# District Health Board

# Obstetrician and Gynaecologist, Dr A

## A Report by the

## Health and Disability Commissioner

## (Case 13HDC01557)

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## Executive summary

1. Mrs B, 46 years old at the time of these events, suffered from menometrorrhagia (frequent and excessive uterine bleeding, both at the time of menstrual periods and at other irregular intervals) and post-coital bleeding. On 11 July 2012, Mrs B underwent a hysterectomy at a public hospital (the Hospital) performed by obstetrician and gynaecologist Dr A.

2. Mrs B consented to undergoing a total vaginal hysterectomy. During the procedure, initial attempts by Dr A to open the Pouch of Douglas (the extension of the peritoneal cavity between the rectum and the posterior wall of the uterus) failed. Dr A then mistakenly identified Mrs B's bowel wall as the Pouch of Douglas and attempted to open it, causing a perforation to Mrs B's bowel.

3. Dr A then stopped the procedure and sought assistance from her supervisor, Dr C. Dr C found that Mrs B had extensive adhesions of the "uterus, tubes [and] ovaries, to the side walls and posterior wall of [the] pelvis". Due to the difficulties with the vaginal hysterectomy, Dr A and Dr C converted to an abdominal hysterectomy.

4. Dr A contacted a general surgeon, Dr D, and requested his assistance with repairing the perforation to Mrs B's bowel. Dr D was unsure about being able to close the perforation entirely (which he noted was approximately 10–12cm long), so decided to perform a loop colostomy. The abdominal hysterectomy was then completed.

5. Dr A and Mrs B have different recollections of what was discussed after the surgery. There are no records of any conversations during which Dr A told Mrs B that she had made an error during the surgery, which resulted in her having perforated Mrs B's bowel.

6. Dr A had been involved in prior adverse events at the Hospital.

### Findings

7. Dr A's failure to seek advice or assistance from a more senior colleague and convert to an abdominal procedure earlier, plus her mistake in incising incorrectly identified tissue amount to a serious departure from expected standards. Accordingly, Dr A failed to provide services to Mrs B with reasonable care and skill and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights.[1]

8. Dr A's poor standard of record-keeping amounts to a breach of professional standards and, accordingly, Dr A breached Right 4(2) of the Code.[2]

9. Adverse comment is made that Dr A did not openly disclose the surgical error in a way that was adequately understood by Mrs B.

[1] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."
[2] Right 4(2) of the Code states: "Every consumer has the right to have services provided that comply with legal, professional, ethical and other relevant standards."



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10. Adverse comment is made about the district health board's (the DHB) systems for identification and reporting of serious surgical events.

## Complaint and investigation

11. The Commissioner received a complaint from Mrs B about the services provided to her by the DHB and obstetrician and gynaecologist Dr A. The following issues were identified for investigation:

- *Whether the DHB provided an appropriate standard of care to Mrs B in July 2012.*
- *Whether Dr A provided an appropriate standard of care to Mrs B in July 2012.*

12. An investigation was commenced on 17 October 2014.

13. The parties directly involved in the investigation were:

| | |
|---|---|
| Dr A | Obstetrician and gynaecologist/provider |
| Mrs B | Consumer/complainant |
| DHB | Provider |

14. Information was also reviewed from:

| | |
|---|---|
| Dr C | Consultant obstetrician and gynaecologist/provider |
| Dr D | General surgeon/provider |

15. Independent expert advice was obtained from a specialist obstetrician and gynaecologist, Dr John Short (**Appendix A**).

## Information gathered during investigation

### Mrs B

16. Mrs B, 46 years old at the time of these events, suffered from menometrorrhagia (frequent and excessive uterine bleeding, both at the time of menstrual periods and at other irregular intervals) and post-coital bleeding. In July 2012, Mrs B underwent a hysterectomy[3] at the Hospital performed by obstetrician and gynaecologist Dr A. During the procedure Mrs B suffered a perforation to her bowel. This report relates to the care provided to Mrs B by Dr A during and following her procedure in July 2012.

[3] Surgical removal of the uterus.



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**Dr A**

17. Prior to coming to New Zealand, Dr A had worked overseas as an obstetrician and gynaecologist specialist. Dr A was employed by the DHB at the Hospital. Dr A was approved by the credentialling committee[4] as a locum consultant obstetrician and gynaecologist specialist for a fixed term of one year. Dr A worked under a provisional scope of practice with supervision being provided by consultant obstetrician and gynaecologist Dr C.

**Supervision provided by Dr C**

18. Dr C was also employed by the DHB. As Dr A's supervisor, Dr C was required to report to his head of department and to the medical director at the DHB, before reporting to the Medical Council of New Zealand (MCNZ) "every three months, or as often as requested by the Medical Council".

19. According to Dr C, for the first few weeks of Dr A's employment with the DHB, he observed Dr A's clinical skills in theatre when she performed major procedures such as Caesarean sections and hysterectomies. Dr C advised HDC that Dr A's surgical skills during this period were "good".

20. Dr C told HDC that during the remainder of Dr A's contract with the DHB, he met with her every morning "to discuss normal and unusual cases handling clinical dilemmas and referrals to tertiary centres".

**Mrs B — Consent to hysterectomy**

21. On 19 June 2012, Mrs B consented to undergoing a total vaginal hysterectomy. It is noted on Mrs B's consent form that the following "risks" were explained to her: "pain, bleeding, infection, damage to other organs". Mrs B did not have any suggested history of endometriosis[5] or other relevant condition that might have indicated that such a procedure would be difficult. Clinical notes dictated by Dr A state:

> "Risks, benefits were discussed after the procedure was discussed with the patient consents were obtained."

**Hysterectomy procedure**

22. On 11 July 2012, Mrs B underwent a hysterectomy at the Hospital performed by Dr A. During the procedure, initial attempts by Dr A to open the Pouch of Douglas[6] failed.

23. Having encountered difficulty entering the Pouch of Douglas, Dr A decided to enter the peritoneum anterior to the uterus. She divided the uterosacral ligaments in an attempt to obtain more descent of the uterus, before making a second attempt to enter the Pouch of Douglas. Dr A mistakenly identified Mrs B's bowel wall as the Pouch of

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[4] Credentialling is a process used by health and disability service providers to assign specific clinical responsibilities to a health practitioner on the basis of his or her education and training, qualifications, experience and fitness to practise. Dr A's credentialling took two weeks.

[5] A condition resulting from the appearance of endometrial tissue outside the uterus and causing pelvic pain, especially associated with menstruation.

[6] The extension of the peritoneal cavity between the rectum and the posterior wall of the uterus in the female human body.



