

**Dr Roman Hasil  
and  
Whanganui District Health Board  
2005–2006**

*A Report by the  
Health and Disability  
Commissioner*



Health and Disability Commissioner  
*Te Toihau Hauora, Hauātanga*



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## EXECUTIVE SUMMARY

### *Introduction*

This inquiry examines why laparoscopic sterilisation surgery (tubal ligation) performed by Dr Roman Hasil at Wanganui Hospital in 2005–06 was unsuccessful for eight of 32 women. Six of those women became pregnant and were confronted by difficult decisions. As one woman said, “I have been forced to make a decision I wish I never had to make.” Most decided to have a termination.

In announcing the inquiry in March 2007, I said that “the women concerned deserve to know what happened and that it won’t happen again”. This report details what happened, attributes responsibility for the failings, and makes some recommendations about a way forward for Whanganui District Health Board, and for other district health boards in New Zealand.

At one level, what happened is simple. Dr Hasil did not place the clips correctly on the Fallopian tubes of eight women. But the story of why he made such basic mistakes — resulting in a sterilisation failure rate of 25%, compared with an accepted failure rate of 0.2% — is far more complicated.

### *A sorry saga*

Dr Hasil was an experienced obstetrician and gynaecologist who had been head of an obstetrics and gynaecology (O&G) department in Slovakia for six years. But from 1996 to 2005, Dr Hasil had a chequered work and medical registration history in Australia.

In August 2005, Dr Hasil commenced work as a medical officer in the O&G department of Whanganui DHB (the DHB), which for many years had been understaffed and unable to recruit specialists. Dr Hasil’s background should have come to light during the process of his employment and registration in New Zealand. It did not, owing to inadequate reference checking and credentialling.

Dr Hasil was granted registration by the Medical Council within a provisional general scope of practice. Under the terms of his registration, Dr Hasil was required to be supervised by the head of the Wanganui O&G department, Dr A. Dr Hasil and Dr A worked in a grossly understaffed department, with a demanding and unsustainable 1 in 2 on-call component.

From the outset concerns were raised about Dr Hasil. They initially related to his competence. Then health issues emerged. Dr Hasil was reported to be smelling of alcohol while on duty on several occasions. The concerns about his competence did not abate, and further patient and staff complaints were received. During 2006, four of Dr Hasil’s patients returned to the DHB pregnant following sterilisation surgery.

The staff concerns and patient complaints were pointers to problems that the DHB should have identified earlier and responded to more effectively. The concerns were addressed in a general way with Dr Hasil, and patient complaints were investigated. However, none of the four known sterilisation failures were reported in accordance with the DHB’s incident reporting policy. The DHB hesitated too long in the face of clear



information that Dr Hasil might pose a risk of harm to patients. No formal or co-ordinated action was taken to assess or monitor his safety to practise until it was too late.

In October 2006, Dr Hasil was again found using alcohol while on call. At this point, he was placed on leave and the Medical Council was notified of the health issues. Dr Hasil agreed to participate in a comprehensive health programme and was expected to return to work at Wanganui Hospital in early 2007.

During his rehabilitation programme, further concerns about Dr Hasil's practice came to light, including concerns about his high rate of failed sterilisations. In February 2007, Patient A complained to the DHB about her failed sterilisation and advised that she was aware of another failure. The DHB commenced an investigation that quickly revealed Dr Hasil's high failure rate. Dr Hasil resigned during the DHB's investigation. He is believed to be residing in Australia.

#### *Key messages*

Good policies and procedures are to no avail if they are not followed in practice. It is unacceptable that the sterilisation failures were not exposed by any of the DHB's systems for quality assurance, such as incident reporting, audit, peer review and supervision. Despite the raft of quality assurance policies and procedures at Whanganui DHB, they were not followed, and chance played a large part in exposing the cluster of failed sterilisations. It is no wonder that many people in Wanganui felt let down by their hospital.

This report highlights the need for hospitals to have effective processes in place to identify and respond to concerns about a clinician's practice. Staff need to be aware of the processes, and adequately trained and supported in their implementation. Management and clinical leadership is critical. It is tempting to cut corners when faced with endemic workforce shortages. But a lack of care in appointing staff, and failure to identify problems and act decisively, results in unnecessary harm to all involved — to patients, to doctors, and to public confidence in a local hospital.

It is the Medical Council's responsibility to ensure that doctors registered in New Zealand are competent and fit to practise. This includes responsibility for registering new international medical graduates and for reviewing reports from its regulatory supervisors during the provisional registration period. However, the Council's responsibility does not detract from a DHB's obligation to properly credential and monitor the performance of an employed doctor.

Given New Zealand's increasing dependence on newly registered international medical graduates to staff hospitals (especially in smaller centres) it is essential that supervision is not "watered down". Effective supervision is critical for safe health care. The Medical Council has a key role to play in training and supporting regulatory supervisors, and employing DHBs must appropriately support and resource clinical supervision.

Public hospitals face major pressures related to workforce and training, distribution of skills and skill mix, and financial resources. They are particularly acute in smaller centres. Isolation is the "kiss of death" for a clinician, a department and a DHB. Regional and

national service planning, and increased co-ordination and collaboration across DHBs, is essential to maintain safe, good quality services in the face of these pressures.

#### *Summary of findings*

Below is a summary of the inquiry findings in relation to Dr Hasil, his supervisor Dr A and Whanganui DHB:

#### *Dr Hasil*

Dr Hasil did not provide services of an appropriate standard in a number of respects. In particular, he did not perform laparoscopic sterilisation surgery on Patients A and B with reasonable care and skill; his record-keeping was inadequate; and his informed consent process in relation to Patient C was substandard.

Dr Hasil breached Rights 4(1) and 4(2) of the Code in relation to Patients A and B, and Rights 6(1) and 7(1) in relation to Patient C.

#### *Dr Hasil's supervisor*

Dr Hasil's supervisor, Dr A, was aware of concerns about Dr Hasil, but did not consider that he was unsafe. Dr A was overworked, but he followed up the concerns with Dr Hasil and remained satisfied that he was performing to an acceptable standard. In hindsight, that was an error of judgement, but given what he knew at the time, Dr A took reasonable actions to supervise Dr Hasil.

Dr Hasil knowingly misled the DHB about his work and registration history in Australia, and his lack of candour affected the way in which the DHB responded to the concerns raised about him.

#### *Whanganui DHB*

Whanganui DHB did not fulfil its duty of care. The DHB breached Right 4(1) of the Code by its lack of care in employing Dr Hasil, by failing to have a system in place to monitor Dr Hasil's practice effectively and by failing to respond to his competence and health concerns in a timely and effective manner.

#### *Further proceedings*

I do not consider that the public interest requires referral of Dr Hasil or Whanganui DHB to the Director of Proceedings for consideration of further proceedings. As a result of the breach findings, Patients A, B and C will be entitled to bring their own claims against Dr Hasil and the DHB before the Human Rights Review Tribunal.

#### *The way forward*

Whanganui DHB appears to be making necessary and appropriate changes following these events, in accordance with the recommendations in two reviews, the *Whanganui Hospital Clinical Review: Report to Whanganui District Health Board and Ministry of Health* (July 2007) and the *Joint Review of Whanganui District Health Board* (August 2007).

The DHB must train and support its staff to implement its quality assurance policies and procedures, so that patients are protected from preventable harm. Both clinical staff and

the services in which they work should be properly credentialled. Clinical supervisors need to be well supported and resourced.

Whanganui DHB must continue to work closely with neighbouring DHBs, supported by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and the Ministry of Health, to ensure safe and sustainable obstetric and gynaecology services (potentially on a regional basis) for the women of Wanganui.

## **INTRODUCTION**

On 9 March 2007, I initiated an inquiry into the standard of care provided by Dr Roman Hasil at Wanganui Hospital, the steps taken by the Whanganui District Health Board (the DHB) to ensure that Dr Hasil was competent to practise, and the measures put in place to supervise, monitor and audit his work. The inquiry was prompted by a complaint to my Office, information provided by the DHB, and community concern about failed tubal ligation procedures undertaken by Dr Hasil. On 24 April 2007, the inquiry was extended to include the steps taken by Dr A to ensure that Dr Hasil was competent to practise.

This report examines the quality of care provided by Dr Hasil, and in particular to Patients A and B on whom he performed an unsuccessful laparoscopic sterilisation procedure, and Patient C, whose ovaries and Fallopian tubes he surgically removed. However, it is primarily about the adequacy of the steps taken by the DHB to identify and respond to concerns about his competence and fitness to practise. The terms of reference for the inquiry are set out in Appendix 1, and the investigation process is detailed in Appendix 2.

I am hopeful that this report will provide guidance to hospitals and other providers on how to respond to similar situations.

## **INFORMATION GATHERED**

### **WANGANUI HOSPITAL, OBSTETRIC AND GYNAECOLOGY SERVICES**

Whanganui DHB is the fourth smallest DHB in New Zealand and serves a population of about 63,000. Wanganui Hospital is the base hospital and provides secondary services to the population. The DHB's management is led by the Chief Executive Officer (the CEO). The CEO is responsible for three divisions — planning and funding, corporate, and provider divisions. There is a general manager, public hospital and health services, and there are four clinical services, each headed by a service manager, and a clinical director. Each clinical director carries a clinical and administrative workload.

An organisation chart and a list of the key personnel are attached as Appendix 3 and 4 respectively.

In 2005, Dr A was the Clinical Director of Surgical and Support Services and head of the department. He also had a clinical workload as an obstetrician and gynaecologist.<sup>1</sup> The management of the Department of Obstetrics and Gynaecology was split — the obstetric service was managed by the Service Manager, Community and Rural Services (Service Manager B), and the gynaecology service was managed by the Service Manager, Surgical and Support Services (Service Manager A).

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<sup>1</sup> Dr A resigned from this position with effect from 4 September 2006. Dr D is currently the Clinical Director, Surgical and Support Services.

The department had funding for about 3.4 full-time equivalent consultant positions, but had not been staffed to this level for some time. Immediately prior to the employment of Dr Hasil, the consultant obstetricians and gynaecologists were Dr A, Dr B and a third consultant. They comprised a total of approximately 2.3 full-time equivalents.<sup>2</sup> Dr A and Dr B also worked in private practice in Wellington and Palmerston North respectively.

As a general rule, Dr A had outpatient clinics on Tuesday to Friday, and theatre on two days. He worked in private practice on Mondays. Dr B had colposcopy outpatient clinics on Monday mornings, theatre on Monday afternoons, and outpatient clinics on Tuesday mornings. Dr B was on call on Mondays and on every fourth weekend, which included Friday, Saturday and Sunday. The third consultant shared the rosters until his retirement in late 2005. There were no registrars in the department because the hospital was not accredited by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) as a training post, owing to its size.

Since 2000, the DHB had been actively looking for consultant obstetricians and gynaecologists to join the department. Over the years of trying to fill the vacant consultant post, it did not receive one expression of interest from within New Zealand. As the recruitment efforts were fruitless, clinical staffing levels remained a challenge.

The shortage of clinical staff placed considerable pressure on the department. The vacant position had been filled briefly by various locums, but it became increasingly difficult as the third consultant moved towards retirement in late 2005. Dr A said that he worked a 1 in 2 on-call roster for about four years. He addressed the Board on two separate occasions about the difficulties in recruiting staff.

The DHB's Medical Advisor, Dr C, said that recruiting a specialist in obstetrics and gynaecology to Wanganui Hospital was an ongoing problem for Dr A because of the on-call roster. Dr C stated that the DHB assisted as best it could, but ultimately the responsibility was Dr A's. The assistance consisted of support from the Service Manager who was actively involved in the recruitment process, and, more generally, from management, which provided financial resources so that short-term locums could bolster the system until a doctor could be found on a more permanent basis.

When it became apparent that it would not be able to find a doctor with the appropriate qualifications to fill the consultant post, the DHB started to look for an alternative — a medical officer in obstetrics and gynaecology.<sup>3</sup>

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<sup>2</sup> This comprised the third consultant as 0.8 full-time equivalent, 1 in 4 on call; Dr B as 0.5 full-time equivalents, 1 in 4 on call; and Dr A as 1.0 full-time equivalent, 1 in 2 on call.

<sup>3</sup> A medical officer is a doctor who is not part of a vocational training programme and is not employed as a specialist.

## **EMPLOYMENT OF DR HASIL**

### *Recruitment of Dr Hasil*

On 30 May 2005, a New Zealand medical recruitment agency forwarded Dr Hasil's curriculum vitae (CV) to the Resident Medical Officers' (RMO) Co-ordinator at the DHB. Dr Hasil's CV indicated that he had more than 20 years' experience in obstetrics and gynaecology, and was looking for a junior medical position.<sup>4</sup> The RMO Co-ordinator forwarded the CV to Dr A on 10 June 2005.

The CV states that Dr Hasil obtained his primary medical degree in 1980 from Comenius University, Czechoslovakia and then worked for four years at Bratislava University Women's Hospital. In 1984, he was awarded a postgraduate degree in obstetrics and gynaecology, level 1, which allowed him to work as an independent specialist in Czechoslovakia. From 1984 to 1989 he completed a further five years of specialised training in obstetrics and gynaecology. In 1989, he sat and passed the level 2 specialisation obstetric and gynaecology qualification. The prerequisite for this was completion of a thesis and a prescribed number of operations. Between 1989 and 1995, Dr Hasil was the Head of the Obstetrics and Gynaecology Department at Skalica Hospital, Slovakia. In 1995, he took 12 months' sabbatical leave to study in Australia, and decided to reside there.

His CV states that from 1996 to 1999, Dr Hasil worked at the Royal Hobart Hospital, Tasmania. In 2000, he passed the Australia Medical Council Multiple Choice Question Examination. From 2001 to March 2005, he worked at Lismore Base Hospital, New South Wales. In 2004, he passed the Australia Medical Council Clinical Examination and obtained general registration in New South Wales. The referees noted on his CV were Referee A, obstetrician and gynaecologist, Royal Hobart Hospital, and Referee B, obstetrician and gynaecologist, Lismore Base Hospital.

The recruitment agency also provided two verbal reference reports to Whanganui DHB that it had recorded on its standard referee's report form on 27 May 2005. The reference reports were from Referee A, who worked with Dr Hasil in Hobart for one year in 1998, and Referee C, paediatrician, who worked with Dr Hasil at Lismore Base Hospital for four years. The reports did not raise concerns or difficulties about Dr Hasil. However, the recorded answers to the questions asked of Referee A and Referee C were brief. Referee C also sent an email to the recruitment agent on 27 May and a letter on 30 May confirming that Dr Hasil had a strong command of the English language.

On 21 June 2005, Dr A interviewed Dr Hasil by telephone between 1.00pm and 2.00pm. There are no records of the interview, and Dr A was unable to recall the details of the

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<sup>4</sup> In about April 2005, Dr Hasil approached the recruitment agency in relation to a junior obstetric and gynaecology position in New Zealand. Dr Hasil's documentation (CV and application for registration in New Zealand) was prepared by the recruitment agency in May 2005 and signed off by Dr Hasil. The recruitment agency forwarded Dr Hasil's CV to a number of district health boards in New Zealand, including Whanganui DHB.

interview. Dr A said he would have asked Dr Hasil questions about the work he was doing, particularly over the preceding few weeks, his family, and why he had left Czechoslovakia, to get a feel for whether or not Dr Hasil would be able to do the job.

Dr Hasil said he told Dr A that he was looking for a quiet hospital so that he could prepare for the RANZCOG Fellowship examination. He said he understood that Wanganui Hospital was a unit where he could work as a medical officer supported by a number of consultants, and where the workload would be such that he would have time to concentrate on studying for the examination outside working hours.

Dr A recalls that Dr Hasil felt he was being abused in Australia — in that he was doing all the work, particularly obstetrics, and the consultants were claiming the money. Dr Hasil told Dr A that he had had an argument with the consultants, and that he was looking for a place where he would not be abused and could spend more time working towards gaining vocational registration. Dr Hasil told Dr A that his family would not be coming to New Zealand immediately but that they intended to once he had settled. Dr A said that he was satisfied insofar as Dr Hasil sounded like somebody who could do the job.

Dr A stated that Dr Hasil told him that he had been offered a senior registrar post in Wellington and planned to sit the RANZCOG Fellowship examination. Dr A said he advised Dr Hasil that if he was seriously considering sitting the examination, then he should take the job in Wellington as the hospital there was more geared toward examination technique than Wanganui Hospital.

Dr A said his usual practice was to ask for written references and for more references than were given. Then, as part of the due diligence process, the references would be checked by a telephone call. Dr A said his usual practice would be to telephone the referees. He explained that the purpose of contacting the referees was to confirm the written references, and to ask whether there was anything further to add. He said he would not normally make a note of the conversation.

Dr A said he did not remember the details of how he went about the reference checking process in relation to Dr Hasil. He could not recall who he did or did not contact. He accepted that he may not have contacted the referees in this case. Dr A recalls that one reference had been from a doctor who had worked with Dr Hasil a number of years previously. However, this reference would not have been particularly useful, so it would not have been checked. He said that the DHB is quite clear about requiring up-to-date references and contacting colleagues who have worked with the applicant most recently.

Referee C and Referee B did not recall being contacted by Dr A. However, they did recall being contacted by a recruitment agent. It appears that Dr A did not follow his usual practice in relation to the recruitment of Dr Hasil. He did not make any independent enquiries in relation to Dr Hasil's credentials or references.

#### *Credentiailling of Dr Hasil*

Dr A was keen to offer a position to Dr Hasil, so he arranged for his urgent credentiailling. Dr A explained that Dr Hasil's credentiailling was considered under

urgency because Dr Hasil wanted to start work as soon as possible. The Credentialling Committee is required to determine whether an applicant is adequately credentialled to work in the position applied for, and this is a prerequisite to the DHB making an offer of employment. The terms of reference for the Credentialling Committee are attached in Appendix 5.

The role of the Credentialling Committee is to review the CV to check that there are no gaps in employment and that the references are current and from the same specialty. The committee does not define the scope of practice but is responsible for ensuring the applicant has the appropriate qualifications, training, experience and competence. The process is intended to provide a safety net for the recruitment process as the committee has significant medical representation and is independent of the department and therefore of the pressures of trying to fill a post.

On 24 June 2005, Dr Hasil's CV and two reference reports were sent to Dr C as Chair of the Credentialling Committee. The credentialling of Dr Hasil was considered under urgency via teleconference. Dr C and two other members of the committee were involved. In an email to Dr A on 28 June, the Credentialling Committee confirmed that they had credentialled Dr Hasil to work as a Medical Officer, Obstetrics and Gynaecology.

On 1 July 2005, the Credentialling Committee held a meeting, the minutes of which state:

“Dr Roman Hasil — Medical Officer, Obstetrics and Gynaecology

The Credentialling for Dr Hasil had already been confirmed telephonically earlier in the week. However, the credentialling was formally noted as an Agenda item. It was reiterated that the relevant head of department and service manager would be advised that he is only being credentialled to work as medical officer in obstetrics and gynaecology, pending confirmation of his registration status by the Medical Council of New Zealand.”

The committee's standard approach is to seek assurance from the relevant head of department that references are satisfactory. However, during Dr Hasil's credentialling process, the committee did not seek any further information or clarification in relation to his credentials. Dr C said that there were no major concerns at the time. Dr Hasil appeared to be very experienced, and had worked as head of department in his own country and had experience in Australia as well.

Dr C subsequently acknowledged that it was unusual that Dr Hasil had a reference from a paediatrician, as it was outside his scope of obstetrics and gynaecology. However, there is an interface between the two specialties, and the DHB tends to employ doctors with general skills, particularly at the level of a medical officer. A member of the Credentialling Committee, Dr D, admitted that it was probably an oversight on the part of the Credentialling Committee that there was no reference from anyone who had been in a collegial relationship with Dr Hasil after 1998.



*Appointment of Dr Hasil*

On 1 July 2005, Dr A wrote to Dr Hasil, via the recruitment agency, offering him the position of Medical Officer, Department of Obstetrics and Gynaecology, under the terms and conditions set out in the letter and attached job description. The appointment was subject to Dr Hasil's registration with the Medical Council and having a current annual practising certificate (APC), and was to commence on 2 August 2005.

The position description for Medical Officer, Obstetrics and Gynaecology set out the key accountabilities, including the expected outcomes. The expected outcomes included assisting the specialist consultants in:

- the operating theatre and carrying out procedures as directed by them under their supervision,
- the provision of outpatient care in antenatal, family planning and gynaecology clinics, and
- the management of patients in the Delivery Suite.

It also stated that the medical officer is "to supervise the inpatient management of patients in the Obstetrics and Gynaecology Department under the direction of the appropriate Specialist Consultant".

In relation to quality assurance and peer review, the expected outcome was that Dr Hasil would attend and participate in regular departmental audit/peer review activities, including morbidity/mortality meetings, and would participate in an annual performance review.

The letter of offer explained that Dr Hasil would be responsible to Dr A as Clinical Director, Surgical and Support Services and noted the frequency of call as 1 in 4, which would become 1 in 3 when cover was required during periods of leave or sickness.

The offer stated that before the appointment was taken up "a set of performance criteria must be agreed between us in writing, against which you will be formally reviewed in writing every six months on the basis of the standard DHB performance review policy". On 5 July 2005, Dr Hasil accepted the contract and signed the letter of offer.

*Registration of Dr Hasil*

On 5 July 2005, the Medical Council received Dr Hasil's application for registration. The application was for registration within a provisional general scope of practice via the comparable health system pathway, based on Dr Hasil's relevant and comparable experience in obstetrics and gynaecology in Australia. Dr Hasil signed a registration form on 1 August 2005. The answers he gave to the questions on the form regarding his conduct, character and professional competence did not give the Medical Council any cause for concern.

The Medical Council received a certificate of good standing from the New South Wales Medical Board, dated 1 June 2005. It certified that the Board was not conducting any proceedings against Dr Hasil under the New South Wales Medical Practice Act 1992.

The Medical Council also received an “*Employer application for approval of position and supervisor*” which was signed by Dr A and the DHB. It stated that Dr A would be the supervisor, and that he would work 24 hours per week with Dr Hasil. The supervision arrangements were stated as:

“Supervision will be provided on an ‘ad hoc’ basis, as when required. Supervision will be available during work hours by all consultants within the Department. Supervision after hours will be available in the first instance via telephone through the Head of Department or other consultants.”

The DHB enclosed a *Supervision and Induction Plan* with the application (details are discussed in the next section). The Medical Council’s registration process requires applicants to provide three comprehensive references from senior medical colleagues that have been verified by the employer or agent.

On the *Employer application for approval of position and supervisor* form, the DHB confirmed that Referees C and A were familiar with Dr Hasil’s current work, and had provided satisfactory reports on his performance. In fact, the DHB had not contacted the referees personally, and Referee A had not worked with Dr Hasil after 1998.

Referee C and Referee A completed the Medical Council’s standard referee’s report form, sent to them by the recruitment agent. The reports, which the Council received on 5 July 2005, were more comprehensive than the earlier referee reports. Referee C, a consultant paediatrician, explained that he had known and worked with Dr Hasil for four years. He commented that Dr Hasil could occasionally be abrupt and undiplomatic but had been made aware of this and had accepted the criticism. He said that Dr Hasil’s manner was mostly as a result of working hard, putting in long hours and becoming tired.

Referee A, a staff specialist in the Department of Obstetrics and Gynaecology at the Royal Hobart Hospital, explained that he had known Dr Hasil since 1998 and had worked with him for about one year. He said that he had had limited contact with Dr Hasil in the last six years.

