and liposuction of the upper arms − to Mrs A by Dr B, Dr C, and Dr D of a city clinic, on 9 July 2002. Mrs A experienced significant postoperative complications, which required further surgical intervention from Dr B, and continues to require rehabilitative assistance in preparation for revision surgery. Mrs A's complaint raises issues regarding the preoperative information provided to her by the surgeons, the surgeons' roles and responsibilities, the standard of surgery they performed, and their management and explanation of her postoperative complications. There are a number of respects in which the parties' evidence on these matters conflicts. Despite an extensive Commissioner's investigation, which has included the release of two provisional opinions, certain key facts have not been conclusively determined. As far as possible this report sets out each party's recollection of events alongside the contemporaneous medical records and relevant correspondence, and draws conclusions where necessary, based on the balance of probabilities.

Information gathered during investigation

Background

Mrs A

On 9 July 2002, at a private hospital, Mrs A underwent the surgery mentioned above for elective cosmetic purposes. She had chosen to have three procedures performed together to save time and the need for repeat general anaesthetics. Mrs A's surgery was performed by Dr B, Dr C, and Dr D, with the assistance of Dr E, a visiting surgeon from overseas, and took four and a half hours to complete. The anaesthetist was Dr F. Five nurses were present. At the time, Mrs A was 51 years old, weighed 108kg, and had a clinical history of hypertension (high blood pressure), depression and left-sided sciatica.[1] Information Mrs A recorded on a "Patient Health Questionnaire for Admission" indicated that she was generally fit and healthy and a non-smoker. A preoperative anaesthetic assessment record noted that she had poor venous access.

When making her complaint Mrs A said that, in hindsight, she was probably very naïve to have had three procedures performed at the same time and to think that her surgery would be straightforward. She had seen such surgery on television and read about it in the media, and had not heard of any major complications. Mrs A recalled that when she was admitted to the private

[1] This information was recorded on the preoperative assessment and admission records completed by Mrs A, the hospital's nursing staff and Dr F on the morning of 9 July 2002. In response to my second provisional opinion, Dr B stated: "At no time did [Mrs A] state that she had any blood pressure problems, any depression or any sciatica. This was not revealed in the notes sent to me."

hospital on 9 July someone said to her, "You're having major surgery", and for the first time she thought, "I suppose I am."

Dr B

Dr B is the Medical Director of both a city clinic and a provincial clinic. He is a fully qualified general surgeon with a special interest in breast surgery. He is not a plastic surgeon, but has visited and worked with leading plastic surgeons overseas (for periods of two weeks in three years in the late nineties). Dr B's training in liposuction techniques includes working with two plastic surgeons, in New Zealand, attendances at the Royal Australasian College of Surgeons ("RACS") Annual Scientific Meeting, the World Congress on Breast Surgery, and "numerous seminars."

Dr B stated that he trained as a registrar on the general surgical unit at a public hospital under the supervision of a surgeon, who had a special interest in obesity surgery, and with whom he performed abdominoplasty procedures. He undertook specialist training in breast surgery overseas and also received training in abdominoplasty while a Senior Registrar on the Professorial Unit.

Dr B informed me that he has performed over 600 abdominal flap procedures, including abdominoplasty, and has performed liposuction in private practice on approximately 40–50 patients per year for the past ten years. In association with a plastic surgeon, he performed "very complicated liposuction, abdominal surgery and breast surgery on at least five major cases per year, for five years" between 1995 and 2001. He is a member of RACS and the Breast Section of the American Society of Surgeons.

Dr B advised that he routinely performs surgery similar to that performed on Mrs A, at a rate of possibly one or two cases a week. In relation to Mrs A's complaint, he said:

> "I was the Surgeon in charge of [Mrs A's] breast reduction and shared the management of her complications [at the provincial clinic] with my colleagues, [Dr G] and [Dr I]. We at [the private clinic] commonly work in teams and I was primarily responsible on the day of surgery for bilateral breast reduction. [Dr C] was responsible on the day of surgery for the abdominoplasty."

Dr B also stated:

> "Over the preceding five years [Dr C] and I have performed bilateral breast reduction surgery on over 500 patients, and abdominoplasty as surgeon, or assistant surgeon, on over 200 patients. This combined approach is intended to minimise the trauma and stress to the patient, and the operative time, with a view to minimising the postoperative complications."

In response to my second provisional opinion, Dr B added the following general comment in relation to a combined surgical and team approach:

> "[Dr C] and I agree to perform specific aspects of a surgery, and as in this case, set boundaries when we do so as to the role each is to take. Complicated procedures are performed by teams of surgeons all over the world as a common practice, and part of the team approach regarding complications is that the patient has a common and shared responsibility from the surgeons performing the procedures, and those complications are a shared responsibility."

Dr C

Dr C is a fully qualified general and breast surgeon, and practises in this capacity at the private clinic. He is a Fellow of RACS and has vocational registration with the Medical Council of New Zealand. He is recorded on the intra-operative record as one of two surgeons performing Mrs A's surgery (the other being Dr B). However, Dr C says his role was limited to "assistant surgeon" and that he was present in theatre for the latter part of the operation only, when he assisted with the completion of abdominal surgery. In an initial response to Mrs A's complaint, he said:

> "[Mrs A] was [Dr B's] patient. I was present as a surgical assistant to aid with aspects of the surgery as is the case with a patient of [the private clinic] that requires the services of more than one surgeon. … [Dr B] was the responsible and principal provider …"

Dr D

Dr D is a general surgeon with special interests in breast and endocrine surgery. He is a Fellow of RACS and member of the breast and endocrine section of the College. He gained experience in breast surgery at two major hospitals within New Zealand, and an overseas hospital.

Dr D was employed by Dr B as a locum surgeon for a short period in July 2002. He was in theatre for the duration of Mrs A's surgery and is recorded on the intra-operative record as an "assistant". He stated:

> "Because the planned surgery was big, I was there to enable the procedures to be performed simultaneously in order to reduce the length of time of the surgery and the complication rate. It is common practice in big or difficult procedures to have more than one or two surgeons operating. In such circumstances, the roles are differentiated and the operation is done under the authority of one of the surgeons, in this case I recall it was [Dr B]."

Dr E

Dr E is an overseas surgeon specialising in the treatment of breast disease. She completed her medical and surgical training at an overseas university.

In a letter dated 19 January 2005, forwarded by Dr B as part of his response to my first provisional opinion, Dr E advised that in June 2002 she had travelled to the city clinic to join Dr B for a two-week period of "preceptorship", during which she was to observe the "day-to-day operations" of the city clinic with a view to establishing a breast centre in her home country. She

stated that on her final day in New Zealand, 9 July 2002, Dr B invited her to assist with Mrs A's surgery, and she did so. Dr E said:

> "I assisted [Dr B] with the reduction mammoplasty, and the other two members of the surgical team, [Drs C and D], performed the abdominoplasty. Working together, we were able to complete the operation in about 4½ hours. I was present for the entire operative procedure and witnessed no apparent intra-operative complications."

Dr E commented that as this was "literally the last thing I did before leaving New Zealand I have a particularly vivid recollection of its details". In a subsequent letter dated 29 March 2005, she clarified:

> "I was actively involved in [Mrs A's] reduction mammoplasty as [Dr B's] assistant. In that role, I cut sutures and held retractors as I learned surgical technique."

Dr E also explained that "[Dr B] made the arrangements for my temporary surgical privileges in New Zealand".

The Medical Council of New Zealand advised that a foreign doctor visiting New Zealand is required to hold registration with the Council if they wish to be involved in clinical practice. The Council has a "special purpose scope of practice" covering situations involving a visit of two weeks or less, whereby an application can be processed within 20 working days and no fee is payable. The Council's view is that the work undertaken by Dr E during Mrs A's surgery fell within its definition of "the practice of medicine" and accordingly she required temporary registration. However, the Council received "no application for registration under the name [Dr E]", and "no practising certificate has been held under the name [Dr E]".

The private hospital's clinical manager advised that the private hospital's "Registration Guide for Visiting Practitioners" (May 1998, page 23) states that "a surgeon may require a professional assistant. In such cases, by prior arrangement with the Hospital manager, assistants may be admitted during a specified time-frame." A further policy in place at the private hospital at the time of these events was "Other Healthcare Professionals' Access to Practise" (September 2000), the purpose of which was to enable the registration with the private hospital of health professionals such as medical practitioners attending in support roles, for example, as surgeons' assistants. That policy required that a doctor "attending casually" have "an appropriate healthcare qualification" and the approval of the hospital manager, who was responsible for deciding the level of necessary supporting documentation "appropriate to the situation". The policy indicated that a visiting doctor from a public hospital would require an annual practising certificate and proof of indemnity insurance, but made no reference to the requirements for health professionals visiting from overseas.

The current clinical manager stated that Dr B's file at the private hospital contains a copy of Dr E's CV on which a handwritten note records that "[Dr B] would like [Dr E] to assist him the next 2 Tuesdays. Please phone him." The current clinical manager could not find any further

documentation relating to this request, but stated that it is "clear that [Dr B] did contact the Hospital Manager in order to gain approval for [Dr E] to assist him in theatre".

Ms K, an enrolled nurse who attended Mrs A's surgery as an instrument nurse, remembers Dr E well and recalls that Dr E came to "a lot" of surgeries at the private hospital, always with Dr B. Ms K stated, "Initially [Dr E] didn't scrub or do anything because she was not allowed to, but towards the end she was involved and helping." Ms K advised that her understanding was that visiting surgeons would have to have "the proper paperwork" and "the patient's permission" to enable them to assist with surgery in one of the private hospital's theatres.

In response to my second provisional opinion, Dr B advised the Commissioner and the Medical Council:

> "[Dr E's] role was as a nurse assistant which meant that she was able to observe my surgical technique and practice at close range.
>
> We often have observers in theatre and if they are trained and able to scrub we suggest they scrub so that they can observe with a closer view.
>
> I brought [Dr E's] CV to the Manager at [the private hospital] and explained to her that her role was going to be that of an observer and an assistant.
>
> At all times when she was to observe the patient I introduced her to the patient and explained that her role would be as an observer.
>
> On her last visit to the operating theatre she scrubbed in and observed the surgery upon [Mrs A].
>
> As is in keeping with observers they often become involved in an active role where they hold retractors, move lights and assist the surgeon. [Dr E] thus became a nurse assistant for a period of [Mrs A's] surgery.
>
> I apologise if this was in breach of the regulations but I relied on the management of [the private hospital] to advise me as to the correct procedure. As [Dr E] was performing the role which is normally performed by nurse observers in theatre I did not realise that we were breaching any rules or regulations. In particular, both the theatre room manager and the hospital manager were fully aware of her status and neither myself [n]or them thought to seek temporary registration through the Medical Council.
>
> As [Dr E's] role was not that of a surgeon, i.e. she did not perform any active procedures, did not see any patients alone and was always introduced as an observer and assistant to my patients, I thought I was carrying out the correct procedure.
>
> I apologise in retrospect that this was in breach of the rules and regulations."

The Medical Council provided Dr B with an "educational" letter in response to this explanation, and informed the Commissioner that "[Dr B] has been advised that if he has any doubt in the future about a medical practitioner's status when visiting New Zealand then he must contact the Council for advice".

Chronology of preoperative events

Initial discussion – the provincial clinic
On 14 June 2002, Mrs A consulted her general practitioner, Dr H, about her wish to have cosmetic surgery. Dr H referred her to the provincial clinic. Mrs A's first consultation was with Ms I, a breast care nurse, on 24 June. Mrs A recalls that this consultation took approximately half an hour. One of her main concerns was to obtain information about the likely cost of breast reduction surgery. She also wanted to gather "general information about this type of intervention and the process".

Ms I provided the Commissioner with an outline of the topics that she usually covers with a patient at a preoperative consultation, all of which she believes were discussed when she first met Mrs A. She said it would be common for her to spend over an hour-and-a-half with a prospective patient, going through everything "from A to Z" and providing written, visual and verbal information.

Ms I stated that she usually shows patients pre- and postoperative photographs, explains the surgical procedure being considered, the length of time surgery may take, and gives an estimate of the patient's recovery time. She describes this consultation as "a standard talk" which allows the patient to ask questions and have them answered. The consultation is free. She believes communication with her is often more "open" than when a patient is speaking to their surgeon, and patients do not feel "rushed or pressured" into making decisions. Ms I expressed the view that patients are often self-conscious when they see the surgeon and "do not always hear what he has to say".

The information Ms I discusses with prospective patients relates to breast reduction surgery only. However, she recalled that as Mrs A also asked about abdominoplasty ("a tummy tuck") and wanted both procedures performed at the same time, she explained that two surgical teams would need to operate simultaneously at the city clinic, and Mrs A would need to stay in hospital for five days.

Ms I does not take any measurements or examine the patient at the preoperative consultation, because "that is the surgeon's responsibility". However, she does schedule all patients over the age of 40 for mammograms before their surgery. As Mrs A was 51 years old at the time she was booked for a preoperative mammogram. This was reported on 25 June 2002 as showing a "defined mass" 6cm from the nipple in Mrs A's right breast, measuring 2.5 x 2.5cm, which was thought to be a benign fibrocystic lesion. A subsequent ultrasound revealed another suspicious lesion, measuring 1.5 x 1.0 x 1.3 cm. A core biopsy revealed no evidence of atypical cells or

malignancy. Ms I advised Mrs A that a wire (known as a D-wire or "hookwire") would be placed in her right breast before her breast reduction surgery, to ensure the removal of tissue from that area.

Consultation – the city clinic

Mrs A saw Dr B at the city clinic on 28 June. He agreed to her request to have both breasts and her abdomen reduced at the same time. During the consultation Mrs A asked whether it would also be possible to have the size of her upper arms reduced. Dr B suggested that liposuction would achieve this. Mrs A stated that as Dr B made these surgical procedures sound "so easy", she also enquired about having surgery on her chin. Dr B declined to provide this.

Mrs A recalls that Dr B told her she would be back at work in three weeks, which sounded reasonable.[2] She remembers him showing her pre- and postoperative photographs of patients who had successful breast reductions; she does not recall seeing similar photographs of patients who had abdominal surgery. Mrs A stated that Dr B told her that "sometimes people get infections but not to worry, it does not happen often". She was aware that two surgical teams would operate on her but did not know the names of the other surgeons who would be involved. Before she signed a consent form to surgery, she was given a brochure about breast reduction. She says that Dr B did not advise her against having such extensive surgery and she had the impression that he was quite "happy" about it. She felt reassured because Dr B told her that she was "a perfect candidate to have breast reduction surgery because she had slim legs and no bottom and she would look great". Summarising her recollection of this consultation, Mrs A said she was "guided by [Dr B], who at no time indicated … that [undergoing simultaneous procedures] was unusual, carried greater risks or posed a greater threat to the likely outcome of the [surgery]".

Dr B informed me that he tried to discuss the procedural and technical details of the intended surgery with Mrs A, but she did not want "explicit details" (ie, the nature and extent of the incisions) explained. Mrs A accepts that she told Dr B she did not want to know exactly what her surgery would involve. However, she did want to be informed about the risks and possible complications and asked Dr B what possible problems there could be.

Dr B said he told Mrs A about the risks of mammoplasty, abdominoplasty and liposuction individually, and explained that there were additional risks in performing three procedures at the same time. He recalls that the risks discussed were "numbness, infection, bleeding, bruising, pain, discomfort and poor wound healing". In an early response to Mrs A's complaint, Dr B said:

[2] In response to my second provisional opinion, Dr B denied that he had told Mrs A that she would be able to return to work three weeks after her surgery. He said: "The normal advice given by myself with major surgery, is that patients require a minimum of six weeks postoperatively to recuperate. … The period of time required is very much dictated by the individual and their particular circumstances. The estimate given is also intended to reflect uncomplicated surgery."

> "[Mrs A] … was initially seeking a consultation about bilateral breast reduction. After some discussion about [this] she stated that she wished to have an abdominoplasty as well. I explained to her that this would require her travelling to [the city] so that we could perform this procedure safely under my care and with the support of a further surgical team so that simultaneous surgery could be performed. Also we would have the presence of an anaesthetist and support services should [complications] arise. [Mrs A] and I had a full and detailed discussion for over an hour about the procedure and the complications. In particular, she received information about the complications, specifically to do with breast reduction. This mentioned nipple necrosis,[3] numbness, infection … I detailed this fully to her and explained to her that these complications were both specific to the breast but were associated with normal surgical procedures.
>
> With respect to the abdominoplasty I explained to her the complications of pain, discomfort, swelling, necrosis and infection. With respect to liposuction I explained to her that liposuction of the upper arms could be performed but the results would be variable.[4]
>
> I explained to her that she would be in hospital for at least 7 days and would require time off work for at least 3–4 weeks."

Dr B says that he also explained that there were general complications associated with anaesthesia, including "lung complications, chest complications and in particular deep vein thrombosis". He stated:

> "[Mrs A] was fully aware of the increased risk of complications from a combined procedure. She was made aware of this concern as I pointed out to her that a breast reduction could be done with 1−2 days' stay locally [at the provincial clinic as opposed to five days' stay in the city clinic for the combined surgery].
>
> Abdominoplasty, breast reduction and upper arm liposuction I explained, was of a greater magnitude and therefore required her to be admitted to [the private hospital] where we had a greater degree of resources available to us and a more experienced nursing and medical team."

[3] Necrosis is the death of skin tissue, sometimes caused by interference with the blood supply.

[4] In response to my first provisional opinion, Dr B added that the information he gave regarding liposuction included that it "was of variable efficacy in a woman of her age and size, but that it would add little in the way of morbidity or time for the procedure … I did advise that if she did not receive benefit from liposuction, … she may require excision of redundant skin." Mrs A does not recall any explanation as to alternative procedures or unsuccessful results. In response to my second provisional opinion Dr B stated that "although [Mrs A's] liposuction has not been entirely successful, neither has it been harmful".

Dr B's position is that his advice to Mrs A that she would need to have her surgery performed at the city clinic was in itself a clear indicator that the combined surgery "carried higher risks, and these risks needed to be managed by the attendance of more sophisticated services".

Dr B said his view was that Mrs A was a very suitable candidate for breast reduction, but:

> "No similar comment was made in relation to either the abdominoplasty or liposuction. [Mrs A] had symptoms which were referable to the breast, and was a fit, healthy candidate for breast reduction … It is implicit that I considered it reasonable at the time to go ahead with abdominoplasty and liposuction. However, no representation was given to [Mrs A] that she was an excellent candidate for these procedures. I do not accept that her expectations were raised unreasonably in that regard."[5]

In a letter to Dr H following this consultation, Dr B stated:

> "[Mrs A] has quite a lot of neck and back pain and is an excellent candidate for bilateral breast reduction.[6]
>
> On examination her nipple clavicular distance is 38cm. She would be suitable for removal of 2kg from each breast to make her a size C.
>
> With respect to her abdomen, she has quite a pendulous abdomen, which would require an apronectomy in routine fashion with tightening of the underlying musculature. In association with this she would like to have liposuction of the upper arms and liposuction of the hips.
>
> I have explained the costs and the complications fully to her and plan to admit her on Monday afternoon for surgery on Tuesday morning, 9 July. Surgery would consist of bilateral breast reduction and apronectomy."

On 3 July 2002, Mrs A signed the private hospital's "Patient Admission Form", the "Agreement to Treatment" section of which reads:

> "I, [Mrs A] agree that I have received a reasonable explanation of the intent, risks and likely outcomes of the treatment and operation breast reduction/ abdo'plasty/liposuction to the both

[5] Dr B interprets certain statements that Mrs A has made to the Commissioner as conceding that her expectations of her surgery were "too high". Dr B says that while he tries to be positive with his patients regarding the potential outcome of their surgery, he is sure that he "did not provide an unrealistic [expectation] of the outcome of the procedures" Mrs A had requested. He notes: "The nature and severity of the adverse outcomes that [Mrs A] has experienced were certainly unexpected."

[6] In response to my second provisional opinion, Dr B explained that by "excellent candidate", he meant that Mrs A was "a genuine [medical] candidate" for breast reduction, "who would receive genuine relief from neck and back pain from the removal of tissue from her breast". He distinguished the medical benefits of Mrs A undergoing the procedure from the situation of patients who elect to have breast reduction for cosmetic reasons.

> side [sic] of my body … and an explanation of alternative procedures which may be needed in relation to my current treatment, and to the administration of general anaesthetic/sedation … I understand and am satisfied that I may seek more information and participate in decision making. I accept the advice of [Dr B] regarding this operation procedure and treatment and care to be carried out."

Scheduled admission to the private hospital

There is a difference of views between Dr B and Mrs A as to her original scheduled admission time and date for surgery.

Dr B says he advised Mrs A that she would be admitted to the private hospital on the evening of Monday 8 July, so Dr F could review her, and Dr C could "see her and discuss the part of the operation he was going to perform, viz abdominoplasty". He is "absolutely clear" that her admission was planned for 5pm the day prior to surgery and his letter to Dr H, quoted above, also indicates that this was his plan. Dr B recalls that Mrs A changed her scheduled admission time to the Tuesday morning.

Mrs A disputes that she was scheduled for admission on 8 July. She recalls being asked to attend the city clinic at 9.30am on 9 July, to have the D-wire placed. She said, "It does not make sense that [the city clinic] would have arranged for this to occur if they had intended [me] to be admitted to [the private hospital the previous night]."

Handwritten entries on the "Patient Admission Form" (which Mrs A had signed on 3 July, and which doubled as the consent form she was to bring to hospital on the day of admission) initially recorded her admission time as "8/07/02 … 5pm". This has been amended in different handwriting, to 10am, 9 July.