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Douglas and attempted to open it. Dr A stated: "I made a small incision posteriorly and then began extending it to accommodate a vaginal retractor".[7]

24. At that point, Dr A became aware that she had caused a perforation to Mrs B's bowel. On examination she estimated this to be two finger breadths in length. Dr A recorded in the operation note with regard to the hysterectomy that she made an incision in what she thought to be the peritoneum.[8] However, she noted that "… once the incision had been made it appeared to be rectum and therefore the procedure was aborted after it was confirmed to be the rectum …" In response to the provisional opinion, Dr A stated that all attempts were made to identify the correct tissue at the time of the procedure, and that no attempts were made to continue the procedure until the appropriate consultants were present.

25. In response to the provisional opinion, Dr A stated that it is not unusual for the first attempt to enter the Pouch of Douglas to be unsuccessful, and that gaining additional descent of the uterus can provide additional exposure to allow a reasonable second attempt. Therefore, she considers making a second attempt to enter the Pouch of Douglas was not unreasonable.

26. Dr A sought assistance from Dr C. Dr C told HDC that on arriving in theatre his findings included:

> "Extensive adhesions[9] of the uterus, tubes [and] ovaries, to the side walls and posterior wall of pelvis. Pouch of Douglas was completely obliterated. Both ovaries were not visualised as they were well embedded in thick walls of adhesions."

27. Due to the difficulties with the vaginal hysterectomy, Dr A and Dr C converted to an abdominal hysterectomy.[10]

*Repair of perforation*

28. Dr A contacted general surgeon Dr D and requested his assistance with repairing the perforation to Mrs B's bowel. In this respect, Dr D recorded postoperatively:

> "I received a call mid-morning from [Dr A] asking for assistance having identified a laceration within the anterior rectum performed at the time of vaginal hysterectomy …"

29. Dr D recorded that the perforation was approximately 10–12cm long. He also recorded:

> "… Due to the fact that I was not sure of having been able to entirely close the laceration I decided to perform a loop colostomy …"[11]

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[7] A surgical instrument.
[8] The membrane that forms the lining of the abdominal cavity.
[9] Internal bands of scar tissue.
[10] The surgical removal of the uterus through an incision in the lower abdomen.



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30. Following Dr D's repair of the perforation and loop colostomy, Dr A and Dr C completed the abdominal hysterectomy.

**Postoperative care**

31. As a result of the loop colostomy performed by Dr D, Mrs B required a colostomy bag.[12] Following the procedure Mrs B was transferred to the intensive care unit (ICU) for close observation. The post-operation note states:

> "Patient admitted from [operating theatre] post Total abdominal hysterectomy and loop sigmoid colostomy. Patient awake and oriented on admission to ICU …"

*Disclosure of perforation to bowel*

32. Mrs B told HDC that she was not made aware by any clinicians involved in her care that during her procedure Dr A had perforated her bowel. Mrs B stated:

> "At no time did [Dr A] advise either me or my husband that there had been a treatment injury caused by her to my bowel. As I was on morphine a lot of the time I didn't comprehend most of what was happening around me … The focus was on the pelvic adhesions not the 10 centimetre bowel injury. At this stage it was both my husband's and [my] understanding that I ended up with the emergency operation because of these [the pelvic adhesions], not because of the treatment injury caused by [Dr A]."

33. In this respect Dr A told HDC:

> "At no time following [Mrs B's] operation did I attempt to keep any information from her or her husband. I returned to the hospital later in the evening on the day of her surgery, to inform the patient of the outcome of her surgery and the complication that had occurred.
>
> I was very aware that the medication used for anaesthesia and pain control could affect [Mrs B's] cognition and memory and, therefore, I repeated the conversation regarding the surgery and complication on several occasions … I continuously asked if all the information was understood or if I needed to re-explain anything and felt I gave the patient ample opportunity to ask any questions …"

34. There is no record of a discussion between Dr A and Mrs B on the evening of 11 July 2012, following her surgery. Dr A told HDC:

> "I know I did everything possible to communicate the nature of the complication to the patient. I am aware that I poorly documented this, but it does not change the fact that I was open and honest with the patient. I made several attempts to explain the complication to the patient and her husband and gave them every opportunity to ask any questions …"

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[11] A surgical procedure in which a stoma (an opening) is formed by drawing the healthy end of the large intestine or colon through an incision in the anterior abdominal wall and suturing it into place. This provides an alternative channel for faeces to leave the body.

[12] Mrs B was required to wear a colostomy bag for the following seven months, until 11 February 2013, when she had further surgery to reverse the loop colostomy (discussed below).



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35. At 2.30am on 12 July 2012, it is recorded in the nursing notes:

> "Patient slept for 1 hour. Awake and anxious. Finding it difficult to get her head around all the surgery and the colostomy …"

36. Later on the morning of 12 July 2012 a house officer reviewed Mrs B and noted:

> "[Discussed with] [Dr A]].
> Post hysterectomy [followed by] bowel perf & [illegible] colostomy.
> …
>
> Plan
> 1) Continue ICU care
> 2) Surgical review by [Dr D]."

37. At 8.35am on 12 July 2012, Dr D reviewed Mrs B and noted:

> "Day 1 post — total abdominal hysterectomy + loop sigmoid colostomy.
> Explained surgery to patient.
> → Why colostomy was done.
> → colostomy temporary.
> O/E Alert and comfortable …"

38. With regard to this conversation with Mrs B on 12 July 2012, Dr D told HDC that he recalls discussing the following:

> "1. There had been an injury to [Mrs B's] rectum during her hysterectomy.
> 2. A laparotomy[13] was required to complete the hysterectomy.
> 3. The rectum was repaired transvaginally.
> 4. A loop sigmoid colostomy was required to allow the repaired segment of the rectum to heal. It diverted faeces externally not past the area of injury.
> 5. The colostomy was temporary and would be reversed in the future when she was well. (I mentioned 3–6 months)."

39. Mrs B told HDC that she has "absolutely no recollection" of this conversation with Dr D. Mrs B's husband was also present during Dr D's conversation with Mrs B. In this respect he told HDC: "[Dr D explained] about the colostomy bag and it[s] function, but I can honestly say I don't recall anything else that he said …"

40. At 12.15pm that afternoon it is recorded in the clinical notes:

> "[General condition]: Quite bright [with] herself, good discussion with consultant re operation follow up …"

41. At 6.00am on 13 July 2012, it is recorded in the clinical notes:

> "Pt has not slept much tonight. Asking a lot of questions — able to discuss what has happened and what is ahead of her …"

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[13] A surgical procedure involving a large incision through the abdominal wall to gain access into the abdominal cavity.



