Orthopaedic Surgeon, Dr A

Dr A's company

A Report by the

Health and Disability Commissioner

(Case 19HDC00455)

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a woman by an orthopaedic surgeon, in particular the information provided to her about her hand surgery and the consent process.

2. In June 2017, the woman suffered an injury to her right wrist. She had also suffered a previous injury to her right wrist in 2005.

3. On 14 September 2017, the woman first saw the orthopaedic surgeon about her wrist injury. She also saw a trainee working under the orthopaedic surgeon, and a hand therapist. The plan was for the woman to continue with hand therapy treatments and then have another review in two months' time to consider surgical intervention.

4. On 16 November 2017, the woman had her second consultation with the orthopaedic surgeon. The woman first saw the trainee, who did not document his conversation with the woman, but told HDC that the details of ulnar shortening osteotomy, including the use of plate and screws, was discussed. The woman then saw the orthopaedic surgeon. The orthopaedic surgeon advised HDC that the trainee told him that he had gone through the operation with the woman in great detail and that she was happy to proceed to surgery.

5. The orthopaedic surgeon signed the consent form with the woman. The consent form noted the operation to be performed, namely a right wrist arthroscopy and debridement, ulnar styloidectomy and ulnar shortening, ligament repair, and capsulodesis. The clinical notes and the consent form from this date do not document in detail what was communicated to the woman.

6. The woman told HDC that neither the trainee nor the orthopaedic surgeon informed her about the use of a plate and screws, or that her ulnar was to be cut in half and shortened with access through her forearm. The orthopaedic surgeon said that he does not directly inform patients that a plate and screws will be inserted, as given that the bone is cut and then needs to be fixed back together, he considered this to be obvious. The orthopaedic surgeon accepted that it was unlikely that he specifically discussed with the woman the insertion of a plate and screws.

7. Surgery was performed on 30 April 2018 and proceeded uneventfully. Subsequently, the woman suffered further complications to her elbow and saw a different orthopaedic surgeon.

Findings

8. The Commissioner considered it unlikely that the woman was informed that her ulna bone would be cut in half, or that her surgery would involve the insertion of a plate and screws. The Commissioner found that the orthopaedic surgeon breached Right 6(2) of the Code and that the woman was not in a position to make an informed choice or give informed consent for the treatment provided, and, as a result, that the orthopaedic surgeon also breached Right 7(1) of the Code.

9. The Commissioner also found that, by not documenting the information that was provided to, and discussed with, the woman regarding the proposed treatment, the orthopaedic surgeon failed to adhere to the Medical Council of New Zealand (MCNZ) standards regarding documentation, and therefore breached Right 4(2) of the Code.

10. The Commissioner considered that the errors that occurred did not indicate broader systems or organisational issues at the orthopaedic surgeon's company, and that the company did not breach the Code.

Recommendations

11. The Commissioner recommended that the orthopaedic surgeon apologise to the woman and undertake further training on communication and informed consent.

Complaint and investigation

12. The Health and Disability Commissioner (HDC) received a complaint from Ms B about the services provided by Dr A and Dr A's company. The following issues were identified for investigation:

- *Whether Dr A provided Ms B with an appropriate standard of care from August 2017 to November 2018.*
- *Whether Dr A's company provided Ms B with an appropriate standard of care from August 2017 to November 2018.*

13. This report is the opinion of the Commissioner.

14. The parties directly involved in the investigation were:

Dr A	Orthopaedic surgeon
Dr A's company	Provider
Ms B	Complainant/consumer

15. Dr D, who was working with Dr A as a trainee, is also mentioned in the report.

16. Further information was received from:

ACC	
Dr C	Orthopaedic surgeon
A hand therapist	
A private hospital	

17. Independent expert advice was obtained from an orthopaedic and hand surgeon, Dr Robert Rowan (Appendix A).

Information gathered during investigation

Background

18. This opinion concerns the care provided by an orthopaedic surgeon, Dr A,[1] and Dr A's company,[2] to Ms B, in particular the information provided to her about her hand surgery.

19. In June 2017, Ms B, then aged in her thirties, suffered an injury to her right wrist while she was working. Ms B had suffered a previous injury to her right wrist in 2005. In August 2017, Ms B was referred to Dr A by ACC.

20. Ms B told HDC:

> "I was never advised my forearm was going to be cut open. I was told I was having an ulna shortening which I believed to be … just removing the old fracture from the styloid[3] process. Nor was I ever advised I would have plates and screws placed in my arm and that my ulna bone[4] was going to be cut in half."

Preoperative consultations

First consultation

21. On 14 September 2017, Ms B had her first consultation with Dr A.[5] She first saw a registered hand therapist and then Dr D, a Fellow (trainee)[6] in hand surgery working under Dr A at the time. Dr D told HDC: "I worked as a Fellow in Hand Surgery under the tutelage of [Dr A] [in 2017]."

22. Dr D told HDC that he would have carried out a physical examination, reviewed pertinent imaging, and had a discussion about his diagnosis and possible treatments.

23. Ms B told HDC:

> "I was taken into the room by [Dr D], he brought up my X-rays/MRI scan films … At no point in this discussion which was approximately 10 minutes was a discussion of screws and plates discussed nor the need for my ulna to be shortened with access through my forearm. Nor was any surgical technique discussed. He simply showed me the damage and discussed surgical interventions was a possibility. He was polite and said he would need [Dr A] to assess further."

24. Dr A said that both the hand therapist and Dr D discussed Ms B's condition with him before he saw her. This discussion was not documented. Dr A told HDC:

[1] Dr A is a Fellow of the New Zealand Orthopaedic Association and a Fellow of the Royal Australasian College of Surgeons.
[2] Dr A provides his services through this company. He is the sole director and 99% shareholder of the company.
[3] Points of attachment for muscles.
[4] The longer of the two bones found in the forearm.
[5] Dr A operates his practice at a clinic that is also shared with hand therapists.
[6] In this context, a Fellowship is a period of medical training after completing a specialty training programme.

> "In our discussion before my initial consult with [Ms B], [Dr D] informed me of the pathology that the patient presented with namely distal radioulnar joint[7] instability and ulnar styloid non-union[8] … [Dr D] stated that he talked to the patient about styloidectomy,[9] ligament repair, and ulnar shortening osteotomies.[10]"

25. Dr A said that Ms B immediately asked him when her surgery was going to take place, but he advised her that he needed to assess her first prior to giving consideration to surgery. Dr A told HDC that at this consultation Ms B denied any major, prior injury. Dr A told HDC:

> "I then presented the options to her including hand therapy and that it was only about 3 months since the events, so I believed further hand therapy was necessary prior to proceeding to surgery. [Ms B] did not appear happy with this approach but reluctantly agreed that this was the right approach."