References were also provided from Referee D, Referee E and Referee F. Referee D, from Tasmania, provided a personal reference, and Referee E was a pharmacist. Referee F’s reference of 1 June 2005 indicated that she had been a general practitioner in Lismore since 1998 and had conducted an obstetric practice for 11 years. She had known Dr Hasil, in his capacity as Senior Registrar in Obstetrics and Gynaecology at Lismore Base Hospital, for several years. She stated that she believed his skills were sound but that he needed to adapt to the Australian system.

On 19 July 2005, the Medical Council acknowledged receiving references from Referee A, Referee C, Referee D, Referee E and Referee F, which had been forwarded by the recruitment agent, and that two references had been verified by direct contact, but that one of these related to an appointment that had ended by 1999. The Medical Council requested that the recruitment agent provide two further references from senior medical colleagues at Lismore Base Hospital. The recruitment agent was advised that Referee F’s

reference could be counted as one of the two, provided that she confirmed that she had verified it.

References were then provided from Referee G and Referee H, who had worked with Dr Hasil at Lismore Base Hospital. On 20 July 2005 Referee G, a consultant paediatrician, provided a referee's report, which was satisfactory. Referee H, Consultant, Obstetrics and Gynaecology, Lismore Base Hospital, provided a reference. His reference, dated 31 May 2005, indicated that he had known and worked with Dr Hasil for three years. He commented that Dr Hasil's record-keeping was suboptimal, but the remainder of the reference was satisfactory.

The recruitment agent signed as referee for both the reports from Referee G and Referee H. In neither of the reports was there an answer to the question, "What would you describe as the applicant's weakness/limitations?"

Dr Hasil met all the requirements for registration under the comparable health system pathway. On 27 July 2005 the Medical Council advised the recruitment agency that it had confirmed Dr Hasil's eligibility for medical registration in New Zealand, and that he must attend an interview with a Council agent, who needed to sight the necessary original documentation before registration could be approved.

On 27 September 2005, the Medical Council wrote to Dr Hasil confirming that he had been granted registration within a provisional general scope of practice to work as a Medical Officer in Obstetrics and Gynaecology at Wanganui Hospital under the supervision of Dr A between 8 August 2005 and 28 February 2006.

A letter was also sent to Whanganui DHB confirming Dr Hasil's registration with the Medical Council. The Council explained that the conditions of his registration were noted on the certificate and that he was not to work outside the conditions. It also stated that Dr Hasil must practise under supervision, and that Dr A, as his supervisor, was required to report to the Council on Dr Hasil's performance at three-monthly intervals.

#### *Undisclosed information*

A review of the documentation Dr Hasil provided to the DHB and the Medical Council revealed some obvious discrepancies and omissions. During this investigation, my Office made enquiries about Dr Hasil with his referees, the hospitals he had worked in, registration bodies and RANZCOG.<sup>5</sup> It appears that Dr Hasil had a chequered work and medical registration history. A number of matters may well have caused concern about Dr Hasil's suitability for appointment or registration, or at least warranted closer scrutiny, had they come to light at the time of his employment by Whanganui DHB.

The first issue of concern relates to Dr Hasil's registration status with the Medical Council of Tasmania. Dr Hasil claimed (in his CV) that he had worked at the Royal

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<sup>5</sup> I acknowledge the co-operation of these persons and organisations; in particular, the Medical Council of Tasmania, the New South Wales Medical Board and the Medical Practitioners Board of Victoria. I note that despite a request, no information was forthcoming from the Office of Health Practitioners Registration Boards, Queensland.

Hobart Hospital from 1996 to 1999. However, Dr Hasil was registered with the Medical Council of Tasmania only from 15 January to 30 March 1997 and from 3 November 1997 to 13 July 1998.

In 1999, the Medical Council of Tasmania advised Dr Hasil that he was not eligible to apply for registration as he had not completed the multiple choice question exam of the Australian Medical Council (AMC). The Medical Council of Tasmania was also considering his false declaration in relation to his criminal record in his application for registration in January 1997.<sup>6</sup>

Due to the outstanding matters regarding his false declarations, and his continued denial of them, despite documentary evidence to the contrary, Dr Hasil is not considered to be in good standing in Tasmania.

Secondly, it is not known whether Dr Hasil worked as a doctor from July 1998 until March 2001. During this time, it appears that he prepared for and sat his Fellowship and AMC examinations. In October 1997, RANZCOG assessed Dr Hasil's training and experience, and considered that it was not equivalent to a Fellow of RANZCOG. Dr Hasil was required to pass the RANZCOG written and oral examination and undergo a period of supervised training in order to become a Fellow. In February 1998, Dr Hasil attempted the written examination but was unsuccessful.

Dr Hasil failed the written Fellowship examination on his second attempt in August 1998, and on his third, in August 1999. He was accordingly unable to proceed with the programme. Dr Hasil was reassessed by RANZCOG in January 2005, and was given a further opportunity to obtain a Fellowship. He made his fourth unsuccessful attempt at the RANZCOG written examination while working at Whanganui DHB in August 2006.<sup>7</sup>

Thirdly, Dr Hasil had been unable to obtain registration in South Australia. It appears that in early 2001 he sought work and registration in other jurisdictions in Australia. In response to enquiries, the Medical Council of Tasmania informed the Medical Practitioners Board of Victoria, the South Australian Medical Board and the Medical Board of New South Wales about Dr Hasil's false declaration. It appears that the South Australian Medical Board was not prepared to register Dr Hasil because of that. However, he obtained registration in New South Wales, and subsequently in Victoria.

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<sup>6</sup> In response to my provisional opinion, Dr Hasil submitted that the application form for registration in Tasmania only asked for a declaration of convictions that had occurred in Tasmania or other Australian states. The Medical Council of Tasmania's Application for Registration in Tasmania requests that the applicant solemnly and sincerely declare that "I have never been charged with a criminal offence, nor are there any criminal charges pending against me". The declaration was false because Dr Hasil did not provide the information about his conviction for an offence for which he had been imprisoned in Singapore in 1995.

<sup>7</sup> The RANZCOG written examination is one of a number of assessment requirements for overseas-trained specialists assessed as partially comparable to an Australian-trained specialist in obstetrics and gynaecology, which must be completed in order to meet the requirements for RANZCOG Fellowship. There were 30 attempts by overseas-trained specialists in the examinations held between the second half of 2005 and the end of 2007, and 17 passed (five passing on their first attempt at the examination and ten on their second attempt).

It appears that Dr Hasil held general registration with the Medical Board of Queensland until 30 June 2007. The Medical Practitioners Register of the Medical Board of Queensland indicates that Dr Hasil currently has general registration (from 19 October 2007 to 30 June 2008). Dr Hasil stated that although he recently obtained registration in Queensland, he does not have employment there and has very little prospect of obtaining any.

Fourthly, Dr Hasil made a rather hasty exit from Lismore Base Hospital while he was under investigation for allegedly “fiddling the books”. Dr Hasil disputes the allegation. From 2001 to March 2005, Dr Hasil was employed at Lismore Base Hospital in New South Wales as a Resident Medical Officer/Registrar. He worked largely in obstetrics and under supervision.

The Executive Officer at Lismore Base Hospital said that early on it became apparent that Dr Hasil was competent and a good all-rounder. He “won the confidence of the consultants”, and was well regarded. No concerns were raised about Dr Hasil’s clinical competence at Lismore Base Hospital; there was no significant instance of inappropriate care and no pattern of substandard care.

However, at the end of 2004, some irregularities were noted in Dr Hasil’s timesheet claims. Lismore Base Hospital commenced an audit of his call-back claims and challenged him. The hospital adjourned for two days to decide on its options, and at that time Dr Hasil resigned. Dr Hasil stated that he understood the hospital had accepted his explanation. The hospital concluded that Dr Hasil was “fiddling the books” as call-backs that had not been done had been claimed and paid for. This matter does not appear to have been reported to the New South Wales (NSW) Medical Board. The Register of Medical Practitioners of the NSW Medical Board<sup>8</sup> indicates that Dr Hasil has general registration until 25 February 2008. The NSW Medical Board has advised that it cannot take any action (for example, a performance assessment) in relation to Dr Hasil as he is not currently resident or working there.

Fifthly, in May 2005, Dr Hasil was dismissed from his employment at Angliss Hospital in Victoria for alcohol use while on duty. On 12 April 2005, Dr Hasil was registered with the Medical Practitioners Board of Victoria via mutual recognition from New South Wales. Dr Hasil disclosed his prior conviction and refusal of registration in Tasmania when making application with the NSW Medical Board.

On 25 April 2005, Dr Hasil was employed as a Resident Medical Officer at Angliss Hospital, Eastern Health, Victoria. On 4 May 2005, Dr Hasil was dismissed for alcohol use while on call. The hospital reported the incident to the Medical Practitioners Board of Victoria. In October 2005 the Victorian Board referred it to the NSW Medical Board. Dr Hasil was removed from the Victorian Register of Medical Practitioners on 12 January 2006, following his failure to pay his renewal fee.

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<sup>8</sup> The Register of Medical Practitioners of the New South Wales Medical Board can be found at <http://www.nswmb.org.au/index.pl>; accessed on 14 January 2008.

The NSW Medical Board arranged for an assessment of Dr Hasil by a NSW Medical Board-nominated psychiatrist on 21 December 2005, and found that Dr Hasil was working in New Zealand.<sup>9</sup> The Board reported the matter to the Medical Council of New Zealand. On 9 March 2006, the Medical Council received this information, which was verified at source and did not indicate that Dr Hasil had any health concerns.

Finally, there are inconsistencies with the references. It is clear that Dr Hasil and the recruitment agency had difficulty in providing satisfactory references. In his CV, Dr Hasil nominated Referee B as a referee along with Referee A. Referee B is a consultant obstetrician and gynaecologist who worked with Dr Hasil at Lismore Base Hospital. However, the recruitment agency did not supply a reference report from him but from Referee C, a paediatrician who worked at Lismore Base Hospital. In my view, this discrepancy in the documentation was obvious. The recruitment agency submitted that, in total, seven referees had been contacted. However, it is noteworthy that only one of these references was from an obstetrician and gynaecologist (Referee H) who had recently worked with Dr Hasil.

Referee B recalls being contacted by a recruitment agent in New Zealand about Dr Hasil and giving a reference as requested, which he described as “damning”. He said he was not impressed with Dr Hasil, particularly his attitude. He said he had observed the Caesarean sections undertaken by Dr Hasil, which were performed satisfactorily, but was not aware of his gynaecology practice.

Referee B later clarified this by saying that he provided a damning report to a woman with a foreign (not New Zealand) accent, that the interview took place on a Friday morning and that the style of questioning was the same as that used in the recruitment agent’s verbal reference reports obtained from Referee C and Referee A. The interviews with Referee C and Referee A took place on 27 May 2005 — which was a Friday.

The recruitment agent (for whom English is her second language) initially informed my staff that she could not recall whether she had contacted Referee B, but later advised that she did not obtain a reference from him. She said that if the recruitment agency could not locate a referee, or if a referee provided a “bad” reference (and others provided a good reference), it is not unusual for her to obtain another reference, as it may be “sour grapes”. She later clarified that she would only disregard one “bad” reference if they have three good ones, but will not disregard a single “bad” reference if there are serious misconduct or behaviour problems. The recruitment agent also explained that if she received a reference that was adverse to the applicant’s professional conduct, then she

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<sup>9</sup> The psychiatrist reported on his uncertainty about Dr Hasil’s openness about his consumption of alcohol at the time of the incident. Dr Hasil said he had a “couple” of beers on the night of the incident. The psychiatrist noted that such an amount would be unlikely to result in a breathalyser reading of 0.2. Dr Hasil corrected himself, saying he may have had a couple of glasses of wine as well. The psychiatrist stated that it was likely that Dr Hasil had consumed more than this. He concluded that Dr Hasil had no ongoing problems and that the Board proposed to take no further action. The NSW Medical Board noted that Dr Hasil had been under some stress at the time but that things had resolved.

would advise the Medical Council and withdraw the application. If the adverse comments related only to personality differences, then the reference would be forwarded to the Medical Council.

I am satisfied that Referee B provided a “damning” telephone reference to the recruitment agent, and that the reference was disregarded — it was not documented nor reported to the DHB or the Medical Council.

I have also noted other inaccuracies in the documentation prepared by the recruitment agency. For example, Dr Hasil’s referee, Referee C, is incorrectly noted as being from Royal Hobart Hospital on the Verbal Reference Report. In the reference section of the application for registration, three referees are listed — Referee C, Referee A and Referee I. However, Referee I and Referee A are one and the same person (using the first name and surname of one referee).<sup>10</sup> While this section appears to have been completed by the recruitment agent, Dr Hasil signed the application. Also, the references provided to the Medical Council were less than impressive.

## **MONITORING OF DR HASIL**

### *Staffing*

On Tuesday 2 August 2005 Dr Hasil commenced work at Whanganui DHB. Dr Hasil was appointed as a medical officer and placed on the on-call roster. The duty roster shows that from the week commencing 8 August 2005 Dr Hasil shared the on-call duty roster with Dr B, Dr A and a third consultant. The first weekend he was on call appears to be 14–16 October 2005. Although initially weekend duty was 1 in 4, the frequency increased to 1 in 2 as the number of consultants in the department decreased. The DHB confirmed that Dr Hasil was operating without direct supervision by 16 September 2005.

The gynaecology timetable from the third week in March 2006 indicates that Dr Hasil had an antenatal clinic on Tuesday mornings, gynaecology outpatient clinics on Wednesday afternoons, family planning clinics on Thursday afternoon, and theatre on Friday. Dr Hasil was usually on call on Wednesdays.

The department staffing levels dropped considerably in 2006. By March 2006 there was a critical shortage of clinical staff.<sup>11</sup> This placed increased pressure on the remaining clinicians working in the department — namely Dr A and Dr Hasil. They did the on-call duties that Dr B could not cover, so they were on call on a 1 in 2 basis when Dr B was on leave. Dr Hasil reported that he worked between 90 and 138 hours per week at this time. Dr A recalls that “Dr Hasil was always keen to do extra on-call duties because of the extra remuneration”. He further noted that “the 90–130 hours per week Dr Hasil claims to have been working relate mostly to on call hours, most of which are not actually worked. Dr Hasil was never asked to increase his clinical load in any other

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<sup>10</sup> In response to my provisional opinion, the recruitment agency expressed regret for this error and stated that the error could not possibly have had a bearing on the outcome of Dr Hasil’s application for employment.

<sup>11</sup> The third consultant retired in late 2005, and Dr B took extended leave from March to July 2006 as a result of an injury.

respect". It was clearly difficult for the DHB to continue to provide a safe and sustainable obstetric and gynaecology service during this period.

#### *Supervision arrangements*

Dr Hasil's job description indicated that he would assist the specialists and work under the supervision of Dr A. The DHB has a supervision and performance review policy.<sup>12</sup> The DHB developed a detailed supervision and induction plan for Dr Hasil. This plan, together with the relevant policies, are attached as Appendices 5 and 6. There was also a supervision agreement with the Medical Council. The Council required Dr Hasil to work under regulatory supervision for at least two years, which included three-monthly supervision reports to the Council.

Dr Hasil was to be supervised by the consultants in the department on an ad hoc basis, as and when required. Dr A would provide supervision for 24 hours per week.<sup>13</sup> Supervision after hours would be available in the first instance via telephone through the Head of Department (ie, Dr A) or other consultants.

In short, Dr Hasil was to be directly supervised or supervised on site during normal working hours. The supervision was largely informal. This meant that assistance was available on site if required. Such an arrangement was premised on the basis that other consultants in the department, in particular Dr A, were on site while Dr Hasil was on duty for 24 hours per week. It did not mean that the consultants directly observed Dr Hasil's practice. Such an arrangement would have been patently impracticable in this environment. After hours, Dr Hasil was to be indirectly supervised. This means that a consultant was available by phone.

It was also anticipated that Dr Hasil would attend relevant departmental and monthly peer review meetings. Dr A was required to review and report to the Medical Council on Dr Hasil's performance at three-monthly intervals. This was also to be reviewed in writing every six months on the basis of the standard performance review policy.

I have received differing accounts of the nature and scope of the supervision that was in fact provided to Dr Hasil. I set out below the perspectives of Dr Hasil, Dr A and other staff as well as a summary of the relevant documentation, in particular, the supervision reports to the Medical Council and meeting minutes.

#### *Dr Hasil's perspective*

Dr Hasil did not recall participating in the supervision and induction plan, but said that he commenced work as a medical officer on Wednesday 3 August. Dr Hasil said that initially he was working in clinic and that he then did one or two days of theatre, and that Dr A oversaw him in the performance of a couple of major cases in theatre, but that Dr A did not review his sterilisation procedures. Dr Hasil said that Dr A sat with him one day for a gynaecological clinic because he did not know about the paperwork.

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<sup>12</sup> The Performance Review Policy is referred to in Dr Hasil's offer of employment. However, the Commissioner's Office has not been provided with a copy of it.

<sup>13</sup> I assume that the 24 hours of on-site supervision from Dr A each week reflected the hours he worked on site at Wanganui Hospital each week.



Dr Hasil said he was treated by the hospital as an obstetrician and gynaecologist despite being “supposedly employed at registrar level”. Dr Hasil said that he had tried to work very hard for Whanganui Hospital, and had taken on the extra responsibility, including doing more on-call work because otherwise there would have been no care offered to patients. He said that generally no one knew who was on call, especially the nursing staff, and this made things difficult for all staff. To find out if he was on call, he had to ask. He had no social life in Whanganui, and very little collegial support. Dr Hasil said that Dr B was absent for much of 2006 and, when he was there, he showed no interest in him.

Dr Hasil felt that very little supervision had been provided to him and that he had been asked to do increasingly complicated procedures, as generally only he and Dr A took the greater workload. He said that as the obstetric department disintegrated, there was very little consultant support.

Dr Hasil believed that the stress of having to work in such conditions, effectively unsupervised, had contributed to the deterioration in his health and ability to cope. He said that the DHB “did nothing to assist ... in coping with the enormous load that it was expecting from him, until it was too late”. Dr Hasil said that although his role was to assist the specialists and to work under the direction of the appropriate specialist, in reality, this did not occur. Instead he had been required to “perform” tasks and onsite supervision had been negligible, particularly during parts of 2006 when Dr A was the only obstetrician and gynaecologist available.

Dr Hasil recalls that the department meetings were held every Monday and that usually he and the midwives attended. Dr A was there every second week at the start of Dr Hasil’s period of employment.

Dr Hasil said that he got on well with Dr A and was able to discuss patients with him when he was available. Dr Hasil’s lawyer acknowledged that “while Dr A did talk with him about concerns that had been raised, these were not serious medical or competence issues but rather advice to Dr Hasil to adjust his practice to be more sensitive to the New Zealand culture”.

Dr Hasil said that the supervision reports to the Medical Council were done infrequently and did not follow any concerted supervision plan. He did not receive any feedback to suggest that there were concerns at the time the supervision reports were completed.<sup>14</sup> At one time Dr A told him that he was “over-performing” as he tried to decrease the waiting lists, and advised him that Whanganui DHB did not have sufficient funding to support this. Dr Hasil was “very shocked to be criticised for over-performing”.

Dr Hasil was not aware of any performance monitoring or auditing of his work by Whanganui DHB.

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<sup>14</sup> The Medical Council’s booklet *Guidance for doctors working in supervised practice and their supervisors* (August 2004) states that supervisors’ responsibilities include providing supervision reports when asked to do so (para 47) and that the doctor working in supervised practice should take responsibility for setting up an appointment schedule with the supervisor (para 26).

*Dr A's perspective*

Dr A said that Dr Hasil did not perform any surgical operations without his direct observation during the first week of his employment. Dr A directly observed and assisted Dr Hasil doing major gynaecological surgery, particularly abdominal hysterectomies, Caesarean sections, and hysteroscopy, laparoscopy, and vaginal repairs, but does not recall observing him performing a sterilisation procedure. Dr A said that Dr Hasil initially sat in during outpatient clinics to get the “feel” of things before he started his own theatre list.

Dr A was satisfied that Dr Hasil was competent to operate independently. Dr A said that he discussed Dr Hasil's scope of practice with him and agreed that he would do a list of core obstetric and gynaecology services. It was agreed that he would not undertake complex surgery, such as level 3 laparoscopic surgery, complex pelvic floor repairs and colposcopy. Dr B advised that he does not perform level 3 laparoscopic surgery either, and refers such patients to MidCentral DHB.

According to Dr A, after the initial period of direct observation, he and Dr Hasil met on a regular basis. They saw each other nearly every day, particularly when they were the only full-time practitioners in the Department of Obstetrics and Gynaecology. From time to time, Dr A would review with Dr Hasil the clinic cases that were placed on the surgical waiting list. They would meet in a more formal way about every three months to complete the supervisor's assessment report for the Medical Council. Dr A would ask other staff in theatre and the delivery suite about Dr Hasil's performance.

Dr A did not have concerns about Dr Hasil's competence. He considered that Dr Hasil “was generally practising safely to the benefit of the Wanganui community”. However, Dr A was aware of concerns about Dr Hasil's judgement, manner, and “sometimes volatile personality”. Dr A was aware that Dr Hasil was having difficulties with his family being in Australia, which was impacting on his manner and possibly on his judgement at the time. However, he recalls that no concerns were raised about Dr Hasil's technical abilities.

Whenever concerns were raised, Dr A addressed them in person with Dr Hasil. They would often sit in the office and discuss concerns, sometimes in a more formal way. Dr A believed that Dr Hasil was prepared to learn and that his practice was improving until he became ill.

Dr A stated that Dr Hasil was never criticised for over-performing, but rather for rushing consultations and for recommending too many women for surgery before other options had been considered. Dr A recalled an occasion on which he did not agree with Dr Hasil's assessment of a patient. Dr A asked Dr Hasil about the history of the case, the reasons for hysterectomy, and other treatment options. The case was reviewed and necessary changes made to the proposed management plan. On one occasion a concern was raised about Dr Hasil booking too many patients for surgery. The clinical records for a number of patients were collected and reviewed. Dr A said that Dr Hasil was always very conciliatory. Dr A categorically denied that Dr Hasil had been asked to do increasingly complicated procedures.

Dr A acknowledged that there had been criticism of Dr Hasil performing “specialist” procedures unsupervised. Dr A said that there is no definition of what a “specialist” procedure is, and that Dr Hasil was by any definition a specialist although he had not obtained vocational registration in Australasia.

*Perspectives of other staff members*

The theatre nurse manager recalls that Dr Hasil was directly supervised during his operations at least once by each obstetrician and gynaecologist employed at the time. She recalls Dr A being in theatre for some of Dr Hasil’s first sessions and Dr Hasil attending and observing Dr A for four or five weeks. Nurse A recalls that when Dr Hasil started he worked mostly with the third consultant, including in theatre. She recalls that Dr Hasil sat in the third consultant’s outpatient clinics a few times.

Dr B recalls Dr Hasil attending one of his theatre sessions. He thought that Dr Hasil would watch him perform some surgical cases, but Dr Hasil stayed for only an hour.

Dr C, the DHB’s Medical Advisor, was aware that Dr Hasil did not have the necessary qualifications to be appointed to a specialist position. He also knew that in practice Dr Hasil was treated as a consultant, and that he was on the consultant roster. Dr C explained that there was no standard policy on performance management that applied to medical staff.<sup>15</sup> He said the process for performance management at Wanganui Hospital tended to be anecdotal and informal. Some departments had regular weekly meetings and peer review, and it was all fairly well documented. Therefore, it was reasonably easy to catch somebody who might be “falling over” in a particular area. However, Dr C stated that some departments at Wanganui Hospital had been under-resourced, which in turn affected the performance management process.