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42. On 13 July 2012, Dr A reviewed Mrs B during her ward round, and a house officer noted: "[Consultant ward round] Post vaginal Hysterectomy [followed by] laparotomy. [Illegible] colostomy from bowel perf …" The swelling had improved and Mrs B had had adequate urine output.

43. The same day, Dr D reviewed Mrs B again and noted "… Operation explained. Discussed stoma …"[14]

44. Between 16 July 2012 and 19 July 2012 Dr A reviewed Mrs B every day during her ward rounds, noting Mrs B's condition each day. During this time, there are no records of any conversations between Dr A and Mrs B regarding Dr A having made an error resulting in the perforation of Mrs B's bowel, or regarding Dr A providing any information to Mrs B about her colostomy bag.

45. Between 20 July 2012 and 23 July 2012 it was recorded that Mrs B was becoming confident using her colostomy bag. On 23 July 2012, Mrs B was discharged from the Hospital with a plan for follow-up care as an outpatient.

**Postoperative follow-up**

46. On 26 July 2012, Mrs B attended an appointment with Dr D at his outpatient clinic in order to have her surgical wound checked and redressed, and to discuss having her loop colostomy reversed. Dr D arranged a follow-up appointment with Mrs B for 9 August 2012.

47. On 9 August 2012, Mrs B and her husband attended another appointment with Dr D. Dr D arranged for a CT scan[15] to check that Mrs B was healing adequately, and suggested that she might be able to have the loop colostomy reversed in December that year.

48. The same day, following her appointment with Dr D, Mrs B and her husband attended an appointment with Dr A at the gynaecology outpatient clinic. Dr A recorded in the clinical notes that Mrs B was healing well and that a CT scan had been arranged. While Dr A recorded that Mrs B "had a vaginal hysterectomy that was complicated by a laceration of the rectum treated with laparotomy and colostomy", there is no record that this was discussed with Mrs B. Dr A arranged follow-up for Mrs B in the outpatient clinic in one month's time.

49. Dr A told HDC:

> "[At this appointment] I offered both [Mrs B] and her husband an additional opportunity to have anything clarified regarding the event. Any questions regarding the colostomy or its reversal were referred [to] the general surgeon, as I did not have adequate knowledge to answer them. Otherwise, I felt that every attempt at communicating the complication and its implication was made on my part."

[14] A surgically created opening on the abdomen which allows stool or urine to exit the body.
[15] A computed tomography (CT) scan produces cross-sectional images of the body using X-rays and a computer.



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**Application to ACC**

50. On 9 August 2012 Dr A completed a "Treatment Injury Claim" form for ACC on behalf of Mrs B.

51. On 23 August 2012 Mrs B received a letter from ACC informing her that it had received her claim. Mrs B stated: "It wasn't until I received an ACC letter dated 23 August 2012 advising that they had received 'my claim' that I went to [Dr D] and asked him what it was all about."

52. Mrs B took the ACC letter with her on 30 August 2012, when she attended a further follow-up appointment with Dr D. Dr D recorded that Mrs B had some questions about ACC and noted:

> "We also talked about ACC and its role in supporting people following a surgery in her context. She had received the paper work this week …"

53. According to Mrs B, at that appointment she asked Dr D about the letter from ACC, as she was not sure why she had received it. Mrs B told HDC: "[I]t was then that I was told that I had a 10 centimetre cut to my bowel which was a result of a treatment injury by [Dr A]."

54. Mrs B's husband stated:

> "It wasn't until we queried the surgeon that we became 'fully aware' of what had happened and how things went wrong … It wasn't until [we] received the ACC letter and took it along to our next appointment and [Dr D] explained in detail what happened with [Dr A] and also again explained about the colostomy bag. It was a very traumatic and stressful time in our lives."

55. Between September 2012 and February 2013 Mrs B attended further appointments with Dr D and Dr A with regard to postoperative follow-up. On 11 February 2013, Mrs B had a procedure for reversal of her loop colostomy, which was successful.

**Previous incidents involving Dr A**

56. The DHB advised HDC that prior to the incident involving Mrs B on 11 July 2012, Dr A had been involved in three incidents at the Hospital, two of which involved laparoscopic surgery. In the third incident, following laparoscopic surgery, the patient was admitted to another hospital within the DHB (Hospital 2) with abdominal pain. A small bowel perforation was found and repaired at that hospital. This incident did not come to the DHB's attention until it reviewed Dr A's cases following the incident involving Mrs B. The DHB stated that initially it was not aware of the case, as the patient was domiciled in one area, had her initial surgery at the Hospital, and then, when she became ill, was admitted to Hospital 2, where she had a repair of her small bowel perforation. The DHB stated: "Unfortunately a Reportable Event [review] was not completed at this time which is our normal process for alluding to these events." The MCNZ was not notified of this event.



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## Events following Mrs B's surgery

*Limitation of scope of practice*

57. Following Mrs B's surgery on 11 July 2012, the DHB undertook a review of Dr A's practice. From 25 July 2012, the DHB limited Dr A's scope of practice to exclude laparoscopic surgery.

58. From September 2012, the DHB also limited Dr A's scope of practice to exclude vaginal hysterectomies. The DHB told HDC that, in order to support Dr A in regaining her surgical confidence, Dr C assisted her in all major surgery for the remainder of her time with the DHB. In response to the provisional opinion, Dr A stated that immediately after the surgical complication with Mrs B, she approached Dr C herself to discuss having him assist with all major surgeries that she performed.

*Dr A's current practice*

59. Dr A has left NZ and has told HDC that currently she is not practising medicine; however, she has retained her medical license, which is unrestricted. Dr A stated that were she to return to practising medicine she would "re-evaluate how [she] select[s] patients for vaginal hysterectomy".

## Changes made by the DHB

60. The DHB told HDC that since these events it has compiled a formal orientation package for obstetrician and gynaecology consultant specialists, and a checklist for registrar orientation, which covers standards and policies relating to open disclosure, clinical documentation, informed consent, and ACC treatment injury claims.

## Further information

*The DHB*

61. The DHB told HDC that it considered that Dr A should have requested assistance from Dr C when she first encountered difficulties on her first attempt to enter Mrs B's Pouch of Douglas.

62. The DHB considered that Dr A should have made a full and frank acknowledgement of the medical treatment injury (bowel perforation) and given a full apology to Mrs B. The DHB noted that there is no record in the clinical records that this was done. The DHB stated that it was "regrettable that in this instance Dr A appears not to have followed [its] Open Disclosure Policy".

