Dr B

A Report by the

Health and Disability Commissioner

(Case 01HDC02274)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Ms A	Consumer
Dr B	Provider / General Practitioner

Complaint

On 1 March 2001 the Commissioner received a complaint from Ms A about Dr B. The complaint is summarised as follows:

- *Dr B failed to adequately explain the risks of surgery to Ms A before removing a tattoo from her right shoulder in November 1999.*
- *Dr B said that the risks of scarring were minimal. Ms A has since learned that the risks of scarring with this particular type of tattoo removal are inevitable.*
- *Ms A would not have agreed to proceed with the surgery if she had known of these risks.*
- *Dr B's post-operative care was inadequate. He instructed Ms A to wear an elastic tube bandage for one month only. Ms A has been advised that she should have worn a pressure bandage for several months after surgery.*

An investigation was commenced on 9 May 2001.

Information reviewed

- Relevant medical records and information from Dr B
- Report from independent dermatologist Dr Amanda Oakley
- Notes from telephone interview with plastic surgeon Dr Earle Brown

Information gathered during investigation

Initial consultation
Dr B is a general practitioner in a town. On 6 September 1999 Ms A sought Dr B's assistance with the removal of a large tattoo on her right upper arm. Dr B offered to remove the tattoo by radiofrequency ablation (Surgitron) under local anaesthetic.

Ms A stated that Dr B advised her there was a small chance of scarring with the radiofrequency ablation. He also said that there was a chance of scarring with any treatment, including laser treatment. Ms A was advised that radiofrequency ablation was a

much cheaper option than laser treatment. Ms A stated that Dr B did not advise her to have laser removal. Ms A signed a form consenting to the radiofrequency ablation. However, she does not believe she was informed in any depth of the possible outcomes of the procedure.

Dr B denied that he said there was a "small" risk of scarring and advised me that he told Ms A that scarring was quite possible with radiofrequency ablation and that he could refer her for laser removal in a city. He said that he advises all his patients having Surgitron removal that scarring, infection and bruising may occur. When questioned further about the information he provided to Ms A about scarring, Dr B advised me:

> "This young woman came seeking tattoo removal and was offered Surgitron removal as communicated earlier under local anaesthetic ('LA'). I told her that laser removal was preferable but was unavailable in [the region] at that time. She was advised (as standard advice) that scarring was quite possible from the Surgitron method and that she could be referred on for laser removal in [a city]. Because keloid and hypertrophic scarring are, I believe, more likely on the outside upper arm than other areas, I certainly highlight the likelihood of scarring. However, I consider that [Ms A] was very keen to have the tattoo removed; she declined the offer of referral to a city for laser removal and signed the consent form. I proceeded.
>
> [Ms A] was questioned as to whether she pigmented in response to trauma, another standard enquiry, as hyperpigmentation is more likely as a complication in patients who develop dark skin from trauma and insect bites."

The consent form, which Ms A signed, stated:

> "I **[Ms A]** have had the following procedure fully discussed and am aware of the possible complications and costs involved.
>
> I am happy to have this performed by [Dr B], and feel adequately informed.
>
> **Procedure**: Removal Tattoo R Upper arm …"

Dr B said that the initial pre-operative consultation lasted about 30 minutes. He advised me that he had performed this procedure for many patients and always offered laser removal as a better option at the initial interview. Radiofrequency ablation is a less expensive option, which has proved satisfactory for many patients. He could not recall whether he had used radiofrequency ablation to remove tattoos on the upper arm.

Test patch

Dr B advised me that before removing the tattoo, he performed a test:

> "We planned a test patch, which was performed under LA [local anaesthetic] eight days later in September 1999, removing a small area of her tattoo. This initially healed well and I advised waiting 3-4 months before proceeding to a full removal to observe the healing over time of this test patch. I suggested the following autumn as a good time as the winter months would be preferable for healing, when it is easier to keep it out of the

> sun etc. She returned on several occasions and requested that I proceed sooner to suit her time requirements. The full removal was then done mid-October 1999."

Ms A confirmed that Dr B advised her to wait until after summer to have the tattoo removed but she preferred to proceed. On 19 October 1999 Dr B removed the full tattoo, using radiofrequency ablation, under local anaesthetic.