Dr C said that although peer review and performance management overlapped, they tended to be kept separate. The relevant clinical directors and heads of department were responsible for overseeing the adequacy of the performance management process. In the case of obstetrics and gynaecology, Dr A was responsible.

Dr C explained that about four years ago a consultant physician was appointed as Clinical Audit Co-ordinator. Dr C said that Whanganui DHB followed ministerial guidelines for credentialling of all senior medical officers, departmental credentialling and clinical audit. The heads of departments were asked about their three clinical priority areas and what needed to be done over the next 12-month cycle. The information was forwarded to the Clinical Audit Co-ordinator who assisted the head of department to ensure audits took place formally. The information was given to the Clinical Governance Unit, and the recredentialling cycle and departmental cycle started.

Dr C said that the system “fell down” because the information did not come back from the heads of department, who said that they were too busy or felt that the process was too managerial. However, the consultant physician persisted and was able to obtain a number of anecdotal and informal clinical audit trials, which a number of the heads of

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<sup>15</sup> The DHB has since clarified that the standard policy applies to all staff, including doctors.

department took an interest in. The Clinical Audit Co-ordinator reported back to Dr C on a two-monthly basis.

The consultant physician said his role as Clinical Audit Co-ordinator was to promote clinical audit amongst senior medical staff at Wanganui Hospital, although he was not actually employed to do the audit. Previous attempts at introducing such a role at the hospital had failed, and he was encouraged to do what he could. He conducted interviews of all heads of department to find out what clinical audit was occurring and what could be done to make it easier. He said that Dr A, as head of department of obstetrics and gynaecology, told him that some compulsory reporting was ongoing, but that he had a huge workload and was unable to take time to do any extra audit.

Finally, evidence was provided that Dr Hasil was professionally and socially isolated. He had little contact with his colleagues and apparently did not avail himself of opportunities to become more integrated into the community. He rarely sought the opinions of the other consultants or referred patients to them for opinions. Dr Hasil explained that given his workload, he did not have the time to actively seek supervision.

#### *Documented meetings*

The Supervision Plan for Dr Hasil<sup>16</sup> set out the meetings he was required to attend. This included:

- weekly formal Department of Obstetrics and Gynaecology team meetings held every Monday morning;
- peer review held on the third Tuesday of every month;
- Obstetrics Standards Review Committee meeting every month;
- Perinatal Review Committee meeting held quarterly.

The minutes have been provided for the *weekly departmental meetings*. The obstetric and gynaecology medical staff and other departmental staff members, such as the head of midwifery and a paediatric representative, attended these meetings. Dr Hasil attended regularly. He did not attend about seven meetings during his employment. Some of these coincided with his leave (14 November, 13 March, 21 August, and 28 August 2005). He attended a local health centre every third Monday morning. Overall, Dr Hasil attended about half of the weekly departmental meetings.

From the minutes it appears that patients in the delivery suite, the ward (postnatal and antenatal women, and gynaecology patients) and the neonatal unit were discussed. Interesting cases and birth statistics, including the number of normal births, home births, semi-elective births, emergency Caesarean sections, and cases involving an induction of labour were also discussed. No other documentation of meetings attended by Dr Hasil has been sighted.

*Peer review meetings* were held on every third Tuesday and involved senior medical staff from all departments. The DHB records indicate that Dr Hasil attended only the meeting in August 2006.

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<sup>16</sup> See Appendix 6.

The minutes of the *monthly department management meetings* indicate that departmental management meetings were held on 4 July, 5 September, 3 October, 7 November and 5 December 2005, then suspended until 22 May 2006 as a result of staff shortages. Dr A, Dr B, the third consultant, the Service Manager of Community and Rural Services (Service Manager B), and the Head of Midwifery attended these meetings. Dr Hasil was not expected to attend the departmental management meetings. The matters discussed at these meetings included funding, service redesign, recruitment in the department and shortages of midwifery personnel, and clinical issues involving patient safety. At the meeting on 3 October 2005, Dr A clarified that Dr Hasil would function on the consultant roster. On 5 December 2005, Dr Hasil's leave from 19 December 2005 until the new year was discussed.

There are also minutes from *Maternal and Perinatal Review Committee meetings* held on 31 August, 12 October and 30 November 2005, and 22 February and 22 May 2006. These meetings involved discussion on matters such as policies and protocols (eg, for pregnant diabetic patients), the national immunisation register, the relationship between the midwives and the neonatal unit, training on neonatal resuscitation, and case reviews of neonatal and intrauterine deaths. It appears that Dr A was the only consultant obstetrician and gynaecologist who attended the committee meetings.

Although attendance at the quarterly Perinatal Review Committee meetings was part of his supervision plan,<sup>17</sup> Dr Hasil stated that he was not invited to attend these meetings, the majority of which were held on Wednesday afternoons. I note that the gynaecology timetable indicates that Dr Hasil was on call all day on Wednesdays and had a gynaecology outpatient clinic on Wednesday afternoons.

#### *Supervision reports*

By March 2006, Dr Hasil had been working at Wanganui Hospital for six months. There are no records of any supervision meetings or reports (as agreed between Dr A and the Medical Council) nor of a performance appraisal (which was noted as due on 2 November 2005, according to human resources records). The November 2005 date coincides with the date the first quarterly supervision report was due.

In addition to the three-monthly supervision reports, the Medical Council also required Dr Hasil to re-certify through the annual practising certificate process and disclose any competence, conduct or health issues. Dr Hasil's practising certificate expired on 28 February 2006. On 17 February 2006, Dr Hasil applied for a renewal of his annual practising certificate (APC). On 6 March, as part of this process, the Medical Council asked the DHB for Dr Hasil's supervision reports (from 8 August to March 2006). Dr A provided Dr Hasil with a satisfactory report for the period from 8 August 2005 to 7 November 2005, which they both signed on 10 March 2006 and sent to the Medical Council. Dr A gave a score of "3" (satisfactory) for Dr Hasil's clinical clerking and communication, and scores of "4" (above expectation) or "5" (exceptional) for the other domains of competence, which included a "5" for personal manner. Dr A commented that Dr Hasil was a valuable member of the team.

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<sup>17</sup> Refer to Appendix 6, Supervision Plan.

The Medical Council then requested and was provided with an updated supervision report. The updated supervision report is virtually identical to the first report but covers the period 8 August 2005 to 10 March 2006. It appears that the period covered by the first supervision report has simply been altered to cover the extended period — “updated” as part of the APC extension process. Dr Hasil’s second annual practising certificate was subsequently issued in the same terms and covered the period 1 March 2006 to 28 February 2007.

On 9 March 2006, at the same time its registration team was renewing Dr Hasil’s APC, the Medical Council received a report about Dr Hasil’s alcohol use while working in Victoria. The Medical Council then referred the report to its Health Committee for determination of Dr Hasil’s fitness to practise. On 7 April, a representative of the Health Committee contacted the New South Wales Medical Board to obtain more details about the events that led to Dr Hasil’s notification to the Board. The Board advised that Dr Hasil had been under some stress, but that things had resolved. The Board confirmed that its nominated psychiatrist had concluded that Dr Hasil had no ongoing problems and that the Board proposed to take no further action. The Health Committee noted this and took no further action. Neither the Medical Council nor Dr Hasil informed the DHB about the notification from the NSW Medical Board about Dr Hasil’s alcohol use or the assessment by a board-nominated psychiatrist.

A supervision report from Dr A and the DHB, covering the supervision period from 10 March 2006 to 9 June 2006, was sent to the Medical Council on 8 August 2006. During this period, Dr A and the DHB were aware, or ought to have been aware, that there had been two failed sterilisations (in April). There had also been the alcohol incidents in March and May and further complaints about Dr Hasil from patients and staff. Despite this, the report advised that Dr Hasil was reliable and satisfactory in all respects. The supervision reports for the periods 10 March to 9 June 2006 and 10 June to 9 September 2006 are included in Appendix 6.

When Dr A resigned, new supervision arrangements needed to be made. There was considerable correspondence between the DHB and the Medical Council regarding Dr Hasil’s supervision. There appears to have been some confusion and duplication in relation to the process, and uncertainty as to whether Dr Hasil could remain on duty in the meantime.

On 18 August, the service managers for Surgical and Support Services (Service Manager A) and Community and Rural Services (Service Manager B) met with Dr C about contingency arrangements for obstetric and gynaecology services. They were concerned that Dr Hasil was not fulfilling his responsibility to ensure that he had a supervisor. It was noted that Dr B would be away for a ten-day period in October, and it was agreed that the service would have to close down as there were no locums. There was reference to Dr A being on leave and returning the following week.

On 4 September 2006, the DHB notified the Medical Council that Dr A was no longer working at Wanganui Hospital, but that he was willing to continue as Dr Hasil’s supervisor. The Medical Council responded that Dr Hasil could not work until it

approved the new supervision arrangements. This suggests that Dr Hasil should have been on leave on 4 September until the new arrangements were approved.

On 5 September 2006, the General Manager of Wanganui Hospital drafted an urgent facsimile to the Medical Council. She forwarded a copy of Dr Hasil's application to amend his APC, the last supervisor's report (for the period 10 June to 9 September 2006, signed by Dr A on 29 August 2006 and the RMO Co-ordinator on 4 September 2006) and a document outlining detailed supervision arrangements. The supervision arrangements for Dr Hasil were:

- “1. [Dr A] will be available by telephone [at] all times for Dr Hasil.
2. Set aside time once a week as agreed by Dr Hasil and Dr A for telephone interview.
3. Monthly person to person meeting and case review.
4. Dr Hasil to keep a written record of all supervision meetings.”

Subsequently, the Service Manager, Community and Rural Services, advised Dr Hasil that the Medical Council had sighted and agreed to the supervision arrangements and that Dr Hasil could resume duties on 6 September 2006.

On 21 September 2006, Dr Hasil telephoned, and subsequently sent an email to, the Medical Council asking what steps he should be taking with regards to his supervision at Wanganui Hospital. He explained that his supervisor, Dr A, would no longer be working at Wanganui Hospital from mid-October 2006 but had agreed to continue as his supervisor. Dr Hasil forwarded the supervision agreement signed by himself and Dr A. In the event that the arrangement was not adequate, he sought detailed advice about what was required, given that there would be no other full-time obstetrician and gynaecologist at Wanganui Hospital.

On 21 September 2006, the Personal Assistant to the Service Manager, Surgical and Support Services, re-sent the application to amend the APC that had been sent by the Medical Council on 5 September. It appears that on 26 September the Service Manager asked Dr B to assist in supervising Dr Hasil.

On 29 September 2006, Dr B advised by letter that he was happy to provide his unqualified support to Dr Hasil in any emergency situation should Dr Hasil request his help. He stated: “This is obviously on the understanding that I am available in Wanganui at the time as my primary residence, as you are aware, is in [another region]”.

On 2 October 2006, the Medical Council confirmed that Dr Hasil could continue to practise as a medical officer at Wanganui Hospital with offsite supervision by Dr A and emergency support from Dr B if he was available. On 2 October 2006, a copy of Dr B's letter was sent to the Medical Council as requested.

Dr A advised that Dr Hasil did not attempt to honour the supervision arrangements. There were no weekly or monthly contacts. Dr Hasil contacted Dr A only once to advise

that he was returning to Australia for an indefinite period. In fact, Dr Hasil had been placed on leave on 5 October 2006, following the alcohol incident. He never returned to duties at Wanganui Hospital.

During the following months, a closer supervision arrangement was made between the Medical Council, the DHB, MidCentral DHB and Dr A as part of a plan for Dr Hasil's rehabilitation and return to work. It was agreed that Dr Hasil would work directly with a consultant obstetrician and gynaecologist at MidCentral DHB for a period of two weeks to develop the supervisory relationship and satisfy the Medical Council that Dr Hasil was competent to practise without direct onsite supervision. Thereafter, Dr A would be Dr Hasil's primary supervisor and would review all his theatre lists and booking sheets one week prior to scheduled surgery. Dr Hasil would be required to contact Dr A once a week and to arrange a face-to-face meeting once a month.

From 12 to 19 February 2007, Dr Hasil worked with the consultant obstetrician and gynaecologist at MidCentral DHB in accordance with the plan for his return to work. The obstetrician and gynaecologist found Dr Hasil's decision-making lacking and, in particular, thought that his practice was not up to date. He also stated that Dr Hasil appeared nervous in theatre and very rushed, with slight handshaking.

## **STAFF AND PATIENT COMPLAINTS**

During Dr Hasil's employment there were a number of complaints and incidents about him. These are discussed below, not with a view of assessing whether any complaint was well founded, but as relevant background in considering whether there were pointers to problems that the DHB might have identified earlier and responded to more effectively.

The DHB has policies and procedures regarding patient complaints, the code of conduct and incident reporting. The Patient Complaints Policy, Incident Reporting Policy and Code of Conduct are attached as Appendix 5. Clinical Quality and Risk Advisor (Manager C) said that she would see all patient complaints and staff incident reports. Manager C explained that the normal process for an employee raising a concern is to complete an IR1 form and fax it through to the Quality and Risk team.

The Service Manager, Surgical and Support Services (Service Manager A) said that he was totally reliant on the clinical director of the service to raise clinical concerns about a clinical staff member. Incident reports and letters of concerns about a particular doctor would go to the clinical director of the service. He said that from a service manager's perspective, the ability to take immediate action against a doctor was difficult because of the environment that doctors worked in, including the agreements with the ASMS (the Association of Salaried Medical Specialists), which made it difficult to stand down a doctor.

### *Nurse A's concerns*

Dr Hasil worked closely with Nurse A in the gynaecology outpatient and family planning clinics, which were held twice weekly. From the outset, there were a number of aspects of Dr Hasil's practice that gave her great concern. She wondered whether he was an "imposter doctor". Dr Hasil responded that he found Nurse A difficult to work with.



Nurse A initially made her own personal notes about her concerns, which included Dr Hasil's cursory history taking and clinical examination, minimal documentation, use of the lithotomy position — and that he “really hurt some people” during clinical examination. She noted that his management plan tended towards a hysterectomy if the uterus was not useful (ie, women had reached menopause) or was causing any trouble. Nurse A said that Dr Hasil examined people extremely quickly and would not tell them what he was about to do. She said that when she was at the top of the examination bed, she tried to tell patients what to do before he examined them. Nurse A also noted that Dr Hasil became angry when women questioned him. She was concerned about him filling in booking sheets for theatre cases and not examining the women. She also said that his clinical notes were inaccurate, and noted specific examples.

Nurse A's notes made on 12 August 2005 record her concerns regarding Dr Hasil's management plan of abdominal hysterectomies only and that he “talked woman out of LAVH [laparoscopically assisted vaginal hysterectomy]”. On 17 August 2005, she was concerned that Dr Hasil suggested “TVT [tension free vaginal tape] for obv. [obvious] Cystocole” and on 24 August 2005, that Dr Hasil “used TVS [transvaginal sonography] — mistook uterus for bladder”. On 25 August, it is noted that she reported these concerns to Dr A. She noted that Dr Hasil “offered woman with lax vagina muscles an abdo hysty”. There were also inconsistent handwritten records of a patient who was discharged by Dr Hasil on 5 April 2006 because she did not attend the outpatient clinic. Dr Hasil's documentation in the outpatient records suggests that he had seen this patient on 5 April 2006 as there was reference to “happy, no problems O/E spec wound healing ... discharge”. Nurse A crossed this out and wrote “written in error” and “DNA [did not attend] discharge pp Dr Hasil” underneath. There was a subsequent note by Dr Hasil indicating that it was *not* written in error. Yet Dr Hasil's dictated clinic letter to the patient's general practitioner confirms that she did not attend and was discharged back to his care.

Nurse A promptly and frequently reported her specific concerns to the Clinical Nurse Manager (who was her manager) and Dr A. That is not disputed. Dr A recalls that many of the concerns were about Dr Hasil's manner and attitude, and the appropriateness of his decision-making regarding hysterectomy. Dr A said he followed this up in discussions with Dr Hasil. These included discussions with him about his use of the lithotomy position, overbooking patients, and the need for thorough examinations and comprehensive notes. He also addressed the concerns by reviewing about 15 to 20 cases with Dr Hasil and changing the management plan in some cases. Dr A said that he ensured that Dr Hasil had training so that he was able to offer an alternative to a hysterectomy. He stated that Dr Hasil was given formal preceptored training in certain newer techniques, such as placement of sub-urethral slings (TVT) and balloon endometrial ablation. Dr A said that in most cases, Dr Hasil's management was appropriate. He said that not all women found Dr Hasil difficult or abrasive; his manner was not always the same for everybody.

It appears that Dr Hasil took on board the comments about examining in the lithotomy position, and Nurse A thought he “mellowed out” a little. However, her concerns did not abate over time. Her apprehension was heightened by her awareness that he had been

found on duty smelling of alcohol and by other “erratic” and “bizarre” behaviour, such as frequently taking breaks from clinics, purportedly to go to the bank.

Nurse A noted a discussion with Dr A regarding the increasing colposcopy waiting list. Nurse A recalls that she and Dr A discussed Dr Hasil performing colposcopies. She said that Dr A commented that “we could take bets on how quickly we would hit the front page of the *Chronicle*”<sup>18</sup> if he did. It appears that discussion occurred in about April 2006.

In May 2006, Nurse A became frustrated by the lack of response to the concerns she had raised about Dr Hasil. She felt disappointed and lacked confidence that anyone was going to do anything about her concerns. Nurse A reiterated her concern about Dr Hasil, amongst other matters, in an email to her manager dated 1 May 2006. She stated:

“Dr Hasil is still a worry. I have given up reporting his ridiculous actions and recording of the same. Nothing is done. He will make a grave mistake.”

No information has been provided to suggest that Nurse A has a history of making frivolous complaints. Her manager had confidence in her judgement.

The Clinical Nurse Manager said that once she read the email, she immediately went to talk to Nurse A. The Clinical Nurse Manager met with Dr A about the concerns. At a later meeting, it was agreed that Dr A would provide guidelines in relation to booking cases for surgery. If Nurse A had any concerns about Dr Hasil filling in the booking sheets, she was to follow them up with Dr A. However, the guidelines did not eventuate.

The Service Manager, Surgical and Support Services, said that on occasions the Clinical Nurse Manager indicated to him that Nurse A was not happy. However, the Service Manager said that Nurse A did not document her concerns in writing, so he could not take them further.

#### *Patient D (complaint 951)*

On 7 November 2005, the DHB received its first patient complaint about Dr Hasil. Patient D complained about the way Dr Hasil carried out his clinical examination on 26 October 2005 and his comments about her having a history of complaining. In her complaint, Patient D asked about Dr Hasil’s qualifications and queried why, if he had none, he was in a specialty like gynaecology without supervision by a senior consultant.

Dr A investigated Patient D’s complaint. As part of the investigation, Dr Hasil and Nurse A were interviewed and Patient D’s clinical record was reviewed. Nurse A was interviewed by her manager. Nurse A’s statement of 11 November 2005 stated that Dr Hasil’s internal examination of Patient D was “his usual practice”. She was concerned that her statement was subsequently altered without her consent to present a more favourable view of Dr Hasil’s care. The words “rough and fast” were removed from Nurse A’s description of Dr Hasil’s examination.

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<sup>18</sup> The *Wanganui Chronicle*, the local newspaper.

On 21 January 2006, a meeting was held and attended by Patient D and her husband, the Clinical Quality and Risk Advisor, and the Service Manager, Surgical and Support Services. A number of issues were clarified. In his letter dated 20 February 2006, in response to the complaint, the CEO advised that it was not the DHB's usual practice to record complaints in the patients' clinical records, and that this reference had subsequently been removed. The CEO fully acknowledged the distress Patient D and her husband experienced and a letter of apology was forwarded from Dr Hasil. Dr A concluded that cultural differences may have contributed to the circumstances surrounding the complaint. The CEO confirmed that at the time the DHB had not received any other complaints about Dr Hasil's treatment and attitude towards patients.

In March, Dr Hasil was disciplined for using alcohol while on call. Dr Hasil had been on leave from 13 March to 23 March 2006. On his first day back on duty, 24 March, Dr Hasil was reported to be smelling of alcohol at 5.15pm. He was again reported to be smelling of alcohol the next morning, on 25 March, at 10.40am. Two incidents reports and a patient complaint were received about this. A further patient complaint was received in May in relation to Dr Hasil's manner and behaviour on the morning of 25 March (complaint 1088 — Patient E). These events are summarised below.

*Incident of 24 March 2006 (complaint 8591)*

Midwife A is a self-employed midwife working in a Lead Maternity Carer role in the community. She had interactions with Dr Hasil when women went into the Maternity Unit for birthing. Midwife A reported that Midwife B called Dr Hasil, who was on call, to attend the delivery suite to review a client. Midwife A was concerned that when he arrived in the delivery suite she could smell alcohol on him. She notified her mentor, and the following day notified Dr A, who encouraged her to put something in writing. An incident report was completed on 27 March 2006. The incident was referred to the relevant Service Managers and Dr A. Dr A said that this incident had come to light during the investigation of the events of 25 March.

Midwife A recalls a number of times when she had thought Dr Hasil smelt of alcohol when he arrived at the hospital. The first time was in January 2006. Midwife A said that she had spoken to her mentor about the incident, but did not take the matter any further because she thought it was a one-off event. However, when she smelled alcohol again in March 2006, she raised her concern with Dr A, in the absence of the Head of Midwifery. The Head of Midwifery then spoke to Midwife A and Dr A, and Dr A discussed the concerns more formally with Midwife A.

*Incident of 25 March 2006 (complaint 8660)*

On 25 March 2006, at approximately 10.40am, Midwife C called Dr Hasil, the on-call obstetrician, to view the perineum of her client, Patient K, following a normal vaginal birth. On arrival at the unit, Patient K's mother noted that Dr Hasil smelt of alcohol. Midwife C agreed with the observation but she did not think that Dr Hasil was impaired. Dr Hasil sutured the perineum with the assistance of Midwife C.

Patient K's mother indicated that she wanted to complain about this event and Midwife C advised her that she would inform the Head of Department, and also suggested that Patient K's mother write a letter of complaint. Midwife C completed an incident report

on 27 March, and notified Dr A. The relevant service managers were also notified about the incident. The DHB received a complaint from Patient K's mother on 4 April 2006.

The DHB commenced an investigation into the incidents, led by the Service Manager, Surgical and Support Services. On 31 March 2006, an investigation meeting took place and was attended by Dr Hasil, his support person, Dr A, the Service Manager and the General Manager, Human Resources.

When confronted with the allegations, Dr Hasil confirmed that they were true — he had been consuming alcohol while on call. He cited mitigating circumstances of being under pressure due to the absence of his family, and said that it was a one-off occurrence. In response to this inquiry, the DHB submitted that those who attended the meeting described Dr Hasil as frank, apologetic, believable and suitably embarrassed. The Service Manager said that the two episodes were accepted as part of the same “binge”. Dr A acknowledged on reflection that Dr Hasil's explanation that he had had a drink the night before “really didn't wash because he was on call the night before as well”. Dr Hasil submitted that, in retrospect, it was sad that no real steps had been taken to address the possibility of alcohol misuse as a result of that notification. He said that “alcohol misuse can lead to a disease process” and that “under extreme stress, doctors are liable to become ill, like other members of the community”.