26. Ms B said that when she first saw Dr A he asked her if she had private insurance to cover her surgery. Ms B told HDC: "[Dr A] told me he was going to wait 9 weeks and reassess me if I was going to go with ACC … [Dr A] only told me to continue resting [the] splint for 9 weeks."

27. Dr A said that he advised Ms B that first she should receive further hand therapy treatments for at least two months before surgical interventions were considered. Dr A told HDC:

> "In summary, [Ms B] was given a thorough explanation as to what surgery would be done if surgery was agreed to. Following presentation of options she agreed to delay surgery."

28. In Dr A's clinical records, which were also sent to ACC, he noted: "[T]he plan is to review in 2 months and then consider surgical intervention which would involve right arthroscopy ulnar styloidectomy and ulnar shortening." There is no documentation of the specific information provided to Ms B or of any discussion about specific surgical procedures.

29. Ms B also said that after this consultation and before her next consultation in November 2017, she saw Dr A briefly and was advised that he would see her in two months' time. Dr A advised: "[T]here is no record of this nor any recollection of such visit by the clinicians and staff of [the Clinic]."

Second consultation

30. On 16 November 2017, Ms B had her second consultation with Dr A, as her non-surgical treatment had not been effective. In response to the second provisional report, Dr A told HDC that subsequent information requested and received from ACC confirmed that a significant wrist injury had in fact been sustained in 2005. Dr A told HDC that from his records, Ms B arrived at the clinic around 11am and saw Dr D prior to seeing him.

[7] The joint between the two bones in the forearm (the radius and ulna).
[8] A visible fracture line.
[9] Surgery to shorten the styloid process.
[10] Surgery to shorten the ulnar bone.

31. Dr D told HDC:

> "I treat every patient the same — a physical exam, review the pertinent imaging, a discussion of the diagnosis and how I made that conclusion, and finally a discussion of treatments … in this case, ulnar shortening osteotomy etc … The details of ulnar shortening osteotomy, including plate and screws is discussed when that treatment is being considered and/or selected but I do not document that 'plates and screws' are used in the notes. Plates and screws are implied when stating ulnar shortening osteotomy."

32. Dr D accepted that the discussion at this consultation was not documented and "simply state[d] that the operative choice [was] ulnar shortening osteotomy". Dr D told HDC:

> "[T]he risks, benefits, alternatives, and complications were discussed with the patient as the patient made the choice to have surgery and signed the consent form with [Dr A] ... the discussions between the patient and myself supplement the discussion between the patient and [Dr A] which is an absolute."

33. Dr A said that his consent process when a Fellow is present, in this case Dr D, is as follows:

> "I expect the fellow to go into great detail with regards to the surgical procedure and if there is an operation that is straight forward such as plate and screw removal, or a carpal tunnel, which are operations of less than 1 hour duration the fellow can sign the consent form. If there is a more complex procedure of >1-hour duration then the consent form is signed by myself."

34. Dr A saw Ms B from around 11.57am until 12.18pm. Dr A told HDC:

> "[Dr D] informed me that he had gone through the operation with the patient in great detail. He stated to me that she was happy to proceed to surgery and as part of our policy the patient then came to my office sitting in front of me while I filled out the consent form and I also went through the operation with her."

35. The consent form that was signed by Ms B and Dr A was provided to HDC. The form documents the following operations to be performed: right wrist arthroscopy[11] and debridement,[12] ulnar styloidectomy and ulnar shortening, ligament repair and capsulodesis.[13] The form contains a standard clause that states:

> "I confirm that I have received a satisfactory explanation of the reasons for, risks and likely outcomes of the procedure/operation/treatment, and the possibility and nature of further related treatment including a return to theatre, should any complication arise.

[11] A procedure for diagnosing and treating joint problems.
[12] The removal of dead, damaged, or infected tissue to improve healing of the remaining healthy tissue.
[13] Repair of the joint capsule.

> I have had an opportunity to ask questions and understand that I may seek more information at any time and participate in decision making about my treatment."

36. Dr A said that he also talked about problems of infection and stiffness, in particular problems to be concerned about postoperatively. The consent form also noted: "[A]dmitting doctor's instructions: infection/stiffness."

37. The notes from this consultation consist of a letter from Dr A to Ms B's ACC case manager, with Ms B's GP copied in. Regarding the surgical procedure that had been selected, Dr A stated:

> "The operation of choice is a right wrist and distal radioulnar joint arthroscopy and debridement, ulnar shortening osteotomy, ulnar styloidectomy, distal radioulnar ligament repair plus capsulodesis."

38. The clinical notes and the consent form do not document in detail what was communicated to Ms B. The notes list the type of surgery but no further details about what the surgery would entail. Neither the consent form nor the clinical notes document the use of plates or screws.

39. Dr A told HDC:

> "As I do with all patients, as I fill out the form, I went through the form step-by-step and asked [Ms B] if she fully understood what she was having done. I said to [Ms B] what I say to all patients which is that they have agreed to sign the form at that moment in time that they agree that the operation is a good idea at that time. I then go on to say that they can change their mind at any time and true consent is that they present to the hospital on the day of the procedure.
>
> …
>
> I discuss with the patient the risks, benefits, alternatives, and complications. I describe the nature of the surgery. I do this with every patient and believe that I did so in the case of [Ms B]."

40. Ms B told HDC that neither Dr D nor Dr A informed her about the use of plates and screws, or that her ulnar was to be shortened with access through her forearm.

41. Dr A stated:

> "It is hard for me to understand how [Ms B] did not know she was going to get an incision in her forearm separate from the styloidectomy. I do not have records that state that I said she will have plate and screws in her forearm. I apologise again for not providing more clarity about plates and screws."

42. The surgery was scheduled for 30 April 2018 at a private hospital.

43. On 27 April 2018 (three days prior to the surgery), Ms B was contacted by a nurse, who carried out a preoperative telephone call. The form that documents the call was provided to HDC, and includes a "yes" tick alongside "Agreement to Treatment completed".