Ms J, the private hospital's check-in and anaesthetic nurse who assisted with Mrs A's admission and attended her surgery, believed that the handwritten changes were likely to have been made by Mrs A or staff at the city clinic. She commented that D-wires are never inserted at the private hospital because the hospital does not have the required imaging equipment, and a D-wire would "definitely not" be inserted the night before surgery, because it would be likely to move.

In response to my second provisional opinion, Dr B clarified:

> "[The private hospital] is located [a short distance from the city clinic]. We commonly admit patients to hospital and they are driven down to [the private clinic] for the placement of D-wires. If the patient is having D-wire placement on the day of surgery, the D-wire is placed before they are admitted. If however they are from out of town, it is standard protocol as was intended in this case, to admit the patient on the evening before surgery so that they can be assessed by the anaesthetist and other surgeons involved in their care (as relevant).
>
> I do recall receiving a telephone call from my nurse [at the provincial clinic] about [Mrs A], saying that she refused to travel to [the city] on Monday. As I recall, she … was involved in

> some business. It was not ideal, but certainly still workable to admit [Mrs A] on the morning of her surgery."

In relation to this issue, and Dr B's advice that he had wished Mrs A to be seen preoperatively by Dr C on 8 July, Dr C provided additional evidence as follows:

> "[Mrs A] did have an appointment at [the city clinic] to have a hookwire placed into her breast [on the morning of 9 July] and therefore an admission the previous night to hospital would not make sense.
>
> The most important piece of new information with regards to this is the fact that I have checked my records for around that time and noticed that I was on annual paid leave from 5th to 8th July. This means that Monday 8th July I physically was not at work and hence on an annual leave day would not be expected or indeed would not have come through to visit a patient unless this was an emergency. [Dr B's] comment [that I would see [Mrs A] on 8 July and discuss the abdominoplasty] is inaccurate in that I was not informed of this (and it appears neither was the patient) and I would not have been able to do this anyway given the fact that I was on annual leave and was only going to meet [Mrs A], as an assistant to [Dr B], on Tuesday 9th July."

Actual admission to the private hospital

On 9 July, Mrs A attended the city clinic where the D-wire was inserted. She then arrived at the private hospital at approximately 11am. Mrs A was weighed and taken to her room where she changed into a hospital gown. Dr B saw her, and met Mr A for the first time. Mr A observed that Dr B had a very good rapport with his wife, and they joked about her "being a C cup" after surgery.

The patient identification label on Mrs A's clinical records (which was duplicated on her wrist bracelet) showed her name, age, and address, and Dr C's name. Dr B's name was not on the label. Ms J advised that this was probably because Mrs A was a patient of the city clinic (ie, Dr B's and Dr C's practice group). Dr B commented: "[Mrs A] was admitted with [Dr C's] label on the bed head, which illustrates that he was regarded as a full part of the operative surgical team." Dr B later submitted that "[Mrs A] was to be admitted under [Dr C's] name so that he would be phoned on her admission and be able to attend her for a preoperative discussion".

However, in response to my second provisional opinion, Dr C advised:

> "The fact that my name was on this patient's identification label and hospital bed is of absolutely no bearing to the responsibility of the surgeons involved. The surgical secretary booking the case in from the Clinic would admit the patient under a single surgeon's name as opposed to both surgeons. At that particular time and in fact for a period of about 1−2 years around then, bookings were on numerous occasions performed under the incorrect surgeon's name. I have had numerous of my patients admitted under [Dr B's] name and vice versa. I needed to therefore quite often change this after the patient had been admitted on the ward so

> that the right doctor would be called with any queries. Numerous staff on the ward remember such events having occurred[7] … [Dr B] commenting in hindsight that the fact that my name was on the label at the head of the bed illustrated that I was regarded as a 'full part of the operative surgical team' is a statement of convenience based on a secretarial mistake. [Mrs A] should have been admitted under [Dr B] but as mentioned above admitting under the wrong surgeon was more than an infrequent occurrence and therefore this carries no significance at all."

Preoperative discussion and marking

A preoperative discussion took place at Mrs A's bedside. There are differing accounts of what was said and done, and who was present at what point. Dr C says that Dr B had asked him to attend this discussion and that he was there. Dr D states that he was not present at any time. In an initial response, Dr B stated:

> "[Dr C] confirmed that abdominoplasty was an appropriate procedure to be performed on [Mrs A's] body, size and shape. There was a combined team discussion, then individual consultation with firstly myself, then [Dr C], and then [Dr F] who assessed [Mrs A] as fit for anaesthesia."

In a subsequent response, Dr B explained that Mrs A was in a "small single room [and] it is not possible to fit four doctors and a nurse plus a patient and her husband into that space"; accordingly, he says, he initially saw Mr and Mrs A with Dr E only, and that he, Dr F and Dr C each "rotated into the room and had separate conversations directly with [Mrs A]".

Mrs A stated that Dr B introduced Dr E and said she was "here to observe New Zealand practices". Mrs A commented that Dr B had not previously asked whether she agreed to this and that "In hindsight, he shouldn't … probably have done that without asking. He didn't ask permission for any of that." Mr and Mrs A do not recall Dr E saying anything to them except "hello".

Dr E advised, "I was introduced as [Dr E], a visiting surgeon from [overseas] interested in breast surgery, who would be observing and assisting with the operation." She described Dr B's preoperative discussion with Mrs A as follows:

> "[He] referred to their previous discussions in his office, and reviewed the major complications associated with the combined procedure. I recall him reminding her that he had brought her to [the city] for the operation, instead of performing it locally, in order to have his entire operating team for a large case such as hers. As is common surgical practice, details of

[7] In support of this point, Dr C provided a short statement from the private hospital charge nurse, who confirmed: "A few years ago, on numerous occasions, patients were admitted as [Dr C's] patients, but were in fact [Dr B's] patients, and these had to be changed frequently."

> an operation are discussed in the office setting, and then reviewed in the preoperative area with an opportunity for questions, and this seemed to be [Dr B's] practice as well."

Dr E also said, "[Mrs A] appeared to be an excellent candidate for both procedures [mammoplasty and abdominoplasty] and as I observed [Dr B's] discussion with her prior to the procedure, she seemed well informed about the attendant risks and benefits."

Dr C recalled, "I was introduced [to Mrs A] and shook her hand and that was the extent of our interaction." He commented, "[Dr B] had seen the patient preoperatively in the rooms and full discussion and the taking of informed consent had been done by him and this is not something I would ordinarily do when present as an assistant. … My role had been explained to her."

Dr B asked if photographs could be taken of Mrs A's breasts and abdomen. Mrs A did not want any photographs to be taken and thought it unfair to be asked this just before surgery. She reluctantly allowed Dr C to photograph her breasts, but not her stomach. Dr C informed me that it is his usual practice to obtain preoperative and postoperative photographs for cosmetic breast procedures so as to "enrich the medical documentation". Dr C said he only ever takes such photographs with the patient's consent. He confirmed that he took photographs of Mrs A's breasts on his digital camera but deleted them at the end of the week as he was to have "no input into this patient's ongoing care".

Preoperative markings were drawn on Mrs A's breasts and arms at this time. There is further conflict whether they were also drawn on her abdomen and if so by whom. Mrs A's recollection is that she sat on the bed and Dr B asked her to bare her breasts, so that he could measure her and mark her breasts for surgery. Mr and Mrs A describe the "marking up" procedure as being done by Dr B in a very casual and brisk manner. They say that he had a plastic ruler about 30cm long and a felt tip pen, with which he drew "free hand" down Mrs A's breasts and upper arms, crossing out and re-drawing some lines. They are unsure whether Dr B also drew lines on Mrs A's abdomen. Mr A recalled that Dr B took some measurements and commented that his wife was a perfect candidate for breast reduction. Mr A remembers Dr B talking to other doctors at the same time and joking, as if to make Mrs A feel comfortable.[8]

Dr B advised that he did not mark Mrs A's abdomen as this was Dr C's responsibility. He stated:

> "With respect to preoperative markings on [Mrs A's] breast and stomach – these markings were performed by myself and by [Dr C] in consultation at the bedside at [the private hospital] … We marked her out in routine fashion for a bilateral breast reduction and abdominoplasty."

[8] Dr B advised that preoperative markings take into account the amount of breast tissue being removed and also the type of breast reduction being performed. He explained, "We mark out the clavicular distance and the amount of shift of the nipple. We also mark out the mid-point of the breast and the flaps which will be brought to the mid-point to allow satisfactory healing and closure of the skin without undue tension." He stated that he has performed markings for breast reduction for "at least 10 years".

Dr E recalled:

> "After [Dr B] discussed the operation with [Mrs A] and marked her reduction mammoplasty, [Dr C] came to talk to her and [Dr B] left. I stayed to observe as [Dr C] marked the abdominoplasty and he discussed the procedure in general terms with [Mrs A] as he marked her."

Dr C commented generally that preoperative markings are "a very critical part of a well executed operation". He emphasised that for this reason, when he performs an operation on a patient, "especially if that procedure is fully my responsibility", he insists on performing the preoperative markings himself. He is emphatic that in this case, he did not perform any markings at all, and that he only watched while Dr B marked Mrs A's breasts, arms and abdomen. In response to my second provisional opinion, Dr C advised: "[Dr E's] recollection of me having performed markings on the abdomen is incorrect."

Dr C recalls speaking to Dr B outside Mrs A's room once the preoperative marking had been completed, and asking him about the decision to perform the surgical procedures simultaneously. Dr C said, "[Dr B] responded that he had considered this matter but that [Mrs A] was insistent[9] on having one anaesthetic and one surgical procedure performed." Dr C added that Dr B's answer inferred that Mrs A had chosen to have her surgery performed simultaneously, and that Dr B had "been through all the issues regarding combined surgery with her". Dr C stated: "With the patient being this close to theatre and me just having met her I was not going to question this any further."

Dr C left the private hospital to go to another hospital where he was due to perform surgery on another patient. He said: "Only on finishing this procedure was I to return and assist [Dr B] in theatre."

Dr F stated:

> "[Mrs A had] filled out a detailed anaesthetic questionnaire, which I had the benefit of reviewing preoperatively prior to meeting her. … I assessed her fitness for anaesthesia and then gave an explanation of the anaesthetic she was to receive, how I would manage her recovery and pain relief and the likely progress of her recovery. I offered her the opportunity to ask questions and explained the risks of the anaesthetic and management of blood loss, to her satisfaction. I was aware of the combination of procedures that she was to undergo and was satisfied that she was fit for the anaesthetic. Her chronic medical conditions were controlled and did not warrant a delay in surgery."

Dr B advised that Dr F is an experienced anaesthetist who had worked extensively with him and the other members of the private clinic's surgical team in the past. As such, Dr F was "fully

[9] Mrs A disputes the suggestion that she "insisted" on having her procedures done simultaneously.

conversant" with the procedures involved. Dr B noted that on occasions, Dr F had cancelled surgery for patients who he had not deemed fit for anaesthesia, or for the anaesthesia and combined surgical procedures. Dr B submitted that he was "entitled to rely on [Dr F's] assessment" of Mrs A's fitness for anaesthesia on 9 July.

Surgery

Overview

A "Clinical Pathway" record notes Mrs A's "proposed procedure" as: "Excision Hookwire R breast, Bilat Breast Reduction, Abdominoplasty, Liposuction both upper arms". The intra-operative record shows that Mrs A entered theatre at 12.55pm, surgery began at 1.10pm, ended at 4.55pm and Mrs A left theatre at 5.10pm. Dr B advised that while Mrs A was in theatre for almost 4½ hours, this included 45 minutes of "set up time", meaning that the "total period available for operational surgery was 3¾ hours". The intra-operative record lists the following information:

> "Surgeon: [Dr B]/[Dr C]; Anaesthetist: [Dr F];
> Instrument Nurse: [Ms K]/[…]
> Anaesthetic Nurse: [Ms J]
> Circulating Nurse: […]
> Assistant: […]/[Dr D]
> Professional Visitor: […]
>
> Type of anaesthetic: General [with] local infiltration
> Details of Operation Performed: Excision of hookwire right breast, bilateral breast reduction, abdominoplasty and liposuction to left and right upper arms."

Dr B's operation note, set out in a letter to Dr H dated 10 July, stated:

> "Bilateral breast reduction was performed removing 2.2kg from each breast. In sequence [Dr D] and [Dr C] removed the abdominal apron and toned the tummy using interrupted nylon to oppose the rectus sheath and interrupted nylon to tighten the abdomen laterally on each side. Following this liposuction was performed to the upper abdomen. The abdomen was closed in layers with interrupted and continuous Maxon plus steristrips around a Redivac drain.
>
> Unusual findings at surgery in the abdomen were an umbilical hernia which was repaired. Liposuction was performed on both upper arms after infiltration with local anaesthetic plus Adrenalin solution. 500ml was removed from each upper arm.

> The breast reduction produced a long pedicle[10] which was shortened with an interrupted Vicryl stitch. The nipples were sutured to 4.5cm nipple rings. The nipples were inverted and these were everted using the external technique and a purse string placed after division of the nipple in half.
>
> All wounds were cleaned with Savlon, steristrips were placed and soft suction drains let down to the breasts on each side.
>
> Intermittent calf compression and antibiotics were given. She was transferred to recovery after a 4+1/2 hour procedure in satisfactory condition."

Dr B advised that shortening the pedicle in the breast involved "placing the sutures vertically and using only 4−5 interrupted sutures". This was a technique he had learnt from a plastic surgeon, and its purpose is to stabilise and prevent the pedicle from falling to the side, "which would place tension on the blood vessels and obstruct venous return".

The operation note does not refer to the hookwire or the removal of the fibrosed tissue that had been identified on the preoperative mammogram, although the intra-operative record shows that tissue specimens were taken from each breast. Subsequent histopathology reports included in Mrs A's medical records confirm that this tissue was removed and tested. No malignancy was noted.

Dr B advised that the surgery involved "[three] surgeons performing the procedure simultaneously"; "a combined team of three consultant surgeons plus assistants"; "two separate teams operating on two separate areas". He is clear that he had responsibility for preparation and draping, the breast reduction, and upper arm liposuction, while Dr C had responsibility for the abdominal surgery. He stated:

> "[Dr C] was assisted by [Dr D] and I was assisted by [Dr D] … which allowed us to perform [the procedures] in a safe period of time under excellent anaesthetic circumstances."

Breast reduction

In relation to Mrs A's breast reduction, Dr B advised:

> "[Mrs A's] breast reduction was significant, with the removal of 4.2kg of tissue. This in itself occupied me for almost the entire operating period. [Dr C and Dr D] performed the abdominoplasty simultaneously in relation [to] the breast reduction. It would simply not be physically possible for one surgeon (me) to perform both procedures, taking into account the quantity of breast tissue removed, in a period of just over four hours."

[10] In plastic surgery, a pedicle is "a narrow folded tube of skin by means of which a piece of skin used for grafting remains attached to its original site".

In response to my second provisional opinion Dr B reiterated that he was "entirely concerned and occupied with the bilateral breast reduction [and upper arm liposuction]" for the entire operative period (ie, 3¾ hours); as the breast surgery was in itself a very large procedure, it would have been impossible for him to have performed any aspect of the abdominal surgery.

Arrival of Dr C

Dr B, Dr F and Dr D do not recall when Dr C joined them. The private hospital's clinical services manager at the time was unable to deduce this from hospital records or systems data. Dr E recalled:

> "[Dr C] arrived shortly after [Dr B] and I had prepped and draped the surgical field and began the reduction mammoplasty. [Dr D] had arrived shortly before [Dr C] and I believe he had begun the administration of the local anaesthesia for the abdominoplasty at the time that [Dr C] arrived …"

Dr D is "certain" that Dr C was present for "the majority" of the abdominoplasty and concurs with the events as recounted by [Dr E], yet he has also previously stated that the abdominoplasty was "initially commenced by [Dr B]" and completed by Dr C.

Dr C disputes Dr E's evidence and says: "Even though this procedure was the last thing [Dr E] was exposed to prior to leaving New Zealand … she in no way has a 'vivid recollection' of its details as identified by the issues of preoperative marking and the timing of my arrival in surgery. I can only conclude that her comments are either an intentional misrepresentation of the truth or a significantly inaccurate recollection of the events."

Dr C does not recall exactly when he arrived in theatre, only that when he did, the surgery was "well underway". He stated: "[Dr B] was onto the second breast reduction and the removal of the excess abdominal tissue had already been performed." He recalls that "[Dr E] was placing sutures into the right breast while [Dr B] was reducing the left breast and [Dr D] was present at the abdominal wound".

In response to my second provisional opinion, Dr C provided the operation record relating to the surgery he had performed at another hospital that day. It shows that that surgery began at 1.10pm (coincidentally the same time as Mrs A's procedure) and ended at 2.36pm. Dr C stated:

> "Thereafter I wrote an operation note for this patient so that the nurses would have instructions for postoperative care. Thereafter I had to change and travel by car to [the private hospital] where once again I had to change into theatre clothing and go down to theatre. All of this would have taken at the least 30 minutes and probably more time. This therefore means that my arrival time in theatre at [the private hospital] would conservatively be 30 minutes from the time of [finishing the other] operation which was 2.36pm, placing me in [Mrs A's] theatre at around 3.06pm which is approximately 2 hours since [Mrs A's] surgery commenced.

> During that 2 hours [Dr B] had performed right breast reduction and had either removed the abdominal tissue himself or supervised [Dr D] on its removal so that when I arrived this part of the operation had already been completed.
>
> You will therefore see that [Dr E's] recollection … of [Dr D] having administered the local anaesthesia only at the time of my arrival is grossly incorrect. Local anaesthetic administration takes 5 minutes at the most and certainly not 2 hours."

Abdominoplasty and hernia repair

Dr B is adamant that he did not perform "any part" of the abdominoplasty. He and Dr E both say this was carried out by Dr C and Dr D. Dr B stated:

> "My advice was sought in relation to the abdominoplasty when [Dr C] referred to an umbilical hernia[11] following the removal of the abdominal apron. After some discussion we agreed that it should be repaired with the intention of preventing complications postoperatively."

Dr C denies that he was responsible for the abdominal surgery and claims that his role was limited to repairing the umbilical hernia and closing the abdominal wall. He said:

> "On arrival at the operating table [Dr B] pointed out to me the umbilical hernia which clearly needed repair to prevent strangulation of abdominal content. This was always going to be a procedure with significant attendant risk for the viability of the umbilicus but one that had to be performed given the unexpected finding of this umbilical hernia. With the hernia having been surgically repaired closure of the abdominal wall in layers over suction drains was performed by both myself and [Dr D], Locum Surgeon. I did not enquire into whether it was [Dr D] or [Dr B] who had performed excision of the abdominal apron. Liposuction was performed to upper abdominal adiposity as well."

Dr D stated that the abdominoplasty was done "as one would do in a similar situation in any other patient", and he is adamant that his role was limited to mobilising the tissues, "tightening" the abdominal wall, and closing the wound on one side, first under Dr B's direct supervision, and then under that of Dr C. He confirms that it was Dr C who re-sited the umbilicus and repaired the hernia, and that he assisted with this by "either holding or cutting the stitches as instructed". Dr D noted: "As an assistant … I did not and would not have attempted to perform [the abdominoplasty] on my own."

Dr D acknowledges that his own contemporaneous operation note would have been helpful to confirm intra-operative events. However, he said: "It would not be usual for an assistant to complete a separate operation record and at the time, there were no circumstances which suggested this would be prudent. That is no longer my practice, and I always now keep notes."

[11] A hernia of abdominal internal organs (viscera) at the navel.

Liposuction
Dr B carried out the liposuction on Mrs A's upper arms. He cannot recall who performed the abdominal liposuction.

In response to my second provisional opinion, Dr D advised that he does not perform liposuction and did not do it in this case, but: "From what I can recall the liposuction of the abdominal wall was done by [Dr C]."

Recovery and discharge
Following surgery, Mrs A was transferred to the recovery unit, where she arrived at 5.20pm. Four drains had been placed in her surgical wounds, two in her abdomen and one in each of her breasts. A urinary catheter, and a patient controlled analgesic (PCA) pump, containing morphine 2mg, doperidol 0.5mg and cyclizine 50mg, had also been inserted. The pump was commenced in the recovery unit, although Mrs A received an additional 2mg of morphine at 5.40pm, 5.47pm and 5.48pm before the PCA analgesia took effect.

Mrs A was taken back to her room at 7pm. Her pain level was recorded as being between 0 and 2 on a scale where 10 represents worst possible pain. Mrs A's observations remained stable and her pain was controlled with morphine supplemented with Panadol. She had slight nausea, which was treated with Maxolon and ondansetron. The following day, Mrs A suffered some vomiting and occasional nausea. She had moderate drainage from her drain sites and ooze through the dressings on her arms, which were accordingly reinforced. All her wound dressings remained intact. On 10 July, Mrs A was able to get out of bed for short periods of time and sit in a chair. The PCA pump was stopped that day at 1pm. Mrs A was prescribed temazepam 10-20mg to take orally at night, and when necessary. The records indicate that she was given temazepam at 9.30pm that evening. Dr F also prescribed the following medications: Maxolon, ondansetron (not with tramadol), three doses of Kefzol, and six doses of dexamethasone (steroid).

Dr B saw Mrs A at 5pm on 11 July 2002. He ordered all four drains be removed and asked that the dressings on her arms and breasts be changed. Dr F also visited Mrs A to review her blood test results, and ordered her intravenous luer be removed the following morning. Mrs A's observations had been stable that day, and her pain was controlled with Panadol. She seemed to be tolerating fluids and a little food and was able to walk.