Tattoo removal
Dr B explained that radiofrequency ablation is the removal of the epidermis; the superficial layers of skin are removed, until no pigment is visible. Professionally done tattoos are of more even depth, while self-tattoos are more variable and often the ink pigment is placed deeper in the skin. Ms A's tattoo was professionally done.

Dr B stated that radiofrequency ablation is "a common technique", which he has performed for eight or so years. The procedure on Ms A was uncomplicated; however, after-care was complicated, and Ms A was asked to return for frequent assessments and dressings. Dr B said that he was "initially happy" with the results, but Ms A ended up with a red scar on her arm in the exact shape of the tattoo.

After-care
Ms A wore an elastic arm bandage for a short while after the operation. However, she was subsequently told by another doctor in a town that, if she has corrective surgery to remove the scar, she will need to wear a pressure bandage for at least nine months. She believed that if Dr B had given her this advice she would not have the scar on her upper arm. Dr B advised me that it is not his general practice to use a compression garment post-operatively, although such garments may be used following plastic surgical scar revision.

Dr B stated that Ms A had a normal post-operative period and attended his rooms many times. On 17 November 1999 Ms A had some excessive granulation tissue evident, which he treated with local silver nitrate. He reviewed her again the following month and found that she was developing a hypertrophic scar. He injected steroids (Kenacort) into the scar. Kenacort is used to reduce the scar tissue but can cause lipoatrophy (local wasting of fat tissue). Ms A described the scar as "lumpy ".

Dr B's notes indicated that steroid injections were repeated in January and March 2000 with what he considered to be "good effect". Dr B stated that he discussed with Ms A the risk of local lipoatrophy, which takes 18-24 months to settle.

Ms A described the steroid injections as follows:

> "I went back to [Dr B] and he gave me some steroid injections into the scar's lumpiest bits and the scar became quite indented in some places. I also have a line across my arm, which he says is from the steroids being injected under pressure, but will eventually disappear. [Dr B] injected my arm with steroids on about four different occasions."

Dr B advised me that Ms A saw his colleague, beauty therapist and registered nurse in April 2000. He said that he advised Ms A to return to the registered nurse for a further treatment in the following two weeks. Ms A said that Dr B asked the registered nurse to view her arm during one of the consultations. Ms A could not recall being asked to return to see her.

On 15 June 2000 Ms A returned to Dr B and there was some lipoatrophy apparent. Dr B injected further steroids and told Ms A it would take many months to improve. He offered to refer her to a plastic surgeon, but she declined.

Ms A did not return for further treatment but instead she saw her general practitioner, who referred her to a plastic surgeon. Dr B wrote to Ms A on 27 September 2000 inviting further follow-up.

Ms A advised me:

> "I was sent a letter [by Dr B] to come in for a check-up in October but I did not make an appointment as I am very unhappy with his work and I do not intend to see him again. I made an appointment with my GP in October to see what he thought I should do. He felt I should have been warned in depth of the possible outcomes and he referred me to a plastic surgeon, to see if he thought I could claim medical misadventure. However, my plastic surgeon informed me that medical misadventure is for rare unexpected results from a medical procedure and that because of the type of removal [Dr B] used on me Keloid scarring is not unexpected."

Dr B considered that Ms A had had an outcome that was "not unusual", but was "cosmetically unacceptable". He did not believe that Ms A's follow-up management was in any way "unusual". He advised me that he has removed tattoos from hands, backs, breasts and shoulders with quite acceptable outcomes but he cannot recall if any were in exactly the same area as Ms A's tattoo.

Dr B explained that individual skin responses cannot be predicted, and keloidal scarring can occur in sites such as the deltoid and pre-sternal areas and over the shoulders. Ms A noted that she had undergone a test patch removal for the purpose of determining how her skin would react to the procedure. She considered that she should have been warned of the risk of this individual skin response.

Dr B advised me that in his opinion Ms A was "fully informed and made a choice but has had, as is usual, a change of heart with an outcome that was not welcomed".

Dr B advised me that he had not charged Ms A for follow-up treatment and would not have charged her for the September visit. He did not receive any communication from Ms A, her general practitioner or the plastic surgeon involved and was unaware of her ongoing management.