The surgery

44. On 30 April 2018, Ms B was admitted to the private hospital for her hand surgery under the care of Dr A. The Patient Admission Assessment form was completed by a nurse, and the form ticked "yes" to "Confirm correct procedure, site and side verbally with patient and against details on the Agreement to Treatment form". The Pre-operative Checklist was also completed by a nurse. The checkbox for "Consent form completed, correct & signed" was ticked "yes".

45. The surgery proceeded uneventfully. Dr A stated that "there were no major issues or complications during the procedure".

Postoperative care

46. Ms B remained at the private hospital from 30 April 2018 until 2 May 2018.

47. Ms B told HDC:

> "[On 30 April 2018] I woke up [sore] post-surgery … I saw the X-rays the nurse had and said 'they are [not] my X-rays I don't have plates and screws'. [The nurse] said 'yes they are and yes you do'."

48. This conversation was not documented in the clinical notes.

49. The nurse who provided postoperative nursing care told HDC:

> "I do not recall talking to the patient about her X-rays or giving her any X-rays to view. It is not part of my practice as an RN to explain the findings of X-rays as that is the role of a specialist. I would have documented if I had observed a specialist doing this."

50. Dr A reviewed Ms B at 7.15pm on 1 May 2018 and documented his visit in the clinical notes. No concerns raised by Ms B were noted in the clinical records on this date by any of the clinical or nursing staff. Dr A told HDC:

> "I have also looked at the hospital records very closely with regards to the next comment about X-rays and the nurse. It would be the policy of the hospital for the nurse to bring such a statement to my attention. There is no record of this, and this was never brought to my attention when I saw the patient at [7.15pm] on the day following the surgery.
>
> …
>
> When I saw her the following day after the surgery [Ms B] did not appear distressed by what was done and did not raise the issue of plates and screws being inserted with me at that time."

51. Conversely, Ms B told HDC:

> "I said post-surgery why did I have screws and plates when [Dr A] finally turned up at 7.15[pm]. He never really gave an answer. That [is] when he told me I was [a] pessimist. I felt deflated angry and powerless as this had not been done under my consent."

52. The anaesthetist who provided operative anaesthetic care to Ms B told HDC:

> "According to my personal records, [Ms B] was contacted daily after surgery. In short she did not report anything unusual. Her recovery and pain management were as expected."

53. Ms B was discharged from hospital on 2 May 2018. Dr A said that on 3 May 2018, Ms B was contacted by a nurse from the private hospital for her post-discharge telephone call. No issues raised by Ms B about her surgery are contained in the records. In response to the second provisional report, Dr A's lawyer told HDC:

> "Hospital policy would require any patient confusion or distress as to what had occurred in surgery to be brought to the lead clinician's attention. No concern over the presence of plates and screws was documented by any of the clinical or nursing staff in the clinical records."

Follow-up care

54. Ms B had a follow-up visit on 15 May 2018 for her two-week postoperative appointment. She saw a hand therapist and also Dr A. Dr A sent a letter to Ms B's hand therapist and to ACC. Dr A noted: "I reviewed this lady in the office today 2 weeks out from her major wrist reconstruction. She is doing very well. The wound looks very satisfactory."

55. Subsequently, Ms B had consultations with Dr A on 14 June, 2 August, 7 August, 18 September, and 15 November 2018.

56. Dr A's clinical notes for the above consultations were provided to HDC. No concerns raised by Ms B about plates and screws or consent issues are noted in the clinical records.

57. From May to November 2018, Ms B was seen by three hand therapists who work in the same facility as Dr A. All three hand therapists told HDC that Ms B did not raise any concerns about the surgery with them. The hand therapists' notes were provided to HDC, and contain no concerns about the surgical process or consent issues.

58. However, another hand therapist who provided services to Ms B in her home city post-surgery from May 2018 told HDC:

> "[Ms B] repeatedly expressed concern to me about her surgery — specifically the ulna shortening that she was adamant that she had not agreed to. I have not documented this in my notes but there was rarely an appointment that it was not mentioned."

59. Dr A stated:

> "15 November [2018] was the last consultation with the patient and at no stage [did] the patient express to us concerns about her management and a desire to get a second opinion. She even contacted the office on 6 January cancelling her future appointments and stated to our staff that she was better."

Subsequent events

60. Ms B suffered a right elbow common extensor tendinosis[14] following the surgery. On 15 January 2019, Ms B engaged a different orthopaedic surgeon, Dr C, and sought further advice from her about her injuries. Dr C noted in her records dated 15 January 2019:

> "[Ms B] tells me that she has been very unhappy with the management she has been given and reports mixed messages at times by [Dr A]. She has lost confidence in his management and has asked for a second opinion."

61. Dr C's clinical notes dated 27 February 2019 document:

> "[Ms B] is very distressed and upset by the sequence of events that [led] to this, she feel[s] she was forced into having surgery under [Dr A's] care … She also feels that [Dr A] never adequately informed her of what the surgery was. She was never aware that she was going to have a shortening of her ulna and when she was shown the X-rays post-operatively she advised the nurse that they had the wrong patient as she said she was completely unaware that a bony shortening with plate and screws was going to be performed."

62. In response to the first provisional opinion, Ms B told HDC that following this event she was affected physically and has developed arthritis, and she "had many months of mulligans[15] treatment and follow up CT scans to identify the elbow issue which was not present prior [to the] surgery".

Further information

63. Dr A stated:

> "I recognise that I have trouble in dealing with challenging strong personalities … I do struggle with people who are directive and certainly this patient [Ms B] has a directive personality …
>
> I did explain the nature of surgical treatment and the potential effects following the surgical treatment, I went through the risks and benefits, alternatives and complications with [Ms B] as this is something I do with every patient.
>
> …

[14] An overuse injury that occurs on the outside of the elbow.
[15] Mulligan manual therapy can be used to treat a variety of injuries and pain, including neck pain, back pain, and upper and lower extremity injuries.

> In term[s] of cases of ulnar shortening, my usual practice over the last 250 cases of ulnar shortening is to inform the patient that I will be cutting the bone and shortening. I do not directly inform patients that plates and screws will be inserted as given the bone is cut then needs to be fixed back together, I considered that it should be obvious to the patient that plates and screws will be inserted. From the complaint, this wasn't clear to [Ms B] and I apologise for this."