*Mrs B*

63. Mrs B told HDC that following her procedure, she sought assistance from a clinical psychologist to deal with the events, including living with a colostomy bag.

## Responses to the Provisional Opinion

64. Responses to the provisional opinion were received from Mrs B, the DHB, and Dr A. Where appropriate, Dr A's comments have been incorporated above. Mrs B confirmed that she had no further comments regarding the "information gathered" section of the provisional opinion and the DHB confirmed that it had nothing further to add as it agreed with the provisional opinion.



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65. Dr A stated that she was open and honest with Mrs B regarding the complication, and that she believed Mrs B and her husband understood the nature of the complication. However, she stated:

> "Unfortunately, this assessment was inaccurate and [Mrs B] did not understand the nature of the complication until after I had left New Zealand. She, therefore, did not have an opportunity to discuss the complication with me further and I, in turn, did not have an opportunity to answer her questions."

## Opinion: Dr A — Breach

### Surgery

66. On 11 July 2012 Mrs B was admitted to the Hospital for a vaginal hysterectomy. She was under the care of Dr A, a locum consultant obstetrician and gynaecologist specialist who was working for the DHB.

67. Mrs B signed a consent form for a "total vaginal hysterectomy". The risks that had been explained to her were "pain, bleeding, infection, damage to other organs".

68. My expert advisor, specialist obstetrician and gynaecologist Dr John Short, advised me that the initial decision to perform a vaginal hysterectomy was appropriate, as there was a clear indication for which it would provide effective treatment, and there was no reason at that time to think it would not be straightforward. Accordingly, I find that the initial decision to perform a vaginal hysterectomy was appropriate.

69. During the hysterectomy performed on 11 July 2012, initial attempts by Dr A to open the Pouch of Douglas failed. When Dr A encountered difficulties with the procedure she continued with the vaginal approach rather than changing to an abdominal procedure, and did not seek advice or assistance. Dr Short advised: "[I]n the circumstances, I do not think it was appropriate to pursue this approach at this stage and she should have converted to an abdominal procedure or at least sought advice from a senior colleague."

70. Having encountered difficulty entering the Pouch of Douglas, Dr A decided to enter the peritoneum anterior to the uterus. She divided the uterosacral ligaments in an attempt to obtain more descent of the uterus, before making a second attempt to enter the Pouch of Douglas. In Dr A's view, making a second attempt to enter the Pouch of Douglas was not unreasonable.

71. During the second attempt to enter the Pouch of Douglas, Dr A mistakenly identified Mrs B's bowel wall as being the Pouch of Douglas and attempted to open it, causing a perforation of Mrs B's bowel. Dr A noted in the operation record that she made an incision in what she thought to be the peritoneum, but, once the incision had been made, it appeared to be the rectum that she had cut and the procedure was stopped.

72. Dr A then sought assistance from her supervisor, Dr C. Due to the difficulties with the vaginal hysterectomy, Dr A and Dr C decided to convert to an abdominal



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hysterectomy. Dr C found that Mrs B had extensive adhesions of the uterus, tubes and ovaries to the side walls and posterior wall of her pelvis.

73. Dr A contacted general surgeon Dr D and requested his assistance with repairing the perforation to Mrs B's bowel. Dr D found that the perforation was approximately 10–12cm long and, as he was "not sure of having been able to entirely close the laceration", he decided to create a loop colostomy.

74. Following Dr D's repair of the perforation and the formation of a loop colostomy, Dr A and Dr C completed the abdominal hysterectomy.

75. Dr Short advised that the explanation for the difficulties that Dr A experienced in identifying the tissue planes was the presence of bowel adhesions involving the Pouch of Douglas, which frequently involve the uterosacral ligaments. He said: "[T]o cut these structures without ensuring prior entry to the 'Pouch of Douglas' is unsafe in my opinion. To take things further and incise unidentified tissue and then extend that incision is also of considerable concern."

76. Dr Short stated:

> "The standard of care … would be to carefully consider why an operation is not going to plan and to consider the potential risks involved in continuing, as well as to consider alternatives that would facilitate safer achievement of the ultimate goal (removal of the uterus with minimal complications)."

77. In my view, Dr A made several errors. After her initial attempts to open the Pouch of Douglas failed, she persisted with the vaginal approach. She did not seek the advice of a senior colleague, and subsequently mistook the anatomy and cut Mrs B's bowel thinking it was the peritoneum. I am particularly critical about Dr A's lack of caution and failure to seek advice.

78. Dr A failed to seek advice or assistance from a more senior colleague and convert to an abdominal procedure earlier. She also proceeded to incise incorrectly identified tissue. In my view, these failures amount to a serious departure from expected standards. Accordingly, I find that Dr A failed to provide services to Mrs B with reasonable care and skill and breached Right 4(1) of the Code.

**Documentation**

79. Professional and legal standards for clinical documentation are very clearly established. The MCNZ publication "The Maintenance and Retention of Patient Records" (August 2008) notes the importance of clinical records for ensuring good care for patients, and requires doctors to keep "clear and accurate patient records that report: relevant clinical findings; decisions made; information given to patients; any drugs or other treatment provided".

80. Dr Short advised me that Dr A's surgical notes are inadequate and provide little useful information. In my view, Dr A's poor standard of record-keeping amounts to a breach of professional standards and, accordingly, I find that Dr A breached Right 4(2) of the Code.



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### Open disclosure – adverse comment

81. Mrs B said that she was not made aware that Dr A had perforated her bowel. Mrs B stated: "At no time did [Dr A] advise either me or my husband that there had been a treatment injury caused by her to my bowel … The focus was on the pelvic adhesions not the 10 centimetre bowel injury." Mrs B believed that the emergency surgery performed by Dr D and the necessity of a colostomy bag was due to her having pelvic adhesions, not an injury to her bowel.

82. Dr A said that she informed Mrs B on 11 July 2012 of the outcome of her surgery and the complication that had occurred. However, there are no records of any such conversations.

83. Dr D told HDC that he recalls discussing with Mrs B on 12 July 2012 that there had been an injury to her rectum during her hysterectomy. He recorded "Explained surgery to patient → Why colostomy was done" in the clinical notes. Mrs B said that she has absolutely no recollection of this discussion, and her husband recalls Dr D discussing the colostomy bag and its function but nothing else.

84. Mrs B told HDC that it was not until the appointment of 30 August 2012 with Dr D, when they discussed the letter that she had received from ACC dated 23 August 2012, that she became aware that she had a cut to her bowel that was a result of a treatment injury by Dr A.