Dr Hasil was given a written warning, and was required to write letters of apology to the complainants, and to give an assurance that he had sought medical help. The Service Manager advised Dr Hasil that Medical Advisor Dr C would be informed of the outcome of the meeting as he had statutory obligations and might have to inform the Medical Council of the matter.

Dr C recalls contacting the Medical Council to seek advice about Dr Hasil in early April 2006. Dr C stated that he discussed the situation with a Council staff member but only in a hypothetical sense. He did not mention Dr Hasil's name. After further consideration and perusal of the Medical Council's guidelines, he decided not to inform the Council of the outcome of the meeting. Dr C informed the Service Manager, Surgical and Support Services, that they needed to remind Dr Hasil that they might need to take a different approach if there was any recurrence in the future.

Dr C considered that reporting the matter to the Medical Council might be counter-productive. He felt they would be reporting a health issue which, as far as he knew, was unfounded. Dr C recalls telling the Service Manager that they needed to be open-handed with Dr Hasil — that if he needed any support or assistance, they were more than happy to provide it. Dr C said that the problem was that they had not identified a specific alcohol problem so it was difficult to suggest a specific programme of intervention.

The Medical Council has no record of Dr C having contacted it in late March–early April 2006. The Medical Council advised me that its Health Manager would usually be responsible for taking telephone calls about such concerns. If she were unavailable, the responsibility would fall to another member of the Health Team or the Council's Registrar. The Health Manager keeps an informal log of telephone calls, and has no note of a telephone call from Dr C during late March–early April 2006.

The upshot was that the DHB treated the incident as a “one-off occurrence”. On 13 April 2006, the Service Manager, Surgical and Support Services, rang Patient K’s mother to discuss the outcome of the investigation. He assured her that there was no indication from staff that Dr Hasil’s clinical skills were impaired at the time that he was attending her daughter. He told her that Service Manager A had met formally with Dr Hasil to discuss her complaint, and that Dr Hasil had admitted that he had consumed alcohol, and that he was very apologetic and had given his assurance that it would not happen again. This discussion was followed up by a letter from the CEO dated 5 May 2006, in which he apologised for the events.

At the time, the Medical Council was already on notice from the NSW Medical Board of a “one-off occurrence” of alcohol use by Dr Hasil while he was on duty at Angliss Hospital in Victoria in April 2005. If the information had been shared (either by the Medical Council informing the DHB of the health report or the DHB informing the Medical Council) it would have been clear that there was a health issue that required addressing. Dr C acknowledged that if the DHB had been aware of the information from the New South Wales Medical Board about a previous alcohol issue, that would have provided a different context altogether. In response to my provisional opinion, the Medical Council expressed concern that it was not notified about Dr Hasil’s possible health problems in early April 2006; an early referral would have allowed Dr Hasil to be assessed and rehabilitated and been effective in protecting public health and safety.

*Patient E (complaint 1088)*

Patient E had a normal delivery at 6.39am on 25 March 2006, but her placenta did not deliver. Her midwife called in Dr Hasil.<sup>19</sup> At 7.30am Dr Hasil examined Patient E and attempted to manually remove the placenta with controlled cord traction. Patient E was in pain and screamed out. When Patient E’s partner asked what was happening, Dr Hasil ignored him and continued to pull the placenta.

At 7.30am, Dr Hasil decided that Patient E needed an evacuation of the retained placenta under anaesthesia, and he immediately booked her for theatre. The midwife asked if a Syntocinon infusion could be administered as bleeding was ongoing, but this did not happen. At 8.50am theatre staff arrived to collect Patient E. She stated that she had waited a long time before surgery took place. On arrival in theatre, she was found to be in hypovolaemic shock and required blood transfusions and fluid resuscitation. The anaesthetist commented to her that she should have been there earlier. Dr Hasil explained that the delay in the availability of the theatre resulted from the time of ordering of the theatre coinciding with the change between two shifts. Following surgery, the anaesthetist explained to Patient E what had happened — that she had a tear that had been repaired, and had lost a lot of blood, but was on the road to recovery.

In a letter to the DHB dated 13 April 2006, Patient E and her partner complained about the services provided by Dr Hasil. In particular, they felt that Dr Hasil’s manner was very rude and poor. They explained that Patient E’s partner had dozed off in the chair and did

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<sup>19</sup> It is significant to note that this event happened the morning after the first alcohol incident and just hours before the second alcohol incident.

not know that Patient E was having problems with the placenta. They said that Dr Hasil had come in and asked who Patient E's partner was, and had said that if he was going to be asleep to "just get him out". They complained that Dr Hasil was rough when he tried to manually remove the placenta and did not explain what he was doing. They said that Dr Hasil was very arrogant and lacked communication skills, and that he had made their birthing experience very unpleasant.

They also raised a number of other concerns — including the delay in Patient E going into surgery, that nothing had been organised when she arrived in theatre, that Dr Hasil had contributed to the blood loss by pulling at the placenta (not recorded), the paucity of medical notes, and a perineal tear during surgery (also not recorded). They also complained that Dr Hasil had provided no explanation after surgery and that Patient E had not been catheterised.

On 4 May 2006, the DHB received the complaint from Patient E and her partner, and commenced an investigation. The DHB notified Dr Hasil of the complaint and that it had been forwarded to the Service Manager and Dr A to investigate.

In a letter dated 17 July 2006, the CEO set out the results of the investigation. He stated that it revealed that Dr Hasil's communication style had left Patient E and her partner feeling excluded and uninformed, and that Dr Hasil had expressed his sincere apologies for the lack of communication. The CEO's letter said that Dr Hasil did not recall asking Patient E's partner to leave the room; however, if he had, he sincerely apologised that his manner had upset them. Dr Hasil also apologised for any pain experienced from his examination of Patient E, but noted that it was usual to gently pull the cord in diagnosing a retained placenta.

The CEO explained in his letter that Dr Hasil had made the decision that Patient E needed to go to theatre at 7.30am on 25 March 2006 and had immediately booked the theatre. At 8.15am, Dr Hasil had gone into theatre to find out when Patient E could be accommodated. The house surgeon had contacted theatre, but they were unable to send for Patient E at the time. At 8.50am, theatre staff had arrived to collect her. The CEO also stated that the anaesthetist's comments that Patient E should have been in theatre earlier were not helpful, and that if he had been concerned about her condition, he should have spoken directly to Dr Hasil.

The CEO also stated that the clinical records indicated that Patient E experienced birth trauma, which was repaired in theatre, and that Dr Hasil had not felt it was necessary to catheterise her.

On receipt of the DHB's response, Patient E felt that her complaint was being "swept under the carpet", but decided it was not worth pursuing. However, following the media attention surrounding other complaints against Dr Hasil, she decided to follow up her complaint with the DHB.

In a letter dated 3 May 2007, the CEO acknowledged Patient E's and her partner's dissatisfaction with the response to their initial complaint. The DHB commenced a re-investigation into the complaint. In his letter, the CEO sincerely apologised for the series

of events that had occurred. He stated that the investigation had revealed that Patient E felt Dr Hasil's communication style and manner were rude and arrogant. Dr Hasil's controlled cord traction technique to remove the placenta was in accordance with standard practice, but the CEO acknowledged that it was extremely painful. The investigation also revealed that theatre staff formally commenced weekend duties at 8.30am and they had been contacted and arrangements had been made for them to set up for Patient E's operation on arrival. Although the midwife had telephoned theatre and requested that the start time of the operation be brought forward, the staff had not been able to respond to this request. The clinical records indicate that Patient E's condition had deteriorated at 7.35am and that she had lost approximately 500ml of blood. Immediately following surgery, her haemoglobin level had been low, at 69g per litre, requiring blood transfusion. The DHB had been unable to establish when the perineal tear had occurred.

Patient E remained dissatisfied with the DHB's response to her concerns, particularly regarding Dr Hasil's controlled cord traction technique, the perineal tear, the delay in getting to theatre, and the recording of the blood loss. On 25 May 2007, Patient E met with the staff involved to discuss her outstanding concerns.

Patient E subsequently made a claim to the Accident Compensation Corporation (ACC) for a treatment injury. In July 2007 ACC accepted the claim for (1) hypovolaemic shock requiring blood transfusion due to delay in proceeding to theatre which was urgently required due to blood loss from retained placenta; and (2) perineal tear. ACC sought clinical advice from Dr Jenny Westgate, obstetrician and gynaecologist, who stated: "Delay in going to theatre for manual removal of placenta caused a large blood loss and need for 5 unit blood transfusion. Dr Hasil's refusal to allow a Syntocinon infusion preoperatively is not acceptable management and contributed to the severity of the post partum blood loss."

#### *Incident of 31 May 2006 (incident 7373)*

On 31 May 2006 at 1.30pm, Nurse A smelled alcohol on Dr Hasil when he arrived to do a gynaecology clinic. She advised her manager. She then confronted Dr Hasil, asking if he had been drinking. After he denied it, Nurse A told him he smelled of alcohol and Dr Hasil said that he had had "a bit" the night before. She checked whether he had been on call the previous night and found that he had not been. Nurse A stated that a short while after she confronted Dr Hasil about the smell of alcohol, she could no longer smell it. Since he had not been on call the previous night, she did not wish to pursue the matter as she believed "he was not at fault". Her manager requested that Nurse A inform Dr A and write an incident report.

An incident form was completed by Nurse A and reported to Quality and Risk Management and the Service Manager. She stated: "I could smell alcohol on Dr Hasil when he arrived to do a clinic. I informed [my manager] — this is the second time." Nurse A's manager said that she did not receive any feedback from the incident report.

The Clinical Quality and Risk Advisor did not recall the incident form being received by the Quality and Risk team, and concluded that it had been sent when she was on leave or

that it had not actually been received and logged. However, it was stamped as received by Quality and Risk on 6 June 2006.

The Service Manager said he was not aware of this incident. He said that the incident would have been brought to the attention of his fellow service manager or himself. In the report for June 2006 from Surgical and Support Services to the General Manager of the hospital, the Service Manager noted this incident. The report stated that “[a]n incident form was completed and forwarded to Risk Management and Head of Department re concerns in regards to a Gynae consultant”, and that no complaints had been received that month.

Nurse A informed her manager that she handed a copy of the incident report to Dr A. Dr A said that the incident was brought to his attention. However, the only evidence was that Nurse A had smelt something. Dr A said that Nurse A partially retracted her statement of concern, saying that the smell might have been garlic, and that she was not absolutely sure it was alcohol she had smelled on his breath. Dr Hasil’s performance had not been impaired. Dr Hasil denied that he had been drinking while on duty or so that it would affect his duty, and there was nothing else to suggest that he had been other than Nurse A smelling something which she later said she was not sure was alcohol. Dr A said that when he raised the matter, Dr Hasil was quite angry and vehemently denied it, and that there was nothing else to suggest that he might have been drinking. Dr A noted that the incident was discussed with Nurse A, her manager and the Service Manager. Dr A considered that no further action was required.

*Patient F (complaint 1305)*

On 31 May 2006 Patient F was admitted to Wanganui Hospital for a planned induction of labour at 37 weeks’ gestation. The induction had been arranged by Dr Hasil.

The induction of labour commenced on the morning of 31 May using prostaglandin gel.<sup>20</sup> Patient F did not go into active labour that day or overnight. On 1 June, Dr Hasil reviewed the plan of care and recommended a second dose of prostaglandin. Labour still did not establish. On 2 June, Dr Hasil attempted an artificial rupture of membranes, which was unsuccessful. Later that day, following a further assessment, a plan of care was discussed, and Patient F was advised that the induction of labour had failed and that an elective Caesarean section would be arranged for 9 June. Patient F was discharged from hospital with instructions to return if labour commenced or there were any concerns.

On 3 June Patient F returned as pre-arranged for an assessment. She complained of a headache, had raised blood pressure, and was advised to remain in hospital. Patient F was unhappy with her maternity care and requested a Caesarean section. The midwife advised that there was no indication for an emergency Caesarean section at that time. On 5 June, Patient F felt unwell, her blood pressure worsened and Dr Hasil recommended an emergency Caesarean section. Patient F delivered a baby girl.

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<sup>20</sup> Later this day Nurse A reported that she found Dr Hasil smelling of alcohol.



On 22 March 2007, Patient F made a verbal complaint to the DHB. She stated that it had been extremely traumatic for her over the five to six days during the admission. She alleged that Dr Hasil was technically wanting and had behaved inappropriately throughout. Patient F said that when Dr Hasil tried to artificially rupture the membranes, he “tore [my] insides”. She said Dr Hasil had risked her life and the baby’s.

Patient F stated that Dr Hasil had screamed in theatre, and in the delivery suite he had been shaking, sweating and was rough. He had told her about his personal problems. She said that it was clear that the nursing staff and midwives were uncomfortable with his behaviour. She wanted to know why the nurses did not report his behaviour. Patient F also raised concerns that parts of a copy of the clinical record of her hospital admission, which were forwarded to her, were missing.

On 23 March 2007, the DHB wrote to Patient F, acknowledging receipt of her complaint and saying that it would be investigated. In a letter dated 26 April 2007, the CEO informed her of the outcome of the investigation.

The CEO referred to a report from the Head of Midwifery, who on several occasions was also present when Dr Hasil assessed Patient F’s condition and formulated a plan of care. The Head of Midwifery’s opinion was that the induction of labour was in accordance with standard practice. The Head of Midwifery’s view was that Dr Hasil had tried very hard to maintain the balance between clinical indications for induction and Patient F’s wish to birth the baby sooner rather than later.

The investigation also involved interviewing theatre staff and the midwife involved. The CEO stated that no one recalled the specific behaviour described by Patient F. Furthermore, as Dr Hasil was no longer working for the DHB, the allegations could not be addressed with him. However, the CEO apologised for any inappropriate behaviour by Dr Hasil. A complete copy of the clinical record of her admission was forwarded to Patient F.

In conclusion, the CEO stated that the investigation revealed that the plan for care was communicated, discussed and agreed upon with Patient F and her partner, and that the plan followed usual practice. The CEO explained that inductions can and do fail leading to emergency Caesarean sections, and that vaginal trauma may occur during examinations and attempts to rupture membranes. Furthermore, the investigation found that timely surgical intervention occurred shortly after clinical signs and symptoms indicated a worsening condition.

#### *Midwife D (incident report 7096)*

Midwife D is a registered midwife working at a nearby rural health centre. If she had any concerns about a client, she would usually discuss them with the obstetrician on call. On 15 June 2006, Midwife D reported an incident that took place on 11 June 2006 at 4.30pm, in which a client was booked for an induction of labour on 12 June 2006 when she was 13 days overdue. The client had pre-laboured since 10pm on 10 June and was exhausted, anxious, vomiting and dehydrated. The client and her family wanted to have something done about the labour. Midwife D felt a sleeping tablet or pethidine was not going to provide relief so she requested that the woman be reviewed at Wanganui

Hospital prior to the induction of labour. She said that if she was not augmented, then at least they had staff on duty 24 hours to support her, and she would have an induction of labour first thing in the morning. Midwife D felt unsafe to continue to care for the woman, as she (the midwife) had already lost one night's sleep, and she had no back-up care for other clients who were also overdue. Midwife D felt that Dr Hasil would not listen to her request for admission, saying that she was just trying to "dump her on Wanganui". Dr Hasil explained that he considered that there was no obstetric indication to admit the woman. Midwife D told him that she would send her to Palmerston North and cancelled the induction of labour for the next day. The patient was augmented and gave birth at 3.31am the next morning.

Dr A recalls Dr Hasil's explanation of the matter, which was that he had talked to Midwife D in a half-joking frivolous manner, and that she had taken it the wrong way and had put the phone down.

*Patient G (complaint 1155)*

On 1 June 2006, Patient G signed a consent form for the "marsupialisation of Left Bartholin's Cyst<sup>21</sup>". Dr Hasil performed surgery on 7 July 2006 at Wanganui Hospital, and Patient G was discharged. Five days later when the swelling had settled, she wondered why she was swollen and uncomfortable on both sides of her body. She then discovered that she had sutures on both the left and right labia. She contacted her general practitioner, who confirmed that she had had surgery on both sides, but there was no indication as to why. Her general practitioner suggested they wait for the operation note.

In her complaint letter to the DHB, dated 7 August 2006, Patient G said she had agreed to the removal of a left-sided cyst and later discovered from her general practitioner that she had also had surgery on a right-sided cyst. The hospital staff had not informed her that she had undergone bilateral surgery.

On 15 August 2006, the DHB acknowledged receipt of her complaint about the additional surgery undertaken without consent and said that it would be investigated. Dr Hasil was also informed of the complaint and that it had been forwarded to Dr A, who would handle the investigation.

In a letter to Patient G, dated 19 October 2006, the CEO outlined the outcome of the investigation into her complaint. The CEO stated that while Patient G was under anaesthetic, Dr Hasil detected a similar sized cyst on the right side and decided to perform a marsupialisation on that cyst also. He felt that it was a related problem and that treatment was necessary and in Patient G's best interests. This would prevent another general anaesthetic with its associated risks. It was also pointed out that Patient G had consented to "the treatment of any other necessary and appropriate related problems".

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<sup>21</sup> A cyst in one of the Bartholin's glands, which are located on each side of the vaginal opening. Marsupialisation is a procedure where a small, permanent opening is surgically created to help the gland drain.

The CEO acknowledged that Patient G was not informed of the additional treatment prior to her discharge, and apologised for the series of events that had occurred. He stated that the lack of communication should not have occurred, and that the staff involved apologised that she was not fully informed prior to discharge. The CEO requested that the clinical team adhere to normal practices regarding informed consent for patients, which includes the surgeon, house surgeon or nursing staff advising the patient of any additional treatment, prior to discharge.

*Incident of 5 October 2006 (incidents 7376 and 7377)*

On 5 October 2006, a pregnant woman attended the outpatient department at 8.30am, as arranged with Dr Hasil the previous day. This was not regular practice.

There was some confusion as to who was on call for obstetrics and gynaecology, and concern about the roster. The Service Manager, Community and Rural Services, said that Dr A was on call that day but had forgotten. Although Dr A disputed this, his initials “[...]” had been handwritten on the draft roster, indicating that he would be on call on 5 October 2006.

Although Dr Hasil was not on call on 5 October, he was contacted on his cellphone and found to be incoherent. Dr Hasil was asked to come in and, when he did, it was noted that he had a strong smell of alcohol.

Nurse A reported the matter and filled out incident report forms. Nurse A then called the CEO’s office and explained the situation as she was so concerned about the safety of the service and had lost confidence that anything would be done. This created some acrimony between her and the Service Manager, Community and Rural Services.

Dr Hasil was immediately placed on sick leave and advised that he should seek the counselling services of the Employee Assistance Programme. He was also provided with medical assistance. Dr Hasil attended an Accident and Medical Clinic that day. He obtained a medical certificate stating that he was medically unfit for work for 14 days. He saw two members of the Mental Health Crisis Team the following day.

On 5 October 2006, Medical Advisor Dr C telephoned the Medical Council’s Health Manager to report that Dr Hasil had turned up at work intoxicated and that this was the second time in six months. Dr C agreed to send a formal letter after the meeting of 9 October at Wanganui Hospital. The Medical Council received Dr C’s letter on 16 October. The Council arranged for Dr Hasil to be assessed by an independent psychiatrist, and then arranged a rigorous return to work programme for him. This involved engagement with a clinical psychologist, drug and alcohol treatment services, breath testing, blood counts, consideration of Antabuse and approved clinical supervision, and limited work hours to allow dedicated time off to attend appointments. The details are set out in Appendix 7.

On 9 October 2006, an investigation meeting was held at the DHB and attended by Dr Hasil, his support person, the Service Manager, Community and Rural Services, the General Manager, Human Resources, and Dr C. Dr Hasil admitted that he had been drinking alcohol while on call on Wednesday 4 October. He explained that he had been

unable to sleep and had consumed a bottle of wine because of personal issues largely associated with his domestic situation. Dr Hasil explained that this incident followed a very unsatisfactory and stressful series of phone calls from his wife in Australia. In addition, he had found out that he had failed his Fellowship examination. Dr Hasil acknowledged that he was on call. He had decided that if he was required to attend to patients that night, he would request a transfer to Palmerston North Hospital. However, he had not discussed this decision with medical colleagues or informed management.

*Dr Hasil on leave*

On 9 October 2006, Dr Hasil was given a final written warning to remain indefinitely on his personal record. The DHB placed Dr Hasil on leave while he obtained professional counselling and medical help, including an assessment by an occupational health physician. The physician considered that, overall, Dr Hasil did not have a serious alcohol problem and could return to work at the end of a two-week leave period provided that an adequate system of support could be provided. This would include consultation with his general practitioner and Employee Assistance Programme counselling. The DHB stated that Dr Hasil should be aware that, if he failed to comply with the conditions outlined, there would be an investigation and the outcome might be dismissal.

Dr Hasil remained on leave for five months to complete his rehabilitation and return to work programme. Dr Hasil returned to work on 12 February 2007, initially for a two-week period under direct supervision at MidCentral DHB. On 23 February 2007, he did not turn up for work and was suspended that day pending investigation into the failed sterilisations (discussed below). He eventually resigned from Whanganui DHB on 5 March 2007.

In response to this investigation, Dr Hasil said that instead of Whanganui DHB offering him assistance, he received a written warning. He said that the DHB did not seem to take into account that he had been working extraordinary hours, trying to make up for the level of staffing at the hospital at that time. Dr Hasil stated that looking at that episode, there were signs that he needed help but the DHB did not offer assistance. He said that in October 2006 he had failed his Fellowship examination for the fourth time, and the impact of this, the stress of the workload, and the lack of consultant availability at Whanganui Hospital were all relevant to the deterioration in his health.

*Dr A's concerns*

Dr A acknowledged that he was aware of concerns regarding Dr Hasil's manner and judgement, and addressed these with him, but had no reason to doubt his technical competence until after he went on leave in October 2006.

After Dr Hasil was placed on leave, the DHB faced a critical shortage of obstetricians and gynaecologists, with significant gaps from 15 October onwards. Dr B was the only obstetrician and gynaecologist who remained at the department and he was part-time. The DHB took steps to secure the services of locums, and had agreements with MidCentral, Taranaki and Capital and Coast DHBs, for all high-risk women to be transferred at an early stage, and for all women requiring semi-urgent Caesarean sections to be transferred by ambulance or helicopter as appropriate. Dr A agreed to provide

locum cover during Dr Hasil's unexpected absence, and became concerned about a number of cases he dealt with (over a period of only a few days).

On 26 October 2006, Dr A notified the DHB that he was reluctant to agree to provide off-site supervision and that he considered that Dr Hasil's practice was currently unsafe. He advised that Dr Hasil "had not made any attempt to fulfil the [supervision] arrangements put in place. This together with the events of the last week or two make me feel his practice is currently unsafe and that any supervision would need to be onsite, if indeed he is deemed well enough to practise." Dr A noted the events of concern. First, he cancelled two elective cases which Dr Hasil had inappropriately booked for theatre: a 152cm tall woman who weighed 157kg and had been booked for an elective total abdominal hysterectomy, and a woman with a complete vault prolapse who had been booked for an anterior bladder repair. He also saw as emergencies three women who had been treated by Dr Hasil. Dr A thought the matters should have been raised with the Medical Council.