At 1.30am on 12 July Mrs A was unable to sleep, and required a further dose of temazepam. Later that day she was "independent with cares". Her records state that she was "extremely anxious, reassured and encouraged to relax. 9.30pm remains very anxious, reassured ++ Liposuction sites to both upper arms moderate ooze covered with [dressing], also some ooze from under right breast; reinforced with [dressing], all other dressings intact, left alone, a lot of bruising evident."

The nursing records for the early hours of 13 July state:

> "Patient remains anxious, complaining bed and pillow being hard … Says she feels that she has infection. No temp or redness around wound although ooze still persists on both arms … Still complaining of nausea, declined anti emetic at this stage. 9am message left on [the private clinic's] answer phone re fitting of bra. [Mrs A] very eager to go home. Message left on [Dr B's] mobile as he is coming in to see [Mrs A] at 12 midday. 10.15 nurse rung from [the private clinic]. [Dr C] will review [Mrs A] re discharge. [Mrs A] to go to [the private clinic] on way home for fitting of bra."

At 10.30am on 13 July Dr C saw Mrs A and discharged her. The nursing notes record that he was also scheduled to see Mrs A on Monday and check her wounds. The discharge summary stated: "Follow surgeon's instructions. If any problems ring surgeon/[the private clinic]. Leave dressing till Monday when seen by [the private clinic]." It appears that this appointment was intended to be at the provincial clinic. However, [Mrs A] did not see [Dr C] again.

Postoperative events

Complications

After discharge from the private hospital, Mrs A developed severe complications including infection and necrosis of her umbilicus and right nipple. It appears that the possibility of necrosis around the umbilicus may first have been raised by a surgeon at the city clinic on 13 July, because Ms I recalls receiving a telephone call and being told that "half of [the umbilicus] wasn't looking great". Ms I cannot remember who told her this but as a result, she arranged for Mrs A to attend the provincial clinic on 19 July, where she saw Dr G, breast surgeon. Dr G reported to Dr H:

> "[Mrs A] was seen by myself on behalf of [Dr B] today. She has recently been discharged following … surgery and at the time it was noted at discharge that she had some evidence of reduced tissue viability from the right nipple and umbo region. She has re-presented to me today on an urgent basis as she is draining seroma fluid from the umbo site.
>
> On review she does indeed have evidence of skin necrosis of the [umbilicus]. At least one half of this is non-viable but the upper half may improve or survive and this would be useful if she requires revision of this. The right nipple appears to have definitely at least 50% loss of viability. Again it would be useful to have a further few days to see whether this would demarcate as it will dictate management. I have therefore arranged dressings of [Mrs A's] umbo over the weekend and early next week. I note that within 4-5 [days] we will be able to see definitely whether this is demarcating or necrosis is continuing of these areas. If this deteriorates she will need assessment [at the city clinic] early next week, but if it improves I will see her in one week's time [at the provincial clinic]."

Mrs A was concerned that Dr B had transferred responsibility for her care to Dr G. Dr B advised the Commissioner that Dr G was one of his colleagues and that responsibility for Mrs A after her

surgery was managed on a "team basis", with the surgeons rotating their attendances between the city and provincial clinics.

In relation to Mrs A's nipple necrosis, Dr B said:

> "Prior to her leaving [the private hospital] all wounds were checked and there was no sign of infection. The nipple on both sides looked quite satisfactory with no sign of nipple necrosis … The fact that her nipple was quite satisfactory for the first week after surgery suggests that this nipple necrosis was produced by oedema and venous thrombosis. This is a late complication that can occur with all breast reductions and is not related to technique but a recognised complication of standard surgery."

As to the necrosis of the umbilicus, Dr B said:

> "I can make no comment about this … However, I would point out that in attempting to repair the hernia and to resite the umbilicus obviously there was some drainage to the blood supply of the umbilicus which subsequently necrosed."

Dr C said:

> "For the umbilicus to necrose its blood supply was obviously inadequate and this may have been related to a combination of the surgical repair of the umbilical hernia and then the suturing of the umbilicus through the new umbilical opening and this created some degree of tension given the thickness of the abdominal wall. …
>
> It is unfortunate that [Mrs A] developed umbilical necrosis (and other complications), however, this occurrence was beyond ordinary control. There is always a risk of umbilical necrosis occurring with an abdominoplasty when an umbilical hernia has to be repaired at the same time which strips some of the inflow blood supply ..."

Dr C subsequently added:

> "It is unfortunate that [in July 2002] the lead surgeon for the case would dictate the operation note and the assistant surgeons would not dictate a separate operation note. Since then this is no more the case since any involvement with any operation is documented by the surgeons involved. Accordingly, I have no record to clarify the length of the umbilical pedicle and this as you have been informed [by expert advisors] would have had some impact on the degree of risk of necrosis. I do, however, clearly remember that the abdominal wall was thick and hence suturing of the umbilicus to the skin placed a reasonable amount of tension on a piece of tissue which might have already had its blood supply compromised by the deeply placed sutures to repair the neck of the hernia. The risk of necrosis would have been discussed with [Mrs A] preoperatively by [Dr B] given the fact that it is a standard risk that needs to be discussed with regards to the skin flaps with breast reduction surgery. Although the risk of umbilical

> necrosis with abdominoplasty under ideal circumstances would have been low, under these circumstances the higher risk eventuated."

Ms I attended Mrs A at home to change her dressings, and recalled that it was basically a "wait and see game", ie, to see whether the necrosis would improve or worsen. On 21 July Mrs A's umbilical wound was discharging profusely. On 22 July, Ms I recognised that Mrs A required urgent specialist attention, and arranged for her to be admitted to the private hospital.

Second surgical admission
On 23 July Mrs A went to theatre at 5.30pm. Dr B recalled:

> "… [T]here was obvious necrosis of the belly button plus some necrosis of the lateral aspect of the right nipple.
>
> Emergency surgery was scheduled and we debrided the belly button and placed drains in the abdomen to allow the seroma which had built up beneath this area to drain freely.
>
> At surgery we also explored the right breast wound and in view of the nipple necrosis this was debrided and the nipple excised.
>
> The right breast was closed loosely to allow any infection and seroma to drain out and she was kept in hospital overnight."

Dr B also fitted Mrs A with a colostomy bag to collect drainage from two drains placed in her abdomen. On 24 July at 8am, Dr B saw Mrs A and discharged her. She had been taught how to empty her colostomy bag. The drains were left in situ and the dressings on her breasts remained intact. Mrs A was given intravenous ("IV") antibiotics (Augmentin) early that morning so that she could travel comfortably to her home in a provincial town.

Mrs A's discharge summary does not state whether she was given any additional prescription, or prescribed medicines to take home. She was nursed at home by her husband, who found it extremely difficult. Mrs A was also seen at home by Ms I.

Mrs A says she saw Dr B again on 2 August at the provincial clinic, when he thought she was improving but advised that she required the colostomy bag for another week. There is no record of this. The next consultation was on 9 August at the provincial clinic, after which Dr B reported to Dr H: "She is still draining copious amounts from her abdomen but it is settling. We have switched her to a better antibiotic and will review her in two weeks' time."

On 16 August Dr G wrote to Dr H, stating:

> "[Mrs A] was reviewed postoperatively at [the provincial clinic] today. She has many questions regarding her progress following her complicated breast reduction and abdominoplasty. Her right breast is improving well and I expect will show some signs of developing new skin over the raw site shortly. We have shortened her abdominal drain today

> as her drainage has dropped to a total of 90ml daily. I do not expect unless there is further drop in drainage, that this could be shortened for another week."

Mrs A said that during this visit, Dr G said to her, "You don't know how worried we were about you," by which Mrs A understood her to mean that staff had been worried about the seriousness of her infection and necrosis. Mrs A said that Dr G had an "honest, frank discussion" with her and informed her that her prospects for a good surgical result were not high. Mrs A informed me that this was the first time she felt her doctors had been honest with her about the result of her surgery.

On 23 August Dr G reviewed Mrs A's condition again and subsequently advised Dr H:

> "Her right breast is making significant progress with signs of good granulation tissue and the T junction scar. Of concern is the fact that she is becoming a little bit more bloated with purulent drainage through the umbo site and shows a little bit of redness at each flank on examination. I have, therefore, performed irrigation with dilute Betadine of the abdominal cavity through a Foley catheter at the umbo site. This provides easy irrigation without spill of fluid and drainage via a urinary bag. I have asked our Breast Care Nurse to carry on these irrigations on a second daily basis until she is consistently getting clear drainage from the umbo site. [Mrs A] will be reviewed by [Dr B] in a further week."

Mr and Mrs A had planned a holiday in September. This had to be cancelled. Dr G wrote a report for Mrs A confirming that this was necessary as a result of "an ongoing severe unexpected complication from her surgery … that in no way could [she] have expected or anticipated".

On 6 September, Mrs A went to the provincial clinic and was seen by Ms I, as Dr B was unavailable. On 7 September, Mrs A was unwell with stomach pains. On 8 September, at approximately 9am, the right side of Mrs A's abdominal scar split open spilling "blood and liquids" onto her bed. Ms I recalls that Mrs A called her, and she advised her to go to a public hospital. Mrs A did so. Antibiotics were prescribed and new dressings applied. Mrs A was sent home to bed. Mr and Mrs A understand that Ms I advised Dr B to call them to arrange her readmission to the private hospital.

Third surgical admission

At 6pm on 9 September, Mrs A went back to theatre at the private hospital as an emergency patient. Under local anaesthetic, Dr B again flushed out her abdominal wound. Mrs A complained that on this occasion Dr B was "rough" in handling her and Mr A was concerned that Dr B told him that he "couldn't find any scissors" during this procedure. Dr B's operation note states:

> "[Mrs A] was reviewed today, with some inflammation and swelling to the lateral right abdominoplasty wound.
>
> FINDINGS: The area was explored in the wound and was washed out where there was a small drain site, which was draining a small amount of serosanguinous fluid. The necessity for drainage, using surgery, is not indicated.

PLAN: Intravenous therapy and review overnight.

The patient was reviewed 24 hours after this admission on antibiotics. The redness and swelling in the lateral right abdomen had settled.

PLAN: discharge home today [ie 10 September 2002]."

Dr B informed me:

> "I explored the drain site on the right side and it seemed to be that she had a small superficial infection of the drain site and I explored this under local anaesthetic draining a small amount of fluid.
>
> We were unable to perform this under general anaesthetic as she had eaten and I believe that this local anaesthetic and drainage of the small abscess at the drain site would resolve the situation satisfactorily."

Dr B stated:

> "There is no doubt that she had a complicated infection which required some time to settle and she had two complications well recognised of the surgical procedures … Postoperatively, I believe she was managed in an appropriate manner but has had complications of the surgery which are unfortunate and for which I apologise but I believe I managed these appropriately.
>
> … In fact the complication that she developed which was infection, is unrelated to the length of surgery and in particular unrelated to the fact that the surgery was combined.
>
> … I believe that at all times I performed a standard of surgery and practice which was appropriate. I am sorry that [Mrs A] developed severe and major complications of her surgery. Each of these was independently explained to her and each of these was resolved according to Surgical Principles with debridement of dead tissues, drainage of infection and appropriate antibiotics."

Mrs A appears to have had the drainage bags removed on 11 September, although there is no record of this. She was seen ten days later by Dr G, when she was experiencing significant back ache as a result of adopting a stooped posture after surgery. Dr G's notes and report to Dr H state that Mrs A's abdominal wound was healing but producing some oedema (swelling). Ultrasound on the left breast or lower abdomen was recommended to soften the tissues and reduce cosmetic deformity. The right breast wound was completely healed. Dr G noted:

> "On clinical examination she has induration of the lower abdominal scar that is giving her a slight rolled appearance of the abdomen. Her left breast is showing some signs on clinical examination of possible early deep fat necrosis."

Mrs A says Dr G told her to "concentrate on getting physically better", advised her against further liposuction because her "tissue type made it dangerous", and told her not to worry about future correction of her scars and misshapen abdomen and breasts. Dr G referred Mrs A to a physiotherapist. This was the last time Mrs A saw Dr G.

Mrs A started back at work on 7 October on limited hours and duties. She had been off work for three months. She visited Dr H the same day. She says that when Dr H saw the results of her surgery he was "very disappointed … his words were simply 'oh dear'. He said we should be filing an ACC medical misadventure claim."

Mrs A summarised her impression of events subsequent to her surgery as follows:

> "[I] was in an extremely vulnerable state at the time immediately following [the] initial procedure and resulting complications… [but] continued to trust the medical care and treatment provided by [Dr B] during the acute phases of [my] postoperative care [and] was not in a position where [I] could possibly be expected to assess the appropriateness of this care and subsequently [feel] disempowered about what has happened … This feeling [was] compounded by [Dr B's] actions since the surgery and lack of care or apology. Furthermore … the quality of care received was compromised by the sheer number of providers involved … [after] the surgery and the lack of follow up by [Dr B] himself."

Dr B advised that [Mrs A] had refused to see him postoperatively "on a number of occasions … despite both my nurse and myself telephoning to arrange a meeting". Mr and Mrs A say this information is incorrect and misleading and that they cancelled one meeting only, which had been planned to address their concerns about the surgery and its complications. This meeting, scheduled for 22 February 2003, was cancelled following legal advice because Mrs A "did not feel comfortable" with Dr B and, as they had already arranged with ACC to seek an opinion from Dr de Chalain, they "did not wish to complicate matters".

Other matters

Fees for services

Mrs A provided the Commissioner with a copy of her invoice from the private clinic. It is dated 9 July 2002, headed with both Dr B's and Dr C's names, and confirms that they and Dr D were Mrs A's surgical providers. The invoice sets out the following:

Description	**Qty**	**Unit $**	**Amount**
Bilateral breast reduction	1	4,750.00	4,750.00
Abdominoplasty	1	2,750.00	2,750.00
Liposuction to Upper Arms	1	2,000.00	2,000.00
Invoice Amount			**$9,500.00**

In addition, a "Statement" from the city clinic sent to Mrs A dated 31 July 2002 shows that she was charged $465.00 for "D-wire localisation" in her right breast.

Dr B advised that Dr C was a "consultant surgeon contracted to [the city clinic] and received the same fees as me for performing 50% of the operative procedure [on 9 July 2002]".

However, Dr C stated that according to the terms and conditions of his contract, he received 25% of the fee collected from Mrs A. He said: "This is the standard payment of 25% for any operation that is shared with [Dr B]. If I perform an operation entirely on my own then 50% of the collected money would be paid to me as a fee." Dr C clarified that the portion of the fee he received was not reflective of the amount of time he spent with Mrs A intra-operatively, or any degree of responsibility he may have had for her, and commented:

> "Such is the nature of the invoicing and if two surgeons are involved in any way in a procedure together then [the] names of both surgeons would [appear] on the invoice.
>
> For the same reason because I was a contracted full time surgeon with [the city clinic], my name appeared under 'Surgeon' together with [Dr B] on the patient's operation records. [Dr D's] name appeared under 'Assistant' given the fact that he was not a full time employee and was a short term locum surgeon. This also means that he did not receive a 25% payment but rather a pre-arranged locum surgeon fee."

Physiotherapy

Mrs A had her first physiotherapy appointment on 9 October 2002. The physiotherapists' initial findings were as described by Dr G and included oedema and indurations of the breasts, left axilla, and lower abdomen; stooped posture and inability to extend the thoraco-lumbar spine owing to abdominal swelling and scar tension; oozing abdominal sinus, heat and tenderness along the breast, and abdominal scars. The physiotherapist queried whether Mrs A still had infection in her lower abdominal region, which remained very tender and often hot to the touch. Massage, mobilisation techniques and connective tissue work was performed over the scar tissue and abdominal swelling, to address Mrs A's symptoms. In February 2003, the physiotherapist reported to ACC:

> "[Mrs A] continues to experience fluctuating abdominal swelling. The swelling is accompanied with persistent hot spots along the scar margin and include the pubic area. The abdomen continues to have thickened nodular areas around the lateral borders of the umbilicus, and the umbilical area itself. She seems to be worse if she increases her swimming activities or stretching programe."

Action taken at the city and provincial clinics
Dr B advised that since July 2002, procedures have been changed at the two clinics to "ensure that a patient who is to undergo surgery with more than one surgeon is seen prior to their admission by both members of the surgical team". Dr C explained:

> "We have taken this opportunity … to put in place clear guidelines for the assumption of primary responsibility for the surgical services we render. Where two surgeons are involved with a procedure both surgeons have to consult the patient preoperatively and both surgeons need to be happy that it is appropriate to proceed. It is made clear to the patient preoperatively which part of the procedure will be performed by which surgeon and hence who will assume responsibility for which part of the procedure and who will assume overall responsibility."

Mrs A's current condition
Mrs A advised that the surgery and its complications have impacted on every facet of her life, both personally and professionally. She continues to have pain and discomfort at her operation sites, especially her abdomen. She is particularly distressed by the scarring on her arms and stomach. She is upset that she has "one breast and not the other", although she notes that her pain is less in the area of her breasts. Her daily activities are restricted; she does not have the physical energy to work full time, and cannot lift anything. Mrs A has received psychiatric intervention and takes medication.

Currently, Mrs A is undertaking a physical rehabilitation and exercise programme to improve her physical and psychological wellbeing, so that she will be physically and emotionally able to deal with reconstructive surgery. That surgery will involve three separate operations, one each on her arms, abdomen and breasts.

Mrs A is particularly upset that in 2002, Dr B did not explain why she had complications or provide an apology. Mr and Mrs A's experience has, they say, "been significantly exacerbated by [Dr B's] lack of remorse and ownership of accountability for their situation".

Accident Compensation Corporation

On 10 February 2003 Mrs A was seen by Dr Tristan de Chalain, a cosmetic and reconstructive surgeon at the Auckland Plastic Surgical Centre. Dr de Chalain was appointed by ACC to assess Mrs A and provide an independent report. He subsequently advised Mrs A that if she wished to undergo cosmetic surgery reconstruction it would cost approximately $32,200. Dr de Chalain's report to ACC included the following comments:

> "… I understand that there were three surgeons involved. Apparently a bilateral breast reduction and abdominoplasty were performed simultaneously (I'm not sure this is physically possible) and then liposuction was performed on the upper arms.

> A week later the patient was taken back to the operating theatre for debridement of a sloughed nipple/areola complex on the [right] breast and umbilicus in the abdominoplasty. Subsequent to this it would appear that the patient went on to develop a collection in the abdominal wound, which broke down as a frank infection and required surgical drainage in early September 2002. Thereafter the patient required serial dressings and has been off and on antibiotics for over 3 months.
>
> She has come to see me because of concerns about excessive and unsightly scarring, as well as disfigurement and pain.
>
> On clinical examination she has a grossly disfigured [right] breast. There has been significant loss of tissue with the breast being flattened and distorted. There has obviously been necrosis along the vertical closure line of the breast reduction and in the 'T' junction area, as well as a complete loss of the nipple/areola complex. The [left] breast, which appears to have healed reasonably well, is also in the patient's estimation, overly corrected with considerable loss of medial breast tissue.
>
> Turning to the abdomen, this is a completely unacceptable result. The patient has been left with a distorting scar and excessive soft tissue overhang along the scar, as well as a gross distortion of the pubic region. The umbilicus has been completely lost due to ischemic necrosis and the secondary infection has resulted in areas of adhesion and sticking down of the superficial tissue to the deep tissue. She still has areas of tenderness and extreme pain as well as sensory disturbance such as numbness over the pubis.
>
> Finally, the liposuction to the arms: these results are not impressive and I believe it is because the wrong procedure was performed. In my opinion what was required was a brachioplasty, which is to say, a resection of the skin and fat. Skin which is thinned and stretched with age and obesity will not 'take up' well after liposuction and this, I understand, was not fully explained to the patient, contributing materially to her subsequent dissatisfaction with a mediocre result."

Dr de Chalain went on to advise ACC that in his view, Mrs A required a complete revisional abdominoplasty, followed by reconstruction of an umbilicus, revision of the breast scars and parenchymal distortion, and the re-creation of a nipple on the right breast. He concluded:

> This lady has had at the least a medical misadventure. While one accepts that no surgery is without risk, this lady seems to have suffered an extremely unfortunate series of events. To what extent they were preventable by proper attention to detail is perhaps moot, but I have seldom seen such an unfortunate outcome from what should be, in properly trained hands, (even allowing for the fact that none of the surgeons involved are bona fide plastic surgeons), three reasonably simple plastic surgical procedures.
>
> In my opinion it is not safe practice to offer both a significant breast reduction and abdominoplasty simultaneously, but especially not in an obese patient with a high body mass

index. This may well constitute an error of judgement and at the very least, the patient should have been fully informed of the significant increased risks associated with combining such surgical procedures.

In my view therefore, taking all the above into consideration, this unfortunate episode constitutes grounds for medical error rather than simple misadventure, since the procedures performed were ill-advised and poorly executed."

The ACC Medical Misadventure Unit also received advice from Dr Chris McEwan, a plastic surgeon and the Director of the Waikato Plastic Surgery and Burns Unit. Dr McEwan's report to ACC stated:

"The outcome of the tissue loss and delayed wound healing can be seen in photographs supplied by the patient and by Mr De Chalain, in summary they can be described as the loss and distortion of the right breast tissue (about 75%)[12] with significant scarring, a scarred abdomen with abnormal contour and considerable protuberance, distorted lower abdominal wall and abnormality of the mons pubis secondary to scarring and delayed wound healing. While the distr[ib]ution of the scarring is consistent with the surgery performed, the tissue distortion and irregularity of both breast and abdomen constitute injury as defined in [ACC legislation]. This injury is the direct result of the surgery performed.