85. With regard to the disclosure of the bowel perforation to Mrs B, Dr A said:

> "I know I did everything possible to communicate the nature of the complication to the patient. I am aware that I poorly documented this, but it does not change the fact that I was open and honest with the patient. I made several attempts to explain the complication to the patient and her husband and gave them every opportunity to ask any questions …"

86. Dr A also stated that she believed Mrs B and her husband understood the nature of the complication. However:

> "Unfortunately, this assessment was inaccurate and [Mrs B] did not understand the nature of the complication until after I had left New Zealand. She, therefore, did not have an opportunity to discuss the complication with me further and I, in turn, did not have an opportunity to answer her questions."

87. The importance of the medical record is well established. Baragwanath J acknowledged the importance of medical records in *J v Director of Proceedings*, stating that record-keeping is a fundamental obligation of the practitioner.[16] Indeed, this Office has often observed that providers whose evidence is based solely on their

[16] *J v Director of Proceedings* HC Auckland CIV-2006-404-2188, 17 October 2006 at [63] per Baragwanath J.



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subsequent recollections (in the absence of written records) may find their evidence discounted.[17]

88. It is unclear exactly what Dr A discussed with Mrs B following her surgery. I find it more likely than not that it was not until the time of the discussion with Dr D on 30 August 2012 that Mrs B understood that her bowel had been cut by Dr A, and the subsequent effects.

89. The MCNZ Guideline "Disclosure of Harmful and Adverse Events" (December 2010) states that when a patient is harmed while receiving medical treatment, MCNZ expects that the senior doctor responsible for the patient's care will advise the patient of the facts of the harm in the interests of an open, honest and accountable professional relationship. The MCNZ Guideline requires that a disclosure be made in a timely manner and states that it is appropriate to make the initial disclosure as soon as practicable with a more detailed discussion with the patient to follow once the team has had the opportunity to meet and discuss the circumstances that led to the patient being harmed. This will give time for the patient to think about the situation and provide an opportunity to ask for more information. The MCNZ Guideline also requires that the doctor document in the patient's clinical notes details of the nature of the harm and any subsequent action, including disclosure to the patient. MCNZ recommends that the patient's clinical notes include who was present during the disclosure, what was discussed, the patient's reaction, and any issues regarding continuity of care.

90. The DHB considered that Dr A should have made a full and frank acknowledgement of the medical treatment injury (bowel perforation) and given a full apology to Mrs B. It also stated that it was regrettable that Dr A appeared not to have followed its Open Disclosure Policy.

91. I note that Dr D documented that he explained to Mrs B the surgery and why the colostomy was done on 12 July 2012. However, in my view, it was Dr A's responsibility to ensure that open disclosure of the error and its potential consequences occurred promptly and in a manner consistent with the DHB's policy and the MCNZ Disclosure Guidelines. While Dr A has said that she was open and honest with Mrs B, it was more than a month before Mrs B understood what had happened to her during the surgery. Doctors need to make sure that open disclosure occurs in a timely manner and that the discussion is recorded adequately. I do not consider that Dr A openly disclosed the surgical error in a way that was adequately understood by Mrs B.

## Opinion: The DHB — Adverse comment

92. A hospital should have a culture that supports safe care, and that promptly identifies risks to patient safety and responds appropriately.

[17] See for example Opinion 04HDC03530 (14 February 2006), p. 28.



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93. A district health board has the duty to monitor the performance of its employed doctors with reasonable care and skill and to manage poor performance appropriately. When Dr A was employed by the DHB she was approved by the DHB's credentialling committee as a locum consultant obstetrician gynaecologist specialist for a fixed term of one year. Dr A worked under a provisional scope of practice with MCNZ supervision being provided by Dr C. Dr Short stated:

> "On the whole, I am of the view that [the DHB] took all reasonable steps to ensure that [Dr A] was suitable for her role and safe to practise."

94. Dr A had been involved in three adverse events at the Hospital prior to the incident involving Mrs B on 11 July 2012. The second and third events were related to laparoscopic surgery. However, at the time of Mrs B's surgery on 11 July 2012, the DHB was aware of only the first two adverse events. After the adverse event relating to Mrs B's surgery, the DHB undertook a review of Dr A's practice and became aware of the third prior adverse event.

95. From 25 July 2012, the DHB limited Dr A's scope of practice to exclude laparoscopic surgery.

96. Regarding the third case, Dr Short stated:

> "It is not clear why [the DHB was] not aware of the complications involving 'case 3'. One would hope that such a serious complication would have been picked up through incident reporting or surgical morbidity audit mechanisms and the fact that this did not happen should be of concern to the DHB. The DHB should be encouraged to ensure it has robust mechanisms in place for early identification and internal reporting of serious surgical morbidity."

97. I agree with this advice and am concerned that the DHB was unaware that such a serious event had occurred. The DHB has explained that it was not aware of the third event at the time it occurred (early 2012) because the consumer had initial surgery at the Hospital, was domiciled in a different area, and was admitted to another DHB hospital when she became unwell and required repair of her small bowel perforation.

98. Dr Short noted that because the second and third events related to laparoscopic surgery, Mrs B's surgery (which was not laparoscopic) would have probably still gone ahead, even if the DHB had been aware of the third case. Dr Short considered that the DHB provided appropriate care to Mrs B, particularly in light of the information they had available regarding the previous incidents.

99. In my view, the DHB should have become aware of the third event shortly after it occurred, because the complication became known at one of its hospitals. It would have been appropriate for the DHB to put in place appropriate measures at that time to address the concerns regarding Dr A's competence. I consider that the DHB's systems for identification and reporting of serious surgical events were inadequate in this case.

100. Furthermore, I am concerned that a reportable event review was not initiated regarding the third event in accordance with the DHB's usual process.



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## Recommendations

101. I recommend that Dr A apologise to Mrs B for her breaches of the Code. The apology is to be sent to HDC for forwarding to Mrs B within three weeks of the date of the final report.

102. I recommend that, before issuing a practising certificate, the Medical Council of New Zealand undertake a review of Dr A's competence should she return to practise medicine in New Zealand.

103. I also recommend that, within three months of the date of the final report, the DHB:

a) Consider introducing a separate credentialling process for advanced surgical procedures in addition to the standard SMO credentialling.
b) Review its mechanisms for early identification and internal reporting of serious surgical morbidity.
c) Report to HDC on the outcomes of these processes.

## Follow-up actions

104. • A copy of this report with details identifying the parties removed, except the expert who advised in this case, will be sent to the Medical Council of New Zealand and two overseas Medical Boards, and Dr A will be named in the covering correspondence.

• A copy of this report with details identifying the parties removed, except the expert who advised in this case, will be sent to the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.