Dr A subsequently stated that around the time of the alcohol incident in early October 2006 he became aware of two further clinical cases of concern other than those that are the subject of this inquiry. They both involved complications as a result of surgery for the evacuation of uterus for miscarriage. One involved the perforation of a uterus during an evacuation procedure, and the second arose from Dr Hasil having torn the vaginal wall during an evacuation procedure. Dr A said that the cases indicated to him that something was "seriously wrong" and that they would have been cause for "grave concern", but that they were brought to his attention at the time Dr Hasil was placed on leave.

#### *Dr B's concerns*

Dr B recalls that he had had some disquiet about Dr Hasil's judgement in terms of case selection long before the sterilisation failures came to light. On at least one occasion, he had discussed with Dr A Dr Hasil's management of an older woman with post-menopausal bleeding. Dr Hasil had planned to undertake a vaginal hysterectomy on this woman. No diagnosis had been noted in the clinical records, and both Dr A and Dr B felt the management was inappropriate because the patient should have been investigated properly in order to establish a cause of the bleeding. Dr B said that if the patient had an underlying malignancy, a vaginal hysterectomy would have been inappropriate.

When Dr A resigned in September 2006, Dr B was not prepared to supervise Dr Hasil (other than in an emergency situation when he was available). He was contacted again about providing supervision as part of Dr Hasil's return to work programme. On 28 November 2006, Dr B telephoned the Medical Council and said that he was not willing to provide any on-site support for Dr Hasil as he had some reservations about his clinical competence and judgement. He said that he worked part-time in Wanganui, and would only be able to provide assistance in emergency situations. Dr B advised that Dr Hasil needed to work with close on-site supervision and teaching. Dr B commented:

"I discussed the potential consequences of being a supervisor with MPS [the Medical Protection Society] and various other colleagues and really it is not a job that attracts a huge amount of kudos and it's a job that potentially can get one

into trouble. And my concern was always to what extent, as a supervisor, is one responsible for the outcome of the person that you're supervising."

The Medical Council sent Dr B an email regarding his concerns about Dr Hasil. They asked for the concerns to be put in writing so they could take action. Dr B did not put his concerns in writing to the Medical Council.

However, a few months later, Dr B notified the DHB of his concerns about Dr Hasil's competence. On 26 January 2007, Dr B advised the newly appointed Clinical Director of Surgical and Support Services, Dr D, that he had taken over management of a number of patients who had been seen at Dr Hasil's gynaecology clinics and recommended for surgery. Dr B reviewed 20 of Dr Hasil's patients. As a result of the review, Dr B expressed concern that in about half of the patients reviewed, his views on management differed at times quite significantly from that advised by Dr Hasil. Dr B said that there had been similar incidents in the past when Dr A had intervened. Dr B also discussed the management with two or three colleagues from other centres.

On 16 February 2007, Dr D responded. Dr B was advised that as part of the stringent conditions placed on Dr Hasil's ability to work in Wanganui, he had to discuss his cases with Dr A. This was part of a system that was put in place for monitoring Dr Hasil's work and clinical performance. Dr D said he would forward Dr B's communications on the cases to Dr A for his perusal and comment. Dr D also advised that as a matter of natural justice Dr Hasil needed to be informed of the concerns. Furthermore, the approach to the concerns would be determined after discussions between Dr C, Manager C, Dr A and himself.

Dr B said Dr D informed him that there were already concerns when Dr A was Head of Department. Other events took over and nothing came of Dr B's concerns. Dr B's impression was that Dr A was aware of his concerns but he didn't give them the same weight as Dr B had.

Dr A recalls that he was involved in the review of some of Dr Hasil's clinical records and that Dr B would have dealt with eight cases differently. Dr A said there was one case where the proposed treatment was not appropriate, but they had already discussed the woman's care and she had been taken off the operating list; Dr A was to perform a different procedure at some later stage. Dr A had since left and the case was then reviewed by Dr B. Dr A said that just because Dr B would have managed the patients differently, it did not mean that Dr Hasil's management plan was necessarily wrong.

Dr B later explained that when the Medical Council asked him if he was prepared to put something in writing in November, he did not because he considered that he did not have any hard facts on which to base his opinion. However, after looking at 20 or more cases, he felt he was able to form an opinion. Dr B notified the DHB about his concerns in late November 2006. He said that he did not consider notifying the Medical Council about those concerns because it became apparent that Dr Hasil was not going to return to work.

*Acute workforce shortages*

The DHB advised that in late 2006 it made considerable efforts to find a sustainable solution to the obstetric and gynaecology workforce shortages. A variety of service models were considered. It stated:

“The Royal Australian and New Zealand College of Obstetrics and Gynaecology and the Ministry of Health became involved in workforce issues from August 2006. The College Executive Officer and Mr Alec Ekeroma, New Zealand Branch Chairperson, were aware of our urgent need to secure locum cover. Mr Ekeroma, himself, provided some locum Obstetric and Gynaecology cover and thus had first hand knowledge of our situation. The Ministry of Health became more involved in November 2006 and arranged a workshop in Wellington in December 2006. The aim of this workshop was to develop sustainable Paediatric and Obstetric models of care. Whanganui District Health Board involved the College, the Ministry of Health and clinicians from [another] District Health board in teleconferences and meetings.”

*Patient A's complaint*

On 14 February 2007, Patient A made a verbal complaint to the DHB, having recently discovered that she was pregnant after a tubal ligation<sup>22</sup> by Dr Hasil performed on 8 September 2006. She said she was aware of another woman who this had happened to (Patient B). She wanted the DHB to trace women who had had tubal ligations by Dr Hasil and have them checked to make sure the procedure had been successful.

Patient A's complaint was instrumental to this inquiry. I acknowledge her courage in bringing her concerns forward during such a distressing time for her and her family. The findings on my investigation into her care are set out later in this report (see pages 66–68).

Manager C commenced an investigation into the complaint and quickly discovered that there had been other failures with Dr Hasil's procedures, yet none with other obstetricians and gynaecologists. They were all using the same theatre and equipment. On Tuesday 20 February, Manager C notified Dr Hasil of the complaint and arranged a meeting to discuss it.<sup>23</sup> Manager C was subsequently unable to contact Dr Hasil on his work cellphone. She visited his residence, and was informed by his flatmate that he had not been seen since Tuesday evening. She notified Dr C about the concerns on 21 February.

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<sup>22</sup> Tubal ligation is a permanent method of birth control for women, and involves an operation to permanently block both Fallopian tubes, preventing sperm from fertilising an egg. The procedure is described in Appendix 9. It is associated with a small risk of failure (approximately 2 per 1,000 procedures).

<sup>23</sup> At this time Dr Hasil was working under the direct supervision of an obstetrician and gynaecologist at MidCentral DHB and attending for breathalysers at the Community Alcohol and Drug Services as part of his return to work programme. He was expected to resume duties at Wanganui Hospital on 26 February 2007.

On 23 February, Dr C advised the Medical Council and was involved in a teleconference with the Medical Council (which included Dr C, Dr A, Dr D, and the Medical Council's Health Manager and Registration Manager). The Medical Council also discussed the situation with the obstetrician and gynaecologist from MidCentral DHB who was supervising Dr Hasil. The obstetrician and gynaecologist reported that Dr Hasil had not shown up since Tuesday (the day he was notified of the complaint) and that he had concerns about his practice.

Over the weekend, Dr B and Dr A audited the laparoscopic sterilisations performed by Dr Hasil. The internal audit identified that Dr Hasil had performed 32 procedures and that five women had become pregnant following the procedure, giving a failure rate which was well outside an acceptable failure rate of 0.2 percent for sterilisations using Filshie clips.<sup>24</sup> They also found that documentation was poor and the photographs taken during surgery were not helpful. The audit report dated 1 March 2007 is attached as Appendix 8.

The DHB contacted the affected women by telephone and arranged a home visit. Two senior staff members, including a social worker, hand-delivered a letter informing each woman of the risk of pregnancy and the necessary steps to take. A formal record was kept of each visit. Where possible, an appointment was made for an outpatient assessment by telephone during the visit. A gynaecology help-line using an 0800 number was established to assist with managing the investigation.

While the home visits were being made to 27 women, a further failure was discovered, which made a total of six sterilisation failures. By 14 January 2008, 15 women had had a hysterosalpingogram.<sup>25</sup> Two of these women were identified as having a patent Fallopian tube, making a total of eight failures out of 32 procedures. The DHB acknowledges that the failure rate of 25% is well outside the accepted rate of 0.2%.

On 26 February 2007, Manager C met with Dr Hasil about the complaint and placed him on leave until the investigation was complete. The next day, Dr Hasil responded to the complaint in writing. He apologised and said that he had no explanation for the failed sterilisations. However, he noted some concerns about the equipment and theatre staff. Dr Hasil recalled that earlier on, during an operation around January 2006, he had had difficulty with the Filshie clip applicator, which had resulted in a bend in the applicator. He had advised the theatre staff that they would have to calibrate. The DHB appropriately investigated Dr Hasil's concerns about the equipment and theatre nurses. I am satisfied that the equipment was serviced and maintained as required, and that the theatre staff were sufficiently experienced.

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<sup>24</sup> See Royal College of Obstetricians and Gynaecologists, "Failed sterilisation: evidence-based review and medico-legal ramifications" *BJOG: An International Journal of Obstetrics and Gynaecology*, (2004) 111: 1322–1332.

<sup>25</sup> A hysterosalpingogram (HSG) is an X-ray test that looks at the inside of the uterus and Fallopian tubes and the area around them. Dye is put through the vagina and into the uterus through a thin tube. Pictures are taken using X-ray as the dye passes through the uterus and Fallopian tubes. The pictures can show problems such as a blockage that would prevent an egg moving through a Fallopian tube to the uterus.



On 5 March 2007, an investigation meeting was held, attended by Dr Hasil, Dr Hasil's support person, Manager C and the General Manager, Human Resources. During the meeting, Dr Hasil volunteered his resignation with immediate effect, which was accepted. On 6 March 2007, Dr C notified the Medical Council of Dr Hasil's resignation in accordance with section 34(3) of the Health Practitioners Competence Assurance Act 2003 as the resignation related directly to a competence issue.

On 28 February, Dr Hasil's annual practising certificate expired. He applied for an extension, but on 7 March 2007 withdrew his application.

*DHB's knowledge of failed sterilisations*

I have received differing accounts as to when the DHB or its staff became aware of the concerning rate of failed sterilisations performed by Dr Hasil. Whanganui DHB states that Patient A brought the issue to its attention in February 2007. I am satisfied from all the evidence that the DHB knew, or ought to have known, about the failed sterilisations well before Patient A complained on 14 February 2007 and the audit was undertaken.

Summarised below is information from the clinical files of Dr Hasil's patients who contacted the DHB in relation to their failed sterilisation before Patient A's complaint in February. None of these incidents were reported in accordance with the Incident Reporting Policy.

— *Patient H*

On 5 April 2006, Patient H's general practitioner referred her to the DHB for a repeat sterilisation noting that she had become pregnant in January 2006 following a sterilisation performed by Dr Hasil on 29 September 2005. The referral letter was reviewed by Dr A on 10 April and assessed as semi-urgent. On 3 May 2006, Patient H saw Dr Hasil for a repeat sterilisation. Dr Hasil explained the possible failure rate. She was booked for surgery but cancelled. Patient H did not proceed with the second sterilisation.

— *Patient I*

The day after Dr A reviewed the request for a repeat sterilisation of Patient H, he was contacted by the emergency department (ED) about another failure. On 11 April 2006, Patient I attended Wanganui Hospital ED having become pregnant following a sterilisation performed by Dr Hasil in January 2006. The ED doctor discussed the failed sterilisation with Dr A. Patient I saw Dr A for a repeat sterilisation in July.

— *Patient J*

On 31 July 2006, Patient J's general practitioner wrote to Dr B about her having become pregnant following sterilisation. Dr B requested the notes for Patient J on 29 August. On 5 September 2006, Dr B wrote to her general practitioner and copied the letter to Patient J, Dr Hasil and the Service Manager, Surgical and Support Services. He noted that the sterilisation had been performed by Dr Hasil on 9 March 2006 and that there was an accepted failure rate. He said he would be happy to see Patient J and offer her a repeat sterilisation. Patient J was instead reviewed at MidCentral DHB. On 24 October 2006, this other DHB wrote to Patient J's general practitioner regarding her review at its clinic. Patient J's general practitioner copied the letter to Dr B.

— *Patient B*

Patient B had a sterilisation in January 2006, and in October 2006 she became pregnant. On 10 November 2006, her general practitioner referred her to Wanganui Hospital for a repeat sterilisation. Dr B reviewed the referral and assessed it as semi-urgent on 27 November. On 9 February 2007, Patient B was seen by Dr B, who noted a failed sterilisation following a procedure performed by Dr Hasil on 20 January 2006.

Dr A said that Patient I was the first failure he was aware of. He reviewed her clinical notes and the photographs taken at the procedure. On careful review, it could be seen that the clip was not on the right Fallopian tube, but on the fold of the peritoneum, adjacent to the Fallopian tube. The clip on the left Fallopian tube was in the correct position.

Dr A took up the matter with Dr Hasil. He showed him the photograph and they discussed it. Dr Hasil said he could see that the clip was not in the correct position and that he would be more careful in future. Dr A said he told Dr Hasil to make sure he looked at what he was photographing, and to ensure that he identified the anatomical structures, such as the fimbria at the end of the Fallopian tubes, during the procedure.

Dr A considered that, at that time, there were no concerns that this would become a trend. He stated that he became aware of the trend after he had left the employment of Whanganui DHB, at the time Dr Hasil was on leave.

Dr B was aware that one of Dr Hasil's earlier sterilisation procedures had failed. He said that sterilisations carried a recognised failure rate, and one failure had little meaning.

Dr B recalls that he also knew about a sterilisation failure in 2006, but had not heard anything more about it. He then received a letter informing him that a patient he had sterilised was now pregnant. Dr B retrieved the file and realised it was not his patient but one of Dr Hasil's. However, they never heard from her again. Dr B concluded that this was the second failed sterilisation that he knew about. Within a week, he received another letter from a general practitioner about a sterilisation failure. As he did not know how many sterilisation procedures Dr Hasil had performed, he rang Manager C to express his concerns. He advised her to retrieve all the files of patients who had had sterilisation procedures performed by Dr Hasil and notify them. Dr B said that he and Dr A reviewed every file and that patients underwent salpingograms to confirm whether sterilisation had been successful.

Dr B said the sterilisation failures surfaced by accident because all referral letters were being forwarded to him. He said he understood that the Social Work Department was aware of the failed sterilisations because the pregnant patients received counselling prior to termination. Dr A commented that Dr B noticed the trend because he was triaging referrals to the service.

*Additional perspectives on Dr Hasil*

It should not be thought that Dr Hasil's time at Wanganui Hospital attracted only criticism. There were positive qualities that witnesses attributed to Dr Hasil. It appears

that he was a hard worker and willing to take on additional duties. Dr Hasil was also regarded as a quick operator before his poor surgical outcomes became known.

In relation to his obstetric care, Dr B's impression was that Dr Hasil was competent. Staff did not seem to have concerns about the Caesarean sections he performed or his decisions on obstetric care.

The Manager of Theatre Services noticed that in theatre Dr Hasil's hands shook and he sweated a lot. She also noted he was impatient and swore a lot. However, when he got to the task, like suturing, "he was fine".

Dr D was the anaesthetist for a few of Dr Hasil's elective gynaecological lists. Dr D did not consider Dr Hasil unsafe in theatre. He said he was a "very quick surgeon" and that he was able to get a baby out fast during an emergency Caesarean section. Dr D did not observe any higher complication rates following Caesarean sections performed by Dr Hasil.

Midwife A was a relatively new practitioner when she was working with Dr Hasil. She said Dr Hasil was generally co-operative and positive. She did not have any concerns about ringing him for advice. He was always well mannered. He appeared homesick and tired towards the end of the year. Midwife A attended some of Dr Hasil's elective Caesarean sections in theatre, and also found that Dr Hasil appropriately explained the procedure to patients.

No concerns were raised with the Service Manager, Community and Rural Services (Service Manager B) about Dr Hasil's clinical care. She was not aware that there were written complaints about Dr Hasil. Any complaints would have been forwarded to Dr A. However, Service Manager B was aware that there were concerns about Dr Hasil's "attitude" and complaints or comments about his "manner". Dr A spoke to her about his discussion of the concerns with Dr Hasil.

The Service Manager, Surgical and Support Services, was not aware of any concerns about Dr Hasil's "surgical performance" while he was working at Wanganui Hospital. He recalls a meeting with Dr B at which Dr B expressed concerns about Dr Hasil's practice, but by this stage Dr Hasil was no longer working at Wanganui Hospital. Dr B talked to the Service Manager about reviewing Dr Hasil's clinical records and indicated that while he concurred with some of the treatment plans, in other cases he did not.

Dr C recalls that there were mumblings and mutterings about Dr Hasil's conduct. However, at the time Dr A was under a lot of stress and sometimes was working a one-on-one roster. He was the Clinical Director of Surgical and Support Services and there were challenges within the Surgical Department at the time. In addition, Dr A was unable to carry out all his administrative duties and was working out of normal working hours. Dr C recalls Dr A bringing up concerns about Dr Hasil, including cultural issues, Dr Hasil's abruptness and style, and his slightly hurried approach. They were of a non-specific nature and Dr C felt that there were no major concerns to bring to the attention of the Medical Council. In Dr C's view, the concerns were symptomatic of a department under stress and understaffed, which needed to recruit more staff.

Dr C said that as the year went on, particularly around July–August 2006, Dr A expressed concerns to him about Dr Hasil. Dr A said that he was concerned for the safety of the department because he was not sure whether Dr Hasil “was up to it”. However, Dr C said that Dr A was not specific in his concerns — it was more about Dr Hasil’s general attitude towards clinical practice. Dr A showed particular concern at the time he was leaving Wanganui Hospital. Following his resignation, Dr A continued to supervise Dr Hasil, but expressed some concerns to Dr C about supervision because of issues regarding Dr Hasil’s clinical practice. Dr C’s response to the concerns was that if Dr A had specific concerns, he needed to raise them with the Medical Council.

The DHB noted that the nature of the concerns raised about Dr Hasil through the patient complaints process, with the exception of the alcohol-related complaints, were similar to those raised about other senior clinicians. However, the DHB cannot recall any other occasion of a nurse notifying the team leader of safety concerns, as Nurse A did in May 2006.

## **QUALITY OF CARE**

This section encompasses the information gathered in relation to the complaints from Patient A, Patient B and Patient C about the quality of care provided to them by Dr Hasil and Whanganui DHB.

### *Overview of complaints*

In March 2006, Patient A consulted Dr Hasil at the DHB’s Family Planning Clinic regarding sterilisation. In September 2006, Patient A underwent a laparoscopic sterilisation under general anaesthesia for unwanted fertility. Five months later, she discovered she was pregnant. As noted above, Patient A made a formal complaint to the DHB about the failed sterilisation procedure. The complaint was the impetus for the DHB’s audit of patients who had undergone a laparoscopic sterilisation performed by Dr Hasil. On 6 March 2007 she complained to this Office.

On 29 March 2007, my Office received a complaint from Patient B. In September 2005, Patient B had consulted Dr Hasil at the Gynaecology Outpatient Department regarding sterilisation. In January 2006, she underwent a laparoscopic sterilisation under general anaesthesia for unwanted fertility. About nine months later, she discovered she was pregnant. In February 2007, Dr B performed a repeat laparoscopic sterilisation. He noted that the Filshie clip was not on the right Fallopian tube.

The third complaint was received from Patient C on 2 July 2007. Patient C had been referred to Dr Hasil with worsening abdominal pain and findings on CT scan consistent with left ovarian pathology. A subsequent pelvic ultrasound scan revealed cystic structures on both ovaries. Patient C understood that Dr Hasil would perform an exploratory laparoscopy/laparotomy and possibly remove the cysts. However, she signed a consent form for laparoscopy/laparotomy and possible bilateral oophorectomy. In September 2005, Dr Hasil performed a laparotomy and bilateral salpingo-

oophorectomy<sup>26</sup> and adhesiolysis (cutting of abdominal adhesions). In May 2007, during a consultation with her general practitioner, Patient C was shocked to discover that both ovaries had been removed during the surgery.

*Dr Hasil's response to the rate of failures*

On 26 February 2007, Manager C informed Dr Hasil of Patient A's complaint and asked him to provide a response. In his letter to Manager C dated 27 February 2007, Dr Hasil indicated that there were aspects about the operation theatre that he considered to be "distractive and can cause some concerns". He stated:

"Nursing staff assisting to laparoscopic sterilisations, from my experience are doing this procedure [for the] first time, the instruments are often incomplete and assembled from different sets ad hoc and what is important — [is that] the applicator is not checked by appropriate gauge before using it. I do not want [to] blame anyone else for failure of this procedure, but I wish that such sensitive operation, from patient's point of view, has to be performed carefully from ALL involved in laparoscopic sterilisations."

Dr Hasil had no explanation for the failure of the sterilisation operations he performed. He stated that he used the recognised sterilisation procedure as he has done for a number of years, and that his failure rate had been comparable to the accepted rate of one per 200 procedures. He explained that he had performed many laparoscopic sterilisations over 15 years, and that it was a straightforward operative procedure.

Dr Hasil submitted that he had never previously had any difficulty with laparoscopic Filshie clip sterilisation procedures. He stated that during an operation at Wanganui Hospital in January 2006 he had had difficulty with the Filshie clip applicator, which had resulted in a bend in the applicator. He had advised the theatre staff that the applicator would need calibration. He further submitted that if he "was being supervised adequately at this time in theatre, the consultant obstetrician and gynaecologist present would have corrected [his] application of the Filshie clips".

Dr Hasil stated that the minor procedures, including laparoscopic procedures, generally attracted nursing staff who were absolutely new or junior, or a multi-skill nurse who did not practise in gynaecology. Dr Hasil was usually assisted by a junior doctor and the anaesthetist for laparoscopic operations was usually a medical officer.

*DHB investigation of Dr Hasil's concerns*

Whanganui DHB carried out an investigation into the concerns raised by Dr Hasil. The Theatre Manager stated:

1. No nurses are permitted to scrub for any procedure without direct supervision and assessment of capability.

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<sup>26</sup> Bilateral salpingo-oophorectomy is the surgical excision of Fallopian tubes and ovaries on both sides.

2. In each case in question the scrub nurse was very experienced with a minimum of eight years' experience in the operating theatre. Four of the nurses involved have more than 15 years' experience.
3. We have two Filshie clipper sets. At no stage have these sets been used incomplete as there is not a suitable replacement instrument, therefore we could not proceed with the operation.
4. The items in each set always stay together and are labeled as such. One item from another set will not match the rest of the other set.
5. Instructions for testing the integrity of the clipper are posted on the gynaecology module which is always present at each gynaecological list.
6. Staff are instructed to test the clipper at each assembly of it using the provided instructions.
7. Instructions are also posted in the set-up books for gynaecology.
8. Each clipper is sent to the company for calibration annually or where the clipper has been used 100 times, whichever is sooner. On all occasions for the years 2000 to 2007 both clippers have been sent by the due date and the clipper has been used for between 40 to 50 procedures."

The DHB requested the records of the maintenance and calibration of the Filshie clip applicators and identified that other obstetricians and gynaecologists performed a similar number of laparoscopic sterilisations in the same period as the 32 procedures performed by Dr Hasil. They were all using the same instruments, and no failures had been identified with their procedures.

As noted earlier, I am satisfied that the DHB appropriately investigated Dr Hasil's concerns about the equipment and theatre nurses, that the equipment was serviced and maintained as required, and that the theatre staff had the appropriate experience.