Independent advice to Commissioner

Dermatologist
An independent dermatologist, Dr Amanda Oakley, provided the following expert advice:

"***Documents and records reviewed***

- Request for Medical/Professional Expert Advice
- Letter from [Ms A] to Commissioner 1 March 2001 and report of phone conversation 26/4/01, labelled 'A'
- Letter from HDC to [Dr B] 9 May 2001, labelled 'B'
- Letter from Dr B to HDC, 16 August 2001, Labelled 'C'
- Photographs of tattoo (more-or-less undated), patient notes, correspondence and consent form dated 19 October 1999, labelled 'D'

Specific questions posed in the Commissioner's letter of request

To advise the Commissioner whether, in my professional opinion, [Ms A] was provided with services with reasonable care and skill by [Dr B]. In particular,

- Whether the method used by [Dr B] to remove [Ms A's] tattoo would inevitably lead to scarring of the magnitude shown in [Ms A's] photograph?
- Whether, from the explanation given by [Dr B], he realistically estimated the degree of scarring [Ms A] would experience?
- Whether [Dr B's] postoperative care was reasonable in the circumstances?
- Any other matter, which in my opinion should be brought to the Commissioner's attention.

My qualifications and experience relevant to the case

I have been a Specialist Dermatologist since 1986, vocationally registered with the New Zealand Medical Council. My relevant qualifications are MBChB FRACP. I am familiar with a Surgitron (but do not own one).

However, I do not offer removal of tattoos in my practice, mainly because of the inevitable scarring that arises from conventional methods. This procedure is generally undertaken by plastic surgeons or by dermatologists who own specific tattoo-removal lasers.

For another opinion, the Commissioner may wish to consult a plastic surgeon experienced in tattoo removal.

Whether the method used by [Dr B] to remove [Ms A's] tattoo would inevitably lead to scarring of the magnitude shown in [Ms A's] photograph?

All conventional non-laser methods of tattoo removal result in scarring.

The Surgitron is a radiosurgery device from Ellman (www.ellman.com). The web site states, in comparison to standard scalpel surgery: *'Radio-surgery is an atraumatic method of cutting and coagulating soft tissues. No pressure is needed and the cells are vaporized in the path of the radiowaves causing them to split apart much like a hot wire through polystyrene. This results in less trauma to the cells, less fibrous scarring, and less post operative discomfort …'.*

An appearance medicine doctor, states on his web site (http://www.2lookgood.co.nz/Surgitron.html): *'Surgitron is a radiosurgery technique for removing tissue without bleeding or sutures and has minimal scarring.'*

However, these descriptions are referring to the superficial removal of skin lesions such as moles and skin tags. I have been unable to find any descriptions of the use of the Surgitron to remove tattoos, although I have no doubt that it is used in many practices because it is multipurpose, readily available and much less expensive than an appropriate laser.

To remove a tattoo, skin has to be destroyed to the depth of the pigmentation. The pigment of professionally-applied tattoos is in the dermis, so simply ablating the surface epidermis may not be adequate to remove it. Scarring results from the repair of injury to dermal collagen and is inevitable if dermal tissue is injured. Hypertrophic scarring is more common in certain anatomical sites including the upper arm.

The Commissioner may find it useful to review tattoo removal by Dr Tina Alster, an acknowledged expert on the subject, in the online textbook emedicine dermatology (http://www.emedicine.com/derm/topic563.htm). She describes how tattoos may be removed by mechanical, chemical, thermal or laser ablation. The expert states: *'Less modern tattoo removal techniques involve the destruction or removal of outer skin layers by mechanical, chemical or thermal means, accompanied by inflammation. Transepidermal elimination of pigment occurs through denuded skin and via an exudative phase that allows tattoo pigment to migrate to the wound surface.'* Referring to mechanical methods of removal, *she states*: *'… hypertrophic scars are common when tissue is removed deeply in an attempt to extract all of the tattoo pigment'.*

She makes similar observations regarding chemical and thermal methods of removing tattoos. Dr Tina Alster states that there is a 25% risk of scarring in the deltoid area (upper arm) from tattoo removal using a CO2 laser – in this method tissue is vaporised in a more precise fashion than is possible with a Surgitron. The Surgitron results in thermal injury to the tissues (burning) because the cells heat up when exposed to the radiowaves.