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## Appendix A: Independent expert advice to the Commissioner

The following expert advice was obtained from specialist obstetrician and gynaecologist Dr John Short on 12 December 2014:

> "I have been asked to provide an opinion to the Commissioner on case number 13/01557. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.
>
> I am a specialist Obstetrician and Gynaecologist, vocationally registered in New Zealand since 2007. I have worked as a senior medical officer in Obstetrics and Gynaecology at Christchurch Women's Hospital since 2006.
>
> I have been asked to provide advice to the Commissioner regarding the care provided to [Mrs B] by [Dr A], Obstetrician and Gynaecologist at [the Hospital], in July 2012. More specifically I have been asked to comment on the following:
>
> The appropriateness of the clinical care provided by [Dr A] to [Mrs B] during her hysterectomy;
>
> The appropriateness and timeliness of [Dr A's] decision to abandon the vaginal hysterectomy and convert to an abdominal hysterectomy;
>
> The appropriateness and timeliness of [Dr A's] decision to request assistance from [Dr C] (supervising gynaecologist at [the Hospital]);
>
> The adequacy of the information provided to [Mrs B] following her surgery.
>
> This report is based upon information provided by the HDC, including copies of clinical records, and responses from the various doctors involved in the case.
>
> Background/Key points
>
> [Mrs B] was admitted to [the Hospital] for a vaginal hysterectomy on 11th July 2012, under the care of [Dr A] (presumably a locum specialist). The indication was menometrorrhagia (frequent and excessive uterine bleeding, both at the usual time of menstrual periods and at other irregular intervals). She had signed a consent form for 'hysterectomy' (route not specified) at an outpatients appointment with [Dr A] on 19th June 2012. This form specifies the potential risks of the procedure including 'pain, bleeding, infection, damage to other organs'. At the same consultation [Dr A] noted 'I did perform a pelvic examination today, uterus is approximately 6 week size. She does appear to have adequate pelvic room with good descent. Therefore I discussed a total vaginal hysterectomy'.
>
> Unfortunately the available notes from the surgery are uninformative. In her statement dated August 26th 2014, [Dr A] does provide more information about the surgery. She does state the indication for surgery was 'Dysmenorrhoea and Menorrhagia' (painful and heavy periods) and that 'After her exam, I felt she was a good candidate for a vaginal hysterectomy'. She then describes events, particularly that there was difficulty identifying a clear tissue plane to allow entry



HDC

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to the posterior cul-de-sac (space between cervix and rectum). Despite this [Dr A] persisted with the vaginal approach, shifting to focus on the anterior cul-de-sac (space between uterus and bladder) with some progress. She then describes dissecting the uterosacral ligaments which, in her view, allowed for more uterine descent and increased exposure of the surgical field. [Dr A] felt it appropriate to re-attempt entry to the posterior cul-de-sac, which led to an injury to the rectum. She consulted with [Dr D], general surgeon, and [Dr C], her 'supervisor'.

Following confirmation of the rectal injury, the vaginal hysterectomy was abandoned and a laparotomy (abdominal incision) was performed. Extensive adhesions were encountered and the hysterectomy was completed with difficulty by [Drs A and C]. [Dr D] then performed a transvaginal closure of the rectal laceration. In his notes he describes a 'long posterior vaginal/anterior rectal laceration'. A loop sigmoid colostomy was then performed.

Postoperatively, [Mrs B] went to intensive care. It is documented at 0230 on 12th July 'finding it hard to get her head around the surgery and the colostomy'. [Dr A] saw [Mrs B] on 12/7/12, at an unspecified time. There is no documentation of any discussion or explanation of the surgical complications. [Dr D] saw [Mrs B] at 0835 (presumably after [Dr A's] visit). It is clearly documented that the surgery was explained and why the colostomy was done.

The remaining postoperative care appears relatively unremarkable. [Mrs B] was reviewed numerous times by [Dr A]. There is no documentation of any discussion at any time regarding the surgical complications.

[Mrs B] left hospital on 23rd July 2012. She underwent reversal of the colostomy on 11th February 2013.

From 25th July 2012 [Dr A's] scope of practice was limited to exclude laparoscopic and vaginal surgeries. [Dr C] assisted [Dr A] in all major surgery for the remainder of her time with [the DHB]. It appears that [Dr A] stopped working in [the Hospital] on 9th November 2012.

[Mrs B] has expressed concerns about the standard of care and communication provided by [Dr A].

Opinion/Comment

Bowel injury is a recognised, albeit relatively rare, complication of pelvic surgery, including vaginal hysterectomy. The risk of injury is increased in the presence of pelvic adhesions, particularly those affecting the pouch of douglas (this is what the Americans call the 'posterior cul-de-sac' — the space between the rectum and cervix). Prior to embarking on such surgery, surgeons may not know if adhesions are present. A vaginal hysterectomy is removal of the uterus through the vagina. The surgery begins with an incision around the cervix. The surgeon then dissects into the peritoneal cavity though the front and back of this incision, entering the 'uterovesical space' (or 'anterior cul-de-sac' — space between uterus and bladder) and 'pouch of douglas' respectively. Care needs to be taken to avoid injury to the



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bladder at the front and the bowel at the back, as both these vital structures are close to the surgical field. Once safe entry to the peritoneal cavity is achieved the surgeon can then proceed to separate the uterus from its attachments and blood supply. The vaginal incision is stitched closed at the end of the procedure.

Not everyone is suitable for a vaginal hysterectomy. Identifiable factors to predict unsuitability include a large uterus, small or narrow vagina, a lack of cervical descent (the cervix does not come down easily with pushing or traction) and previously known adhesions (usually due to previous surgery or conditions such as pelvic inflammation or endometriosis).

Based on the available records I would conclude that the initial decision to perform a vaginal hysterectomy was appropriate. There was a clear indication (frequent and excessive periods) for which it would provide effective treatment and there is no reason to think it would not be straightforward.

Unfortunately [Dr A's] surgical notes are inadequate and provide little useful information. She provides more detail in her typed statement to 'ACC' dated August 26 2014, although this is more than 2 years after the event. I am also unsure of [Dr A's] exact status at the time. I presume she was a locum specialist, under nominal supervision as a requirement for Medical Council registration.