64. In relation to the use of plates and screws, Dr A also said:

> "Whilst my records do not state that I specifically told the patient about plates and screws, I know that myself and [Dr D] explained the nature of the surgical treatment and the potential effects following the surgical treatment. I accept however that it is unlikely that I specifically discussed inserting plates and screws with [Ms B] and I am sorry that she did not comprehend that this would be necessary."

65. Dr A's company stated: "We don't have any relevant written policies or procedures. The relevant processes and protocols that we follow have been summarised by [Dr D] in his response."

Changes made since incident

66. Dr A told HDC that as a result of this incident he made changes to his practice as follows:

a) With his new Fellows from overseas, he now insists that they spend two weeks directly observing him with regard to treating patients professionally. He said that because of this, he feels that the Fellows are better placed to give empathy and understanding of the New Zealand system and needs of the New Zealand patient.

b) He has made adjustments to his practice to allow him to spend more time with each patient.

c) He now informs all patients who are to have plates and screws inserted specifically of this.

Responses to provisional opinion

Ms B

67. Ms B was provided with an opportunity to comment on the "information gathered" section of the first provisional opinion. Where appropriate, her comments have been incorporated into this report. Ms B emphasised how the event affected her physically, and told HDC:

> "If [Dr A] felt I was a difficult patient he could not effectively communicate with he as a surgeon had an obligation to refer me to an alternative practitioner … There was no discussion ever about potential ranges of risks or potential outcomes of the surgery … Without full disclosure of the potential risks or ongoing limitations."

Dr A

68. Dr A was provided with an opportunity to comment on the first provisional decision.

69. Dr A's lawyer told HDC:

> "[Dr D] and [Dr A] were working in tandem in respect of the consenting of [Ms B] and explaining the procedure and [Dr D] was appropriately qualified to do so. The consent process for the procedure that [Dr A] was undertaking involved [Dr D] and what he told the patient, as much as it involved [Dr A]."

Dr A's company

70. Dr A's company was provided with an opportunity to respond to the first provisional opinion, and had no further comments.

Dr A's responses to second provisional opinion

71. In response to the second provisional decision, Dr A's lawyer told HDC:

> "[Ms B] did receive all appropriate information, and accepted that this was the case — up until the (recognised) post-operative complication of persisting stiffness caused her to reconsider whether having the operation was the correct course."

72. Dr A's lawyer also referred to the 2011 MCNZ "Information, choice of treatment, and informed consent" statement, and told HDC that the statement enables practitioners to share the responsibility of ensuring that patients are fully informed, and the statement encouraged practitioners not to proceed unless they were comfortable that the patient had an adequate understanding of the procedure to be undertaken. Dr A's lawyer stated:

> "[Ms B] had the benefit of consulting with [Dr A] and [Dr D] — both highly qualified and experienced clinicians. She was invited to ask any questions, on numerous occasions — by various health care workers — right up to the consultation immediately prior to surgery."

73. Dr A's lawyer submitted that it is "not appropriate" to proceed on the basis that, without documentation, clinicians' versions of events will not be accepted, and that this "does not reflect the reasonable realities of medical practice and extends far beyond the Council's 2011 statement".

Relevant standards

74. The MCNZ statement "Information, choice of treatment, and informed consent" (March 2011)[16] stipulates:

> "10. You must keep clear and accurate patient records that report information given to patients and decisions made. The Medical Council recognises that every aspect of a consultation cannot realistically be noted in the patient's record. As a result we recommend that you adopt written consultation protocols that specify what

[16] This was the relevant MCNZ statement in place at the time of the events.

information in the form of discussion, publications and questions will be given in a specific type of consultation (e.g. all patients experiencing migraines). You do not need to spend unnecessary time writing extensive notes. Instead, you can note in the patient record that the protocols were fulfilled and only outline any exceptions to the protocol. If the patient is referred or requests a copy of his or her record you should include a copy of the protocols.

…

14. If you are the doctor who is providing treatment or advice, then you are responsible for ensuring the patient makes an informed choice and consents before initiating treatment.

…

16. The patient must have the opportunity to consider and discuss the relevant information with the treating doctor. You can only proceed after the patient has made an informed choice and given informed consent, with the exceptions in paragraphs 20–23. Under Right 7 of the Code, a patient has the right to refuse services or withdraw consent at any time, reflecting self-determination."

75. MCNZ's statement "Maintenance and Retention of Patient Records" (August 2008) states:

"01 (a) You must keep clear and accurate patient records that report:

relevant clinical findings
decisions made
information given to patients
any drugs or other treatment prescribed.

(b) Make these records at the same time as the events you are recording or as soon as possible afterwards."

Opinion: Dr A — breach

76. This opinion concerns the process undertaken by Dr A to obtain Ms B's informed consent for hand surgery. I note that this opinion is not about the quality of the surgery. Ms B told HDC that she was never advised that her forearm would be cut open, that she would have a plate and screws placed in her arm, and that her ulna bone would be cut in half.

77. The principle of informed consent is at the heart of the Code of Health and Disability Services Consumers' Rights (the Code). Right 7(1) of the Code provides that apart from exceptional situations, health services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent. Right 6(2) of the Code recognises that for this to occur, consumers have the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent.

78. My expert adviser, orthopaedic surgeon Dr Rowan, advised: "It would be important for the patient to know that osteotomy (cutting the bone) would be undertaken, and that the bone would be fixed with a plate and screws."

79. In my view, and taking into account Dr Rowan's advice, it was reasonable in these circumstances for Ms B to expect to be told specifically what her surgery would entail, including that her ulnar bone would be cut in half at the forearm and fixed back together with a plate and screws. However, there is conflicting evidence about what information Ms B was, in fact, provided, including whether Dr D or Dr A informed Ms B that the surgery would involve opening up her forearm and cutting her ulna bone, or whether Ms B was informed by Dr D about the insertion of plates and screws. This is discussed further below.

Information provided to Ms B

First consultation

80. Ms B had her first consultation with Dr A in September 2017. At this consultation, she also saw Dr A's Fellow, Dr D. Dr A concluded that Ms B required further hand therapy before consideration of surgical treatment.

81. Dr A said that Dr D explained to Ms B the possible surgical treatments, including ulnar shortening, ligament repair, and styloidectomy. Ms B told HDC that there were no discussions about the need for screws and plates or the need for the ulnar to be shortened with access through her forearm. Dr A documented the possibility of wrist arthroscopy, ulnar styloidectomy, and ulnar shortening, but there is no mention in the clinical notes of what was said or explained to Ms B.