The areas in which this situation deviates from the norm is in the scheduling of three significant operations of a cosmetic nature to be performed at the one time by two surgical teams. I believe that it might be likened to mastectomy and immediate reconstruction with a TD Flap and reduction of the contralateral breast, however the principal difference is that this is entirely elective surgery and the risk benefit advice skewed in a conservative fashion. The combination of abdominoplasty with any other procedure significantly increases the associated risks for both procedures. Similarly there is a significant increase in delayed wound healing rates where liposuction of the central abdomen is combined with abdominoplasty. The presence of the umbilical hernia should have not increased the risk of umbilical necrosis significantly[13] …

[Mrs A] expresses her concerns about lack of communication from [the private clinic] both before and after her operation … This raises the question whether the potential risks and complications of such a combined procedure were explained outside of the risks of the procedures individually. The written information provided (unavailable to me) is unlikely to describe materially the changes of risk in such a combination procedure as such combinations

[12] Commissioner's note: Dr B has advised me that this was not his final clinical review of Mrs A's situation and that her loss was "at most 25% when I saw her last".

[13] Commissioner's note: In his response to my second provisional opinion, Dr C challenged Dr McEwan's view on this point, stating: "Plastic surgeons are not trained … to repair herniae. I am a general surgeon and therefore have had more exposure both at a training and post-graduate level to repairing body wall herniae. This statement is therefore a reflection of his opinion and is not in my opinion an accurate assessment."

are uncommon. It is often thought that reducing surgical time reduces risks significantly, however, there is a point that having multiple teams operating increases the 'trauma' associated risks as opposed to the anaesthetic related risks which tend to be more time related.

I wish to express my concern in relation to two sets of comments and criticisms about the immediate preoperative period and the conduct of [Dr B]. [Mr and Mrs A] (patient and Husband) several times point out [that] [Dr B] indicated that [Mrs A] was a 'perfect candidate' for this surgery, such comments tend to trivialise the appropriate risks that [Mrs A] was going to encounter [and] increase expectations unreasonably and secondly they complain that [Dr B] was very 'casual' about the pre surgical markings on the right breast …

The standard of care, especially around the advice associated with the risks of the combined, elective procedure is marginal but not clearly below the standard expected. … I would estimate the likelihood of significant tissue necrosis to be greater than 10%, however, accepting the severity of the tissue loss and the extent and duration of the disability this may well then bring the risk to well less than the 1% threshold [pursuant to ACC legislation].

I believe that this outcome was predictable and very preventable, the patient should have been advised of the high risk of complication associated with doing these three operations at one time and advised that going ahead with them in combination was probably unacceptable. The relative casualness with which this was undertaken is frightening, the outcome unacceptable for the patient and by any surgical standard.

… I believe that some consideration for competence review should occur, to ensure that the marginal … standard of informed consent apparently demonstrated is addressed."

On 1 July 2003, ACC advised Mrs A that it had accepted her medical misadventure claim arising from "infection causing disfigurement of [the] right breast and stomach allegedly caused by cosmetic surgery". The Medical Misadventure Report to Mrs A stated:

"*Medical error*
Medical error occurs where a registered health professional or organisation fails to observe a standard of care and skill reasonably to be expected in the circumstances. … In this case Mr McEwan raised several issues of concern. However, his conclusions were that 'The standard of care, especially around the advice associated with the risks of the combined, elective procedure is marginal but not clearly below the standard expected.'

Mr McEwan comments that the standard of informed consent regarding the uncommon combination of surgical procedures and associated risks was not ideal. For this reason he has recommended that [Dr B] be referred for a competence review by the Medical Council. …

Medical mishap
Medical mishap occurs where there is an adverse consequence of treatment, and where the treatment has been properly given by, or at the direction of, a registered health professional. The personal injury caused must be rare and severe. 'Rare' means the probability of the adverse consequence must be 1% or less. … Mr McEwan advised ACC that [the likelihood of] postoperative wound infections and tissue necrosis is likely to be greater than 10%. However, the severity of the tissue loss that [Mrs A] suffered as a result and the length of time that [she has] suffered significant functional ability, would be a risk 'well less than the 1% threshold'. Therefore, both the criteria for rarity and severity are met. … This claim is accepted as Medical Mishap."

Independent advice to Commissioner

Plastic and reconstructive surgeon
The following expert advice was obtained from Dr Graeme Blake, a plastic and reconstructive surgeon:

"You have requested me to provide an opinion to the Commissioner on case 03/05435. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

Qualifications
FRCS (England) 1968
FRACS (Plastic Surgery) 1973

I have been in full time plastic surgical practice from December 1972 to mid 2002 with both hospital and private practice and am still practising in a private capacity. Breast reduction surgery and abdominoplasty would be my most commonly performed major procedures in private practice.

My instructions from the Commissioner in this case were:

Purpose
To provide independent advice about whether [Mrs A] received an appropriate standard of care from [Dr B, Dr C and Dr D].

Background
[Mrs A] elected to have breast reduction surgery. During a consultation with breast surgeon [Dr B], [Mrs A] requested liposuction to her upper arms and an abdominoplasty. [Mrs A] was keen to avoid several operations/general anaesthetics and wished therefore to have the procedures performed in the one operation.

[Dr B] agreed to combine the procedures and requested the assistance of surgeons [Dr C] and [Dr D]. [Mrs A's] surgery was performed on 9 July 2003 at [a private hospital]. An umbilical hernia was encountered during surgery and repaired. [Mrs A] subsequently experienced postoperative complications (bleeding and infections). She lost a nipple and her belly button through necrosis and required surgery.

[Mrs A] is dissatisfied with the results of her breast reduction, abdominoplasty and liposuction and requires corrective surgery.

Complaint

[Dr B]:

1. *incorrectly advised [Mrs A] that she was a suitable candidate for a liposuction procedure*
2. *did not make accurate preoperative markings on [Mrs A's] breasts and stomach*
3. *did not perform the bilateral breast reduction surgery and liposuction to an appropriate standard on 9 July 2002*
4. *did not provide adequate information about the risks and complications of the surgery (including the complications associated with combining several surgical procedures)*
5. *did not explain why [Mrs A's] care was to be transferred to another surgeon*
6. *did not explain why [Mrs A] developed complications.*

[Dr C]:

- *did not perform an abdominoplasty to a satisfactory standard on 9 July 2002*
- *did not provide [Mrs A] with adequate information about the risks and complications of the surgery (including the complications associated with combining several surgical procedures).*

[Dr D]:

- *did not perform an abdominoplasty to a satisfactory standard on 9 July 2002*
- *did not provide adequate information about the risks and complications of the surgery (including the complications associated with combining several surgical procedures).*

Expert Advice Required

To advise the Commissioner whether, in [my] professional opinion, [Dr B, Dr C and Dr D] provided services to [Mrs A] with reasonable care and skill.

[Dr B]

1. Please advise whether [Dr B] was appropriately experienced and qualified to perform the breast reduction surgery and liposuction.

2. [Mrs A] advised that [Dr B's] preoperative markings were performed 'free hand'. Was this adequate in the circumstances? How are preoperative markings made?
3. [Mrs A] stated that she did not want to know the details of how the surgery was going to be performed (eg the surgical incisions). Should information about risks be influenced by what the patient is willing to hear? What is the surgeon's responsibility in this respect?
4. What information should [Mrs A] have been told about benefits and risks of combining several surgical procedures (breast reduction, abdominoplasty and liposuction)? Whose responsibility was it to provide this information?
5. What are the risks and benefits of combining breast reduction, abdominoplasty and liposuction procedures into one operation? Do the risks outweigh the benefits?
6. Is it common practice to combine several procedures?
7. Please advise whether it was appropriate to combine the above procedures in light of [Mrs A's] age, weight, skin type and the fact that she lived in [a provincial town and Dr B was based in a city]?
8. Was [Mrs A] 'a good candidate' for these procedures?
9. [Dr B] advised the Commissioner that [Mrs A] 'elected' to have surgery and requested that the breast reduction, abdominoplasty and liposuction be performed in one operation. However, should the patient's wishes influence clinical decision making in this respect?
10. Please comment on the surgical procedure performed by [Dr B]. Was it of an appropriate standard?
11. Was [Dr B's/the private clinic's] management of [Mrs A's] postoperative complications adequate in the circumstances? In particular, were interventions timely and well coordinated with other team members?
12. Was [Mrs A's] postoperative care adversely affected by the fact that she lived in [a provincial town rather than a city]?
13. What caused [Mrs A's] complications? Were they preventable? Were they linked to the standard of surgery performed on 9 July?

[Dr C and Dr D]

14. [Dr C and Dr D] advised that as they were surgical assistants to [Dr B] therefore it was not necessary for them to have an involvement with the patient's pre and postoperative care. However, should [Dr C and Dr D] have provided [Mrs A] with advice relating to the potential complications of her surgery (specifically from combining procedures)?
15. Please comment on the standard of [Dr C and Dr D's] surgery (abdominoplasty) on 9 July 2002.
16. Was it appropriate to proceed with the abdominoplasty after the umbilical hernia was discovered?

17. Did the hernia contribute to the outcome of the abdominoplasty?
18. Were the complications that [Mrs A] experienced linked to the standard of [Dr C and Dr D's] surgery?
19. Are [Dr C and Dr D] suitably experienced and qualified to perform this surgery?
20. Who was the primary surgeon with overall responsibility for [Mrs A's] abdominoplasty?

Documents Reviewed

- Letter of complaint from [Mr and Mrs A] including supporting information and action note of conversation on 26 May 2003 with [Mrs A] with HDC
- [Mrs A's] ACC file
- [Mrs A's] notes [from the private hospital]
- Information from [Dr B] and [the clinic's medical records]
- Information from [Dr C]
- Information from [Dr D]
- Interview transcripts with [Ms I]
- Interview transcripts with [Mr and Mrs A]
- Response from anaesthetist [Dr F]
- Medical records from general practitioner [Dr H]
- 5 postoperative photographs supplied.

Factual summary of case

14 June 2002
Letter of referral from [Dr H] to [the provincial clinic].

24 June 2002
Seen by [Ms I], Nurse, at [the provincial clinic]. Bilateral mammogram performed.

28 June 2002
Consultation with [Dr B] at [the provincial clinic]. Excerpt from letter to [Dr H]: 'Excellent candidate for bilateral breast reduction ... Nipple clavicular distance 38cm … Suitable for removal 2kg from each breast …'

'… She has quite a pendulous abdomen which would require apronectomy in routine fashion with tightening of the underlying musculature.'

'... She would like to have liposuction of the upper arms and liposuction of the hips.'

'… Explained complications fully to her and plan to admit her on Monday afternoon for surgery on Tuesday am 9 July.'

8 July 2002
[Mrs A] failed to appear for admission at 5pm.

9 July 2002
[Mrs A] travelled from [the provincial town to the city].

9.30am [the city clinic] – D-wire positioned to localise suspicious areas in lateral quadrant right breast.

11am Admitted [the private hospital]. Seen and marked by [Dr B. Dr C, Dr D] present.

1pm Operation
Procedure: bilateral breast reduction,
bilateral upper arm liposuction,
abdominoplasty.

Surgeons: [Dr B, Dr C, Dr D]
Anaesthetist: [Dr F]

13 July 2002
Discharged.

19 July 2002
Seen by [Dr G at the provincial clinic].

'Draining seroma fluid from umbo site. Evidence of skin necrosis of umbo. Right nipple appeared to have lost 50% of viability. If deteriorates will need assessment [at the city clinic].'

23 July 2002
Admitted [to the private hospital].

Right nipple areolar complex and necrotic umbilicus debrided by [Dr B] under general anaesthetic – [Dr F].

9 August 2002
Seen by [Dr B at the provincial clinic]. 'Still draining copious amounts from abdomen.'

16 August 2002
Seen by [Dr G at the provincial clinic].

23 August 2002
Seen by [Dr G at the provincial clinic]
'Right breast making significant progress. Purulent drainage through umbo site and irrigating catheter inserted. Nurse to continue with irrigations.'

29 August 2002
[Mrs A] provided with certificate advising not to travel [overseas] – due to leave on 25 September 2002.

8 September 2002
Fluid ++ gushed from abdomen.

9 September 2002
Readmitted [the private hospital]. [Dr B] explored lateral right abdominoplasty wound because of inflammation and swelling. Wound washed out.

10 September 2002
'Redness and swelling settled.' Discharged.

20 September 2002
Seen by [Dr G at the provincial clinic].

'Abdominal wound making significant progress.'

'Left breast showing some signs of possible early deep fat necrosis.' 'Right breast completely healed.'

'Getting significant backache. Referred for physiotherapy.'

7 October 2002
Saw [Dr H]. ACC Medical Misadventure claim initiated.

9 October 2002
Physiotherapy treatment commenced and still continuing on 26 May 2003 – last dated document received.

23 December 2002
Letter to [ACC], from [Dr B].

10 February 2003
Consultation with [a cosmetic and reconstructive surgeon] and cancelled appointment with [Dr B] scheduled for 22 February 2003.

Advice Requested
I have numbered the items for which advice was sought and provide this with my opinions.

[Dr B]

1. [Dr B] is a fully qualified General Surgeon who has taken an interest in breast surgery. While he has had no formal Plastic Surgical training he has worked with and

visited Plastic Surgeons and attended appropriate workshops and courses. He is undoubtedly qualified to perform breast reduction surgery and liposuction.

2. Breast reduction markings are performed preoperatively with the patient sitting, ie before any premedication is given and the patient is drowsy. They are performed 'free hand' frequently with the aid of a pattern. A ball point pen is preferable for the preliminary sketch plan before using a permanent marker as this produces a tidier result. A tape is used to ensure the nipples are positioned an equal distance from the sternal notch and from the midline of the sternum.

The abdominal markings are performed with the patient standing, again 'free hand' and usually checking for symmetry with a tape.

Areas for liposuction should also be highlighted preoperatively.

In this case adequate markings appear to have been carried out but in rather messy manner with respect to the permanent marker lines.

3. If a patient does not wish to know the details of how surgery is going to be performed then there is no need to inflict these. It is important in this type of surgery, however, to indicate where the scars will be as they are quite extensive and these are 'cosmetic' procedures. Risks come into a different category and must be enunciated.

4 – 6. The benefits of combining procedures are efficiency (ie less time off work and inconvenience) and cost saving. The risks are those for any plastic surgical procedure, ie infection, bleeding, tissue loss, sensory alteration and also associated general risks, ie deep vein thrombosis and pulmonary embolus, and anaesthetic risks.

It is common practice to combine procedures and it is the surgeon's responsibility to decide and advise if the risks outweigh the benefits.

7 & 8. In [Mrs A's] case I consider the risks far outweighed the benefits and [Dr B] made an error of judgement in planning to carry out three procedures. [Mrs A] was overweight, 108kg on admission, and labelled 'morbid obesity' by [Dr F] on his preoperative anaesthetic assessment sheet.

The breast reduction was a large one – theatre measurement 4.29kg from both breasts – and the abdominoplasty tissue removed weighed 5.58kg. These figures are high meaning a big procedure.

In [Dr B's] letter to [Dr H] following his initial consultation (28 June 2002) he states [Mrs A] 'is an excellent candidate for bilateral breast reduction'. [Mrs A] was obviously overweight with marked abdominal redundancy and while a breast reduction would definitely be beneficial for her she was hardly an excellent candidate.

An excellent candidate is a person who has large breasts, way out of proportion to their overall body size.

The fact [Mrs A] lived in [a provincial town] meant the postoperative care was more hassle rather than difficult and more expensive. I would have expected her to stay in [the city] longer and there are also travel costs but otherwise it is not an issue.

The regular visits by [the city clinic] personnel to [the provincial clinic] with a Nurse on site was advantageous.

9. Patients frequently desire to have as much done as possible in the one procedure. It is the Surgeon's responsibility to make the judgement of what is advisable.

10. The result is unacceptable judging from the photographs supplied. Unfortunately no preoperative photographs are available. None were taken of the abdomen as far as I can determine and the digital photographs taken preoperatively have been deleted ([Dr C]). The photographs, however, correlate with the descriptive picture indicated by Mr C McEwan and Mr T de Chalain. My deduction is that the standard of surgery was inadequate.

The operation note states that 'in sequence [Dr D and Dr C] removed the abdominal apron and toned the tummy.' However, in the letter of 4 June 2003, [Dr C] states that he arrived when the procedure was well underway, that [Dr B] was onto the second breast and removal of excess abdominal tissue had already been performed. The umbilical hernia was pointed out to him by [Dr B].

It is difficult to deduct from the notes when the liposuction of the upper abdomen was performed, who carried it out and whether local anaesthetic with Adrenaline solution was injected prior to liposuction as it was on the arms. The extent of liposuction and the injection of solution could contribute to the seroma formation and fat necrosis which obviously occurred.

[Dr B] states in his letter to [ACC] of 23 December 2002 that 'at surgery a combined team of three consultant surgeons plus assistants performed the procedure simultaneously.' I presume the arms were out on arm boards for the procedure and I find it difficult to see how all these people could physically fit into the space available and still operate adequately – a point noted by Mr T de Chalain.

Judging from the photographs available, I consider that liposuction was ill-advised for her arm redundancy. It is an inadequate procedure for this type of laxity in a patient of her age. A brachioplasty, ie excision of skin and fat, either initially or following liposuction, would produce a much better result but, as stated previously, should not have been carried out simultaneously with her other procedures.

11. The postoperative management was adequate.

12. [Mrs A's] postoperative care was made more difficult because she lived in [a provincial town], probably leading to more distress and discomfort, but I doubt it made any difference to the outcome. The Nurse [at the provincial clinic] appears to have been very attentive.

13. The risk of fat necrosis and possible associated infection in obese patients like [Mrs A] is relatively common and delays but doesn't alter the long-term result. Nipple necrosis is rare. It is associated with a pedicle which is too long, or tension in the overlying skin flaps, both of which can compromise the blood supply to the nipple. [Dr B] states in his original assessment letter of 28 June 2002 that the nipple clavicular distance was 38cm but in his letter of 23 December to [ACC] the distance was 36cm. Whichever is correct, it means a long pedicle. Also in his operation note he mentions shortening the long pedicle with an interrupted Vicryl stitch. I consider this would further compromise the blood supply. He again states that 'the nipples were inverted and these were everted using the external technique and a purse string placed after division of the nipple in half' yet another compromise which I consider was not indicated at that stage.

    It is difficult to state definitely if the nipple necrosis was preventable or not but it possibly could have been. Again, surgical judgement is important. If the pedicle is considered too long, the risk of necrosis high and the patient older (usually over 60) a free nipple graft procedure should be considered.

    The umbilical necrosis has been attributed to the repair of the umbilical hernia. These umbilical herniae, strictly paraumbilical, are usually small and with careful technique can be repaired without compromising the blood supply to the umbilical pedicle. If [Mrs A] had a very long pedicle and it was reinserted with tension, then repair adjacent to the base of the pedicle could be an additional factor contributing to necrosis.

    Seroma, abdominal fluid, of varying degree is common following abdominoplasty but usually doesn't alter the final outcome.

[Dr C and Dr D]

14. These Surgeons both appear to have been assistants to [Dr B]. There is no mention of separate accounts [ie invoices being sent to Mrs A] especially for [Dr C], which would indicate individual responsibility.

15. As [Dr C and Dr D] have not written any separate operation notes, or been involved other than as assistants, it is inappropriate to comment on their standard of surgery.

16. It was appropriate to proceed with abdominoplasty after discovery of the umbilical hernia. These herniae are usually small and paraumbilical. They are not detected preoperatively due to obesity of the abdominal wall. Surgeons performing abdominoplasties should always be aware of encountering a hernia.

17. Covered in item 13.

18. Covered in item 15.

19. Not enough information supplied to answer this.

20. [Dr B] was the primary Surgeon and the overall responsibility for the breast reduction, abdominoplasty with hernia repair and the liposuction of the arms, was his.

Conclusion

I consider that [Mrs A's] complaint:

1. that [Dr B] advised her she was a suitable candidate for a liposuction procedure when she was not, is justified;

2. that [Dr B] did not perform the bilateral breast reduction or abdominoplasty to an appropriate standard, is justified; [Dr C and Dr D] are excluded as mentioned above;

3. that [Dr B] did not provide adequate information about the risks and complications of surgery was rather an error of judgement in carrying out these three procedures simultaneously. Risks and complications of the individual procedures were undoubtedly mentioned but [Dr B] made an unwise decision, hence the complaint is justified;

4. that [Dr B] did not make accurate preoperative markings, is not justified;

5. that [Dr B] did not explain why [Mrs A's] care was to be transferred to another Surgeon, is not justified. I presume this means follow up care with [Dr G] and not the shared surgical management in the operating theatre. The management at [the provincial clinic] appears to be very well organised;

6. that [Dr B] did not explain why [Mrs A] developed complications, is partly justified. Perhaps in hindsight he could have spent more time with Mrs A and been more compassionate but this is a matter of personality and attitude which I am not in a position to assess. In this regard, [Mr and Mrs A] are surprised that [Dr B] has not contacted them. This again is a personal matter and if [Dr B] knew they had sought another opinion he may have felt he was not longer wanted.

The complaints against [Dr C and Dr D] are not justified for reasons mentioned previously. Finally, the article on 'Management of the Primary and Contralateral Breast: The Repertoire of the Oncoplastic Breast Surgeon' [provided to the Commissioner by Dr B] is totally

irrelevant in the context of this case. It does show that [Dr B] is involved in major breast surgery in an article dealing with breast cancer. [Mrs A], however, had an elective procedure for which she didn't receive the best advice."[14]

General surgeon

The following expert advice was obtained from Dr John Simpson, general surgeon, on 6 April 2004. In his report, the numbering in square brackets under the heading "Specific questions" relates to the same series of questions set out by Dr Blake above.