It would appear that from early on in the procedure [Dr A] encountered some difficulties with the procedure, particularly with entry to the 'pouch of douglas' posteriorly. Rather than convert to an abdominal procedure she opted to further pursue the vaginal approach, without seeking advice or assistance, which ultimately led to the bowel injury. In the circumstances I do not think it was appropriate to pursue this approach at this stage and she should have converted to an abdominal procedure or at least sought advice from a senior colleague. This view is echoed by [Dr C] who states 'I am of the opinion that [Dr A] should have abandoned the Vaginal Hysterectomy much earlier'. Bowel adhesions involving the 'pouch of douglas' are an obvious explanation for difficulties identifying tissue planes and will also frequently involve the uterosacral ligaments, so to cut these structures without ensuring prior entry to the 'pouch of douglas' is unsafe in my opinion. To take things further and to incise unidentified tissue and then extend that incision is also of considerable concern.

Postoperatively, [Dr A] saw [Mrs B] on a number of occasions. However it is not documented on any of these occasions that she explained the complications or discussed events. However, it is very clearly documented on 12/7/12 that [Dr D] explained the surgery to the patient. Therefore, on the issue of the adequacy of information provided by [Dr A] to [Mrs B], one would have to take the side of the patient and conclude that the information provided was inadequate despite [Dr A's] protestations to the contrary.

Aspects of this case also raise concerns about the adequacy of the supervision provided to [Dr A]. Obvious questions to ask include:



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— What assessment had been made of her surgical ability prior to allowing her to operate unsupervised?

— Why was [Dr A's] scope of practice limited to exclude laparoscopic and vaginal surgeries after this event? Had there been pre-existing concerns or other complications to prompt this radical step?

— Were there any reasons [Dr A] would be reluctant to seek assistance?

In response to the HDC's specific questions:

The appropriateness of the clinical care provided by [Dr A] to [Mrs B] during her hysterectomy;

The appropriateness and timeliness of [Dr A's] decision to abandon the vaginal hysterectomy and convert to an abdominal hysterectomy;

The appropriateness and timeliness of [Dr A's] decision to request assistance from [Dr C] (gynaecologist at [the Hospital]).

Please see above. Appropriate care was not provided. [Dr A] tried too hard to achieve a vaginal hysterectomy and ideally should have abandoned this sooner. She did not request assistance early enough. Doing so may have prevented injury to [Mrs B]. The standard of care, particularly for a junior specialist under supervision, would be to carefully consider why an operation is not going to plan and to consider the potential risks involved in continuing, as well as to consider alternatives that would facilitate safer achievement of the ultimate goal (removal of the uterus with minimal complications). I would rate the level of departure to be moderate.

The adequacy of the information provided to [Mrs B] following her surgery.

Please see above. There is no evidence that [Dr A] provided any information to [Mrs B]. The records are more consistent with [Mrs B's] version of events. The standard of care would be open disclosure with honest, open and transparent explanation of events as promptly as possible with further reinforcement. Whilst it is possible that [Dr A] may have done this, as it is not documented and the patient presents an alternative view I have to conclude that, until proven otherwise, a severe departure from accepted practice occurred.

Based on the review of the records, I would also conclude that [Dr A's] record keeping is inadequate. One could accept that the initial operation note is such due to her 'distress' following the complication. However, this provides insufficient mitigation. Accurate contemporaneous record keeping is essential to safe practice. In this, there has been a severe departure from accepted standards. It may be that more documentation is available to refute this (eg typed or electronic record), so I am willing to revise this view if such information is provided.

I also have some concerns regarding the adequacy of supervision provided to [Dr A]. I would suggest the HDC seek clarification from [the DHB] in this regard.



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<u>Summary</u>

Based on a review of the information provided I conclude that the complications suffered by [Mrs B] were potentially avoidable. [Dr A] failed to provide an adequate standard of care on a number of points, including safe surgical practice, documentation and provision of information to her patient. It is possible that [the DHB] failed to provide appropriate supervision to [Dr A] and the HDC should seek clarity on this.

I hope you find this report helpful and please contact me if you need any further comment."

The following further advice was received from Dr Short on 1 September 2015:

"I have been asked to provide further advice to the Commissioner on case number 13/01557. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

I am a specialist Obstetrician and Gynaecologist, vocationally registered in New Zealand since 2007. I have worked as a senior medical officer in Obstetrics and Gynaecology at Christchurch Women's Hospital since 2006.

I have already provided advice to the Commissioner regarding the care provided to [Mrs B] by [Dr A], Obstetrician and Gynaecologist at [the Hospital], in July 2012. I have now been asked to provide advice to the commissioner regarding the appropriateness of the clinical care provided to [Mrs B] by [the DHB]. I have been asked to specifically comment on the following:

1. The appropriateness of the clinical care provided by [the DHB] to [Mrs B] in all of the circumstances including:
    a. The information available to [the DHB] at the time of the events relating to [Mrs B], regarding previous incidents involving [Dr A]
    b. Supervision being provided to [Dr A] by [Dr C]
2. The appropriateness of any actions taken by [the DHB] following each incident involving [Dr A]
3. The appropriateness of [the DHB] policies in place at the time of these events
4. The appropriateness of changes made to relevant DHB policies

This report is based upon information provided by the HDC, including copies of clinical records, and responses from the various persons involved in the case and subsequent investigations.

<u>Background/Key points</u>

Details of the care provided to [Mrs B] by [Dr A] are dealt with in my previous advice to the Commissioner. I will not repeat those details here. In that report I



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also raised concerns about the adequacy of supervision provided to [Dr A], including:

— What assessment had been made of her surgical ability prior to allowing her to operate unsupervised?

— Why was [Dr A's] scope of practice limited to exclude laparoscopic and vaginal surgeries after this event? Had there been pre-existing concerns or other complications to prompt this radical step?

— Were there any reasons [Dr A] would be reluctant to seek assistance?

The DHB has kindly provided further information to answer these questions. This includes a brief description of the credentialing process, Medical Council supervision reports, details of numbers of surgical cases performed by [Dr A] at [the Hospital] and details of other complications suffered by [Dr A's] patients.

[Dr A] is [an overseas trained] Obstetrician and Gynaecologist. She was awarded her diploma from the […] Board of Obstetricians and Gynaecologists in 2007. Presumably she worked [overseas] before taking up a locum position at [the Hospital], commencing in [month and year of employment].

Initially she underwent a credentialing process. Full details are not available. However, she spent 2 weeks [under the supervision the head of department of obstetrics and gynaecology]. 'This included induction and orientation into New Zealand practice, observation and to be observed in clinical settings including gynae surgery'.