82. From the information provided, I consider that some discussion was had about the possible surgical treatments. However, from Dr A's perspective, it appears that the focus of the discussion was on hand therapy. Ms B's recollections appear to be centred on whether the surgery, if it were to go ahead, would be funded by ACC or private insurance.

83. As noted above, neither Dr A nor Dr D documented what information was provided to Ms B at this first consultation. The importance of the medical record is well established. Baragwanath J acknowledged the importance of medical records in *J v Director of Proceedings*, noting that record-keeping is a fundamental obligation of the practitioner.[17] Indeed, this Office has often observed that providers whose evidence is based solely on their subsequent recollections (in the absence of written records) may find their evidence discounted.[18]

84. Owing to the absence of any records documenting the information that was discussed, and the differing accounts of Ms B, Dr A, and Dr D, I consider it unlikely that at this consultation Ms B was informed that the surgery would involve her ulna bone being cut, and a plate and screws inserted. However, given the agreement reached was that Ms B would receive further hand therapy for at least two months before proceeding with surgery, in my opinion

[17] *J v Director of Proceedings* HC Auckland CIV-2006-404-2188, 17 October 2006 at [63] per Baragwanath J.
[18] See: www.hdc.org.nz — 04HDC03530.

it would not have been necessary for Dr A or Dr D to go into great detail about the surgery at this consultation. As such, I am not critical that Ms B was not provided with detailed information at this stage.

Second consultation

85. Ms B had her second consultation with Dr A in November 2017. Hand therapy to date had been unsuccessful, and surgery was proposed. Ms B saw Dr D first, and then Dr A.

86. Ms B told HDC:

> "I was never advised my forearm was going to be cut open. I was told I was having an ulna shortening which I believed to be … just removing the old fracture from the styloid process. Nor was I ever advised I would have plates and screws placed in my arm and that my ulna bone was going to be cut in half."

87. Dr D told HDC that he discussed with Ms B the "risks, benefits, alternatives and complications". Dr D stated:

> "I treat every patient the same — a physical exam, review the pertinent imaging, a discussion of the diagnosis and how I made that conclusion, and finally a discussion of treatments … in this case, ulnar shortening osteotomy etc … The details of ulnar shortening osteotomy, including plate and screws is discussed when that treatment is being considered and/or selected but I do not document that 'plates and screws' are used in the notes. Plates and screws are implied when stating ulnar shortening osteotomy."

88. After Ms B saw Dr D, she saw Dr A for 20 minutes. Dr A told HDC that Dr D informed him that he had gone through the operation in "great detail" with Ms B and she was happy to proceed to surgery. Dr A said that he expected Dr D to have gone into great detail regarding the surgical procedure.

89. Dr A told HDC that he "went through the form step-by-step and asked Ms B if she fully understood what she was having done". He believes that he discussed with Ms B the risks, benefits, alternatives, complications, and nature of the surgery.

90. However, Dr A also stated:

> "[I]t is unlikely that I specifically discussed inserting plates and screws with [Ms B] and I am sorry that she did not comprehend that this would be necessary …
>
> I do not directly inform the patients that plates and screws will be inserted as given the bone is cut then needs to be fixed back together, I consider that it should be obvious to the patient that plates and screws will be inserted."

91. In response to my first provisional opinion, Dr A stated that he and Dr D were "working in tandem" in respect to the consenting of Ms B and explaining the procedure, including the shortening of the ulnar and the use of plates and screws.

92. The notes from this consultation consist of a letter from Dr A to Ms B's ACC case manager, with Ms B's GP copied in. Regarding the surgical procedure that had been selected, Dr A stated:

> "The operation of choice is a right wrist and distal radioulnar joint arthroscopy and debridement, ulnar shortening osteotomy, ulnar styloidectomy, distal radioulnar ligament repair plus capsulodesis."

93. The letter does not include the information that was provided to Ms B. Dr A advised HDC: "[M]y usual practice over the last 250 cases of ulnar shortening is to inform the patient that I will be cutting the bone and shortening."

94. The consent form lists the procedures to be undertaken during the surgery — right wrist arthroscopy and debridement, ulnar styloidectomy and ulnar shortening, ligament repair, and capsulodesis — and Ms B has signed this form. However, there is no documentation whatsoever about the information provided to Ms B prior to her giving her consent.

95. As noted at paragraph 83 above, providers whose evidence is based solely on their subsequent recollections (in the absence of written records) may find their evidence discounted.

96. I have considered the conflicting accounts of Dr D, Dr A, and Ms B, as well as the lack of documentation of the discussion between them.

97. The consent form makes it clear that shortening of the ulna would occur during surgery, but does not specify an osteotomy or how the shortening would be achieved. While it may be clear to clinicians that an osteotomy involves "cutting the bone", the same cannot necessarily be assumed of a consumer. Although Dr A stated that his "usual practice" is to advise patients that the surgery will involve the bone being cut, and his consultation note from this date records that "the operation of choice" included an ulnar shortening osteotomy, there is no documentation of the discussions that took place or the information that was provided to Ms B about the procedure. The letter from this consultation was addressed to ACC with Ms B's GP copied in, but there is no indication that Ms B was given or sent a copy of the letter.

98. Similarly, there is no documentation to support Dr D's view that he discussed metal screws and plates with Ms B, and Dr A acknowledges that it is unlikely that he discussed screws and plates with Ms B. I do not accept Dr A's statement that "it should be obvious to the patient that plates and screws will be inserted". Providers have an obligation to inform consumers, and it is inappropriate to assume that they have knowledge of specialised technical procedures.

99. According to Ms B, she was "never advised [that her] forearm was going to be cut open". Ms B stated that she was told that she would be having "an ulna shortening which [she] believed to be … just removing the old fracture from the styloid process". Ms B said that she was not told that she would have "plates and screws placed in [her] arm and that [her] ulna bone was going to be cut in half".

100. As noted above, I consider that reasonable consumers in Ms B's circumstances would expect to be told that their surgery would involve the ulna bone being cut in half at the forearm, and that metal screws and plates would be inserted into the arm. I have carefully considered the totality of evidence and the parties' submissions in response to my first and second provisional opinions. Noting the discrepancy in the accounts of Ms B and her clinicians, and in the absence of any documentation to prove otherwise, I consider it unlikely that Ms B was informed that her ulna bone would be cut in half, or that her surgery would involve the insertion of plates and screws.