Dr Tina Alster describes how scarring is much less likely and much less severe using modern tattoo-removal lasers in which the pigment is selectively destroyed – in many cases the surrounding skin is more-or-less unaffected because it does not absorb the laser light.

When used to remove skin cancers, electrosurgery and radiosurgery also result in scarring. About 20% of those on the upper arm are hypertrophic. I have been unable to

find any scientific article reporting the risk of hypertrophic scarring using a Surgitron to remove a tattoo, but an educated guess is that the risk would be about the same.

[Dr Tina Alster's article describes the risks of tattoo removal by thermal tissue destruction by laser (light waves) therapy but does not specifically address the risks of Surgitron (radio frequency waves).]

The photographs supplied show the original tattoo in September 1999, coagulated test patch the same day, wounded test patch, wounded entire area (including full thickness ulceration and eschar formation), and subsequent severe hypertrophic scarring.

In conclusion, I consider scarring of the magnitude shown in [Ms A's] photograph consistent with the method used but not inevitable.

Whether, from the explanation given by [Dr B], he realistically estimated the degree of scarring [Ms A] would experience?

Hypertrophic scarring arises months after injury but is unpredictable. The result from the test patch could not have been predicted at the time the full tattoo was removed, as the test had only been performed a month previously.

If only epidermis is removed, hypertrophic scarring is less likely. But [Dr B] states, *'The epidermis is removed with a high frequency radiofrequency device, until no pigment is visible.'* But, to get rid of pigment, he must also have removed dermis.

[Dr B] also states, *'She has had a not unusual outcome but cosmetically an unacceptable outcome. She was indeed fully informed of these possible outcomes …'*

[Dr B] relates his considerable experience of radiofrequency ablation. [Dr B] will have been aware of the risk of hypertrophic scarring and will also have observed it occurring in other patients. On the other hand, the technique continues to be used by this doctor and others because some patients get a good result.

I conclude from reading these notes that [Dr B] knew of the risk of this degree of scarring, but it seems likely the patient did not.

Whether [Dr B's] postoperative care was reasonable in the circumstances?

[Dr B's] postoperative care consisted of regular COD (change of dressing):

- 19 Oct 00 'Compress dress' (sic.) then Allevyn dressings or Jelonet, then yellow soft paraffin. (These are standard wound dressings.)
- 50 Trisul tabs (oral antibiotics to prevent secondary infection)
- Silver nitrate 'stat sev areas' (sic.) 17 Nov 99 (to destroy over-healed 'granulation tissue')
- Kenacort 60 mg 21 Dec 99, ?dose 10 Jan 00, 40mg x2 22 Mar 00, ?dose 15 June 00
- Pressure bandage 21 Dec 99

There is quite a lot of data to support firm compression to prevent hypertrophic scarring of healing wounds at risk. However, in practice consistent compression is difficult to achieve and may not make a lot of difference to the end result.

[Dr B] used quite large doses of intralesional Kenacort (triamcinolone acetonide, an injectable corticosteroid) but this would have been necessary because of the size of the scar. Lipoatrophy may have arisen from injecting the steroid too deeply, or because of the high dose.

I consider the postoperative care was reasonable. Retrospectively, more attention to compressing the healing wound may have been helpful, but it is unlikely to have prevented hypertrophic scarring because this relates to the tissue injury, the site and inevitable susceptibility.

Any other matter, which in my opinion should be brought to the Commissioner's attention.

[Ms A's] understanding of the procedure she underwent may have been influenced by exposure to publicity about the excellent results possible when tattoos are removed by Nd-YAG, Alexandrite, Q-switched Ruby and other lasers. Advertising material shows little perceptible scarring. In 1999, there were possibly three suitable lasers in Auckland. However, even with these, unpleasant scarring can arise."

Plastic surgeon

Independent expert advice was also sought from a plastic surgeon, Dr Earle Brown, in particular whether hypertrophic scarring was a likely result from Surgitron treatment to remove tattoos from the upper arm, in light of Dr Oakley's comment that the chance of scarring of this magnitude was in the vicinity of 20–25%, but that was her "educated guess".