During the audit (described above), Dr B noted that the quality of most of the photographs taken by Dr Hasil during the operation was indeterminate and that he was unable to tell whether the clip was in the correct place or whether it was completely across the Fallopian tube.

Dr B said that Dr Hasil often placed the clips too laterally, not close to the uterus where the Fallopian tube is thin and the tube is relatively avascular (no blood vessels). If Dr Hasil had taken the time to carefully check the placement of the clips, it may have given him the opportunity to review the placements, which were incorrect.

#### *Patient A*

##### *— Family planning clinic*

On 27 December 2005, Midwife E referred Patient A, a 30-year-old woman, to the Family Planning Clinic, Whanganui DHB. Midwife E stated: "Tubal ligation as soon as possible please (completion of family)." In a letter dated 11 January 2006, the Specialist

Administrator advised Patient A that the DHB had received the referral letter and that the gynaecologist had classified it as routine.

On 1 March 2006, Patient A was seen by Dr Hasil. The DHB's "Gynaecological record sheet" is used to record consultations. It includes various prompts, such as the patient's past obstetric history, contraception and previous medical history, and has a section in which to record clinical examination findings. Dr Hasil did not complete the record sheet. He recorded:

"G<sub>4</sub>P<sub>3</sub> NVD [normal vaginal delivery]  
unwanted fertility  
gynae examination NAD [no abnormality detected]  
PAP taken  
for sterilisation"

He dictated a letter to Patient A's general practitioner stating that he had booked her for a laparoscopic sterilisation. Patient A and Dr Hasil signed a consent form for a laparoscopic sterilisation on 1 March 2006. Patient A stated that Dr Hasil explained the process and risks of the procedure.

— *Preoperative assessment*

On 27 July 2006, Patient A had a nursing assessment prior to the laparoscopic sterilisation. The nurse noted that Patient A was taking the oral contraceptive pill and had had a recent bout of diarrhoea treated by her general practitioner with anti-diarrhoea medication. The nurse also noted that Patient A had had no previous problems with anaesthesia. Patient A was given educational information in the form of a booklet about anaesthesia. A note dated 11 August 2006 recorded that that a beta-HCG<sup>27</sup> was to be performed on 10 August.

— *Laparoscopic sterilisation surgery*

At 11am on 8 September 2006, Patient A was admitted to the Surgical Day Unit. The anaesthesia part of the consent form was signed by the anaesthetist and Patient A on that day. Patient A underwent a laparoscopic sterilisation performed by Dr Hasil under general anaesthesia. The operation record noted "unwanted fertility" as the indication for a laparoscopic sterilisation. The procedure was performed by two port laparoscopy. Dr Hasil recorded that the organs of the abdominal cavity were "macroscopically NAD [no abnormalities detected]", and that Filshie clips were placed on the right and left Fallopian tubes.

The nursing records noted that Patient A returned to the ward after the procedure and was discharged home later that evening. The gynaecology discharge summary/audit dated "12/9/5" by the Resident Medical Officer recorded the arrangements on discharge — follow-up with general practitioner as required, and medications on discharge,

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<sup>27</sup> Human chorionic gonadotropin (HCG) is a hormone produced during pregnancy and appears in the blood and urine of pregnant women as early as ten days after conception.

Panadol and ibuprofen (non-steroidal anti-inflammatory medication used for pain and inflammation).

— *Subsequent events*

On 12 February 2007, Patient A attended the Whanganui Accident and Medical Clinic. Nurse B noted that Patient A had her “tubes tied” last year and had found out that day that she had become pregnant. She noted that Patient A had three children and was feeling quite stressed about the situation, being financially unable to support more children. Nurse B advised Patient A to call Wanganui Hospital and ask for Community Health to arrange some counselling.

Patient A was then seen by a locum GP at the Wanganui Accident and Medical Clinic. The GP noted that Patient A had had worsening right lower quadrant pain for two weeks and was suffering from morning sickness, and that a beta-HCG was positive on that day. The GP’s clinical examination revealed tenderness with rebound and guarding at the right lower quadrant of the abdomen, and tenderness on the right tubo-ovarian region on bimanual palpation. She ordered an ultrasound scan of the pelvis.

The GP referred Patient A to a doctor at the Emergency Department at Wanganui Hospital. On 12 February, the Emergency Department doctor saw Patient A and noted that she had a two-week history of increased right lower abdominal pain and a high level of beta-HCG at 140,389. The vaginal ultrasound scan showed a normal early pregnancy consistent with Patient A’s menstrual history.

The Emergency Department doctor referred Patient A to Dr B for a gynaecology outpatient appointment. He stated that Patient A was 31-year-old woman, referred by a general practitioner with a history of amenorrhoea (abnormal absence or suppression of menstruation) and right lower abdominal pain.

Patient A recalls that around July–August 2006, she had seen Patient B, a former school friend who had recently found out that she was pregnant after a sterilisation procedure. When Patient A later became pregnant, she discovered that Dr Hasil had performed both sterilisation procedures.

On 14 February 2007, the DHB received a verbal complaint from Patient A. She complained that she had had a tubal ligation on 8 September 2006 and that she was seven weeks’ pregnant. She asked why the procedure had failed and indicated that she knew of another woman who had also had a failed sterilisation performed by the same doctor. Patient A suggested that the DHB trace and review the women who had had tubal ligation procedures undertaken by Dr Hasil to ensure that the procedures had been successful. Manager C, who was responsible for the investigation, arranged for social work support for Patient A.

On 23 February 2007, Patient A presented to Dr B at the Gynaecology Clinic. He noted that she had had a laparoscopic sterilisation on 8 September 2006 that had failed. He also noted that the photos taken during the procedure appeared to suggest the clips had been placed quite laterally on each tube. He could not establish whether they were completely occluded. Dr B noted the ultrasound scan performed on 12 February 2007 and that



Patient A's last menstrual period had been about 24 December 2006. He also recorded that discussion of the risks of surgery and the giving of an information pamphlet were "not documented but done".

Dr B discussed options with Patient A and noted that she would probably have a termination of pregnancy. He planned to see her again in four to six weeks following the termination, and noted that she would have a repeat laparoscopic sterilisation. He also noted that Patient A had seen a social worker. Patient A recalls Dr B telling her that he had seen two previous cases of failed sterilisation.

In her complaint to HDC, dated 6 March 2007, Patient A stated: "I have been forced to make a decision I wish I never had to make and I am heading to Wellington for surgery of termination." Her main concern was that the DHB had failed to act when they became aware of two previous failed sterilisation procedures before she presented. She alleged that the DHB had allowed a doctor with social problems to continue working, and that his surgery had been unsupervised. She had expected some follow-up contact from the DHB following her complaint, but had not received any.

In a letter dated 27 March 2007, the CEO acknowledged Patient A's complaint and apologised for the extremely stressful and distressing time she and her partner had experienced. The CEO stated that the DHB's investigation revealed that Dr Hasil's failure rate for laparoscopic sterilisations was well outside the accepted failure rate and that it had identified a number of areas — such as clinical audit, credentialling and supervision — that needed to be scrutinised. He conveyed Dr Hasil's sincere apologies for the failure of the sterilisation. The CEO also explained that the DHB had implemented Patient A's suggestion of reviewing women and noted its plan for follow-up.

Patient A has been seeing a counsellor. She never wanted to be in the position of having to make a choice about an abortion.

— *Claim to ACC*

Patient A made a claim to ACC for compensation for pregnancy due to failed tubal ligation. On 16 March 2007, ACC declined the claim stating that it did not meet the criteria for treatment injury.

ACC decided to re-investigate Patient A's claim for compensation following the High Court decision of *ACC v D*.<sup>28</sup> In this case, Mallon J ruled that pregnancy following a failed sterilisation procedure can be described as a "physical injury" and therefore constitutes a "personal injury" under the Injury Prevention, Rehabilitation, and Compensation Act 2001. ACC sought advice from its external advisor, Dr Digby Ngan Kee, obstetrician and gynaecologist, who advised:

"In my opinion [Patient A's] personal injury was caused by failure to carry out the laparoscopic sterilisation procedure with the required level of skill and

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<sup>28</sup> *ACC v D*, unreported, High Court, Wellington, CIV-2006-485-765, 16 May 2007, Mallon J.

expertise. ... [Dr Hasil] moved to Wanganui and was working under general registration (rather than vocational registration). As such, he should have been carefully supervised in his work. It now appears that Dr Hasil has an unacceptably high rate of failure from laparoscopic sterilisation. It has been confirmed that the equipment used was in good working order and properly calibrated, so that the conclusion that must be drawn is that the failures are due to operator error.”

Dr Ngan Kee advised that the failure rate of sterilisation with Filshie clips has been extensively studied and is between 1:300 and 1:450 cases, which is a substantially lower rate than that experienced by Dr Hasil’s patients.

On 10 September 2007, ACC advised Patient A that her claim had been declined as no personal injury had been identified. ACC considered that the High Court decision in *ACC v D* was wrongly decided in finding that pregnancy is a personal injury in the context of treatment injury claims.<sup>29</sup>

#### *Patient B*

##### *— Gynaecology outpatient appointment*

On 10 May 2005, Patient B, a 29-year-old woman, was referred by her general practitioner to the Gynaecology Outpatient Department. He noted that Patient B had completed her family and was interested in tubal ligation for permanent sterilisation.

On 22 September 2005, Patient B was seen by Dr Hasil. He recorded his findings on gynaecological examination and his plan for laparoscopic sterilisation. In his letter to her general practitioner dated 22 September 2005, Dr Hasil noted that Patient B was in generally good health and that she had had a conisation<sup>30</sup> one year previously. However, Patient B informed my staff that she underwent cauterisation of the cervix, not conisation. Dr Hasil also noted that Patient B was very adamant that she did not want any more children and wanted a sterilisation. They had discussed different types of contraception, but Patient B was adamant that she wanted a laparoscopic sterilisation. Dr Hasil recorded that on clinical examination the speculum revealed blood from the cervix from menses. He noted a uterus of normal size, and that he had detected no abnormality of the adnexa and pouch of Douglas. He placed her name on the waiting list. Patient B and Dr Hasil signed a “Request and agreement to treat consent form” for the operation of laparoscopic sterilisation on 22 September 2005.

##### *— Preoperative assessment*

The nursing assessment on 12 January 2006 noted that Patient B’s general health was excellent, she had no problems with general anaesthesia, and that she was fit for anaesthesia. It was also noted that Patient B had a good understanding of the procedure and had been given anaesthesia and laparoscopic sterilisation brochures.

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<sup>29</sup> The High Court decision in *ACC v D* is currently under appeal.

<sup>30</sup> A procedure where a small cone-shaped sample of tissue is removed from the cervix and examined under a microscope for any signs of cancer.

— *Laparoscopic sterilisation surgery*

On 20 January 2006, Patient B underwent laparoscopic sterilisation surgery. The operation record indicates that Dr Hasil was the surgeon and Dr E was the anaesthetist; the indication for the procedure was unwanted fertility. It was performed under general anaesthesia with three port laparoscopy. Dr Hasil recorded: “Left tube Filshie clip, right tube Filshie clip on part of tube and meso-salpinx. Clip removed, slight bleeding. Haemostasis. New Filshie clip on the right tube.” The plan for postoperative care was “routine” and Patient B was for discharge home the next day if “OK”, with follow-up in six weeks’ time by a general practitioner.

On return to the ward following the operation, Patient B was noted to have some wound ooze at the top of the port site and base site, and loss per vaginum with several thready clots. She complained of mild discomfort and remained in hospital overnight.

At 9.00am on 21 January 2006, Patient B was seen on the ward round by Dr B. Her observations were stable and the wounds were inspected. Dr B explained to Patient B that a second clip had been applied on the right side and the first clip removed, which had caused some bleeding. This had resulted in the procedure being lengthened. Patient B was discharged later that day with a prescription for paracetamol and ibuprofen, and advised to take regular pain relief for the next 48 hours.

— *Subsequent events*

On 10 November 2006, Patient B was referred by her general practitioner to the gynaecology outpatient clinic. He noted that she had a history of tubal ligation on 20 January 2006, which had failed and resulted in a pregnancy confirmed in October 2006. He requested a repeat tubal ligation. He also noted that the pregnancy had been terminated and that Patient B had had an intrauterine contraceptive device (IUCD) fitted pending repeat tubal ligation. On 1 December 2006, the Specialist Administrator wrote to Patient B advising her that the specialist had seen the referral and triaged it as semi-urgent.

On 9 February 2007, Patient B was seen by Dr B, who recorded a failed sterilisation following a procedure performed by Dr Hasil on 20 January 2006. Dr B also noted that there had been some difficulty on the right side during the operation and that no photos had been taken. He planned a repeat laparoscopic sterilisation and removal of the IUCD on 26 February 2007.

On 26 February 2007, Patient B underwent a laparoscopic sterilisation under general anaesthesia, performed by Dr B. The indication for surgery was recorded as, “Fertility control. The patient has two children, requests sterilisation and has a previously failed procedure.”

The findings at operation were a normal vulva, vagina and cervix. The uterus was retroverted, normal in size, and mobile. It was noted that on the left side a Filshie clip had been correctly applied, although somewhat laterally, and the tube was completely occluded. On the right, placement was incorrect with the tube not encompassed by the Filshie clip.

A Filshie clip was reapplied to each tube medially, and correct placement confirmed and documented with clinical photographs. The planned postoperative care was routine, and Patient B was to be discharged later that day, with removal of sutures by her general practitioner.

In her complaint to HDC, dated 29 March 2007, Patient B raised concerns about two aspects of the sterilisation procedure performed by Dr Hasil: first, that a further incision had been required to remove and re-place the clip on the right Fallopian tube, which had resulted in bleeding and an overnight hospital stay; and secondly, that the procedure failed. She stated: “I would like compensation for the emotional distress, due to having to make a decision about another life that I should have never had to have made. ... Would like Dr Hasil to be held accountable for his inability to complete successful surgeries also a formal apology from Dr Hasil and WDHB for myself and all the other women involved in this case.”

On 30 March 2007, Patient B made a verbal complaint to the DHB. She raised concerns about the failed sterilisation surgery and that she had not been contacted by the DHB at any stage about the failure. She asked for a hysterosalpingogram to ensure that the sterilisation had been successful. She indicated that she had no confidence in Whanganui DHB. On 30 March 2007, the DHB acknowledged receipt of the complaint and advised that it would be investigated.

On receipt of the complaint, Manager C telephoned Patient B and informed her that six sterilisation failures had been identified and that Patient B was one of these six women.

In his letter to Patient B dated 3 May 2007, the CEO explained that the DHB had undertaken an investigation into her complaint, which involved reviewing the clinical records and conducting interviews with the obstetricians and gynaecologists, including Dr B. The CEO also noted that prior to receiving Patient B’s complaint, the DHB had commenced an investigation into laparoscopic sterilisations performed by Dr Hasil.

The CEO also stated that there were no photographs of Patient B’s sterilisation and that the auditors were unable to reach a conclusion about her procedure at the time of the audit. The CEO stated that the investigation into her complaint “revealed that a personal approach was taken in order to communicate with [her] and that [she] was as well informed as all affected women had been to date”. However, he acknowledged the extremely distressing experience and sincerely apologised for the event. Patient B was advised that the DHB would reimburse actual expenses incurred as a result of the sterilisation failure.

In April 2007, Patient B had a hysterosalpingogram, which showed that the second laparoscopic sterilisation procedure was successful.

*Patient C*  
— *Clinical care*

Patient C, a 45-year-old woman, was seen by Dr Hasil in the gynaecology outpatient clinic on 25 August 2005. During the previous year, she had suffered from ongoing and progressing worsening left-sided abdominal pain. Her past surgical history included an

ectopic pregnancy, hysterectomy, appendicectomy, dilatation and curettage, breast abscess, and shoulder surgery. Investigations had been undertaken by the Surgical Department. A colonoscopy was clear. A CT scan performed on 30 June 2005 reported cystic lesions in the left side of the pelvis measuring 8 x 6cm consistent with left ovarian pathology of a cystic nature, and suggested further gynaecological assessment. The Surgical Department referred her to the Department of Obstetrics and Gynaecology.

Dr Hasil recorded that Patient C suffered from constipation and sharp pain in the left epigastric region. He recorded his findings on speculum examination and palpation. Dr Hasil planned for Patient C to have an ultrasound scan, tumour markers in light of the previous CT scan findings, and a review in three weeks' time. In his letter to her general practitioner, Dr Hasil stated that Patient C had had a hysterectomy 22 years previously for menorrhagia, and that she had a "full surgical work-up for constipation which was her major problem". He noted the findings of his gynaecological examination, including no abnormality on palpation despite the CT findings of a left ovarian cyst of about 8cm, and his management plan.

On 21 September 2005, Dr Hasil reviewed Patient C with the results of the investigations. The ovarian tumour markers were negative, but an ultrasound scan on 19 September 2005 revealed an enlarged left ovary measuring 5.3 x 3.9 x 3.2 cm overall, containing two cystic areas. On the right ovary a bilocular cystic structure was noted. The report concluded "given the increased vascularity on the left, a malignant process cannot be excluded". He found "nothing suspicious" on clinical examination. In light of the ultrasound scan and CT scan findings, Dr Hasil booked Patient C for a diagnostic laparotomy, with possible bilateral oophorectomy (the surgical removal of both ovaries) and informed her general practitioner of his management plan.

On 22 September 2005, Patient C and Dr Hasil signed a request and agreement to treat consent form. The surgery is described as "Dg laparoscopy/laparotomy ± bilat. oophorectomy". The handwriting is difficult to decipher. The consent form states: "I AGREE, that I have received a reasonable explanation of the intent, risks and likely outcome of the operation / treatment ..." It also states that the patient gives consent for the treatment of other necessary and appropriate related problems that may be found or arise in the course of this procedure where it is in the patient's best interests. There is no record of the content of any discussion Dr Hasil had with Patient C regarding the side effects of bilateral oophorectomy, including information about hormone replacement therapy.

Patient C recalls Dr Hasil informing her that she had two "lumps". He did not tell her whether or not the lumps were on her ovaries. He advised her that, if necessary, the lumps would be cut out during the operation. She does not recall being told whether the lumps were benign or malignant.

In response to my provisional opinion, Dr Hasil explained that this case was difficult so he had taken considerable time to explain and clarify every aspect of the proposed operation, the postoperative outcomes and future management. He submitted that it was his practice to ask patients if they understood the explanation given and then make himself available for questions.

On 26 September 2005, a preoperative anaesthetic assessment was performed. The assessor's name is illegible. The assessment form notes a diagnosis of "ovarian cyst", and the plan for laparoscopy/laparotomy and bilateral oophorectomy.

— *Operation*

On 30 September 2005, Patient C was admitted to Wanganui Hospital. Dr Hasil performed a laparotomy and bilateral salpingo-oophorectomy (surgical excision of Fallopian tubes and ovaries on both sides) and adhesiolysis under general anaesthesia that day. The operation record states the indication for surgery as "bilateral ovarian cyst". Dr Hasil noted massive adhesions in the abdominal cavity for which he performed adhesiolysis (cutting of adhesions).

The clinical records note that on 1 October 2005 Patient C was seen by both Dr B and Dr Hasil, and that Dr Hasil "explained the operation to patient". An entry on 3 October 2005 records that Patient C was reviewed post-gynaecological surgery and that she had already been given a leaflet (the content of the leaflet is not noted). Patient C said that she understood that during the operation Dr Hasil had removed cysts and cut adhesions. She had not been told that both ovaries had been removed and the implications of the removal.

On 4 October 2005, Patient C was discharged from hospital. The discharge note, written by the resident medical officer, and sent to her general practitioner, stated that Patient C had had a salpingo-oophorectomy and adhesiolysis on 30 September 2005. Follow-up arrangements included an outpatient appointment in six weeks' time and a course of antibiotics.

The histopathology report dated 3 October 2005 stated: "right ovary and fallopian tube, resection — haemorrhagic corpus luteum and simple cyst; left ovary and fallopian tube, resection — paratubal (mesonephric) cyst". This indicated that the right and left ovary and Fallopian tubes were resected.

On 23 November 2005, Patient C saw Dr Hasil, who stated that she had no complaints at her follow-up six-week appointment following surgery.

Patient C did not experience any change in symptoms following the operation. She suffers from hot flushes and continues to experience abdominal pain.

On 31 May 2007, Patient C presented to her general practitioner with symptoms of premature menopause. On review of her clinical records, it became apparent to him that both ovaries had been removed at surgery in 2005.

— *Claim to ACC*

Patient C made a treatment injury claim to ACC regarding bilateral oophorectomy during a laparotomy procedure causing surgical menopausal symptoms. On 11 August 2007, ACC declined the claim for cover.

ACC sought clinical advice from gynaecologist Dr Hilary Liddell. Dr Liddell advised that it was the correct decision for Dr Hasil to remove both Fallopian tubes and ovaries. She

considered that he had acted in Patient C's best interests by proceeding with bilateral oophorectomy and that the possibility of this had been discussed with the patient preoperatively. She also advised that this was again documented on the gynaecological pre-admission, and the surgical procedure that was booked included the possibility of bilateral salpingo-oophorectomy.

## **CHANGES TO DHB SYSTEMS AS A RESULT OF FAILED STERILISATIONS**

Whanganui DHB advised that, as a result of the failed sterilisations, it is considering or has taken actions in the following areas:

### 1. Human resources

- The DHB will provide training to all staff on the requirements of the policy concerning complaints and investigation. This training will include the roles and responsibilities of managers and clinicians in the process.
- Clinical Directors and Heads of Departments will be provided with training in regard to performance management of medical staff to ensure they are equipped with the leadership skills and expertise to complete this requirement.
- The DHB seeks to provide enhanced support for health professionals, particularly medical staff from overseas who often arrive without their families for a period of time while migration arrangements are finalised.
- In early 2007 the DHB centralised the recruitment function for medical staff in order to centralise and co-ordinate the administration of medical recruitment. This will be evaluated to ensure it meets best practice standards.
- The DHB will develop a specific policy on the use of alcohol and drugs.

### 2. Complaints and incident management systems

- In October 2006, the DHB instituted an electronic Incident Reporting System (RiskMan), which is available to all staff at their work stations to report incidents in their workplace. (This system was used by staff to report suspected alcohol issues involving Dr Hasil.)
- The DHB is considering enhancements to RiskMan, including the automatic generation of status reports on outstanding issues, and making search facilities more robust.
- The DHB has formally reminded staff of the policy on whistleblowing-protected information disclosure through a business-wide staff notice.

### 3. Service audit and peer review

- The DHB endeavours to ensure the supervision process is both active and robust by requesting status reports from medical supervisors regarding staff being supervised and their current state of competency. In addition, consideration has been given to an internal audit process.

### 4. Credentialling for obstetrics and gynaecology

- The DHB has developed a credentialling questionnaire template for senior medical staff which includes an assessment of competencies for the assessment and management of various obstetric and gynaecological conditions and procedures.

The DHB had also been planning a wider clinical review as a result of the incidents involving Dr Hasil. However, this was superseded by the joint Ministry of Health and Whanganui DHB review (see below).