101. As the operating surgeon, it was Dr A's responsibility to ensure that Ms B was provided with the information that a reasonable consumer, in her circumstances, would need to make an informed choice or give informed consent to the surgery.

102. As a Fellow, Dr D was (in his own words) "under the tutelage" of Dr A. In his response to HDC, Dr D described his discussions with patients as designed to "supplement the discussion between the patient and [Dr A], which is an absolute". While it is acceptable for the treating surgeon to delegate aspects of the informed consent process to another provider, overall responsibility for obtaining informed consent must lie with Dr A as the treating surgeon.[19] In addition, I note that the consent form itself was signed by Dr A, not Dr D, further highlighting that the ultimate responsibility for informing Ms B about her treatment lay with Dr A.

103. My expert adviser, orthopaedic surgeon Dr Rowan, advised: "It would be important for the patient to know that osteotomy (cutting the bone) would be undertaken, and that the bone would be fixed with a plate and screws."

104. Dr Rowan also advised:

> "I would see the operating surgeon and the consultant in charge of the surgical treatment to be primarily responsible for ensuring that adequate consent for surgery was gained."

105. I agree. I am critical that Dr A, as the consultant in charge of the surgical treatment, did not ensure that Ms B was given the information necessary for her to give informed consent.

Documentation

106. As outlined above, MCNZ's 2011 informed consent statement in place at the time of the events stipulates that doctors "must keep clear and accurate patient records that report information given to patients and decisions made".[20] The statement recognises that doctors cannot realistically record every detail of a consultation, and recommends that practitioners "adopt written consultation protocols that specify what information in the form of discussion, publications and questions will be given in a specific type of consultation", so

[19] Medical Council of New Zealand: "Information, choice of treatment, and informed consent" (March 2011) at paragraph 14.
[20] See paragraph 74 above.

that they can "note in the patient record that the protocols were fulfilled and only outline any exceptions to the protocol".[21]

107. MCNZ's August 2008 statement regarding the maintenance of patient records also states that doctors "must keep clear and accurate patient records that report … information given to patients".[22]

108. As discussed above, neither Dr D nor Dr A documented their discussions with Ms B on 16 November 2017. Dr A's company advised that it did not have "any relevant written policies or procedures", and that "[t]he relevant processes and protocols that [it] follow[s] have been summarised by Dr D in his response".

109. Ms B did sign a consent form with Dr A on 16 November 2017 confirming that she had "received a satisfactory explanation of the reasons for, risks and likely outcomes of the procedure/operation/treatment". However, Dr A's clinical notes and the consent form do not document in detail what information was discussed with Ms B. The notes list the type of surgery but no further details about what the surgery would entail. Neither the consent form nor the clinical notes document that plates or screws would be used or that the bone would be cut.

110. In my opinion, as the operating surgeon, Dr A was not only responsible for ensuring that Ms B was fully informed and provided informed consent, but also for ensuring that the consent process was documented adequately and that the information that was discussed with Ms B about her treatment was recorded. I am critical that this was not done.

Conclusion

111. The facts in this matter are finely balanced. In my opinion, and being guided by my expert, it was important for Ms B to know that her surgery would involve cutting her bone in half at the forearm and then inserting a plate and screws. The failure to provide this information to Ms B meant that she did not receive the information that a reasonable consumer, in her circumstances, needed to make an informed choice or give her informed consent to the surgery. Accordingly, I consider that as Ms B's responsible clinician, Dr A breached Right 6(2) of the Code.[23] It follows that Ms B was not in a position to make an informed choice and give informed consent for the treatment provided. Consequently, Dr A also breached Right 7(1) of the Code.[24]

[21] See paragraph 74 above.
[22] See paragraph 75 above.
[23] Right 6(2) states: "Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent."
[24] Right 7(1) states: "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."

112. In addition, by not documenting the information that was provided to, and discussed with, Ms B regarding the proposed treatment, Dr A failed to adhere to MCNZ's guidelines regarding documentation, and therefore breached Right 4(2) of the Code.[25]

Opinion: Dr A's company — no breach

113. Dr A is a sole practitioner and is the sole director of his company. He provides his service through this company. Dr A has been practising as an orthopaedic surgeon for a number of years. Dr A's company told HDC that it has no written policies or procedures.

114. Dr Rowan opined:

> "From a clinical perspective [Dr A] is acting as a sole practitioner which is how most private practice surgeons in New Zealand work. In this regard I do not believe that [Dr A's] company would in normal circumstances have policies that determine how its surgeons practise or behave.
>
> [Dr A] (the individual surgeon) is required to practise medicine in an appropriate and safe manner according to the Codes of Good Practice, the Code of the Medical Council and that of the Health and Disability Commissioner."

115. I accept Dr Rowan's advice. I consider that the errors that occurred did not indicate broader systems or organisational issues at Dr A's company. Therefore, I consider that Dr A's company did not breach the Code.

Recommendations

116. I recommend that Dr A:

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

b) Undertake further training on communication and informed consent, and provide HDC with evidence that the training has been completed, within four months of the date of this report.

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

Follow-up actions

117. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Medical Council of New Zealand, the New Zealand Orthopaedic Association, and the Royal Australasian College of Surgeons, and they will be advised of Dr A's name.

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

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from Dr Robert Rowan, an orthopaedic and hand surgeon:

"23 September 2019

My name is Robert Rowan. I have read and agreed to the Health & Disability Commission's Guidelines for independent advisors.

My qualifications are MBChB (Auckland) 1994 and FRACS (Orth) 2003. I am a subspecialist orthopaedic hand surgeon with fellowship training in hand surgery.

I have been asked to comment on

1. The appropriateness of ulnar shortening in this instance
2. The appropriateness of anchors and sutures used during the surgery
3. The usual steps undertaken when obtaining informed consent for this procedure
4. [Dr A's] decision to not provide a pre-operative consultation for [Ms B]
5. Whether delay in surgery was reasonable within the circumstances
6. Any other matters you consider warrant comment

In answer to the questions:

1. The ulnar shortening osteotomy that was undertaken by [Dr A] was appropriate for the presenting pathology

[Ms B] presented following an injury with pain on the ulnar side of the wrist. She was noted by [Dr A] in his report on 14 September 2017 to have tenderness over the ulnar styloid.