Dr Brown advised me that, although he is not familiar with Surgitron therapy, hypertrophic scarring was a very strong possibility because the tattoo was removed from the upper arm. He said that Dr Oakley's estimate of "20 to 25% possibility" was conservative. It is his experience that any surgery to the upper deltoid muscle will inevitably scar and most plastic surgeons try to avoid surgery to the upper deltoid and upper chest area for that reason. If ever he has to operate in that area he not only warns of the risk of scarring but "strongly warns" of the risk.

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.*

RIGHT 6
Right to be Fully Informed

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

…

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

RIGHT 7
Right to Make an Informed Choice and Give Informed Consent

1) *Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.*

Opinion: Breach – Dr B

In my opinion Dr B breached Right 6(1)(b) and Right 7(1) of the Code.

Right 6(1)(b)

Ms A had the right to information that a reasonable consumer, in her circumstances, would need to make an informed choice or give informed consent. Ms A needed to be told the options for removing her tattoo, the benefits and risks of each option and, because this was a cosmetic procedure, to be given some indication about how her arm would look after her tattoo was removed. She should have been enabled to decide whether the likely results would meet her expectations. The question is whether Ms A was given all the information she could reasonably expect to receive, in her circumstances, before she consented to treatment. In my opinion, she was not.

Severity of scarring
My independent dermatologist advised me that scarring results from the repair of injury to the dermal collagen of the skin and is inevitable if dermal tissue is injured. She said that Dr B used a conventional method to remove Ms A's tattoo and, in her view, all conventional non-laser methods result in scarring. From Dr B's description of how radiofrequency ablation removes tattoo pigment, he must have removed, and therefore injured, the dermis.

My independent dermatologist advised me that hypertrophic scarring (keloid scarring), on the other hand, is not inevitable but is more common following treatment to the upper deltoid region. She referred me to articles written by Dr Tina Alster, a recognised expert in tattoo removal. Dr Tina Alster indicates that the risk of scarring in the deltoid region is substantial using tattoo removing lasers and there is a greater risk using other methods. Dr Tina Alster indicates that keloid scarring is common when tissue is removed deeply in an attempt to extract all of the tattoo pigment. In Dr Tina Alster's experience scarring is less likely and less severe using modern tattoo removal lasers, in which pigment is selectively destroyed.

It appears that there is more risk of keloid scarring with radiofrequency ablation techniques than with modern laser methods and, because Ms A's tattoo was on her upper arm, there was an increased risk of keloid scarring. Both Ms A and Dr B agree that Ms A was warned that there was some risk of scarring from radiofrequency ablation. In Dr B's opinion he gave Ms A an adequate explanation of the risks. Ms A believed that the potential degree of scarring and the magnitude of the risk were not made clear to her.

Dr B performed a test patch and advised Ms A that, as the results of the test patch could not properly be read so soon, she should wait some time before proceeding to full tattoo removal. Ms A wanted the tattoo removed before then. Dr B was not required to comply with Ms A's wishes if, in his clinical judgement, it was not clinically advisable to do so. Having decided to proceed, before results of the test patch were known and against his clinical judgement, Dr B carried a greater responsibility to provide more information, and ensure that Ms A fully understood the risk she ran, before removing the remainder of her tattoo.

The evidence suggests that Ms A was at considerable risk of keloid scarring given the position of her tattoo and the method Dr B used to remove it. I am not satisfied that Ms A was adequately informed of the magnitude of the risk before she gave Dr B consent to proceed.

Degree of risk

My dermatology expert advisor was unable to give a definite estimate of the risk of keloid scarring with radiofrequency ablation tattoo removal but considered it was likely to be in the vicinity of 20–25%. My independent plastic surgeon considered this estimate conservative. In his experience, any surgery to the upper arm will inevitably scar and, when operating in that area, he "strongly warns" patients about the risk.

Dr B told me that he could not predict keloid scarring would occur because it is an individual response. Although Dr B may not have been able to tell Ms A that she would have a large keloid scar, he could and should have told her that the risk was significant. In real terms, 25% means that one of every four patients Dr B treats by this method is likely to develop keloid scarring. He has a duty to advise each patient accordingly.

In my opinion Dr B did not bring home to Ms A the real risks of having her tattoo removed with the Surgitron method and of proceeding with the treatment before the results of the patch test were known. In these circumstances Dr B breached Right 6(1)(b) of the Code.