"1. This report is written by John Stuart Simpson, medical practitioner of Wellington, vocationally registered in general surgery.

2. I am a Fellow of the Royal Australasian College of Surgeons (1977) and formerly General Surgeon at Wellington and Hutt Hospitals. I have been involved with general and breast surgery over a period of 32 years. I am a former Chairman of the RACS Section of Breast Surgery. I am currently Executive Director of Surgical Affairs (NZ) for the Royal Australasian College of Surgeons and continue to practise in the field of breast disease.

3. In writing this report, I have had access to copies of certain medical records, reports, letters and photographs but have not interviewed any of the parties concerned.

4. **The complaint**
The complaint is that in July 2002, [Drs B, C and D] did not provide services of an appropriate standard to [Mrs A].

5. **Background**
In May/June 2003 [Mrs A] was referred by her GP [Dr H] to [the city clinic] with a request for breast reduction.

6. [Mrs A] saw [Dr B] on 28 June 2002. Surgery was booked for 9 July at [the private hospital].

7. The operation consisted of bilateral reduction mammoplasties, abdominoplasty and liposuction to both upper arms. The operation record states that [Dr B] did the mammoplasties and the liposuction and the other two surgeons did the abdominoplasty. The surgery is reported to have taken 4 1/2 hours in total.

[14] In response to my first provisional opinion, Dr B disagreed with Dr Blake that the article was irrelevant, stating: "The article was independently researched by a dedicated research surgeon and was presented at the American College of Surgeons' annual meeting in March 2003. It demonstrates that as a member of a surgical team I perform abdominoplasty and breast reduction on a regular basis with low complication rates in keeping with world literature."

8. [Mrs A] left [the private hospital] on 13 July and returned to her home in [a provincial town] on 18 July. On 19 July she returned to see [Dr G] at [the provincial clinic].

9. On 21 July [Mrs A] was experiencing problems with her umbilicus and was seen by [Ms I], a nurse employed by [the clinic], that day and again on 22 July. In consultation with [Dr B] arrangements were made for [Mrs A] to be readmitted to [the private hospital] on 23 July.

10. She was found to have an ischaemic right nipple and umbilicus. Both were removed by [Dr B] on 23 July and she went home the next day.

11. She was followed up at [the provincial clinic] by [Drs B and G] until 8 September when her abdominal wound burst. She was readmitted to [the private hospital] the following day for wound toilet and debridement. Following this procedure the wound slowly healed but the result was regarded as 'disappointing' by [Mrs A].

12. On 10 February 2003 Mrs A saw Dr Tristan de Chalain (plastic surgeon) for an independent assessment following an ACC Medical Misadventure claim.

13. **General comments**
    This has been a prolonged, unpleasant and unsatisfactory saga for [Mrs A]. The result can only be described as very poor at this stage and she experienced severe and unexpected morbidity from what are individually usually safe and satisfactory procedures. When a procedure(s) is done for cosmetic reasons the expectations are invariably high. In this case, [Mrs A's] expectations were most certainly not met and in addition she experienced quite the impact of her wound complications.

14. **Complaints**
    These complaints relate to [Dr B] and his two associates [Drs C and D]. The exact status of [Drs C and D] is not made clear to me by the documentation supplied but my best judgement is that [Dr C] was a surgeon employed by [the private clinic] and [Dr D] was a relatively short-term locum. From every point of view Dr B must be regarded as the lead surgeon. Thus the responsibility for events that followed must fall disproportionately on his shoulders.

a) Complaints regarding [Dr B]:

1. Preoperative assessment. The quality of the advice given to [Mrs A] that she was a suitable candidate for liposuction is something that I cannot assess from the available information. If [Dr B] told [Mrs A] she was 'the perfect candidate' (for what I am not sure) he was unwise to say the least, in terms of her expectations.

2. The quality of the explanation of risks and complications is something that is almost impossible to assess retrospectively unless the consultation is recorded or detailed notes

are made at the time. There is no evidence that either of these measures to record what he said were used in this case. Such recording would not be standard practice in New Zealand. It seems almost certain that [Dr B] did discuss at least some of the risks, but there is no evidence that he discussed the cumulative risks of several procedures. [Dr B] states that this (combining the three procedures into a single 'operation') was what [Mrs A] wanted. Dr de Chalain expressed the view that combining the procedures increased the chances of complications.

3. Skin marking is done as a guide to making incisions and is done in different ways by different surgeons. There is no absolute right or wrong technique and again a retrospective assessment is impossible.

4. An inadequate standard of surgery for breast reduction and liposuction is, in my view, the most serious and important complaint. The operations did not meet [Mrs A's] expectations and the view of the two plastic surgeons she has seen support the view that the result was unexpectedly poor. Is this simply an unusual but well recognised complication occurring from time to time, as such things do through no more than bad luck, or was the operation not performed to an acceptable standard? This question is a vitally important one and in answering it, I am influenced by the views of the two plastic surgeons who have provided reports on [Mrs A]. Even allowing for possible interdisciplinary prejudice, I would generally accept their view and conclude that an acceptable standard was not reached. I would describe this as a significant departure from best practice. The question of whether breast reduction is part of general surgery (for a surgeon with a major breast interest) is still a matter of debate with a number of general (breast) surgeons describing themselves as onco-plastic surgeons and doing such procedures. However, there would be few general surgeons who would regard liposuction of the arms as a regular part of general surgery. If a surgeon strays outside the accepted boundaries of his/her speciality the question will always be asked whether the procedure would have been done better by another specialist working within his/her own field. In this instance my answer is that there is a very high probability it would have been done better.

5. Transfer to another surgeon. Presumably this refers to much of the postoperative care being carried out by [Dr G]. [Dr G] is employed by [the private clinic] as a surgical member of their team. I would view this as [Dr B] engaging in a type of team care with an Associate and not as a transfer of care. This form of shared care is acceptable but must be explained in explicit terms to the patient.

6. Explanation of reason for complications. It is an expected part of the total care of a patient with complications to give as much of an explanation as possible as to why they have occurred. Often the doctor may not know the reason but as much information as possible should be given. I could find no evidence either way to determine whether [Dr B] did or did not provide an explanation.

b) Regarding [Dr C and Dr D]

1. It is hard to conclude that the abdominoplasty was performed to a satisfactory standard. The wounds took 3 months to heal, the umbilicus was lost and [Mrs A] describes her abdomen as 'hugely deformed'. The key question is who was responsible for this procedure. There is clearly a difference in perception between [Dr B] and [Drs C and D]. [Dr C] describes himself a 'surgical assistant'. [Dr B] states that [Dr C] was 'responsible for the abdominoplasty'. [Dr D] also describes himself as an assistant. I prefer to regard [Dr B] as the responsible surgeon as he was clearly the senior member of the team and the person [Mrs A] was referred to, obtained informed consent and did the pre-surgical visit to [Mrs A] in [a private hospital]. None of the above descriptions could be applied to [Dr C] who was, in addition, only present for half the operation.

2. Neither [Dr C] nor [Dr D] had the opportunity to discuss the risks of surgery with [Mrs A]. [Dr B] took on this role and did not involve the other two surgeons in the consent process. If this process was inadequate for [Mrs A's] needs the responsibility must lie with [Dr B].

Specific questions

[Dr B]

1. Qualifications and experience.

[Dr B] has considerable experience of breast surgery in general, and without doubt, has had a good deal of experience of breast reduction even though he is not a trained plastic surgeon. Breast reduction is performed in this country by a small number of general (breast) surgeons of which he is one, but the great majority is done by plastic surgeons. Liposuction to the arms is not an accepted part of general surgery, nor is abdominoplasty as a cosmetic procedure. Thus he must be seen to have strayed significantly outside the generally accepted boundaries of general surgery.[15]

2. Markings.
Many surgeons use freehand marking and this is generally accepted. Marking is a very individual thing and I have no basis for criticism of [Dr B] in this regard.

[15] Commissioner's note: In his further advice dated 19 September 2005, Dr Simpson substituted the last sentence of this paragraph in light of additional evidence subsequently obtained, to read: "In electing to perform these procedures which are not part of 'core general surgery', he must accept that his colleagues in plastic surgery are likely to regard any complications as evidence of problems relating to surgical technique." See page 57 below.

[3] Information about benefits and risks.
The [Code of Health and Disability Services Consumers' Rights] requires surgeons to disclose all material risks. Clearly the consent process for these risks will vary from patient to patient depending on their individual needs and preferences. The quality of the process is impossible to assess from the information supplied.

[4] Combining procedures.
Explanation of the risks for each procedure plus any compounding of these risks when several procedures are done together should be regarded as the standard. Provision of such information is very definitely the responsibility of the lead surgeon, in this case [Dr B].

[5] The risks and benefits of combining these procedures is not really my area of expertise but in general, the benefits are that it is all over in one go and the risks include more pain, more risk of infection and a longer recovery period.

[6] It is reasonably common practice to combine procedures but the risk of an outcome like this always exists.

[7] I would not regard any of the factors listed [Mrs A's] age, weight, skin type and the fact that she lived in [a provincial town] as an absolute contraindication to combining the procedures.

[8] I have no information to classify [Mrs A] as a 'good' or 'not so good' candidate [for these procedures].

10. Taking the procedures together, my view would be that they were not carried out to an appropriate standard.

11. The management of postoperative complications was in my view satisfactory and the part played by the breast nurse is acknowledged by [Mr and Mrs A].

[13] The precise reason for the complications is unlikely ever to be known but skin infarction is usually due to impaired blood supply, generally a technical failure. This suggests that they were potentially preventable.

[Drs C and D]

[14] Whether [Drs C and D] were surgical assistants or independent specialists is an important question in deciding their level of responsibility for [Mrs A's] problems. If assistants their role would be determined by [Dr B] and he would shoulder much of the responsibility for their actions. Provided that they were not asked to do something clearly contrary to the principles of good practice, their role was to follow [Dr B's] instructions. As assistants they did not carry the responsibility for informed consent. If they were acting as

independent specialists they would be responsible for consent and would carry the main responsibility for the part of the operation they performed.

[15] The abdominoplasty did not go well but if [Dr D's] description of himself as an assistant is accurate he carries only a limited part of the overall responsibility and the main responsibility comes back to [Dr B]. In the case of [Dr C] his presence for only half the operation is unusual to say the least and again I am of the opinion that [Dr B] carries much of the responsibility for his actions too.

[16] The hernia was not in my view a contraindication to completing the abdominoplasty.

[18] The surgery performed by [Drs D and C] contributed to the complications, however as already stated, [Dr B] should carry the great majority of the responsibility for the bad outcome.

[19] Abdominoplasty as a cosmetic procedure is not regarded as part of general surgery. Both [Drs C and D] are qualified general surgeons. I am unaware that either of them has received any special training in this type of surgery.

[20] Without doubt [Dr B] was the surgeon with overall responsibility for all three parts of the operation.

Summary

The outcome of these procedures done for cosmetic reasons was far from good. Everything points to this being a preventable situation with virtually all the problems stemming from the way the surgery was performed. It is disappointing to find major differences of opinion between the three surgeons about who was responsible. Everything points to [Dr B] as the person who must accept most of the responsibility for the bad outcome. Other aspects of pre- and postoperative care seem to have been of an acceptable standard."

Responses to first provisional opinion

Dr B

Dr B responded to my first provisional opinion as follows:

"I consider that the complications were dealt with appropriately as they arose. I regret that I did not see [Mrs A] myself at the time of discharge [on 13 July 2002] and immediately when she suffered the complications associated with necrosis. However I do not accept this warrants a finding that I have breached the [Code of Health and Disability Services Consumers' Rights] and nor do I accept the advice from [the Commissioner's expert

> advisors] Mr Simpson and Mr Blake supports that breach finding. [Mrs A] was seen and discharged [on 13 July] by [Dr C], as a member of the surgical team. Her follow up care by [Dr G and Ms I] is in keeping with well established practice at [the city clinic]. This shared care approach is necessary given the logistics of having two clinics, in [a city and a provincial town]. Your advisors are not critical of this approach. …
>
> I do not accept that [Mrs A's] complications arose as a consequence of inadequate surgical procedure. First, the risk of these complications was not increased as [a] result of the combined procedure; they equally could have occurred had the procedures been performed separately.
>
> Nipple necrosis and T junction necrosis are well documented and I am familiar with both complications. Necrosis of the umbilical hernia and subsequent wound infection of the abdomen occurred separately, and likely were related to the repair of the umbilical hernia. This is also a well documented complication.
>
> A literature search confirms that nipple necrosis occurs in 2−4% of cases. Patients at extreme risk are those who are smokers, who have major breast reductions, or pedicles that are longer than 40cm. [Mrs A] was aged 51, she was a non-smoker, and her pedicle height was between 36cm and 38cm as documented. Therefore she was not a patient who could be said preoperatively to be at greater risk of this complication. Having said that, nipple necrosis (and the potential loss of the nipple) was discussed preoperatively with [Mrs A]."

In response to my proposed recommendation that Dr B, Dr C and Dr D seek advice from the Royal Australasian College of Surgeons (RACS) as to the appropriate limits of their practice in general surgery, Dr B stated:

> "I understand my qualifications as a breast surgeon are accepted. I have also trained in abdominoplasty and liposuction. There are now a number of general and breast surgeons who perform these procedures having been trained in them, and I consider this appropriate."

Dr B also advised: "I accept that with hindsight there are aspects of this case that could have been dealt with differently and I have learned from this experience. … The complications experienced by [Mrs A] are undoubtedly distressing to her, and were very unfortunate."

Dr D

In response to my first provisional opinion, Dr D stated:

> "I was employed as a locum at the relevant time. In that capacity, I was asked to assist with the operation. It was my clear understanding that I would be performing those parts of the surgery I was required to assist with as an assistant under the direct supervision and directive of the other two surgeons present. As I had not met [Mrs A] preoperatively I had played no part in the decision making and consent process. In those circumstances I do not believe that I

assume responsibility for the patient, other than to exercise the expected level of care which is the case with all procedures."

In response to my proposed recommendation that advice be sought from RACS, Dr D said:

"… I do not consider this is necessary. I am well aware of the boundaries on a general surgeon and practice within these. My practice involves breast surgery which includes benign and malignant conditions, thyroid surgery, laparoscopic cholecystectomy, appendicectomy and hernia repair, laparotomy, uncomplicated small and large bowel surgery, varicose vein surgery and various skin lesions both benign and malignant. Any condition requiring cosmetic surgery input is usually done with the plastic surgeon. It is not my practice to perform abdominoplasty on my own. Any cosmetic procedure which I assist with is always with a plastic surgeon. In this case, I recognise that [neither Dr B] nor [Dr C] are plastic surgeons but it was my understanding that they were competent in performing the cosmetic procedures to [Mrs A]. Had I considered otherwise I would not have agreed to assist."

Dr C

Dr C did not provide a substantive response to my first provisional opinion.

Information from the Royal Australasian College of Surgeons

I sought information directly from Dr Murray Pfeifer, Chairman of the New Zealand National Board of RACS regarding the limits of general surgery. His advice was as follows:

"There is a clear statement from the Board in Plastic and Reconstructive surgery that their curriculum includes both of these procedures [abdominoplasty and liposuction]. The general surgery curriculum does NOT include these procedures. The appropriateness of a general surgeon performing these procedures is not quite as black and white as the sentence above might suggest. There are a number of procedures that general surgeons may occasionally perform that are not included in the General Surgery curriculum but might be described as on the border between general surgery and one or more other specialities.

The verdict on whether it is appropriate should be decided on a case by case basis. The following factors should be considered in reaching a verdict:

- Is the procedure really a borderline one or is it really in the heart of another specialty?
- What training has the surgeon had in the procedure and is it considered adequate?
- Is the surgeon performing a sufficient number to develop and maintain skills?
- Has an audit of outcomes been carried out with acceptable results?
- Is the procedure not inherently high risk and without well recognised major complications?
- Has the surgeon the necessary facilities, instruments and assistance?

- Does the surgeon work with a specialist in the 'adjoining' speciality to provide some form of oversight?
- Has appropriate informed consent been obtained including an acknowledgement that the surgeon is not in the speciality normally performing this procedure?

It must be recognised that the above questions do not have clear-cut 'correct' answers based on well accepted standards. However, if generally favourable answers are obtained for all of these questions it is probably acceptable practice for a surgeon to perform 'borderline' procedures. It must be recognised, however, that the chances of a complaint being made if problems ensue are probably substantially increased. If the answer to any of the questions is 'no' then the procedure should be referred on to a surgeon from the appropriate speciality."

Responses to second provisional opinion

Dr B

In his response to my second provisional opinion, Dr B expressed concern at the comments of my expert advisor Dr Simpson, and the above advice provided by Dr Pfeifer. Dr B stated:

"1. To my knowledge Mr John Simpson is not an active practising general surgeon and has been retired from active practice for several years. I am concerned that some of his comments reflect perhaps an outdated view, and not the present reality of general surgeons undertaking a variety of procedures in which they have trained. By way of example, I consider his comment that I bear the vast responsibility for the surgery is out of kilter with modern practice.

2. With respect to Dr Murray Pfeifer's statement that my practice was outside that of the standard practice of a general surgeon, I take a contrary view and consider Dr Pfeifer's comment to be demonstrably incorrect. As medicine has evolved the areas of surgery have overlapped: for example, ENT surgeons are performing plastic surgery, as are general surgeons practising in areas in which they obtain special expertise and interest – such as my own interest in breast surgery.

While I do not purport to have directly sought comment from the RACS I am aware that [Dr C] did so, in that he wrote to [a practising paediatric surgeon] in New Zealand and is the President of the Royal Australasian College of Surgeons. It is my understanding … that the true position is that, with the changes in modern surgery the scope of surgical practice conducted by a general surgeon [is] defined by –

i. Their training and experience.

ii. The registration and the case load that they are allowed and licensed to perform at the individual hospitals.

iii. The audit of their clinical standard practice as carried out by the surgeons and the hospital.

3. There is no question from any of the experts instructed by the Commissioner that my training for the procedures performed on [Mrs A] was not adequate.

4. I am a member of the Royal Australasian College of Surgeons, breast section, and I regularly send my patients for audit to the College audit.

5. I have my practice audited at [the private hospital] on a regular basis.

6. I have fairly recently been the subject of a competency review by the Medical Council of New Zealand. They have found no fault with my standard of surgery. Whilst the reviewers found that I could improve my communication in some areas there were no concerns as to my competence.

Concluding comments
I genuinely do my best to assist all of my patients, both [at the city clinic and the provincial clinic]. I believe that we have established a system that enables patients [at the provincial clinic] to obtain an excellent level of care, and I do not read any criticism of this in the second provisional opinion, or from your advisors. I am mortified that [Mrs A] has suffered as she has, which [was] unforeseen, following procedures that were performed by independent, skilled surgeons without apparent complications (other than the hernia). While I did discuss complications with [Mrs A] (as [Ms I] confirms) the complications that she suffered were unexpected, and I do not accept that they were rendered more likely simply because of the decision to combine procedures".

Dr C
Dr C responded substantively to my second provisional opinion and stated:

"It has been mentioned by [Dr B] that I was responsible for the abdominoplasty part of [Mrs A's] procedure. This isn't true and is not reflected by this patient's journey through the clinic. When I am responsible for a patient I will see the patient preoperatively, counsel the patient, obtain informed consent and mark the patient out fully preoperatively and perform the surgery myself with or without assistance and be present for the entire operation from start to finish. None of the abovementioned applies to my involvement with [Mrs A].

…

If I had truly been responsible for the abdominoplasty then the following points would have applied: (1) The abdominoplasty would not have been performed at the same time as the breast reduction given the volume of tissue that needed to be removed from both areas. (2) I would have had preoperative visits with the patient where counselling was done and informed consent obtained. (3) Preoperative marking for the abdominoplasty would have been

performed by myself. (4) I would have been present for the whole of the operation and performed it myself with or without assistance. (5) If I had been responsible for the abdominoplasty the lead surgeon would not have allowed me to go to another hospital to perform another operation at the same time and then return at a later stage to assist with completion of this procedure. (6) I would have managed postoperative abdominal complications myself, especially returns to theatre in this regard.

…

I acknowledge that any surgeon doing anything to any patient surgically is responsible for their actions. Responsibility in this case, however, cannot be given to me, even on a shared basis, because [Dr B] was quite happy for me to go to another hospital and perform another operation and that he would be in charge and supervise the procedure and for me to return when able to and help with its conclusion. I cannot accept that I was 'second in command' in that if that was true then [Dr B] would have instructed, and I would have been the first to agree, that I should be present for the entire operation. … [Dr B] allowing me to come in after 2 hours of the procedure had elapsed is acknowledgement of my assistant status."

Dr D

Dr D commented on the information provided by RACS as follows:

"With regards to my participation in performing abdominoplasty, I clearly acted as an assistant and performed surgery under direct supervision of [Dr B] and in conjunction with [Mr C]. The procedure was done as directed by those two surgeons. This was so, even though I had relevant experience as a general surgeon together with experience working with plastic surgeons. It was my understanding that both [Dr B and Dr C] had performed similar procedures in the past and that they were well versed with these. Given the [Commissioner's provisional opinion] that [Dr B] was properly trained to perform abdominoplasty I find it difficult to accept that it was unreasonable to assist him, particularly in a limited capacity. I cannot comment on the finding that [Dr C] was not similarly trained, but certainly that was not my understanding.