## **OTHER EXTERNAL INQUIRIES**

Since 2006, concerns have been raised about patient safety at Wanganui Hospital. Three episodes of suboptimal clinical care and management have been highly publicised — the failed tubal ligations performed by Dr Hasil, the discovery in October 2006 of 166 unprocessed patient referral letters, and the case of a 52-year-old woman who was referred to Wanganui Hospital Emergency Department and discharged on three occasions over 11 days in early 2004 and died the day after the third occasion.<sup>31</sup> These episodes, and public allegations of unsafe clinical practice, prompted a review into the quality of clinical services at Wanganui Hospital, initiated by the Ministry of Health in March 2007. A second review, jointly undertaken by the Ministry of Health and Whanganui DHB, examined the organisational performance of Whanganui DHB.

### *Clinical review*

This review was commissioned by the Ministry of Health. The objectives of the review were to ensure the clinical safety and quality of services at Wanganui Hospital, to restore public confidence in the services, to preserve the professional reputation of the competent clinical staff practising at Wanganui Hospital, and to identify opportunities for quality improvement.

The review was carried out by three external reviewers: Dr David Sage, Chief Medical Officer, Auckland DHB, Helen Pocknall, Director of Nursing and Midwifery, Wairarapa DHB, and Dr Bill Sugrue, General Surgeon, Northland DHB. The reviewers interviewed hospital staff and individuals external to the hospital.

The findings of the report, *Wanganui Hospital Clinical Review: Report to Whanganui District Health Board and Ministry of Health* (July 2007), can be summarised as follows:

- Clinical practice at Wanganui Hospital is not unsafe.
- Clinical quality systems in place for Wanganui Hospital are comparable to other New Zealand hospitals; the level of safety is acceptable and compares favourably with other hospitals.

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<sup>31</sup> This case was the subject of a complaint to the Health and Disability Commissioner: Opinion 05HDC14141, 28 February 2007, at <http://www.hdc.org.nz/files/hdc/opinions/05hdc14141-dhb.pdf>.



- There is ample room for clinical quality improvement at Wanganui Hospital but the gap between current state and ideal is similar to that seen throughout New Zealand.
- Absence of delays in patient access to acute surgical treatment results in better patient access in Wanganui compared with metropolitan hospitals.
- Three patient injury incidents at Wanganui Hospital publicised in 2006–07 (but occurring in 2004–06) had no similarities and did not reflect a current safety problem.
- Eighty percent of the senior medical workforce at Wanganui Hospital are fully qualified specialists.
- There is a stable and well qualified nursing and midwifery workforce.
- Sustainable medical workforce recruitment in two unstable areas (O&G and General Surgery) requires new models of secondary service delivery.

In relation to service models, the authors stated:<sup>32</sup>

“There has been a failure to persuade the community that the alternative [regional] models are more likely to provide expert subspecialty secondary services within the district and that high quality access to the complete range of 24/7 specialties is only sustainable within that regional approach. Wanganui residents should expect to travel to a regional secondary base hospital for some treatments, as occurs throughout the rest of New Zealand over a similar or greater distance.

...

As it stands the adjacent DHBs in the region have a huge amount to offer each other in terms of collegiality for isolated medical specialists, but little to offer each other in terms of capacity sharing. However, future sustainability of secondary services depends on shared capacity and the logic of the future expansion of Palmerston North as a base hospital in the region is inescapable from a clinical quality perspective alone.”

The *Clinical Review* recommended that:

1. confidential verbal reference checking be included in the standard recruitment process for SMOs
2. the Credentials Committee further refine within speciality categories, eg, core and non-core approach as begun in medicine
3. Whanganui DHB introduce immediate short-term measures to remedy the transcription timeframe deficiencies
4. fitness to work policy and decision-making be reviewed, including access to resources for expert assessment
5. expert advice including consumer input be used to put in place laparoscopic tubal ligation quality audit

<sup>32</sup> David Sage and others, *Wanganui Hospital Clinical Review: Report to Whanganui District Health Board and Ministry of Health* (July 2007) p 22.

6. a Quality Framework describing strategy and structure be developed
7. management structures and reporting at governance level be altered to integrate clinical governance.

*Joint Ministry–DHB Review*

The DHB and the Ministry of Health decided to embark on a joint review in May 2006 to identify how Whanganui DHB can fund appropriate services and live within its means. “The main trigger for the review was that the DHB [was] asking for a substantial amount of money for its hospital rebuild, while having a \$5m deficit, despite earlier claims that the health board would have no deficit at all.”<sup>33</sup>

The Ministry of Health felt it prudent to evaluate the efficiency of Whanganui DHB, what services it was providing, and ways in which the DHB could “live within its means” before releasing full funding for the new buildings.

The review was undertaken by the Ministry of Health and DHB staff. The joint working group and joint steering group included the Chief Executive Officer and Chair of Whanganui DHB and the Deputy Director-General and Finance Manager of the Ministry of Health’s Sector Accountability and Funding division.

The report of the Ministry of Health and Whanganui DHB, *Joint Review of Whanganui District Health Board* (29 August 2007), made 53 recommendations across the range of organisational performance, including the following:

- Eight recommendations relate specifically to the board and how it can improve its systems and processes — these range from placing greater emphasis on monitoring the DHB’s financial situation to actively pursuing measures to ensure the board is acting with coherence and unity.
- Four recommendations focus on management structure, noting the need for medical and nursing input at management level.
- Seven recommendations outline how the hospital’s theatres could run more efficiently.
- Another four recommendations relate to expenditure and how the DHB can reduce its costs.
- Other recommendations cover links with primary health care, paediatric and obstetric services, mental health, telemedicine and information technology.

Whanganui DHB is working through the recommendations and implementing a number of changes. The DHB reports on progress to the Ministry of Health at its monthly meetings. The DHB will also formally meet with the Ministry of Health six-monthly to report on the progress in implementing the recommendations of the *Joint Review of Whanganui District Health Board*. The first meeting is planned for the end of February 2008.

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<sup>33</sup> Whanganui DHB Press Statement, *Whanganui Hospital “as safe as any other” — says independent review* (30 August 2007).

## CHANGES TO MEDICAL COUNCIL PROCESSES

It is the Medical Council's responsibility to ensure doctors registered in New Zealand are competent and fit to practise. In response to my provisional opinion, the Council stated that during part of his time in New Zealand, Dr Hasil was clearly not fit to practise. It accepts responsibility for the registration of Dr Hasil.

Since the events in question, the Medical Council has undertaken a review of its actions regarding Dr Hasil. Although it found no errors in the registration process or in the subsequent handling of health information, the Council has identified ways in which its processes can be made more robust, and has actioned several changes.

### *Registration*

The Medical Council has requirements for the registration of international medical graduates via the provisional general scope, comparable health system pathway (the pathway Dr Hasil was registered under). In addition to the requirements set out in its policy, the Medical Council will also check a doctor's application to ensure there are no gaps in employment of more than three months. Where there is a gap, further information is requested from the doctor or his or her agent.

A doctor registered under this pathway will work under provisional registration for a period of two years. Regulatory supervision during these two years is required, including three-monthly reports to the Medical Council. Registration within a general scope of practice is granted after two years of satisfactory supervision reports. Poor reports are brought to the Medical Council's attention and steps are taken to manage public health and safety. This may include declining registration.

If, during the registration process, the Medical Council becomes aware that a doctor has provided false information, this matter is referred to a full Council meeting for consideration.

The Medical Council has identified the following ways in which the registration process could be made more robust:

- The Council is currently contacting all recruitment agents and DHBs to ensure that all information, including all referee reports, is provided to the Council to inform the registration decision. It will require negative as well as positive referee reports.
- The Council is reviewing its current policy that doctors must provide a certificate of good standing for a period of only three years, and considering the advantages and disadvantages of extending this time.
- In situations where the applicant meets registration requirements but there are aspects of the application that raise questions, such as unexplained employment gaps, Council staff will ensure these are brought to the employer's attention.

### *Doctors' health*

Section 45 of the Health Practitioners Competence Assurance Act 2003 requires referral to the Medical Council of any doctor who is "unable to perform the functions required for the practice of his or her profession because of some mental or physical condition". The Council has processes for working with doctors to assess and manage any health concerns, with the key aim of protecting public health and safety. It also works with doctors to help them regain and maintain their fitness to practise and to allow them to continue practising provided that safeguards are in place to protect the public.

Decisions on whether to share health information about a doctor with his/her employer are made on a case-by-case basis. The main factors taken into account are the level of risk posed by the doctor and the role or responsibility the employer will have in managing issues concerning the doctor's health and practice. The Medical Council keeps the health process confidential in order to improve confidence in its role and processes, and help facilitate the referral of doctors with health problems to it.

The Medical Council may receive information about a doctor's health from an overseas regulatory authority. Where there is any uncertainty about the nature of the information, contact is made with the relevant authority. The information is assessed by the Health Team, Health Manager, Registrar, Chair of the Health Committee or the full Health Committee, depending upon the level of concern.

The Medical Council is concerned that no notification about Dr Hasil's possible health problems was made in early April 2006, and that there was a discussion about a hypothetical situation where Dr Hasil was not named. The Council is taking action to prevent this situation occurring again. In future, it will not participate in any anonymous discussions about doctors with health concerns.

The Medical Council is working with DHBs and doctors to ensure that its health programme is better understood and that referrals are made more promptly. Health concerns are handled confidentially and in a manner that not only protects public health and safety but also supports the doctor. The Council states that this needs to be appreciated by employers and health professionals if referrals are to be made in a timely manner.

### *Supervision*

The Medical Council sees it as one of its key roles to work with supervisors, providing support and advice and working together to resolve individual supervisory issues. It is now working closely with DHB chief medical officers to develop and provide a training programme for regulatory supervisors and an orientation programme for international medical graduates.

## RELEVANT CODE PROVISIONS

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

### *RIGHT 4*

#### *Right to Services of an Appropriate Standard*

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

### *RIGHT 6*

#### *Right to be Fully Informed*

- (1) *Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including —*
  - (a) *an explanation of his or her condition; and*
  - (b) *an explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; ...*

### *RIGHT 7*

#### *Right to Make An Informed Choice and Give Informed Consent*

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

## COMMISSIONER'S OPINION

### QUALITY OF CARE — DR HASIL — BREACH

#### *Introduction*

In my opinion, Dr Hasil did not provide services of an appropriate standard in a number of respects. In particular:

- He did not perform laparoscopic sterilisation surgery with reasonable care and skill.
- His record-keeping was inadequate.
- His informed consent process in relation to Patient C was substandard.

I asked Dr Ian Brown, formerly an obstetrician and gynaecologist, and Director of Medical Services at Northland District Health Board, to provide independent expert advice on this matter. Dr Brown's advice is attached as Appendix 10.

Dr Brown has made a number of criticisms relating to the quality of care provided by Dr Hasil. Overall, my advisor considered that in many respects, Dr Hasil failed to perform to the standard expected of a medical officer. A number of other obstetricians and gynaecologists have also raised concerns, including ACC advisor Dr Ngan Kee and the obstetricians and gynaecologists who have reviewed aspects of his care — Dr A, Dr B and a consultant obstetrician and gynaecologist at MidCentral DHB.<sup>34</sup>

The specific deficits in Dr Hasil's practice are set out in my consideration of the three individual complaints from Patients A, B, and C. I will deal with each in turn.

#### *Patient A*

##### *— Clinical care*

In March 2006, Patient A consulted Dr Hasil for a tubal ligation. Dr Hasil briefly recorded the consultation including "unwanted fertility ... for sterilisation" and that no abnormality was detected on gynaecological examination. Dr Hasil explained the procedure and associated risks and they both signed a consent form for laparoscopic sterilisation.

On 8 September 2006, Dr Hasil performed laparoscopic sterilisation surgery under general anaesthesia. He recorded that the Filshie clips were placed on the right and left Fallopian tubes. Five months after the operation, Patient A discovered that she was pregnant, and this was confirmed at the Emergency Department on 12 February 2007. Patient A saw Dr B, who noted that the photographs taken during Dr Hasil's surgery suggested the clips were placed laterally on each tube. Dr B was unable to establish whether the Fallopian tubes were completely occluded.

Whanganui DHB subsequently became aware of eight failed sterilisations from a total of 32 sterilisation operations performed by Dr Hasil. Dr Brown commented that in light of

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<sup>34</sup> See Dr Ngan Kee's advice to ACC regarding Patient A (page 53), Dr B's concerns (page 41) and the comments of the consultant obstetrician and gynaecologist at MidCentral DHB (page 28).

Whanganui DHB's review, and the high failure rate, Dr Hasil had not performed the procedures with the appropriate skill.

I accept Dr Brown's advice that Dr Hasil did not perform Patient A's laparoscopic sterilisation operation with appropriate skill. This is consistent with Dr Ngan Kee's advice to ACC that Patient A's personal injury was caused by Dr Hasil's failure to carry out the laparoscopic sterilisation procedure with the required level of skill and expertise.

In my opinion, Dr Hasil failed to provide Patient A with laparoscopic sterilisation surgery services with reasonable care and skill, and therefore breached Right 4(1) of the Code.

— *Clinical photographs*

Clinical photographs are often taken during laparoscopic sterilisation surgery. Dr A said that four photographs are usually taken — one close up to show that the clip is across the Fallopian tube and a second view that shows that the structure is the tube. He explained that where a woman falls pregnant, the photographs are used to determine whether the clip is in the correct place. Dr B stated that photographs are routinely taken “to document medico-legally that the clips are properly applied”.

Dr Hasil took photographs of his laparoscopic sterilisation surgery, although they appear to have been of variable quality. Dr B noted that the photographs taken during Patient A's surgery appeared to suggest the clips were placed laterally on each Fallopian tube; he was unable to establish whether the tubes were completely occluded.

There is no “medico-legal” reason to take the photographs — after all, if examined during a subsequent inquiry, they may be exculpatory or inculpatory. Furthermore, I consider it unacceptable to review such photographs only *after* a pregnancy is confirmed.

Taking photographs of the operation site at surgery, and reviewing them to ensure correct placement of the clips, may be a useful quality audit tool. I note that the report, *Wanganui Hospital Clinical Review: Report to Whanganui District Health Board and Ministry of Health* (July 2007), recommended that expert advice including consumer input be used to put in place laparoscopic tubal ligation quality audit.<sup>35</sup> In my view, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists should take the lead in developing guidelines on such audit (including whether photographs are an effective quality tool), with consumer input.<sup>36</sup>

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<sup>35</sup> Page 18 of the *Wanganui Hospital Clinical Review: Report to Whanganui District Health Board and Ministry of Health* (July 2007) states: “The sole preventable element in [the failed sterilisations] is effective quality control of laparoscopic tubal clipping, sadly not available to the group of Whanganui women affected.”

<sup>36</sup> In response, the College supported this proposal and made the sensible point that quality audit processes should be applied to all gynaecological surgery, without necessarily singling out sterilisation. The College noted that these events highlight the importance of effective audit.

— *Record-keeping*

A fundamental element of good medical practice is good record-keeping. *Cole's Medical Practice in New Zealand* states:<sup>37</sup>

“[Record-keeping] is a tool for management, for communicating with other doctors and health professionals, and has become the primary tool for continuity of care in many practices as well as in hospitals. To fulfil these tasks, the record must be comprehensive and accurate.”

It is a doctor's responsibility when making a record of a consultation with a patient (particularly a handwritten record) to do so in accordance with professional and ethical standards — which include writing legibly, recording the date and time, and signing the notes legibly.

Dr Hasil did not complete the “Gynaecological record sheet” for his consultation with Patient A on 1 March 2006, but briefly recorded the consultation as follows:

“G<sub>4</sub>P<sub>3</sub> NVD [normal vaginal delivery]  
unwanted fertility  
gynae examination NAD [no abnormality detected]  
PAP taken  
for sterilisation”.

His letter to Patient A's general practitioner reiterated his findings and plan.

My advisor stated that Dr Hasil's record of the initial outpatient assessment was inadequate, with minimal clinical history and no details of examination. Although a general consent form was signed at the assessment visit, there is no evidence on the form related to specific complications, including failure of sterilisation. Dr B subsequently recorded that a discussion of the risks of surgery and the giving of an information pamphlet were “not documented but done” by Dr Hasil.

Dr Brown advised that Dr Hasil's record-keeping was inadequate and the standard clinical record sheet for gynaecology patients was not utilised properly. I accept that Dr Hasil did provide some information regarding risks of sterilisation to Patient A. However, he failed to document his discussion.

I note Dr Hasil's submission that in an inadequately resourced department, it is likely that standards for record-keeping will be the first failing for any health practitioner. However, I am satisfied that the adequacy of his record-keeping has been considered in context. In my view Dr Hasil should have made more detailed note of his consultation with Patient A. I consider that his standard of record-keeping was inadequate and that he breached Right 4(2) of the Code.

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<sup>37</sup> Ian St George (ed), *Cole's Medical Practice in New Zealand* (Medical Council of New Zealand, 2004) p 68.



*Patient B**— Clinical care*

On 22 September 2005, Patient B consulted Dr Hasil about tubal ligation. He recorded his findings on gynaecological examination and his plan for laparoscopic sterilisation. They signed a “Request and agreement to treat consent form” for laparoscopic sterilisation. Although Dr Hasil did not document that the risks of surgery had been discussed at the preoperative assessment, it was noted that Patient B had a good understanding of the procedure and had been given brochures on anaesthesia and laparoscopic sterilisation.

On 20 January 2006, Dr Hasil performed laparoscopic sterilisation under general anaesthesia. The Filshie clips were applied on both sides. Dr Brown commented that the operation was not straightforward as the right Filshie clip was partly on the meso-salpinx and not positioned correctly. The clip was removed and this was associated with some bleeding. The bleeding was stopped and a second clip was placed on the tube. Patient B remained in hospital overnight as she had mild discomfort and wound ooze. Dr Brown advised that Patient B’s postoperative care was appropriate.

Dr Hasil did not take photographs of the Filshie clips during the surgery so no photographs were available for review.

I accept Dr Brown’s advice that the second Filshie clip was also not applied correctly, as was clear when the second procedure was undertaken on 26 February 2007. Dr Brown advised that the first laparoscopic sterilisation procedure by Dr Hasil was not undertaken with reasonable care and skill.

In my opinion, Dr Hasil failed to provide Patient B with laparoscopic sterilisation surgery with reasonable care and skill, and therefore breached Right 4(1) of the Code.

*— Record-keeping*

Dr Hasil’s initial outpatient assessment of Patient B was very poorly documented. It appears that he explained the risks of sterilisation to Patient B, but failed to document the discussion.

I accept Dr Brown’s advice that Dr Hasil’s record-keeping was inadequate and the standard clinical record sheet for gynaecology patients was not utilised properly. Dr Hasil should have made more detailed notes of his consultation with Patient B. In my opinion, Dr Hasil’s standard of record-keeping was inadequate and he therefore breached Right 4(2) of the Code.

*Patient C**— Informed consent*

On August 2005, Patient C presented to Dr Hasil with abdominal pain and an earlier CT scan showing left ovarian pathology of a cystic nature. He arranged for further investigations to be done. On review on 21 September 2005, Dr Hasil noted the ultrasound findings of cystic lesions on the ovaries, for which a malignant process could not be excluded on the left ovary, and negative tumour markers. He then booked Patient C for a diagnostic laparotomy and possible bilateral oophorectomy. On 30 September

2005 Dr Hasil performed a laparotomy and bilateral salpingo-oophorectomy and adhesiolysis under general anaesthesia for “bilateral ovarian cyst”.

Dr Brown advised that in light of the clinical history and examination findings on 25 August 2005 and the previous CT scan finding, it was appropriate for Dr Hasil to ask for an ultrasound scan and tumour markers. It was also reasonable to proceed with a laparoscopy/laparotomy and adhesiolysis, and possible bilateral oophorectomy, given the results of these investigations.

The key issue is whether Patient C received adequate information about the bilateral salpingo-oophorectomy performed by Dr Hasil, and the implications of the surgery. I accept that Dr Hasil did provide some information to Patient C, and that the consent form she signed included consent to the procedure she underwent. However, I am not satisfied that the information provided was adequate or that Patient C made an informed decision to have a bilateral salpingo-oophorectomy.

Patient C recalls that Dr Hasil informed her that she had two “lumps” and that he might cut them out during the operation. She was not told the lumps were on the ovaries or whether they were benign or malignant. She is adamant that Dr Hasil did not inform her that her ovaries might be surgically removed or explain the consequences of such a removal, particularly the need for hormone replacement therapy. Furthermore, when Patient C saw Dr Hasil, both during the immediate postoperative period and at a follow-up appointment on 23 November 2005, she was not informed that both ovaries had been removed, nor told the implications of removal. Her understanding was that Dr Hasil had removed the cysts and cut the abdominal adhesions. It was not until 31 May 2007, 20 months after the operation, that Patient C discovered that both ovaries had been removed.

The possibility of a “bilateral oophorectomy” during surgery has been documented in the clinical records. On 22 September 2005, Patient C and Dr Hasil signed a request and agreement to treat consent form for “Dg laparoscopy/laparotomy ± bilat. oophorectomy”. The patient booking sheet dated 22 September 2005 states: “Dg laparoscopy ± bilat. oophorectomy”. Bilateral oophorectomy was also documented at the preoperative anaesthetic assessment on 26 September 2005. The discharge note of 4 September 2005 stated that Patient C had had the procedure of salpingo-oophorectomy and adhesiolysis. Furthermore, following the operation, on 1 October 2005 the clinical records note that Dr Hasil “explained the operation to patient”.

However, there is no record that a detailed discussion took place between Dr Hasil and Patient C and that he provided her with information on what bilateral oophorectomy meant, including the effects of removing both ovaries and information about hormone replacement therapy. In his expert advice, Dr Brown stated that it would be standard practice to inform any patient undergoing bilateral oophorectomy of the side effects and the options for hormone replacement. Dr Brown advised that Dr Hasil should have discussed the potential outcomes of the procedure in more detail, including:

- the likelihood of improving Patient C’s main complaint of left iliac fossa pain;
- the details of the operation to be performed;

- the possible risks of the procedure, including bleeding and possible damage to other organs in view of the known adhesions; and
- the effects of removing the ovaries.

Dr Hasil had clearly considered that removing both ovaries during the operation was a strong possibility. The possibility of “bilateral oophorectomy” surgery is evident in the clinical records. The consent form signed by Patient C on 22 September 2005 is ambiguous. On the face of the consent form, it appears that Patient C did give consent for a possible bilateral oophorectomy. The standard form also states that the patient has received a reasonable explanation of the intent, risks and likely outcome of the operation. However, the handwriting on the consent form is difficult to decipher, particularly for a patient unfamiliar with the terminology, and there is no record of the content of any discussion Dr Hasil had with Patient C about the proposed surgery.

I note Dr Hasil’s submission that Patient C’s case was difficult so he took considerable time to explain and clarify every aspect of the proposed operation, the postoperative outcomes and future management. He explained that it was his practice to ask patients if they understood the explanation given and then make himself available for questions.

On balance, I am not satisfied that Dr Hasil obtained informed consent from Patient C to perform a bilateral salpingo-oophorectomy. A signature on a consent form is not necessarily determinative that a valid and effective discussion resulting in consent has been given. Consent, once obtained, needs to be adequately documented. The documentation should reflect what is discussed and agreed upon by patient and doctor, and should be clear and unambiguous. That did not happen in this case.

I am persuaded by Patient C’s account that she did not receive an adequate explanation from Dr Hasil about the proposed surgery and the side effects of removing both ovaries. This information was not provided prior to surgery or during the postoperative period. Patient C was shocked to discover her ovaries had been removed 20 months after the event and that she was experiencing premature menopause as a result.