Right 7(1)

Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent. In this way Right 6(1) and Right 7(1) work together to ensure that a consumer has all the information needed to make a choice about the most appropriate treatment option. Ms A said that she would not have consented to the treatment if she had known that removing the tattoo would leave a large keloid scar.

Consent

The consent form signed by Ms A states that the procedure had been "fully discussed" with her and that she felt "adequately informed". Written consent does not, in itself, prove that adequate information has been imparted to a patient. Dr B cannot abdicate his responsibility if, in fact, he has failed to "fully inform" about the impending treatment. If he proceeds to treat an inadequately informed patient, his treatment is not truly consensual.

Ms A was in no position to judge whether she was adequately informed, since the only information she received was from Dr B. Dr B retained the responsibility to fully discuss her treatment with her and, as discussed above, failed to do so.

I am satisfied that Ms A would not have consented to have her tattoo removed if she had been fully informed of the risks and likely outcome. In my opinion Ms A did not make an informed choice about the best method to remove her tattoo and, consequently, was unable to give informed consent. In these circumstances, Dr B's decision to proceed with Surgitron treatment amounted to a breach of Right 7(1) of the Code.

Opinion: No breach – Dr B

Right 4(1)

In my opinion Dr B did not breach Right 4(1) of the Code.

Inadequate post-operative care
Ms A had the right to medical services provided with reasonable care and skill. This included appropriate after-care of her wound.

Ms A believed that Dr B's post-operative care was inadequate because he did not insist that she wear a pressure sleeve for some months after he removed her tattoo. If he had, she believed she would not have the degree of scarring she has experienced. The plastic surgeon who Ms A was referred to told her that following corrective surgery she would have to wear an elastic sleeve for at least nine months.

Dr B prescribed an elastic sleeve for Ms A to wear for a short time but said that it is not his practice to use pressure garments after tattoo removal. He is aware that it is usual to wear such garments after plastic surgery. He told me that Ms A's post-operative recovery was normal. She had some excess scar tissue that he was treating with steroid injections, but she did not continue with the treatment. It was clear that Dr B expected that it would take many months of steroid injections to achieve the desired outcome.

The advice I received from an independent plastic surgeon and a dermatologist indicates that keloid scarring occurred because of the anatomical position of the tattoo and the method Dr B used to remove it, rather than the post-operative treatment. My dermatologist advisor noted that Ms A's keloid scarring was not caused by her failing to use an elastic sleeve. Dr Oakley commented that there is data to support firm compression to prevent keloid scarring of healing wounds at risk, but in practice consistent compression is difficult to achieve and may not make a lot of difference to the end result. I am guided by this advice.

In November and December 1999, when excessive granulation and hypertrophic scarring became obvious, Dr B attempted to reduce scarring with silver nitrate and quite large doses of steroids. It is clear that he would have continued to treat Ms A had she not sought treatment elsewhere.

Although Ms A's treatment was protracted, and in my opinion beyond that anticipated when she agreed to have her tattoo removed, there is no evidence to indicate that Dr B failed to exercise reasonable care and skill in his follow-up care. Accordingly, in my opinion Dr B did not breach Right 4(1) of the Code.

Actions taken

- In response to my provisional opinion, Dr B provided an apology. The apology has been forwarded to Ms A.

Other actions

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

- A copy of this opinion, with identifying features removed, will be sent to the Royal New Zealand College of General Practitioners, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Other comment

Dr B has been subject to seven other complaints received by the Health and Disability Commissioner since December 1999.

Two of the complaints resulted in no further action by the Commissioner. One complaint was referred to the Medical Council of New Zealand with a recommendation that it consider a review of Dr B's competence to practise medicine, with particular reference to communication. One complaint is currently under investigation. The other three complaints resulted in the following findings:

- File No 99HDC13348 – Breach of Right 6(1)(b) (adequate information). Recommendation of an apology and self review of practice.

- File No 00HDC03278 – Breach of Right 6(1)(b) (adequate information). Recommendation of an apology and self review of practice.

- File No 00HDC03688 – Breach of Rights 5(1), 5(2), 6(1)(b) and 7(1). Recommendation of an apology and self review of practice.

I am concerned by the recurrent pattern evident from the above complaints and my investigation findings.