I do not consider that I acted outside my scope of practice, and I disagree with [the Commissioner's provisional] findings in this regard. As I have made clear, my role was purely as an assistant. I do not consider that I should have had to question the experience and training of [Dr B and Dr C]. To my knowledge both surgeons practiced through [the private clinic] as breast and reconstructive surgeons, with no previous problems known to me.

…

I have indeed made some changes in the way I practice as a consequence of this case. I make detailed notes on every procedure I perform either as a lead surgeon or as an assistant. I have also not taken the offer of doing any more work through [the private clinic]. I also remain in the mainstream of general surgery and perform surgery which I am comfortable with and with

a well informed patient with regard to risk and complications. I have no doubt that I practice well within the requirements of the College."

Dr D also wished to clarify that he had not deliberately omitted to refer to the involvement of Dr E in any of his previous responses to the Commissioner, and in any event, he had not known the extent of her involvement in Mrs A's care. He noted that Dr E's role had seemed to him to be "one of an observer" and "an assistant to [Dr B]". Dr D advised that it was an "oversight" that he had not referred to her in the earlier information which he provided to my Office.

In concluding his response, Dr D stated: "I have been in medical practice since 1986 and as a specialist since 1998, and until this matter I have not had any complaints against me. I have taken this matter very seriously, and have certainly learned from this process."

Further independent advice to Commissioner

Following consideration of Dr B's and Dr C's responses to my second provisional opinion, I sought additional expert advice from Dr Simpson.

Dr Simpson was sent the following material:

1. Second provisional opinion, 31 May 2005

Re: [Dr B]
2. [Dr B's] response to the second provisional opinion (24 June 2005)
3. [Dr B's] letter to the Medical Council of New Zealand (20 June 2005)
4. [Dr B's] response to the first provisional opinion (20 January 2005)
5. Letter from the Medical Council of New Zealand (25 February 2005)

Re: [Dr E]
6. Letter from [Dr E] (19 January 2005)
7. Letter from the Medical Council of New Zealand (23 March 2005)
8. Letter from [Dr E] (29 March 2005)
9. Letter from Commissioner to the Medical Council of New Zealand (7 April 2005)
10. Fax from [Dr E] with [details of relevant qualifications from her home country]
11. Letter from [the current clinical manager of the private hospital] (26 April 2005) (with attached CV of [Dr E])

Re: [Dr C]
12. [Dr C's] response to the second provisional opinion (7 June 2005)
13. Letter from [Dr C] (22 June 2005)
14. Letter of apology from [Dr C] to [Mrs A] (7 December 2004)

Re: [Dr D]

15. [Dr D's] response to the second provisional opinion (July 2005)
16. [Dr D's] response to the first provisional opinion (29 November 2004)

Re: [Mrs A]

17. Letter from [Mr and Mrs A] (5 April 2005) and supporting documents
18. Full medical records from [the private hospital] (the copy previously provided to the Commissioner was missing some pages of the intra-operative record for [Mrs A's] surgery)

Royal Australasian College of Surgeons

19. Letter from RACS New Zealand Chairman Dr Murray Pfeifer (12 April 2005)

On the basis of the above information, Dr Simpson was invited to amend or expand as necessary upon the conclusions set out in his report dated 6 April 2004, and discuss:

1. *The attendance of Dr E*
    a) Whether Dr E's participation in Mrs A's surgery was appropriate, either as a "nurse assistant" or as a visiting surgeon on a preceptorship.

    b) Whether Dr B gave adequate and appropriate information to Mrs A about Dr E.

2. *The nature of Dr B's and Dr C's responsibilities*
    a) Whether they were adequately discharged if:

        (i) as Dr B states, Dr C was a "consultant surgeon working as a contractor", Mrs A was admitted under Dr C's name so that he would "attend her for a preoperative discussion", Dr C spoke to Mrs A preoperatively and "marked up" the abdominoplasty, Dr C arrived "shortly after" surgery commenced and supervised and performed the abdominoplasty, and Dr C received the same fees as Dr B for doing 50% of the surgical procedure; or

        (ii) as Dr C states, his role was that of an assistant only, his name on Mrs A's patient label was a secretarial mistake, he did not "mark up" Mrs A preoperatively, he arrived in theatre after 3pm (with Dr B's approval) when the abdominal surgery was "well underway", assisted in the completion of that part of the surgery, and received only 25% of the total fee.

    b) Whether, in each scenario, either surgeon failed to provide an appropriate standard of care.

3. *The "team approach" to Mrs A's surgery*
    a) Whether the team approach described by Dr B is common.

b) Whether appropriate boundaries were set for and observed by each surgeon.

c) Whether the level of communication and co-operation between each surgeon was acceptable.

d) The nature of each surgeon's responsibility in regard to record-keeping when involved in a team (now, and in 2002).

4. *Appropriate limits of competence*

a) Whether these were observed in light of the advice of the Royal Australasian College of Surgeons, and the providers themselves.

Dr B's comments that:

b) Some conclusions in Dr Simpson's original expert advice "reflect … an outdated view";

c) Dr Pfeifer's statement that his (Dr B's) practice was outside the standard practice of a general surgeon is "demonstrably incorrect";

d) the "true position" of the scope of surgical practice conducted by a general surgeon is defined by training and experience, registration and caseload, and audit of clinical standard practice.

5. *Other matters*

a) Dr F's assessment of Mrs A's fitness to undergo anaesthesia, and how this would have impacted on Dr B's decision to proceed;

b) Dr C's comments as to the presence of the umbilical hernia and its impact on the risk of umbilical necrosis.

Dr Simpson's supplementary advice of 19 September 2005 stated:

"**Supplementary Report to the Health and Disability Commissioner**

03HDC05435 [Mrs A]

1. This report, which supplements a report written in April 2004, is written by John Stuart Simpson of Wellington, a medical practitioner vocationally registered in general surgery.

2. I am a Fellow of the Royal Australasian College of Surgeons (1977) and formerly General Surgeon at Wellington and Hutt Hospitals. I have been involved with general and breast surgery over a period of 32 years. I am a former Chairman of the RACS Section of Breast

Surgery. I am currently Executive Director of Surgical Affairs (NZ) for the Royal Australasian College of Surgeons and continue to practice in the field of breast disease.

3. In writing this report, I have had access to copies of certain medical records, reports, letters and photographs but have not interviewed any of the parties concerned.

4. ***New Information***

There is new information available since the report written in April 2004. This falls into 2 categories:

a) On the presence in the operating theatre for [Mrs A's] operation of [overseas certified] surgeon, [Dr E]. None of the three surgeons involved with [Mrs A's] operation made any mention of her presence in their initial reports. This seems strange in itself but probably has no direct bearing on [Mrs A's] main complaint which is the standard of surgery. It does however raise issues about how appropriate it was for [Dr E] to participate in the operation and whether suitable consent was obtained for her presence in the operating theatre. The letter written by [Dr E] dated 19 January 2005 confirms her presence in the operating theatre and her role as an assistant to [Dr B]. Her letter dated 29 March 2005 states that [Dr B] did not perform any part of the abdominoplasty and that the preoperative discussions and markings were carried out by [Dr C]. She is also fairly specific about the timing of [Dr C's] arrival. [Dr E's] letter is generally supportive of [Dr B's] view that he was not responsible for the abdominoplasty.

b) There is further evidence of major differences between [Drs B and C] on what might be termed 'factual matters' relating to the operation. This would include [Dr C's] time of arrival at the operation.

5. ***My 2004 report***

I stand by the general conclusions of my earlier report. However, [Dr E's] letters are of relevance if an attempt is to be made to decide between '[Dr B's] version of events' and the '[Dr C's] version'. If as [Dr C] suggests, [Dr B] did about half of the abdominoplasty I would stay with my original conclusion that [Dr B] must accept most of the responsibility for the bad outcome. If he did not do any of the abdominoplasty then I would change my view somewhat to [Drs B and C] sharing responsibility for that aspect of [Mrs A's] complaint. This is on the basis that [Dr B] was the 'lead surgeon' for the three procedures in addition to being the surgeon to whom [Mrs A] was referred and with whom she consented for all 3 operations.

In terms of [Dr B's] qualification and experience, my view would be the same as that expressed in Dr Pfeifer's letter. The only minor modification to my 2004 report I would like to make would be to reword the last sentence of the paragraph entitled '[Dr B] 1. Qualifications and experience'. This is to make the meaning quite clear. It would now read: 'In electing to perform these procedures which are not part of 'core general surgery', he must accept that his

colleagues in plastic surgery are likely to regard any complications as evidence of problems relating to surgical technique'.

[1][16] *The attendance of [Dr E]*

a) [Dr E] [overseas certified] surgeon who was visiting [the city clinic] to learn 'what a modern comprehensive breast centre should look like' prior to developing such a centre [overseas]. She states that [Dr B] agreed to her 'coming [to visit the city clinic] and to observe in the operating theatre'. [Dr E] was clearly a visiting surgeon who had obtained her '[qualifications]' the previous year. As I understand it, if she was to participate in patient care of any sort, she required some form of temporary registration from the Medical Council of New Zealand. In addition, [Dr B] should have obtained consent from any patient whose treatment [Dr E] would be involved with. Without such registration, patient consent and agreement from the hospital her participation was inappropriate.

It would not be appropriate to call a fully trained surgeon a 'nurse assistant' and I would regard doing so as a post hoc attempt to justify her presence as a member of the scrub team. I regard the description of [Dr E] as someone who 'cut sutures and held retractors while learning surgical technique' (her words) as being somewhat disingenuous. My interpretation of [Dr E's] presence at [the private clinic] was primarily to see a 'comprehensive breast centre' in action and to learn about the organisation of such a Centre rather than to learn surgical technique. I am unclear what [Dr E's] exact role was in the operating theatre and whether her level of participation was as planned or resulted from the possible late arrival of [Dr C].

b) Appropriate information about [Dr E] would include her name, status and her degree of participation in the operation. Verbal consent for her presence in theatre would be expected. It certainly seems uncertain whether all these measures were taken, firm evidence either way is lacking.

[2] [*Dr B and Dr C's] responsibilities*

a) I find it incredible that there is no agreement between [Dr B and Dr C] about their status with regard to the operation, whose care [Mrs A] was under, who marked her up, when [Dr C] arrived and what fee [Dr C] received. If it is important enough surely these matters can be resolved by an examination of the evidence.

Responding to the Commissioner's request with regard to the two scenarios described: if scenario 1 applies ([Dr C] was an independent contractor) I would see responsibility being shared equally. Under these circumstances, it would not be appropriate for [Dr C] to arrive late. He should have seen [Mrs A] for a detailed preoperative discussion and should have

[16] Commissioner's note: The numbers in square brackets in this section of Dr Simpson's report relate to the numbers of the questions put to him, as set out above (pages 55–56).

'marked her up' himself. [Dr B] would not be primarily responsible for the abdominoplasty but would be for the breast reduction and liposuction. He would carry the responsibility for any deficiency in these procedures. If scenario 2 applies and [Dr C] was an 'assistant' then the prime responsibility would lie with [Dr B] for all 3 procedures and I would not hold [Dr C] responsible in a major way.

It is possible that neither scenario applied fully and that the real state of affairs lay somewhere between the two. In other words [Dr C] was a consultant surgeon but clearly junior to [Dr B] and effectively an employee of [Dr B]. This would in turn lead to a sharing of responsibility but not equally with [Dr B] carrying the majority of it.

b) In scenario 1 both surgeons probably failed to provide an adequate standard of care. This failure would probably be considered to be in the mild to moderate category.

In scenario 2 [Dr B] would have failed to provide an adequate standard of care but [Dr C] probably would not have failed in this way. [Dr B's] failure would be in the moderate category.

In my third scenario both would have failed to provide an adequate standard of care with [Dr C] at the mild end of the scale and [Dr B] moderate.

[3] *The team approach*

a) There is a growing trend worldwide including New Zealand to use surgical teams rather than individual surgeons for complex major procedures. This reduces the operating time and also the stress on the surgeon; it is a trend to be supported.

b) There are different perceptions about [the appropriate boundaries set for each surgeon]. My view would be based on the wrangling that still continues that there were not appropriate boundaries.

c) I cannot answer this question [as to communication and co-operation between each surgeon]; there is no evidence either way.

d) Record keeping is a vitally important part of surgical care. A detailed record of the operative procedure(s) is perhaps the most important aspect of all. This record should be available in the hospital medical records and in the notes kept by a clinic such as [the private clinic] and in individual surgeons' notes where applicable. With the growth in team care the availability of clinical information continues to grow in importance.

[4] *Limits of competence*

a) [Dr B] clearly believes that he was working within his limits of competence. I believe that he seriously misquotes Mr Pfeifer when he says that Mr Pfeifer states 'that my practice was outside that of the standard practice of a general surgeon'. Mr Pfeifer states that the

curriculum for general surgery does not include abdominoplasty or liposuction. This is a statement of fact.

b) [Dr B] is incorrect in his statement that I have been retired for several years. I remain a vocationally registered general surgeon and continue to have a consulting practice in breast disease. I do not agree with his statement that my comments 'reflect an outdated view' or 'are out of kilter with modern practice'. I spend a good deal of time every week dealing with surgical issues in my role as Executive Director of Surgical Affairs and I am confident that my opinions are contemporary.

c) Dr Pfeifer is grossly misquoted and this requires no further comment.

d) I think that [Dr B] has misunderstood the nature of general surgery in 2005. It is a well defined speciality with a detailed curriculum and not as it was in the past anything that a surgeon wished to do and had had some experience of performing. It is clear that [Dr B's] views and mine could not be more different on this issue.

[5] *Other matters*

a) [Dr F's] opinion: [Dr B's] remarks about a senior anaesthetist giving advice about fitness for surgery and anaesthesia are appropriate. As a general rule, the fitter the patient, in the anaesthetist's view, the more likely the surgeon would be to proceed with a lengthy combined procedure(s).

b) [Dr C] on umbilical hernia problems: Umbilical necrosis is a recognised complication of abdominoplasty but I have no information about the impact of an umbilical hernia on the incidence of necrosis. It seems reasonable to expect that a sutured hernia repair would make ischaemia and hence infarction more likely."

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

1) *Every consumer has the right to have services provided with reasonable care and skill.*

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

RIGHT 6
Right to be Fully Informed

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

   a) *An explanation of his or her condition; and*

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

   …

   d) *Notification of any proposed participation in teaching or research … ; and*

   e) *Any other information required by legal, professional, ethical, and other relevant standards; …*

Relevant Standards

Good Medical Practice – A Guide for Doctors (Medical Council of New Zealand, 2003):

"*The duties and responsibilities of a doctor registered with the Medical Council of New Zealand*

Patients must be able to trust doctors with their lives and wellbeing. To justify that trust, members of the profession have a duty to maintain a good standard of practice and care and to show respect for human life. In particular, as a doctor you must: …

- give patients information in a way they can understand …
- recognise the limits of your professional competence. …
- work with colleagues in the ways that best serve patients' interests ...

Domains of competence …

3. In providing care you must:
   - recognise and work within the limits of your competence: know when you do not know or cannot do capably
   - be willing to consult colleagues …
   - keep clear, accurate, and contemporaneous patient records that report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed

- keep colleagues well informed when sharing the care of patients …

Collaboration

Working in teams

22. Increasingly, multidisciplinary teams provide health care. You are expected to work constructively within teams and to respect the skills and contributions of colleagues. Make sure your patients and colleagues understand your role and responsibilities in the team, your professional status and speciality.

23. If you lead the team you must:
    - take responsibility for ensuring the team provides care that is safe, effective and efficient …

24. When you work in a team you remain accountable for your own professional conduct and the care you provide."

Guidelines for the Maintenance and Retention of Patient Records (Medical Council of New Zealand, October 2001):

"1. Maintaining patients' records

a) Records must be legible and should contain all information that is relevant to the patient's care.

b) Information should be accurate and updated at each consultation. Patient records are essential to guide future management, and invaluable in the uncommon occasions when the outcome is unsatisfactory."

Opinion: Breach — Dr B, Dr C, Dr D

Introduction

Factual issues

As noted at the beginning of this report, some facts regarding Mrs A's surgery remain uncertain, despite extensive and thorough investigation and the surgeons' responses to my two provisional opinions. At this distance in time I consider it unlikely that conflicts in the parties' evidence − particularly as to Mrs A's admission arrangements, the preoperative bedside discussion, the actual time Dr C arrived in theatre, and which surgeon performed the abdominal liposuction − can be definitively resolved through further investigation. In forming my final opinion I have drawn conclusions where I am satisfied that the stated facts are established on the balance of probabilities.

The Code of Health and Disability Services Consumers' Rights

Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) affirms every patient's right to have services provided with reasonable care and skill. Right 4(2) of the Code gives every patient the right to have services provided that comply with relevant standards, including professional and ethical standards. Mrs A's complaint raises the question whether Dr B, Dr C and Dr D provided services of an appropriate standard when they performed her surgery on 9 July 2002. Issues requiring particular consideration in terms of the Code and the above-mentioned Medical Council guidelines are whether the surgeons' level of co-operation and communication was sufficient to enable the provision of safe and effective treatment of an appropriate standard; whether the responsibility of each surgeon was clearly understood; and whether the appropriate limits of their competence were observed.

Right 6(1) of the Code gives patients the right to information that a reasonable patient, in that patient's circumstances, would expect to receive. Doctors are obliged to offer sufficient information at each stage of care, and the provision of information prior to treatment is an essential element of the process of obtaining informed consent. In circumstances where the provision of services will involve a provider being trained or taught, the Code specifically requires the consumer to be informed, pursuant to Right 6(1)(d). Mrs A's complaint about the lack of information provided to her is a significant aspect of this case. Of particular concern is whether she was adequately informed about and understood the risks and potential complications of combining surgical procedures; whether she knew her surgery would involve a "team" approach; and whether she was properly informed about and consented to Dr E's presence as an active assistant to Dr B in the context of preceptorship, observation and/or surgical training. While this report also considers the level of information provided to Mrs A postoperatively, a review of the postoperative care Mrs A received was not part of my investigation.

Responsibility of each surgeon

The first issue for determination is who was Mrs A's lead surgeon. While Dr B accepts he was the lead surgeon for the breast reduction and upper arm liposuction procedures, there is disagreement as to whether Dr B or Dr C had primary responsibility for the abdominal surgery. Both my advisors initially concluded that Dr B was the lead surgeon for the entire surgery, with Dr Blake commenting that "in the case of [Dr C] his presence for only half the operation is unusual to say the least and again I am of the opinion that [Dr B] carries much of the responsibility". Dr Simpson's view of Dr B's role as lead surgeon is unchanged in light of additional evidence subsequently received from Dr C about the nature of his contract with the clinics and his recollection of his degree of participation in Mrs A's surgery.

I agree with my advisors that Dr B was the lead surgeon, with ultimate responsibility for Mrs A's care and coordination of the surgical team. He held the initial discussion with Mrs A at the clinic in June 2002; led the preoperative discussion at her bedside on 9 July; wrote to her GP, obtained her written consent and recorded the only operation note for all procedures performed; and was present for the entire surgical procedure. His role also included ensuring that each surgeon understood their role within the team.

Dr B has suggested that he has been "unreasonably" left to bear "full responsibility" for Mrs A's surgery. That is not so. The Medical Council's guide, "Good Medical Practice", clearly states that when working in a team, each individual remains accountable for their own professional conduct and the care they provide. Both Dr C and Dr D are fully qualified, experienced general surgeons. It is not acceptable for them to claim they are absolved from responsibility on the basis that Mrs A "was [Dr B's] patient". By agreeing to participate in Mrs A's abdominal surgery, Dr C and Dr D each assumed a duty of care to perform it with reasonable care and skill. Accordingly, while responsibility falls − to use Dr Simpson's words − disproportionately on Dr B's shoulders, Dr D and Dr C are each also responsible for their individual actions.

Initially, the evidence obtained indicated that both Dr C and Dr D were "assistants" to Dr B and that they should be held proportionately responsible for their actions on that basis. Additional information provided in response to my first provisional opinion – in particular, from Dr B and Dr E – swayed me towards a different view, that Dr C's role was more significant than that of an assistant and he was, in fact, the consultant surgeon to whom much of the responsibility for the abdominal surgery had been delegated by Dr B, ie, he was in effect "second in command". Dr C's reaction to that evidence in his response to my second provisional opinion, together with Dr Simpson's supplementary advice, indicates that the true position may be somewhere in between.

Like Dr Simpson, I find it very surprising that two experienced surgeons who work together closely in a private surgical clinic cannot agree on so many fundamental issues of one patient's operation, ie, their status, responsibilities, admission procedures, the timing of their attendance and actions in theatre, and their fees. The evidence of Dr C as to his annual leave and surgery schedule at the time of Mrs A's operation also calls into question the administrative and surgical rostering systems in place at the private clinic.

Dr B's advice that Dr C received "the same fees as me for performing 50% of the operative procedure" is in direct conflict with Dr C's statement that he was present for approximately half the total operative period, but performed a minimal proportion of the total abdominal surgery, and received 25% of the total fee. Based on the figures contained in the invoice provided to me by Mrs A that would amount to $2,375.00, a figure that is less than the stated unit cost of the abdominoplasty.

Other evidence is also in direct conflict. On the one hand, Dr B says that Mrs A's surgery involved "two separate teams" and that Dr C's name on Mrs A's wrist bracelet, clinical records and bed indicated that he "was regarded as a full part of the operative surgical team". Later, Dr B also stated that this was intended as a prompt to ensure that upon Mrs A's admission, Dr C would be called to see her preoperatively. Dr B's evidence is that he expected Dr C to discuss the abdominoplasty with Mrs A on her arrival at the private hospital, and take responsibility for the preoperative markings for that procedure.