Plain x-rays undertaken prior to that appointment on 11 July 2017 showed a bony ossicle distal to the tip of the ulnar styloid with some erosion within the ulnar styloid process. There was no true PA x-ray of the wrist but there is a PA x-ray undertaken of the forearm which suggests ulnar positive variance of 2mm.

It is very important to understand what is meant when we discuss ulnar variance. Ulnar variance is a measure of the length of the ulna relative to the radius. For assessments of the ulnar variance to be accurate they must be taken on PA (posterior-anterior) x-rays of the wrist undertaken with the forearm in neutral rotation. This is best undertaken with the shoulder abducted 90° and the elbow flexed 90°. If the x-ray is taken without the patient in neutral forearm rotation (i.e. in either supination or pronation), the assessment of ulnar variance will not be accurate. That is because the position of forearm rotation changes the relative length of the ulna and radius at the wrist. There have been a number of x-rays undertaken prior, to, and following the surgery that [Ms B] underwent. Many of these x-rays are not standard PA x-rays of the wrist and therefore assessment of the ulnar variance on these x-rays is unreliable.

As stated above, the ulnar variance on the pre-operative x-ray was suggestive of slight ulnar positive variance (+2mm), associated with this there was a large bony ossicle distal

to the ulnar styloid and erosion of the ulnar styloid process. An MRI scan that was undertaken on 28 July 2017 did not confirm ulnar positive variance. It did however show the erosion within the ulnar styloid. Ulnar variance is not accurately assessed on the MRI scan as the position of the wrist within the MRI scan is variable.

Ulnar sided wrist pain with the findings noted on the x-ray and MRI scan is often secondary to abutment of the distal ulna or ulnar styloid against the carpal bones. This is more likely to occur when the wrist is moved into a position of ulnar deviation.

The most appropriate surgical management in this situation is to undertake an ulnar shortening osteotomy. I therefore believe the ulnar shortening osteotomy that was undertaken by [Dr A] was appropriate for the pathology that [Ms B] presented with.

2. The appropriateness of the anchors and sutures used during the surgery

At the time of [Dr A's] assessment of [Ms B] on 14 September 2017 he noticed that the distal radioulnar joint had mild laxity which was similar to the left wrist. In his surgical report he noted grade 2 laxity of the distal radioulnar joint suggestive of mild to moderate instability of the distal radioulnar joint.

The information available to me would suggest that the appropriate management for [Ms B] was to undertake an arthroscopy of the wrist followed by an ulnar shortening osteotomy combined with excision of the bony ossicle that was present at the tip of the ulnar styloid. If at the time of removal of this bony ossicle there was noted to be significant detachment (either prior to or subsequent to removal of the bone fragment) of the triangular fibrocartilage (which attaches to the distal ulna), it would be appropriate to repair the triangular fibrocartilage into the fovea.

[Dr A] noted some laxity of the distal radioulnar joint and also noted that much of the triangular fibrocartilage was not attached to the fovea. He therefore placed a suture anchor within the distal ulna to repair the triangular fibrocartilage back to the fovea. On the basis of the operative findings described by [Dr A], it was therefore appropriate to repair the triangular fibrocartilage. This could be undertaken using a suture anchor or sutures through drill holes in the ulna. The surgery that was undertaken is appropriate.

3. The usual steps undertaken when obtaining informed consent for this procedure

The usual steps to obtain consent would be to discuss with the patient the nature of the surgery, the potential complications, the expected outcome, to ensure that the patient had satisfactory understanding of the surgery that was to be undertaken, and that the patient had the opportunity to ask questions and advise whether they would like to proceed with the surgery.

The complaint would suggest that the surgical procedure was not adequately explained to [Ms B]. If the surgical procedure had been adequately explained, it certainly wasn't fully understood by [Ms B] as she stated that she was not aware that she would have plates and screws in the arm.

On the basis of the information given and [Ms B's] complaint, it is clear that the surgical consent process was not adequate. I note that [Dr A] had a fellow (a doctor in advanced hand surgery training) working with him. He states clearly that this fellow had recently commenced work with him and he had delegated much of the responsibility for surgical consent to his fellow. Despite this, I would see the operating surgeon and the consultant in charge of the surgical treatment to be primarily responsible for ensuring that adequate consent for surgery was gained. With the information available to me it does appear that adequate surgical consent was not obtained as [Ms B] was not aware of the surgery that would be undertaken. It would be important for the patient to know that osteotomy (cutting the bone) would be undertaken, and that the bone would be fixed with a plate and screws.

4. [Dr A's] decision to not provide a pre-operative consultation for [Ms B]
5. Whether delay in surgery was reasonable within the circumstances

These two questions will be answered as below.

The patient's symptoms developed following an injury at work on 23 June 2017. The first consultation with [Dr A] was on 14 September 2017. At that time [Dr A] initially advised further non-operative management. This is appropriate as the duration of symptoms was relatively short, and the imaging would suggest some long standing pathology. Non-operative treatment would give a fair chance of the symptoms settling down to return to the pre-injury state. Further follow-up was undertaken on 16 November 2017 and at that time, because of ongoing symptoms not responsive to non-operative management, a decision to proceed with surgery was made.

It is unclear to me why the surgery was delayed until 30 April 2018. There is no medical indication for urgent surgical treatment to be undertaken. The surgery in this situation is elective, being undertaken to address the pain and disability that the patient is suffering from. In this situation many patients will delay the surgery until a date that is suitable for them. In some circumstances the surgeon is unable to undertake the surgery because of resource limitations or leave. The exact reason that surgery was delayed in this circumstance is not apparent to me. I would not consider the delay of undue concern, and I would not consider the delay detrimental to the long term outcome. The timing of surgery in this circumstance more relates to patient preference and surgeon availability. I have not been given any specific details as to why the surgery date was set for 30 April 2018.

The decision not to undertake a pre-operative consultation is reasonable.

In my practice if there is a significant delay from the timing of consultation until the date surgery is undertaken, I will thoroughly review the notes in the week prior to surgery. If I have any concerns or if the patient wishes to see me, I will arrange for a pre-operative consultation to go over the surgery that is being undertaken in detail. In most circumstances I will plan to see the patient on the day of surgery, I would go over the surgery that is to be undertaken and the patient's expectations and current symptoms before proceeding with surgery. In this circumstance when the patient lives a

considerable distance from the city that surgery is to be undertaken, there are also further barriers to a pre-operative consultation. For this reason it is often practical to see the patient on the day of surgery or the day prior.