After being approved by the [the DHB] credentialing committee she began work at [the Hospital]. [Dr C] provided ongoing supervision on behalf of the Medical Council. This is a standard procedure for overseas medical graduates beginning work in New Zealand. As part of this process her clinical skills, including surgery, were apparently observed in the first few weeks. There were regular meetings between [Drs A and C]. Reports (on standardised forms) were provided to the Medical Council every 3 months. Reports dated 17/2/12, 17/5/12 and 15/9/12 rate [Dr A] as meeting or exceeding expected standard in all domains except 'relevant procedural skills'[18]. In all 3 reports this domain is marked as 'N/A Not observed'. There was no formal supervision process on behalf of [the DHB].

During her time at [the Hospital] [Dr A] performed 136 surgeries, including 13 abdominal hysterectomies, 5 vaginal hysterectomies and 31 caesarean sections. There were four serious events involving patients cared for by [Dr A], including the case of [Mrs B]. One of the cases (dubbed 'case 1' by [the DHB]) is not relevant to the matter at hand. However, the other two cases are highly relevant. Both involve small bowel perforations during laparoscopic surgery performed by

[18] In response to my provisional report Dr C stated "I marked the domain 'relevant procedural skills' as not observed. My interpretation of the domain 'relevant procedural skills' (venesection, arterial blood gases, peak flows etc) is that it does not include surgical procedures. I always marked this domain as 'not observed'."



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[Dr A] in April 2012. Details are limited but it appears that [the DHB], [Dr C] and [Dr A] were aware of the first of these cases ('case 2') at the time, but possibly not the second ('case 3') until long after the event as [the consumer] was admitted to [a different hospital] with her complications.

Following [Mrs B's] surgery in July 2012, [Dr A's] scope of practice was limited to exclude laparoscopic and vaginal surgeries. [Dr A] ceased employment with [the DHB] and presumably departed New Zealand in November 2012.

Opinion/Comment

There were clearly serious performance issues with [Dr A]. At the time of [Mrs B's] surgery the DHB was aware of one other case of a serious surgical complication ('case 2'). This case was of a laparoscopic hysterectomy converted to an abdominal hysterectomy. This was a very different procedure to that intended for [Mrs B]. I am of the opinion that all surgeons will have complications at some point in their careers and to stop [Dr A] from performing surgery after 'case 2' would have been an over-reaction. Even had the DHB taken such a step it would probably only have been reasonable to prevent her from performing laparoscopic procedures. Since [Mrs B's] surgery was not laparoscopic it would probably have still gone ahead anyway.

Had the DHB been aware of the complications occurring in 'case 3', then it would have been appropriate to prevent [Dr A] from performing laparoscopic surgery independently. However, this would also mean [Mrs B's] surgery would probably still have gone ahead. It is not clear why the DHB were not aware of the complications involving 'case 3'. One would hope that such a serious complication would have been picked up through incident reporting or surgical morbidity audit mechanisms and the fact that this did not happen should be of concern to the DHB. The DHB should be encouraged to ensure it has robust mechanisms in place for early identification and internal reporting of serious surgical morbidity. This is clearly not an easy undertaking and presents significant challenges. Also, I doubt there will ever be a perfect system for this purpose in any DHB. For these reasons, I offer this suggestion only as constructive advice rather than as a criticism as I am quite certain that all DHBs can improve in this area.

The procedure attempted in 'case 2' was an advanced laparoscopic procedure. These require an additional skill set and additional training. It is not clear what credentials [Dr A] possessed to be attempting such procedures. I note she had been through a credentialing process, although detail of what this involved is limited. It is certainly encouraging that such a process took place, particularly as it does appear to have involved a committee covering the whole DHB rather than just the O&G department. If they do not already do so, the DHB may wish to consider a separate credentialing for advanced surgical procedures in addition to the standard SMO credentialing. For example, such a system exists within [a group of NZ private hospitals]. Again, this is suggested only as constructive advice rather than as a criticism as I am again quite certain that all DHBs can improve in this area.



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[Dr C] provided supervision to [Dr A] on behalf of the Medical Council. He states that he observed [Dr A] perform surgery prior to her beginning independent practice. Unfortunately there is a discrepancy between this statement and the reports provided to the Medical Council, in which [Dr C] has marked 'not observed' for the domains of 'procedural skills'. The Commissioner may wish to seek clarification on this matter. Beyond that [Dr C] appears to have been a conscientious and supportive supervisor. Having undertaken the role myself many times in the past, I am well aware of how onerous and challenging it can be. Following [Mrs B's] surgery, [Dr C] acted promptly and appropriately to deal with the issues of [Dr A's] performance. Subsequent to that, the DHB actions were also prompt and appropriate.

On the whole I am of the view that [the DHB] took all reasonable steps to ensure that [Dr A] was suitable for her role and safe to practise. Regarding the role of supervisor, it seems that [Dr C] performed this role appropriately although there appears to be some discrepancies in the observation of procedural skills. This may be a simple misunderstanding. For example, whilst I would assume this domain includes surgical procedures [Dr C] may not see it that way.

The only other comment I would like to make is a general one regarding surgery. Surgery is often (incorrectly) viewed as a purely technical process and the impression I have from the information provided is that some within [the DHB] take that view.[…]. How DHBs address [attributes of surgeons] within the credentialing and supervision process is hugely challenging and I certainly do not think [the DHB] are any more deficient in this regard than any other DHB.

Regarding the Commissioner's specific questions:

1 The appropriateness of the clinical care provided by [the DHB] to [Mrs B] in all of the circumstances including:

   a The information available to [the DHB] at the time of the events relating to [Mrs B], regarding previous incidents involving [Dr A]

   b Supervision being provided to [Dr A] by [Dr C]

2 The appropriateness of any actions taken by [the DHB] following each incident involving [Dr A]

3 The appropriateness of [the DHB's] policies in place at the time of these events

4 The appropriateness of changes made to relevant DHB policies

1a and b and 2 have been dealt with above. Regards 3 and 4 I think the DHB policies were and are appropriate. Unfortunately, the existence of an appropriate policy does not mean staff are aware of it or follow it. However, [Dr A] was orientated to New Zealand practice and supported by [Dr C] so should have been aware of these.



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<u>Summary</u>

It is my opinion that [the DHB] provided appropriate care to [Mrs B], particularly in light of the information they had available regarding previous incidents involving [Dr A]. Pending clarification of contradictions between his statements and supervision reports I am also satisfied that [Dr C] provided appropriate supervision. In my opinion the DHB responded appropriately following the incidents it was aware of. As mentioned above the DHB policies were and are appropriate.

I would advise that the DHB, for its own future benefits, internally review its credentialing process re advanced surgical procedures and its incident identification processes. As these matters would not directly have altered the outcome for [Mrs B] I would see no need for them to report back to the commissioner on these matters.

I hope you find this report helpful and please contact me if you need any further comment.”



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