Conversely, Dr C explained that his name was on Mrs A's identification label because of a "secretarial mistake", while its presence on the intra-operative record and invoice was consistent

with the terms and conditions of his contract as a "full time surgeon with [the private clinic]". I accept these explanations to a point, but am also mindful of the comment of Ms J, the private hospital's check-in nurse, that she had interpreted Dr C's name on Mrs A's label as simply identifying her as a patient of the private clinic.

Dr C is clear that because he was on annual leave on 8 July, his first opportunity to meet Mrs A was the morning of her surgery. He says his limited contact with her was based on his understanding that Dr B had previously discussed "all the issues", including the surgeons' roles. I accept that if Dr C did not expect to lead the abdominal surgery, then it would have been reasonable for him not to have undertaken the preoperative marking or have a more detailed conversation with Mrs A. I also accept that he cannot have returned to the private hospital to participate in Mrs A's surgery until at least 3pm on 9 July. However, I do not believe this should automatically lead me to view Dr C merely as an "assistant" in this case.

Rather, on the basis of the evidence in totality, I consider it reasonable to conclude that Dr C was in effect an employee of the clinics (of which Dr B is a director) and that for the purposes of this particular patient's surgery, he assumed a role that was "junior" to that of Dr B. I accept Dr C's submission that Mrs A's "journey through the clinic" indicates that Dr B was in every respect her lead surgeon with ultimate responsibility for her care. Nevertheless, Dr C's status at the private clinic and his involvement in Mrs A's discharge from the private hospital are also reasons why he cannot avoid some degree of responsibility for what occurred. Whether or not the other patient on whom Dr C operated on 9 July 2002 was also a client of the private clinic, it is reasonable to infer that both surgeons knew that Dr C was "double booked" with roles in two surgeries both commencing just after 1pm that day. A high level of discussion and planning was warranted to ensure that neither patient's care would be in any way compromised by such an arrangement.

The divergence of the two surgeons' views as to Dr C's anticipated and actual involvement in Mrs A's surgery indicates that while Dr B may have expected Dr C to have participated more actively and extensively, this was not properly communicated and understood between them. Both Dr B and Dr C appear to have tacitly accepted this in retrospect; guidelines are now in place at the private clinic for cases involving more than one surgeon, which ensure that it is clearly established who will assume responsibility for each part of the procedure, and who will assume overall responsibility.

On balance, my view is that Dr B was the lead surgeon with overall responsibility for all three of Mrs A's procedures, including the majority of the abdominoplasty, irrespective of whether he performed any of it. I accept, on the basis of information set out in Dr C's substantive response to my second provisional opinion, that his degree of responsibility was not at the level of "second in command". However, he was a consultant surgeon and a full-time employee of the private clinic and he adopted a supervisory role when assisting the completion of the abdominal surgery with Dr D. He reviewed Mrs A in place of Dr B on Saturday 13 July and discharged her from the private hospital. He was scheduled to see her again on Monday 15 July. Overall, I prefer the view adopted by Dr Simpson, that Dr C must share with Dr B responsibility for the abdominoplasty,

but not equally. Dr D was an assistant on a locum contract, and responsible for the standard of surgery he performed while operating under supervision. In the discussion that follows, the surgeons' conduct is judged accordingly.

Surgical decisions and treatment

Dr B

Decision to undertake simultaneous procedures
When Mrs A first met Dr B on 28 June 2002, she asked whether it would be possible to have both her breasts and her abdomen reduced at the same time. In addition, Mrs A wanted to have the size of her upper arms reduced. Dr B suggested that liposuction to Mrs A's upper arms could achieve this. He agreed to simultaneously provide bilateral mammoplasty and abdominoplasty, together with liposuction. It appears that Mrs A perceived this to be cost and time efficient, because she would need less time off work, a single general anaesthetic, and only one hospital admission. I do not believe that she "insisted" on this approach.

Doctors are not beholden to their patient's requests to provide clinically inappropriate services. If a patient asks a surgeon to provide services that the surgeon believes are clinically inappropriate because the risks outweigh the benefits, a responsible surgeon will decline to proceed. Dr B says that he would not have proceeded with Mrs A's surgery had he "not had experience with similar procedure[s], and had [he] not considered that [it] could be performed safely in a simultaneous fashion". In my view, his assessment of the safety of this approach for this particular patient was wrong, as the risks did outweigh the benefits, to the point of it being clinically inappropriate. I agree with my advisors that Dr B made an error of judgement.

Mrs A was overweight with high blood pressure. Dr B's claim that Mrs A did not tell him about her blood pressure problems does not excuse his error of judgement, as it was his responsibility to take active steps at the preoperative consultations to discover such information. Bilateral breast reduction was a major surgical procedure for Mrs A, with risks such as infection, bleeding, necrosis and sensory alteration. Abdominoplasty and upper arm liposuction involve the same risks. Combining abdominoplasty with any other procedure significantly increases the associated risks for each procedure. While noting Dr Simpson's view that, in general, the risks of combining procedures are not an absolute contraindication, the comment of ACC's advisors that "it is not safe practice … but especially not in an obese patient with a high body mass index" is compelling.

In response to my first provisional opinion, Dr B stated that Mrs A's weight did not, in itself, convey an accurate picture of her fitness for the combined procedures. He believed she was "fit and active, notwithstanding being overweight", because she swam every day and climbed stairs regularly in the course of her work. Mrs A assessed herself as "generally fit and healthy" on her "Patient Health Questionnaire for Admission" dated 9 July 2002, the day of her surgery. I accept that Dr B was entitled to rely on Dr F's assessment that day of Mrs A's fitness for anaesthesia and the combined procedures.

However, I do not accept that her perceived level of fitness outweighed the overall risks of a combined surgical approach, in an overweight 51-year-old with high blood pressure. As lead surgeon it was ultimately Dr B's responsibility to make a safe decision to proceed with Mrs A's surgery on the day. In my view that decision was unsafe in circumstances where Dr B knew that Dr C would not be available until part way through the procedure, and when his own time would be predominantly taken up with a major breast reduction as well as a degree of teaching and/or supervision of Drs D and E. Accordingly, Dr B's decision to simultaneously perform two major surgical procedures and liposuction on Mrs A on 9 July 2002 was ill-advised and clinically inappropriate. In relation to this issue, Dr B did not exercise reasonable care and skill, and therefore breached Right 4(1) of the Code.

Participation of Dr C and Dr D

Dr Simpson has stated that it is unusual to carry out simultaneous major elective procedures such as those offered to Mrs A, especially without the assistance of a plastic surgeon. The RACS and Dr Simpson have advised that abdominoplasty and liposuction are not included in the general surgery curriculum. Although there will be occasions when it may be appropriate for a general surgeon to perform them, technically they are cosmetic or plastic surgery procedures.

Dr B, Dr C and Dr D are not plastic surgeons; they are general surgeons with a special interest in breast surgery. I acknowledge that Dr B has previously provided "very complicated liposuction, abdominal surgery and breast surgery" simultaneously to a number of patients, in association with a plastic surgeon. I also accept that Dr B and Dr C have often worked together and provided combined breast reduction and abdominoplasty to "over 200" patients, and that a team approach to surgery for complex major procedures is a positive and growing trend with benefits for both patients and doctors. I note too the comment of Dr D that while any cosmetic procedures with which he assists are "always with a plastic surgeon", he believed that in this case, Dr B and Dr C were "competent in performing the cosmetic procedures to [Mrs A]".

Nevertheless, I must also consider the questions posed by RACS in the assessment of whether it was appropriate for these three general surgeons to provide abdominoplasty and liposuction to Mrs A. I note in particular the following questions: Is the procedure not inherently high risk and without well recognised major complications? Does the surgeon work with a specialist in the 'adjoining' specialty to provide some form of oversight? Has appropriate informed consent been obtained including an acknowledgement that the surgeon is not in the specialty normally performing this procedure? The RACS's advice is that if the answer to any of these questions is "no", then the procedure should be referred on to a surgeon from the appropriate specialty. I consider that the answers were clearly "no" in this case.

While Dr B's own expertise and training may be sufficient to satisfy the RACS criteria, I do not believe that the same can be said for Dr C and D. In my view, Dr B's decision to engage them to perform the abdominoplasty and liposuction − even if under his supervision − was unsafe, unwise, and inconsistent with the Medical Council's guidelines regarding collaboration and team work. In these circumstances Dr B breached Rights 4(1) and 4(2) of the Code.

Assistance of Dr E

In June and July 2002, Dr E visited the city clinic at Dr B's invitation and attended surgery with him at the private hospital. Ms K, the private hospital's instrument nurse, advised that although Dr E first attended surgeries at the private hospital and did not participate, she was later "involved and helping". Dr Simpson is sceptical of Dr E's explanation that she was present at Mrs A's surgery to "learn surgical technique", given that she is an overseas certified surgeon specialising in the treatment of breast disease and, at the time of these events, charged with responsibility for developing a comprehensive breast centre in her home state.

I originally understood that Dr E's involvement in Mrs A's surgery was limited to that of an observer and that this was the basis on which she had been introduced to Mr and Mrs A during the preoperative bedside discussion. None of the initial statements provided to the Commissioner by Dr B, Dr C or Dr D mentions Dr E. I accept Dr D's submission that this was an honest omission on his part, on the basis that as lead surgeon, it was Dr B's responsibility to inform me about Dr E's presence and actions. In this respect it is relevant that neither Dr B's operation note nor the intra-operative record refers to her, although in the latter, it is possible that the letter "[..]"next to the heading "Professional Visitor" is an abbreviated or incomplete reference.

In statements provided to me in January and March 2005, Dr E acknowledged that she was "actively involved in [Mrs A's] reduction mammoplasty as [Dr B's] assistant". Dr E also said that Dr B made arrangements for her "temporary surgical privileges" while in New Zealand. Those arrangements should have included obtaining the approval of the hospital manager at the private hospital in accordance with the hospital's policies, "Registration Guide for Visiting Practitioners" and "Other Healthcare Professionals' Access to Practice", and ensuring that Dr E had appropriate temporary registration with the Medical Council of New Zealand. The Council advised me that it received no application for registration for Dr E and that no practising certificate has been held in her name.

The current clinical manager at the private hospital says it is "clear" from notes on the hospital's file that Dr B gained the approval of the hospital manager at the time and that Dr E was permitted to attend surgery as a "professional assistant". Dr B has also said that the hospital manager was "fully aware" of Dr E's status and that he had relied on the manager to advise him as to the "correct procedure". In my opinion, there is no conclusive evidence either way in relation to these matters.

Retrospectively, Dr B has described Dr E's attendance as that of a "nurse assistant" and explained that he did not seek to register Dr E temporarily with the Medical Council because her role "was not that of a surgeon, i.e. she did not perform any active procedures, did not see any patients alone and was always introduced as an observer and assistant". In my view this explanation is questionable. I agree with Dr Simpson that while Dr E's exact role and level of participation is unclear, to call her a "nurse assistant" when she is a fully trained surgeon is inappropriate.

Dr B was responsible for ensuring that appropriate approval and temporary registration had been obtained to legitimise Dr E's attendance and any participation in surgery on his patients. It was insufficient for him to rely solely on the private hospital's manager. In any event, my review of the private hospital's policies in place at the time suggests that they were insufficient to accommodate the attendance of a foreign-registered visitor. In this respect, it is relevant that the Medical Council has recently informed Dr B that *he* must seek Council's advice if he has any doubt about a visiting medical practitioner's status in the future.

In these circumstances Dr B's decision to allow Dr E to participate in Mrs A's surgery was a breach of Right 4(2) of the Code.

Bilateral mammoplasty

Dr B performed Mrs A's bilateral breast reduction with the assistance of Dr E. Mrs A suffered significant complications, scarring, disfigurement and pain in the weeks immediately following her discharge from the private hospital in July 2002, and for many months afterward. My advisors, Dr Blake and Dr Simpson, viewed postoperative photographs of Mrs A's surgical sites, taken by Mr A. On the basis of those photographs and the "descriptive picture" indicated by ACC's advisors, they considered that Mrs A's breast surgery was not carried out to an appropriate standard. I agree.

According to his operation note, Dr B removed 2.2kg of tissue from each of Mrs A's breasts, which produced "a long pedicle which was shortened with an interrupted Vicryl stitch". The view of the two experts who examined Mrs A and advised ACC is that as a result of this procedure, she has a "grossly disfigured" right breast, with approximately 75 percent loss and distortion of the breast tissue and "significant scarring". Mrs A developed infection and necrosis of her right nipple, which became so severe that the nipple was removed. Dr Blake noted that while the risks of fat necrosis and infection are "relatively common" in obese patients, they do not alter the long-term result. However, nipple necrosis is rare, and usually associated with "a pedicle which is too long, or tension in the overlying skin flaps, both of which can compromise the blood supply to the nipple". Both of these risk factors were present in Mrs A's case. She had a long pedicle (either 36 or 38cm according to Dr B's records), which he attempted to shorten. Dr Blake advised that this would have compromised blood supply to the nipple, while the manner in which Dr B everted Mrs A's nipples further compromised viability. Dr Blake concluded that Mrs A's nipple necrosis was "possibly" preventable, and that Dr B's surgical judgement was a factor in this.

Similarly, Dr Simpson remarked that "skin infarction is usually due to impaired blood supply, generally a technical failure. This suggests that [nipple necrosis was] potentially preventable." He considered whether the outcome for Mrs A was "simply an unusual but well recognised complication occurring from time to time, as such things do through no more than bad luck". He concluded that this was not the case, and described the standard of Mrs A's breast reduction as a "significant departure from best practice".

Dr B disagrees with the views of my advisors, and says that by suturing the pedicle, he stabilised it and prevented undue tension being placed on the blood vessels. He also disputes the ACC advisors' assessment of the degree of Mrs A's right breast tissue loss. The fact remains that the blood supply to Mrs A's nipple *was* impaired. I accept Dr Blake and Dr Simpson's conclusions. Dr B failed to perform Mrs A's bilateral mammoplasty with reasonable care and skill, and breached Right 4(1) of the Code.

Upper arm liposuction
Dr B refers to this procedure only briefly in his operation note, stating that "liposuction was performed on both upper arms after infiltration with local anaesthetic plus adrenalin solution. 500ml was removed from each upper arm." Dr B is clear that he had "responsibility" for this procedure and performed it.

Dr de Chalain saw the results and remarked: "[They] are not impressive and I believe it is because the wrong procedure was performed. In my opinion what was required was a brachioplasty, which is to say, a resection of the skin and fat. Skin which is thinned and stretched with age and obesity will not 'take up' well after liposuction and this, I understand, was not fully explained to the patient, contributing materially to her subsequent dissatisfaction with a mediocre result." Mrs A was subsequently advised against further liposuction, and understood from Dr G that her "tissue type made it dangerous". Dr G's view was in keeping with Dr de Chalain's opinion, that the nature of Mrs A's skin meant that further liposuction would not have the desired effect.

Dr Blake agreed that liposuction was "ill-advised" for Mrs A's arms, for the same reason. He also noted that brachioplasty would have produced a far better result but, in any event, upper arm liposuction "should not have been carried out simultaneously with [Mrs A's] other procedures".

Dr Simpson advised:

> "[T]here would be few general surgeons who would regard liposuction of the arms as a regular part of general surgery. If a surgeon strays outside the accepted boundaries of his/her speciality the question will always be asked whether the procedure would have been done better by another specialist working within his/her own field. In this instance my answer is that there is a very high probability it would have been done better."

Consistent with this, in his supplementary advice, Dr Simpson amended his earlier conclusion that Dr B had "strayed significantly outside the generally accepted boundaries of general surgery", to make the qualification that in electing to perform a procedure that is not part of "core general surgery", Dr B "must accept that his colleagues in plastic surgery are likely to regard any complications as evidence of problems relating to surgical technique".

"Good Medical Practice" makes clear that a doctor is expected to work within and recognise the limits of his professional competence – "know when you do not know or cannot do capably". I have carefully considered whether Dr B complied with this professional standard. I have taken

into account the advice of RACS regarding the appropriateness of a general surgeon performing a cosmetic procedure such as liposuction. I have noted in particular the extent of Dr B's training in liposuction techniques and his advice as to the number of liposuction procedures he has performed. I agree with Dr Simpson that Dr B's dispute with Dr Pfeifer's advice is based on Dr B having misquoted a statement of fact. I have weighed Dr Simpson's revised advice on Dr B's qualifications and experience in light of the opinion of Dr Blake, who says that while Dr B has had no formal training in plastic surgery, he has worked with and visited plastic surgeons and attended "appropriate" workshops and courses and thus is "undoubtedly qualified to perform … liposuction". On balance, I accept that in appropriate cases it is, to use RACS's words, "probably acceptable" for Dr B to perform upper arm liposuction.

However, plastic surgeons Dr Blake and Dr de Chalain are clear that this was not an appropriate case because of Mrs A's age and the original condition of her skin. I consider that the decision to provide upper arm liposuction to Mrs A should have been made in consultation with a plastic surgeon. In this instance, Dr B overstepped the boundaries of a general surgeon; performed a procedure that was inappropriate for his patient's circumstances; and did not perform it to an appropriate standard. In respect of these matters Dr B breached Rights 4(1) and 4(2) of the Code.

Dr B, Dr C, Dr D

Abdominoplasty, abdominal liposuction and hernia repair

In a letter to Dr H dated 28 June 2002, Dr B said Mrs A would require "an apronectomy in routine fashion with tightening of the underlying musculature. In association with this she would like to have … liposuction of the hips." There are disparate accounts of this aspect of the surgery.

Dr B and Dr E say they performed no part of the abdominoplasty and that it was undertaken by Dr C and Dr D. Dr D initially said that Dr B commenced the abdominoplasty with his assistance, and that when Dr C arrived he supervised its completion. Subsequently, however, Dr D has concurred with Dr E that Dr C was present for the "majority" of the abdominoplasty. Dr C says he arrived around 3pm, to find Dr D at the abdominal wound and the abdominal apron excised and excess abdominal tissue removed. Dr B and Dr C disagree as to who discovered the hernia, although it is agreed that Dr C and Dr D worked together to repair it, before closing the abdominal wall. The surgeons cannot agree or do not recall who performed the abdominal liposuction; only Dr D suggests that this was done by Dr C.

Dr B's operation note provides little assistance. It refers very briefly to the umbilical hernia, stating "unusual findings at surgery in the abdomen were an umbilical hernia which was repaired". Dr C informed me that this "clearly needed repair to prevent strangulation of abdominal content. This was always going to be a procedure with significant attendant risk for the viability of the umbilicus but one that had to be performed." This risk subsequently eventuated.

Dr Blake advised me that an umbilical hernia is usually small, and with careful technique can be repaired without compromising the blood supply to the umbilical pedicle. He noted that obesity of

the abdominal wall precludes detection of a hernia preoperatively and, accordingly, surgeons performing abdominoplasty should always beware of encountering such a complication. On this basis, I accept that the presence of the hernia was not a contraindication to performing or completing Mrs A's abdominal surgery, and it was appropriate for Dr C and Dr D to repair it.

However, none of the surgeons made contemporaneous notes about the way in which the repair was conducted, or the length of the umbilical pedicle adjacent to it. In response to Mrs A's complaint, Dr C stated that necrosis may have occurred because the blood supply "was obviously inadequate and this may have been related to a combination of the surgical repair of the umbilical hernia and then the suturing of the umbilicus through the new umbilical opening and this created some degree of tension given the thickness of the abdominal wall". Dr Blake advised me that if Mrs A had a very long pedicle which was reinserted with tension, hernia repair adjacent to the base of the pedicle could have been an additional factor contributing to the necrosis. Dr Simpson also states that it seems reasonable to expect that a sutured hernia repair would make ischaemia and infarction more likely.

Mrs A's umbilicus was lost, and she now has a severely scarred abdomen, the contour of which is abnormal and distorted. She required extensive physiotherapy and is so traumatised that she is currently receiving psychiatric rehabilitative care to prepare her for reconstructive surgery. Dr de Chalain described the overall result of the abdominal surgery as "completely unacceptable" and remarked that he had "seldom seen such an unfortunate outcome from what should be, in properly trained hands, (even allowing for the fact that none of the surgeons involved are bona fide plastic surgeons), [a] reasonably simple plastic surgical procedure". My advisor Dr Simpson agreed that "the outcome of these procedures done for cosmetic reasons was far from good. Everything points to this being a preventable situation with virtually all the problems stemming from the way the surgery was performed."

I cannot resolve the factual conflicts arising from this component of Mrs A's surgery. If I were to accept that Dr B was "entirely concerned and occupied" with the bilateral breast reduction and did not perform "any part" of the abdominoplasty, and that Dr C did not arrive in theatre until at least 3pm, then I would be obliged to draw the inference that Dr D had begun the abdominal surgery on his own without supervision –which he denies. However, if I were to accept Dr D's evidence that his role was limited to that of an "assistant" and that Dr B provided "direct supervision" until Dr C's arrival (at around 3pm), then it would beg the question whether Dr E was yet more involved in the "very large" bilateral breast reduction than she and Dr B have acknowledged. If Dr B was in fact focused on performing the mammoplasty and demonstrating surgical technique to Dr E, it is difficult to see how he could have adequately supervised Dr D at the same time.