I would see it as very important that adequate discussion of the surgery is undertaken at the time of consultation. It is important to ensure that the patient understands the information that is given. It is also important to confirm the patient's understanding and desire to proceed with surgery on the day of surgery. A pre-operative consultation can be helpful in this process but I do not think is absolutely required and, on the basis of this, I would not criticise [Dr A's] decision not to undertake a pre-operative consultation. If the patient however requests a consultation, of course this is appropriate and should be undertaken.

6. Any other matters you consider warrant comment

(1) I note that the patient has developed osteoarthritis in the distal radioulnar joint and was told subsequently that the ulna was shortened excessively. I do note that the pre-operative plain x-ray (which was not standardised) suggested ulnar positive variance of 2mm. A postoperative x-ray undertaken on 14 June 2018 showed 3mm of ulnar negative variance on a PA x-ray. A forearm x-ray undertaken at the same visit suggested 1mm of ulnar negative variance. It is uncertain if these x-rays were undertaken in a standard position. This would suggest that the ulna was shortened between 3mm and 5mm.

[Dr A] commented that he used a [specific] ulnar shortening device and shortened the ulna by 3mm. It is possible to shorten the ulna more than you intended with these devices although I am not familiar specifically with the [brand of the] implant. In this situation it would be common to shorten the ulna between 3mm and 5mm. I therefore believe that the degree of shortening undertaken at the time of surgery was appropriate. [Ms B] subsequently had been given an opinion that her ulna was shortened more than required.

I do note that on her follow-up imaging there appeared to be osteoarthritis with point loading in the distal radioulnar joint. This has subsequently been treated by another surgeon with a corrective procedure to reduce the ulnar negative variance. It is my opinion that the ulna was not excessively shortened. I agree that the patient has had a complication of surgery and has gone on to have point loading of the distal radioulnar joint. It would be very common for patients to have the same amount of shortening of the ulnar undertaken for similar pathology. Most of these patients do not go on to develop osteoarthritis in the distal radioulnar joint.

Although the osteoarthritis of the distal radioulnar joint has been addressed by a procedure to change the ulnar variance, I do not believe that the amount of shortening undertaken of the ulna was inappropriate.

(2) I believe the consent process was below the standard expected as noted above. This is a significant departure from standard care, and would be viewed with concern by surgical peers.

(3) I note that [Dr A] has appropriately apologised in his response for the inadequacy in the consent process.

(4) I think many of the issues raised in the complaint relate to communication between [Dr A] and [Ms B]. I do note that [Dr A] comments on his inadequacies in this regard and outlines that he has been working to try and improve his communication.

(5) I do note that the surgical time was longer than I would expect for the underlying pathology that was present. I note that some surgeons undertake surgery quickly and others take longer to complete the same procedure. Although the length of the operative procedure was longer than I would have expected, I do not believe that this relates to the underlying essence of this complaint.

(6) [Ms B] underwent an arthroscopy, repair of the triangular fibrocartilage and ulnar shortening osteotomy plus a capsulodesis of the distal radioulnar joint. I do note that she developed significant stiffness in the wrist and this was a cause of ongoing symptoms. The tightening of the capsule of the distal radioulnar joint (capsulodesis) possibly could have contributed to this and may not have been necessary. The procedure that was undertaken was based on the findings at the time of surgery and I do not consider the surgical treatment to be outside of the spectrum of surgery that would be undertaken for this condition. There is no departure from standard care, however not all surgeons would have chosen to undertake the exact same surgery.

In summary,

— The ulnar shortening osteotomy was appropriate and would be viewed by our peers as appropriate surgery.
— The anchor placed in the distal ulna was appropriate and would be viewed by our peers as appropriate surgery.
— The consent process was not at the standard that would be expected. This is a significant departure from standard care.
— The decision to not provide a pre-operative consultation was acceptable.
— The delay in surgery was acceptable.

[Dr A] comments that he has undergone training to improve his communication which may make the occurrence of similar problems less likely in the future.

Yours sincerely

Sighted & electronically approved by:

ROBERT ROWAN
ORTHOPAEDIC & HAND SURGEON
ROWAN ORTHOPAEDIC LTD”

The following further advice was obtained from Dr Rowan:

"31 January 2020

…

Reference: 19HDC00455

My name is Robert Rowan. I have read and agreed to the Health & Disability Commission's Guidelines for independent advisors.

My qualifications are MBChB (Auckland) 1994 and FRACS (Orth) 2003. I am a subspecialist orthopaedic hand surgeon with fellowship training in hand surgery.

I have been asked to comment on:

1. Whether further information provided causes me to amend conclusions drawn in my initial advice, or to make additional comments.
2. The appropriateness of lack of written policies or procedures at [the clinic].
3. Any other matters in this case that you consider warrant comment.

In answer to the questions:

1. The further information provided does not cause me to amend the conclusions I made in my initial advice.

I note that there is a discrepancy regarding the information provided in the consent process. [Dr A] and his fellow [Dr D] outline the details of the consent process that they undertook. What they have outlined is different than what was understood by the complainant.

On the basis of this my comments with regard to the consent in my initial report are unaltered. From the information given by the complainant, it is clear that the complainant did not fully understand the procedure that was undertaken.

2. The appropriateness of lack of written policies or procedures at [the clinic].

[Dr A] is an independent orthopaedic surgeon. The commercial structure that he has applied in his clinical practice is to work as a sole practitioner in the employment of a company named '[Dr A's company]'. From a clinical perspective [Dr A] is acting as a sole practitioner which is how most private practice surgeons in New Zealand work. In this regard I do not believe that [Dr A's company] would in normal circumstances have policies that determine how its surgeons practise or behave.

[Dr A] (the individual surgeon) is required to practise medicine in an appropriate and safe manner according to Codes of Good Practice, the Code of the Medical Council and that of the Health and Disability Commissioner.

Many surgeons have a similar practice model, I think it would be unlikely that many (or any) surgeons in similar situations have clearly outlined policies that determine how the employed surgeon is required to practise.

On the basis of standard of practice, and standard of care, I therefore do not believe that any specific policies or procedures are required to be outlined by [Dr A's] company.

3. I believe my initial report clearly outlines the issues that are pertinent to this complaint.

Yours sincerely

Sighted & electronically approved by:

ROBERT ROWAN
ORTHOPAEDIC & HAND SURGEON
ROWAN ORTHOPAEDIC LTD"