It seems that Dr D did participate in the abdominoplasty before Dr C's arrival, and then assisted in the completion of the procedure under Dr C's supervision, having assisted him with the hernia repair. Given the extensive conflicts in the evidence I am unable to draw any further factual conclusions on this issue. It is of concern that three experienced surgeons participated in a major

surgical procedure yet cannot agree who performed specific aspects. I concur with Dr Simpson that based on the worrying degree to which the surgeons' recollections are inconsistent, there cannot have been appropriate and clear boundaries set for the role and tasks of each in the surgery overall. As "Good Medical Practice" makes clear, effective collaboration and team work requires an understanding between colleagues as to each person's role and responsibility. In this case, such understanding appears to have been lacking.

Moreover, abdominoplasty is a cosmetic procedure and is not an accepted part of general surgery. Dr C and Dr D were not properly qualified to perform an abdominoplasty. Even if Dr B's experience and training in abdominoplasty was sufficient to enable him to perform the procedure himself for a suitable patient − a matter which my experts, particularly Dr Simpson, dispute − I consider that it was most unwise for him to engage Dr C and Dr D to perform it in Mrs A's case.

Ultimately, each surgeon was responsible − to a degree proportionate to their overall role in the surgical team − for ensuring that the abdominal surgery was provided with reasonable care and skill, irrespective of who performed specific aspects. Abdominoplasty was a major surgical procedure for Mrs A and, given her weight and her medical history, it was inappropriate to combine it with any other procedure. Combining it with abdominal liposuction undoubtedly contributed to the three-month delay in her wounds healing. Performing it in these circumstances in the absence of a plastic surgeon was irresponsible. Accordingly, in relation to these aspects of Mrs A's surgery, I conclude that Dr B, Dr C and Dr D breached their duty of care and professional standards and therefore breached Rights 4(1) and 4(2) of the Code.

Patient information

Dr B

Preoperative information
Mrs A received information about bilateral mammoplasty from two sources preoperatively, Ms I and Dr B. Ms I provided verbal and written information; the latter was considerably detailed. It was appropriate and reasonable for Ms I to have taken responsibility for this aspect of Mrs A's preoperative counselling.

As lead surgeon, it was ultimately Dr B's responsibility to provide Mrs A with sufficient information to enable her to make an informed choice about a combined surgical approach. In other words, Dr B was obliged to inform Mrs A about what was clinically appropriate for her particular circumstances.

Mrs A signed the "Agreement to Treatment" section of the "Patient Admission Form" on 3 July 2002, recording that she had received "a reasonable explanation of the intent, risks and likely outcomes" of the surgery and accepted Dr B's advice regarding the procedure to be carried out. However, a patient's signature on a form is not in itself proof that all necessary information has been provided, in a way that enables the patient to understand it.

Under the Code, Dr B was obliged to provide Mrs A with information about the available surgical options, expected risks, side effects and benefits. Mrs A specifically asked about risks. Dr B says he informed Mrs A about the risks of each procedure, and the general risks associated with anaesthesia. He says he also explained that there were additional risks involved in performing the procedures simultaneously. Options and alternatives were outlined – for instance, Mrs A was made aware that if she wanted all three procedures at once, she would have to travel to the city, whereas bilateral mammoplasty alone could be performed in the provincial town. I am not convinced by Dr B's suggestion that his advice to Mrs A that she needed to be in the city to receive the combined surgery was in itself sufficient to effectively convey to her the heightened degree of risk involved.

Mrs A recalls being told about the risks of infection, and receiving written information about breast reduction. I am not persuaded that Dr B discussed brachioplasty as an alternative procedure for Mrs A's upper arms, as he has claimed. Nor does Dr B appear to have sufficiently emphasised that combining abdominal liposuction with abdominoplasty carried an increased risk of the development of seroma and necrosis in the postoperative period.

Dr B attempted to explain the technical details of the surgical procedures to Mrs A, but she did not want to receive this level of information. I agree with the advice of my expert Dr Blake that if a patient does not wish to know the *details* of how surgery is going to be performed, then "there is no need to inflict these". However, it was important for Dr B to explain to Mrs A the nature of the surgery requested (including that abdominoplasty and liposuction are technically deemed cosmetic/plastic surgery procedures), and who would be performing her surgery. Dr B should have explained the roles and qualifications of Dr C and Dr D, the extent to which they would be involved in the abdominal surgery, and that they were not plastic surgeons. I note RACS's concern that "appropriate informed consent" should be obtained from the patient "including an acknowledgement that the surgeon is not in the specialty normally performing this procedure". All of this information would have enabled Mrs A to make a fully informed choice whether to proceed. It was not provided.

Dr B was also specifically required to inform Mrs A that Dr E was attending her surgery, and why. Mr and Mrs A say that during the preoperative bedside discussion, Dr B told them Dr E was present "to observe New Zealand practices". It is not clear whether he also advised that Dr E would be present and assisting in theatre, although that is Dr E's own recollection of how she was introduced. Significantly, Mrs A was concerned that her permission for Dr E's attendance was not sought. I believe that Dr E's role and status, and the reason for her presence, were not made clear to Mrs A, and that Dr B failed to obtain Mrs A's consent to Dr E's participation in the surgery.

Overall, I am not satisfied that Dr B provided balanced or adequate information about a combined surgical approach. Mrs A's impression was that Dr B was "happy" to perform all her surgery at the same time and she was reassured by his opinion that she was a "perfect" or "excellent" candidate for breast reduction surgery. These comments, also made in Dr B's letter to

Dr H dated 28 June, and directly to Mr and Mrs A preoperatively on 9 July, have been the subject of particular criticism by the experts advising the Commissioner and ACC.

Dr Blake was concerned that Dr B's description of Mrs A as a "perfect candidate" was inaccurate and swayed her expectations as to the success of her surgery. Dr Blake said that because Mrs A was overweight and had marked abdominal redundancy, "while a breast reduction would definitely be beneficial for her she was hardly an excellent candidate. An excellent candidate is a person who has large breasts, way out of proportion to their overall body size." Dr Simpson also noted that if Dr B told Mrs A she was "the perfect candidate" for any elective cosmetic surgery procedure, he "was unwise to say the least, in terms of her expectations". Dr McEwan, advising ACC, said such a comment would "tend to trivialise the appropriate risks that Mrs A was going to encounter and increase expectations unreasonably".

Dr B acknowledges that he described Mrs A as an "excellent candidate" for bilateral breast reduction, but has qualified this by saying his intention was to convey that she was a genuine medical candidate for whom the benefits would be physical as opposed to purely cosmetic. Even if this explanation is accepted, it is doubtful that the qualified meaning would have been obvious to either Mrs A or Dr H.

Dr B does not accept that in relation to the liposuction and abdominoplasty, the information he provided raised Mrs A's expectations "unreasonably". He denies that he told Mrs A that she was an "excellent candidate" for these procedures. However, it is notable that Dr E's impression, having observed Dr B's preoperative bedside discussion, was that Mrs A *was* an "excellent candidate" for abdominoplasty. This suggests that Mrs A may have formed the same impression having heard Dr B's advice. I infer that Mrs A's expectations *were* high as a result of Dr B's preoperative information – and not, as Dr B attempts to suggest, because she had an unrealistic expectation irrespective of the information he had given her.

I believe that Mrs A would not have consented to a combined surgical approach had she received adequate, balanced information. She was influenced by Dr B, who "at no time indicated that [this] was unusual, carried greater risks or posed a greater threat to the likely outcome". That Dr B's preoperative advice was inadequate is evident from Mrs A's comment that she did not comprehend the significance of her combined surgery until her admission to the private hospital, when it was pointed out to her by someone else, and her belief that she would require only three weeks off work. Dr B failed to convey a balanced assessment of the risks and benefits of simultaneous surgery, together with a frank explanation of the qualifications, responsibilities and status of the surgeons who were to be involved. In these circumstances, Dr B breached Rights 6(1)(a), (b), and (d) of the Code.

Postoperative information

Mrs A had the impression that after her discharge from the private hospital, Dr B transferred her postoperative care to Dr G in the provincial town. Mrs A complained that this was not explained

to her and she is understandably distressed that Dr B did not call her or schedule postoperative appointments with her, to check on her progress.

As a team, Dr B, Dr G and on occasion Dr C rotated consultations between the city clinic and provincial clinic. Mrs A saw Dr G on a regular basis once her complications developed, and was seen by Dr B at the private hospital only on the two subsequent occasions when her complications required surgical management. There is no evidence that Dr B actually transferred Mrs A's care to Dr G. It appears that there was an informal "shared care" arrangement between them. However, this arrangement was not explained to, or understood by, Mrs A. It is unacceptable for a patient to be left in the dark about who is responsible for their postoperative care. I agree with Dr Blake that Dr B's "casual" manner may well have influenced Mrs A's perception that her care had been handed over to another surgeon and that he was unaware of, or unconcerned about, her postoperative complications.

Mrs A experienced (in Dr Simpson's words) severe and unexpected morbidity from what are individually usually safe and satisfactory procedures. She was naturally very upset and worried. She expected Dr B, as her lead surgeon, to help her understand what was happening, and why. I agree with Dr Simpson's advice that "[i]t is an expected part of the total care of a patient with complications to give as much of an explanation as possible as to why they have occurred. Often the doctor may not know the reason but as much information as possible should be given." Physicians have a duty to be open and honest, and patients have a right to full disclosure when something goes wrong. The omission of information about the outcome of an operation calls into question a doctor's professional conduct.[17]

Dr B should have personally explained to Mrs A the results of her surgery and nature of her complications. He should also have advised her of the plan for her postoperative management, including the shared care arrangement. This was information that Mrs A wanted to know and was legally entitled to receive. I consider that Dr B's failure to provide this information in the postoperative period was a breach of his professional and ethical duty. Accordingly, Dr B breached Rights 4(2), 6(1)(a) and (e) of the Code.

Record-keeping

Dr B and Dr C

The obligation to maintain adequate patient records, which contain "all information that is relevant to the patient's care", is set out in the Medical Council's "Guidelines for the Maintenance and Retention of Patient Records". The guidelines specifically state that patient records are "essential

[17] See *Skidmore v Dartford and Gravesham NHS Trust* [2003] UKHL 27, House of Lords; Commissioner's Report 03HDC05563 (www.hdc.org.nz); and *Director of Proceedings v T*, Health Practitioners Disciplinary Tribunal, Decision No. 18/Med04/01D (www.hpdt.org.nz).

to guide future management, and invaluable in the uncommon occasions when the outcome is unsatisfactory". In circumstances where a patient's care is to be managed by a number of providers in different locations, it is particularly important that the clinical records contain all information relevant to the patient's care, that notes are updated at each consultation, and that they are accurate. These obligations are affirmed by Right 4(2) of the Code.

I am concerned that the clinical records kept by Dr B and his colleagues were, on occasion, inadequate. For example, Dr B's operation note dated 10 July 2002 does not refer to the D-wire in Mrs A's right breast or the removal of tissue for histology; it is unclear from the records and operation note which surgeon carried out each aspect of the surgery, particularly the liposuction; the means by which the hernia was repaired and the length of the umbilical pedicle are not recorded; and there is no mention of the presence of Dr E. The intra-operative record completed by one of the private hospital theatre nurses does not show Dr E's name; only the letter "[…]" is entered next to the heading "Professional Visitor". The "Agreement to Treatment" section of the "Patient Admission Form" is inconsistent in that the portion signed by Dr B describes the procedure to be carried out as "bilateral breast reduction, abdominoplasty, [and] liposuction to upper arms" (and does not mention abdominal liposuction); whereas the section signed by Mrs A refers to "breast reduction/ abdo'plasty/liposuction to the both side[s] of my body" (sic) and does not refer to the upper arms. The discharge summary dated 24 July does not say whether Mrs A was prescribed antibiotics to assist with her postoperative recovery.

The digital photographs of Mrs A's breasts, taken by Dr C preoperatively at Dr B's request, were not retained. Dr C stated that it is his usual practice to obtain preoperative and postoperative photographs so as "to enrich the medical documentation". However, in this case he deleted the images after a week, because he was to have "no input into this patient's ongoing care". I find this explanation surprising, particularly as Dr C ultimately discharged Mrs A from the private hospital and, as a full-time employee of the city clinic with responsibilities that extended to the shared care arrangement with the provincial clinic, he could very well have had further involvement in her postoperative management. Moreover, having taken the photographs, Dr C had a professional duty to ensure they were retained and placed on Mrs A's file. As Dr Simpson has noted, with the growth in team care, the availability of clinical information is of vital importance.

I consider that in relation to these matters, both Dr B and Dr C failed to meet the standards expected of experienced surgeons participating in a major surgical procedure in a private hospital. Accordingly, they breached Right 4(2) of the Code.

Opinion: No Breach — Dr B

Preoperative marking

Mrs A questioned the standard of the preoperative markings drawn on her body before her surgery on 9 July, describing them as "messy" and "casual". Mr and Mrs A recall Dr B speaking to other people in the room while at the same time drawing "free hand" lines on Mrs A's breasts, upper arms, and possibly her abdomen, without making measurements, and on occasion crossing out lines and redrawing them.

Dr B has confirmed that he marked Mrs A's breasts and upper arms. He says he did not mark her abdomen, as this was Dr C's responsibility. Dr E states that Dr B was not present when she observed Dr C marking Mrs A's abdomen for the abdominoplasty and discussing the procedure with her "in general terms". Dr C is adamant that Dr E's recollection is either an "intentional misrepresentation of the truth or a significantly inaccurate recollection", and is certain he performed no preoperative markings at all. He says he watched while Dr B made all the relevant markings, including on Mrs A's abdomen. In light of these divergent accounts (in itself a matter of concern), I cannot be sure whether abdominal markings were made, or by whom. My opinion on this issue is therefore limited to the accuracy and appropriateness of the breast markings made by Dr B.

The digital photographs of Mrs A's breasts, if taken by Dr C after the markings were made, may have provided useful evidence of the nature of the breast markings. However, the photographs have been destroyed. I am therefore reliant on my experts' advice as to the requirements of preoperative marking. Dr Simpson says that preoperative skin marking is a guide to the surgical incisions and "is done in different ways by different surgeons. There is no absolute right or wrong." Dr Blake commented that "usual practice" is for breast reduction markings to be performed free hand, with the patient sitting. He explained that frequently a pattern is used to aid marking, and "a ball point pen is preferable for the preliminary sketch plan before using a permanent marker as this produces a tidier result". A measuring tape is usually used to ensure the nipples are positioned an equal distance from the sternal notch and from the midline of the sternum. Abdominal markings are performed with the patient standing, again free hand.

In light of my advisors' comments, I consider that Dr B's approach to the preoperative marking of Mrs A's breasts, while apparently casual in manner, was nevertheless within accepted standards and that he did not breach the Code in relation to this issue.

Opinion: No Breach — Dr C and Dr D

Information

Dr C

Dr C first saw Mrs A on 9 July. There is conflict regarding the extent of his interaction with her at the preoperative bedside discussion that morning. Dr B's evidence is that Dr C confirmed with him that abdominoplasty was appropriate for Mrs A. Dr E says she observed Dr C discuss the procedure with Mrs A in general terms. However, Dr C is adamant that he was introduced to Mrs A and shook her hand and this was the limit of his involvement. He reinforced this by adding that in a "corridor conversation" shortly thereafter, he accepted Dr B's explanation regarding Mrs A's procedures being performed simultaneously and "just having met her … was not going to question this any further".

It seems strange that Dr B would have expected Dr C to confirm that it was "appropriate" to perform the abdominoplasty, given that he had already made that decision and obtained Mrs A's consent to the procedure (and she had signed the "Patient Admission Form"). Dr B's comment is also surprising given Dr C's advice that when he asked why the procedures were to be provided simultaneously, Dr B explained Mrs A's wishes. On the evidence available I consider it probable that Dr C's interaction with Mrs A at the preoperative discussion was limited and general in nature, as he believed that preoperative information as to the risks, benefits, possible complications, and the roles of the surgeons, had already been explained by Dr B in his capacity as lead surgeon. He also believed that Mrs A "was [Dr B's] patient" and that he was an assistant only. I accept Dr C's submission, in response to my second provisional opinion, that he *would* have had preoperative visits with Mrs A, counselled her, and obtained her informed consent himself, had he been fully responsible for the abdominoplasty.

While it is unfortunate that Dr C did not take the opportunity to confirm with Dr B the extent of his surgical role and responsibility, I am nevertheless satisfied that his responsibility for providing preoperative information to Mrs A was minimal. Accordingly, Dr C did not breach the Code in relation to this matter.

Dr D

In response to my first provisional opinion Dr D clarified that he did not meet Mrs A preoperatively. I accept Dr D's evidence on this issue. Accordingly, the question of his responsibility for providing Mrs A with preoperative information and his compliance with the Code in this regard does not arise.

Other comments

In the course of this investigation it has become apparent that the policies in place at the private hospital in July 2002 regarding the "casual" attendance of health professionals visiting from overseas may have been insufficiently robust to ensure that they were appropriately registered. These policies placed responsibility on the hospital manager to ensure that appropriate documentation – such as a practising certificate and insurance – was obtained. The information provided in this case indicates that the level of consultation and understanding between the private hospital's manager at the time and Dr B was insufficient, and appropriate documentation was lacking. This led to Dr E participating in Mrs A's surgery without appropriate temporary registration with the Medical Council of New Zealand. I recommend that the private hospital review its policies regarding visiting practitioners to ensure that such a situation does not recur.

Actions taken

Dr B
On 28 February and 1 March 2005, the Medical Council undertook a review of Dr B's competence to practise. In deciding to conduct this review, the Council took into account the Commissioner's notification of the investigation of Mrs A's complaint. The competence review had a broad scope, including assessment of Dr B's standards of practice, processes for obtaining informed consent, and record-keeping.

The Medical Council has advised me that the Performance Assessment Committee believed Dr B was practising at the required standard, but it had made some recommendations as to areas in which he needed to upskill. A decision whether Dr B is required to undertake an educational programme has been deferred pending his report back to the Council on education he has undertaken to improve his communication skills and oncological management, and whether he has made any changes to his informed consent processes.

Dr B has provided a written apology to Mrs A in which he expressed regret that she suffered from serious complications and a long period in recovery.

Dr C
In response to my first provisional opinion, Dr C provided a written apology to Mrs A in which he stated:

> "I would like to place on record my sincere apologies for the problems you have had after your surgery through [the clinic]. I apologise for the breaches of the Code as outlined by the Health and Disability Commissioner. I am sorry also that I was not involved in your preoperative planning and in your postoperative care."

Dr D

Dr D provided a written apology to Mrs A, in which he stated: "Complications do occur but I would not want to wish on any one to go through what you have over two years … I do feel for you."

Dr D advised that since these events, his practice is:

> "to stay in the mainstream of general surgery in the areas I am specifically trained in. … Any cosmetic surgery combined with a general surgical procedure is performed with a plastic surgeon. I have made a conscious decision to ensure I practice in this way and will continue to do so."

In relation to my proposed recommendation that he review his practice in relation to record-keeping and information he provides to patients, Dr D advised:

> "I have changed my practice in that I keep my own records outlining the specific details of any procedure I am involved in as an assistant. I was not involved in [Mrs A's] preoperative care and therefore was not in a position to give her any information. However, I always advise my patients clearly of the risks and complications of any procedure. If a complication does occur it is my usual practice to sit down with the patient and go through the options of management, and I always express my regret that the complication has occurred … Prior to [this investigation] I was unaware of the complications which [Mrs A] suffered. Had I known I would not have hesitated to contact her to apologise at that time. After the complaint was lodged, I was unsure whether that was appropriate."

Dr D reiterated many of these comments in his response to my second provisional opinion and also advised that he no longer does any work for the city clinic. He said: "I have no doubt that I practice well within the requirements of the [Royal Australasian College of Surgeons] … I have certainly learnt from this [investigation] process."

Concluding comments

In July 2002, Dr B, Dr C and Dr D were each experienced consultant general surgeons. It is unacceptable that they failed to coordinate their roles and responsibilities within the combined surgical team, and that they did not ensure that Mrs A received safe and effective treatment of an appropriate standard. In the course of this investigation, they have each questioned their individual responsibility for their professional conduct and care. Their responses have been to varying degrees disappointing.

It is entirely understandable that Mrs A should feel significant grief and distress about what happened to her, particularly in the absence of any clear explanation or contemporaneous apology

from Dr B as to the results of her surgery and nature of her complications. I extend my sympathies to both Mrs and Mr A for the trauma and upset they have experienced.

Recommendations

I recommend that Dr B, Dr C and Dr D review their practice in light of this report, particularly in relation to their role and responsibilities in combined surgical procedures, the provision of information to patients, and record-keeping. I recommend that Dr B continue to take steps to improve his communication skills.

Follow-up actions

- Dr B and Dr C will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any action should be taken.
- A copy of this report will be sent to the Medical Council of New Zealand, ACC, the Royal Australasian College of Surgeons, the city clinic, the private hospital, and Dr Tristan de Chalain.
- A copy of this report, with details identifying the parties removed, will be sent to the New Zealand Private Hospitals Association and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes, upon completion of the Director of Proceedings' processes.

Addendum

The Health Practitioners Disciplinary Tribunal found that Dr B failed to gain informed consent from Mrs A; failed to maintain adequate records; and failed to provide adequate post-operative information. Dr B appealed the Tribunal's finding of professional misconduct. The appeal against the Tribunal's substantive decision was allowed, but only to a limited extent – one finding in relation to a sub-sub-particular of the charge being set aside. Otherwise, the Tribunal's substantive findings stand. The High Court substituted a fine of $5,000 for the $7,500 fine imposed by the Tribunal. Other penalties imposed by the Tribunal, including a recommendation of a competence review, were not disturbed on appeal. The Director was entitled to costs on the appeal, it having been largely unsuccessful.

The Director of Proceedings decided not to issue proceedings in relation to Dr C.