In my opinion, Patient C consented to a laparoscopy or laparotomy and the removal of cysts. However, I am not satisfied that Patient C made an informed choice and gave informed consent to have both ovaries removed. Dr Hasil did not adequately inform Patient C about the operation, and the associated risks and side effects. This is information that a woman in her situation would expect to receive — and was entitled to under Right 6(1)(b) of the Code. In these circumstances, Dr Hasil breached Rights 6(1) and 7(1) of the Code.

— *Record-keeping*

In relation to the consultation of 25 August 2005, Dr Brown advised that there was a very brief clinical history in the clinical notes. Dr Hasil’s recording of the past clinical history was inadequate and he made little comment about the nature of Patient C’s pain. Dr Hasil should have made more detailed notes of his consultation with Patient C. In my opinion, Dr Hasil’s standard of record-keeping was inadequate and he therefore breached Right 4(2) of the Code.

### *Conclusion*

I conclude that there were significant deficits in Dr Hasil's practice in the three cases I have investigated, and that he did not meet the standard expected of a responsible medical officer.

Dr Hasil's surgery on Patients A and B was substandard, he did not obtain informed consent from Patient C, and his record-keeping in relation to all three patients was inadequate.

### *Supervision*

Dr Hasil was not registered within a vocational scope of obstetrics and gynaecology, nor was he a Fellow of RANZCOG. However, he had gained qualifications, training and experience overseas as an obstetrician and gynaecologist, and effectively acted as an obstetrician and gynaecologist at Whanganui Hospital. My advisor, Dr Brown, noted that Dr Hasil was employed by Whanganui DHB as a medical officer but was essentially functioning as a specialist or senior medical officer. Whanganui Hospital needed an obstetrician and gynaecologist to maintain the service requirements. The shortage of senior medical officer staff forced Dr Hasil into the role of a specialist.

Dr Hasil said that he understood that his contract with Whanganui DHB required him to work under supervision. Although there was no formal supervision (ie, regular dedicated time for support and advice from his supervisor, Dr A), informal supervision was available. Dr Hasil felt he had a good relationship with Dr A and could discuss matters with him when he was available. However, Dr Hasil stated that consultant support did not occur and that he had very little collegial support. On the other hand, Dr A said that he and Dr Hasil were in contact regularly, seeing each other nearly every day, particularly when they were the only full-time practitioners in the Department of Obstetrics and Gynaecology. I note that the weekly team meetings were an opportunity for collegial input, although Dr A generally did not attend these meetings.

Despite his apparent openness to supervision, it does not appear that Dr Hasil actively sought it. I do not agree with Dr Hasil's submission that given his workload, he did not have the time to actively seek supervision. Dr Hasil did not appear to demonstrate an understanding of his responsibilities as a medical officer under regulatory supervision. He had a responsibility to participate and engage in the supervisory process, and to bring any concerns (eg, being asked to do increasingly complicated procedures without consultant support) to his supervisor's attention.

### *Candour*

Dr Hasil failed to disclose relevant information relating to his background to Whanganui DHB.<sup>38</sup> Dr Hasil knowingly misled the DHB by failing to disclose his registration history in Tasmania and the circumstances surrounding the termination of his employment in Victoria and New South Wales, and falsifying his work history. In response to this inquiry, the DHB submitted that "we now know the extent to which Dr Hasil misled

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<sup>38</sup> Giving incorrect information on an application for an APC form is an offence.

WDHB (and others)”. In my view, Dr Hasil’s lack of candour affected the way in which the DHB responded to the concerns raised about him.

In response to this inquiry, Dr Hasil said that he is now very distressed by the lack of support he received during his employment at the DHB. He commented that the department “disintegrated” (following the third consultant’s retirement and when Dr B took extended leave) and that “it is impossible to describe the effect of such a situation and workload”.

The adequacy of the steps taken by the DHB in response to Dr Hasil’s situation is discussed below. However, Dr Hasil had a professional responsibility to be more candid about his background and, in particular, to disclose the previous alcohol incident leading to his dismissal in 2005 in Victoria. When he was first found using alcohol on duty at Wanganui Hospital in March 2006, he misled the DHB by stating that it was a “one-off occurrence”.

Health professionals have an ethical duty to disclose to their registration body (ie, the Medical Council for doctors in New Zealand) any significant health issue or impairment that potentially affects their work performance. The registration body can then decide whether any support arrangements are necessary as part of the health professional’s practice, including whether the supervisor and employer need to be informed about this issue — so that they can monitor and support the affected individual. In addition, the New Zealand Medical Association *Code of Ethics* states: “Doctors should seek guidance and assistance from colleagues and professional or healthcare organisations whenever they are unable to function in a competent, safe, and ethical manner.”<sup>39</sup>

If Dr Hasil had disclosed his previous alcohol incident to the Medical Council (if not to the DHB), it could have alerted his supervisor, Dr A. This may have led to closer monitoring and support for Dr Hasil when he worked at the DHB. This was a missed opportunity to afford Dr Hasil with support, particularly after the first alcohol incident in March 2006. In my opinion, by his lack of candour, Dr Hasil contributed to his own demise.

## **SUPERVISION — DR A — NO BREACH**

### *Introduction*

There were at least three roles at Whanganui DHB with management and leadership responsibilities for obstetric and gynaecology services: the Clinical Director, Surgical and Support Services/Head of Department; the Services Manager, Surgical and Support Services; and the Services Manager, Community and Rural Services. The Medical Advisor also had clinical leadership responsibilities across all clinical areas. Their management and leadership responsibilities will be considered in the next section on organisational responsibility.

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<sup>39</sup> The Medical Council’s publication, *Doctors’ Health*, also states: “A doctor is not fit to practise if, because of a physical or mental condition, he or she is not able to perform the functions required for the practice of medicine” and that such a doctor must be referred to the Registrar of the Council.

It is only Dr A from the management team who is specifically under investigation. The reason for singling him out for investigation is that he was personally responsible for supervising Dr Hasil. A supervisor has a duty to provide supervision with reasonable care and skill and in accordance with professional standards. This duty is recognised at common law.<sup>40</sup> The duty of a supervisor has been considered in several major HDC reports, including *Southland District Health Board Mental Health Services February–March 2001*.<sup>41</sup>

#### *Definition of supervision*

Supervision is a broad and somewhat fluid concept. In practice, it varies in nature and degree.<sup>42</sup> Supervision can be both formal and informal.<sup>43</sup> It is important to distinguish between the different types of supervision in a medical context.

One type of supervision is *regulatory supervision*. The Medical Council may require that a doctor practise under supervision and that the supervisor assess and report on the performance of the supervised doctor.<sup>44</sup> Regulatory supervision is supervision provided at the request of the Medical Council for doctors who are provisionally registered, such as an international medical graduate (IMG) new to the country.<sup>45</sup> Regulatory supervision does not necessarily take place within the same clinical team. Offsite regulatory supervision — where the supervisor works somewhere else — is permitted in certain cases, particularly in provincial or rural settings. The supervisor is an agent of the Medical Council. The Medical Council provides guidance on the supervision of new doctors in New Zealand.<sup>46</sup>

The more familiar type of supervision in medicine is when a more senior doctor supervises a more junior doctor within a clinical team (eg, a senior doctor of a registrar or medical officer; a registrar of a house surgeon).<sup>47</sup> This is *clinical supervision*.<sup>48</sup> A basic principle of clinical supervision is that the supervisor may delegate care to the

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<sup>40</sup> *McKenzie v Medical Practitioners Disciplinary Tribunal* [2004] NZAR 47 (HC), paras 24–25.

<sup>41</sup> Health and Disability Commissioner, October 2002; accessible at [www.hdc.org.nz/publications/reports](http://www.hdc.org.nz/publications/reports).

<sup>42</sup> The Medical Council defines supervision as “the provision of guidance and feedback on matters of personal, professional and educational development in the context of a doctor’s experience of providing safe and appropriate patient care”. Whanganui DHB has a supervision policy that provides that supervision is a process in which the supervisor enables, guides and facilitates the supervisee in meeting certain organisational, professional and personal objectives.

<sup>43</sup> Formal supervision involves regular protected time, specifically scheduled. Informal supervision involves regular communication and conversation providing advice, guidance or support as and when necessary.

<sup>44</sup> Health Practitioners Competence Assurance Act 2003, section 23.

<sup>45</sup> Professor John Campbell, “Supervision — why the concern?” *New Zealand Doctor*, 26 September 2007, 14.

<sup>46</sup> Medical Council of New Zealand, *Guidance for doctors working in supervised practice and their supervisors* (August 2004), which has been replaced by *Induction and supervision for newly registered doctors* (October 2007).

<sup>47</sup> R Paterson and M van Wyk, “Supervisory Responsibility of Specialists” (2002) 10 *Journal of Law and Medicine* 187, 190.

<sup>48</sup> Professor John Campbell, “Supervision — why the concern?” *New Zealand Doctor*, 26 September 2007, 14.

supervisee where he or she has good reason to believe that they are competent to carry out the delegated tasks. The supervisee should be encouraged to seek assistance if he or she feels out of their depth. The supervisor needs to be available to provide assistance as required.<sup>49</sup>

A critical issue in cases involving clinical supervision is whether the supervisor acted reasonably in relying on the supervisee acting in the role assigned. In deciding this issue, several factors are considered, including the supervisee's experience and the supervisor's knowledge of their skills and experience.<sup>50</sup>

One variant of clinical supervision is the supervision of a medical officer by a specialist within a service.<sup>51</sup> The supervisory relationship between a specialist/Clinical Director and a medical officer within a mental health service was discussed in *Director of Proceedings v O'Flynn*.<sup>52</sup> In considering the adequacy of the supervision, the Tribunal adopted the objective test referred to by Venning J in *McKenzie v Medical Practitioners Disciplinary Tribunal*.<sup>53</sup> The Tribunal indicated that specialist/clinical director Dr O'Flynn was not required to provide close supervision. In the absence of any specific knowledge of the medical officer's shortcomings, the specialist/Clinical Director is entitled to expect the medical officer to conduct himself to a standard commensurate with his qualifications and experience as a senior member of the medical staff.

If the person responsible for delegating clinical responsibilities in a service has worked closely with a medical officer, and is confident that the medical officer can act in the role assigned, it would usually be reasonable for the specialist to rely on the medical officer to act independently, in effect as a specialist.<sup>54</sup> I accept that there are medical officers who are well able to act independently, in effect as specialists. However, if a medical officer's competence is in doubt, or not known to the supervisor, closer supervision is required.

Effective clinical supervision is critical for safe health care. One of the essential checks within the system will be lost if the requirement for supervision is "watered down". A

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<sup>49</sup> There has been a tremendous change in nature of the medical workforce and hospital medicine in the past 20 years, which is undermining the traditional model of supervision. The supervisors may not be familiar with the supervisee's level of competence. Concomitantly, the supervisee may not recognise their own limitations due to their lack of experience.

<sup>50</sup> *McKenzie v Medical Practitioners Disciplinary Tribunal* [2004] NZAR 47 (HC).

<sup>51</sup> A medical officer, previously known as a medical officer special scale (MOSS), falls between the cracks in relation to the professional colleges. Professional colleges have a role in relation to their fellows and trainees. For example, there is generally a requirement for formal supervision as part of registrar training programmes.

<sup>52</sup> *Director of Proceedings v O'Flynn*, Medical Practitioners Disciplinary Tribunal, 291/03/110D, 15 July 2004.

<sup>53</sup> *McKenzie v Medical Practitioners Disciplinary Tribunal* [2004] NZAR 47 (HC), para 562–563.

<sup>54</sup> *Director of Proceedings v O'Flynn*, Medical Practitioners Disciplinary Tribunal, 291/03/110D, 15 July 2004.

system based on delegation without supervision and responsibility will not work to the benefit of the patients and the community.<sup>55</sup>

### *Supervision of Dr Hasil*

Both clinical and regulatory supervision may occur at the same time. In such cases, there will be some overlap in terms of responsibilities as well as some differences. In this case, Dr A was responsible for Dr Hasil's clinical and regulatory supervision when he was the Clinical Director and Head of Department. It was a requirement of the DHB at the time that supervision be in place for Dr Hasil, which was provided by Dr A.<sup>56</sup> After Dr A's resignation from the DHB, he continued to provide offsite regulatory supervision for the Medical Council. The issue for determination is whether Dr A provided adequate supervision in the circumstances.

A key issue in this case is the amount of supervision that was required and was in fact provided to Dr Hasil. As noted above, the level of supervision required will vary with the experience and competence of the doctor being supervised, and how well the supervisor knows their attributes and the level of confidence they can reasonably have in them.

Dr Hasil's CV indicated that he had more than 20 years' experience in obstetrics and gynaecology. He had been working in a comparable health system since 1996. Dr Hasil was employed as a medical officer to assist the specialists in the department under Dr A's supervision. At the outset, Dr A took appropriate steps to familiarise himself with Dr Hasil's practice. Dr A directly observed Dr Hasil for a few weeks and considered that he was competent to provide obstetric and gynaecology services independently. Dr Hasil was then rostered on the consultant roster and shared the obstetric and gynaecology duties with the consultants (even though he was not a Fellow of RANZCOG or registered within a vocational scope of practice).

Dr A provided "informal supervision" to Dr Hasil. Dr A was available to Dr Hasil if he required assistance. Dr A saw Dr Hasil frequently, although this contact was largely limited to informal discussions rather than formal meetings or routine peer review. Dr A and Dr Hasil had a constructive working relationship. Dr Hasil attended the weekly team meetings, although Dr A was not regularly in attendance. Dr A met with Dr Hasil on an "ad hoc" basis to discuss his clinical practice, frequently at first, then less over time.

Dr A was aware of concerns about Dr Hasil but did not consider that they were clinically significant. I accept that whenever concerns were raised, Dr A discussed them openly with Dr Hasil, who appeared to respond well to feedback. On occasion, Dr A facilitated further training for Dr Hasil. Dr A concluded that Dr Hasil was making necessary improvements and that his practice was at or above the minimum standard. Dr A remained satisfied that Dr Hasil possessed the appropriate level of skills and experience to undertake the work allocated to him. Accordingly, Dr A's reports to the Medical

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<sup>55</sup> Professor John Campbell, "Supervision — why the concern?" *New Zealand Doctor*, 26 September 2007, 14.

<sup>56</sup> See Appendix 6.



Council did not indicate any matters of concern regarding Dr Hasil, and Dr A reported that Dr Hasil was reliable and satisfactory in all respects.

Whatever the potential value of the various supervision meetings and interactions between Dr A and Dr Hasil, none of them separately or cumulatively gave Dr A reason to consider that Dr Hasil was potentially unsafe to practise. It is likely that Dr Hasil's lack of candour contributed to this view, as discussed in the previous section.

It was only when Dr Hasil went on unexpected leave in October 2006, and Dr A took over the review of a number of his patients, that he realised the extent of Dr Hasil's deficiencies. At this time Dr A had significant concerns about the safety of his practice, which he reported to the DHB.

Dr Brown, my independent advisor, commented that Dr A's supervision of Dr Hasil was within the Medical Council's guidelines, although closer and more consistent supervision would have been ideal.<sup>57</sup> He felt that in the context of acute staff shortages and other supervisory responsibilities undertaken by Dr A, the level of supervision would be much the same as that provided in many other DHBs.

I accept that this type of supervision arrangement is not peculiar to this department, or indeed to Wanganui Hospital. A lay observer might well consider such an "ad hoc" arrangement to be "supervision" in name only, when it is so curtailed by time pressures and so heavily dependent on the supervisee recognising and disclosing their own limits, and seeking assistance.

Dr A concedes that with hindsight his supervision was not adequate and failed to promptly identify the extent of Dr Hasil's shortcomings. It can now be seen that Dr A should have increased the frequency and regularity of his meetings with Dr Hasil, and routinely reviewed cases with him to be satisfied that he was practising safely. If this was not feasible, he should have alerted management and the Medical Council that he could not fulfil his supervisory responsibilities.

It is likely that closer supervision would have exposed the extent of the problems earlier. However, expecting such a high level of supervision from Dr A was neither reasonable, in the absence of any specific notice of Dr Hasil's shortcomings, nor practicable in the circumstances.

### *Conclusion*

Undoubtedly, Dr A had to grapple with a difficult and complex set of circumstances over a lengthy period of time. A picture emerges of a hard-working and dedicated supervisor. Although he was already carrying additional responsibility as Head of the Department of Obstetrics and Gynaecology and Clinical Director, Surgical and Support Services, he was willing to step up to the plate and supervise Dr Hasil when others were not.

Dr A was stretched in his ability to perform all his tasks, in particular his administrative as well as clinical responsibilities, and was working in an environment of constant time

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<sup>57</sup> See Appendix 10, Independent Advice to Commissioner

pressures. The legal issue is whether Dr A took reasonable actions in the circumstances to supervise Dr Hasil.

It is easy with hindsight to see the deficiencies in the supervision. I agree with Dr A's own analysis that, in retrospect, his supervision was not adequate and failed to promptly identify the extent of Dr Hasil's shortcomings. At the time, he formed the not unreasonable (though optimistic) view that Dr Hasil was generally performing at a competent level. Dr A addressed Dr Hasil's limitations with him on a case-by-case basis. He was entitled to expect Dr Hasil to conduct himself professionally and to a standard commensurate with his qualifications and experience as a senior member of the Obstetrics and Gynaecology department who had 20 years' experience. While aware of Dr Hasil's limitations, Dr A had no specific knowledge of the extent of Dr Hasil's shortcomings as a practitioner until after Dr Hasil was placed on indefinite leave.

On balance, I accept that Dr A took reasonable actions in the circumstances to supervise Dr Hasil. Accordingly, Dr A did not breach the Code.

## **ORGANISATIONAL RESPONSIBILITY — WHANGANUI DHB — BREACH**

### *Introduction*

Whanganui DHB is subject to a legal duty to provide health services with reasonable care and skill and in accordance with relevant standards. A hospital has an obligation to take reasonable steps to ensure that its clinical staff are competent and fit to practise, in order to protect patients.

This duty is well recognised in the common law. In *Wilsher v Essex AHA*, Browne-Wilkinson V-C stated that a hospital has a duty "to provide doctors of sufficient skill and experience to give the treatment offered at the hospital".<sup>58</sup> In subsequent case law, other aspects of a hospital's duty of care have been recognised. They include the obligation to select competent staff and monitor their continued competence; provide proper orientation, training and supervision for staff; ensure that staff have adequate back-up and on-call support; and establish systems necessary for the safe operation of the hospital.

The organisational duty of care of a public hospital has been considered in several major Health and Disability Commissioner reports, including *Canterbury Health Ltd* (1998),<sup>59</sup> *Southland District Health Board Mental Health Services February–March 2001*, Opinion 03HDC05563 (2004) and the *Tauranga Hospitals Inquiry* (Opinion 04HDC07920, 2005).

The present inquiry examines the context of the Whanganui DHB's obstetric and gynaecology service in 2005–2006, and seeks to determine whether the DHB took adequate steps to identify and respond to concerns about Dr Hasil and ensure that he was competent to practise.

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<sup>58</sup> *Wilsher v Essex AHA* [1987] QB 730 (CA) 778.

<sup>59</sup> See generally, Skegg & Paterson (eds), *Medical Law in New Zealand*, (2006) para 2.8.1.

### *Staffing shortages*

Like other health services in provincial New Zealand, Whanganui DHB's obstetric and gynaecology service suffers from a shortage of qualified staff.<sup>60</sup> There was a chronic shortage of obstetricians and gynaecologists, which resulted in Dr Hasil in effect practising as a specialist without adequate supervision.

The root cause of the problems facing the department throughout the relevant period was a grossly inadequate number of specialist staff to provide a safe and sustainable service. To achieve this, at least three specialists were required. The lack of clinical staff was not because of budget problems. It reflected the national workforce crisis and the hospital's inability to attract specialists to the area, despite persistent recruitment efforts. The solution adopted was to attempt to provide the service with non specialists.

After Dr Hasil joined the DHB, the clinical staff numbers rose, but within a few months they dropped again when the third consultant retired, and then again when Dr B was on five months' leave. The on-call component for Dr A and Dr Hasil was, from a personal and professional perspective, too demanding and unsustainable. Internationally, a 1 in 2 on-call roster is considered so unsafe that it is regarded as unreasonable to allow it to continue.<sup>61</sup> It burns out and exhausts staff, thus increasing risks to patient safety.

The shortcomings of Whanganui DHB must be viewed in the context of the national workforce shortages. I have carefully considered the staffing constraints, in particular how they restricted the DHB's ability to provide an appropriate standard of service to consumers.

While I accept that the DHB had made strenuous attempts to fill vacant positions, after more than six years one would have expected serious consideration of other ways of providing the service. There is little evidence that other options were pursued vigorously until late 2006. The DHB submitted that serious consideration was given to alternatives in August 2006. It faced considerable pressure for services to be continued, with the Mayor of Wanganui being quoted in the *Wanganui Chronicle* on 14 August 2006 as saying: "It must always be an option for Wanganui mums-to-be to have their children in Wanganui whether low risk or not."

Nonetheless, I am not satisfied that the DHB (which in this context must include the board itself, as well as senior management) addressed the critical issue of staffing shortages in the obstetric and gynaecology department with sufficient urgency.

### *Policies and procedures*

A hospital should have a culture that supports safe care, promptly identifies risks to patient safety and responds appropriately. There should be effective systems for clinical

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<sup>60</sup> See Appendix 11 which discusses the development of the medical workforce in New Zealand.

<sup>61</sup> Hon Geoffrey Davis (30 November 2005) "Queensland Public Hospitals Commission of Inquiry", Queensland Government, accessed at [http://www.qphci.qld.gov.au/final\\_report/Final\\_Report.pdf](http://www.qphci.qld.gov.au/final_report/Final_Report.pdf), 25 January 2008, p 263.

supervision, performance management, incident reporting, complaint management and credentialling, together with traditional audits of morbidity and mortality within specialties. A hospital is responsible for ensuring that staff are aware of these systems, adequately trained and supported to comply with them.

Whanganui DHB had a number of policies and processes for quality assurance or improvement, such as incident reporting, credentialling, mortality and morbidity review, complaints management, audit, performance appraisal and supervision. Overall, the policies and processes look reasonably sound, at least on paper. But many staff were not aware of the policies, and they were routinely circumvented — for example, in relation to audit processes, incident reporting, supervision and performance management. There was a significant gap between the rhetoric and the reality on the ground. The gaps were especially evident in the areas identified below.

#### *Employment of Dr Hasil*

A DHB has a duty to exercise reasonable care and skill when employing staff. This involves establishing clear and appropriate recruitment processes and supporting staff to comply with them. In my view, Whanganui DHB failed to fulfil its responsibilities as an employer in the following respects.

Dr Hasil was offered a position as a medical officer at the DHB following a review of his CV, a brief reference report from an obstetrician and gynaecologist who had worked with him for a short period more than six years ago, and another report from a paediatrician who had more recent experience of his obstetric practice. Dr Hasil was interviewed by telephone, then credentialled under urgency. Credentialling<sup>62</sup> is part of a risk management system designed primarily to protect patients.

There were obvious shortcomings in the employment of Dr Hasil, as highlighted earlier in this report. My expert advisor commented that while the credentialling processes were appropriate as part of an employment exercise, the references should have been checked.<sup>63</sup> The fact that the written references were old and, in the main, not from obstetricians, should have been queried.

As noted, the DHB's policies and processes were reasonably sound and consistent with those of some other DHBs. What happened when employing Dr Hasil was a departure from usual practice. The reference checking was undertaken by a recruitment agency. Such agencies have a commercial interest in "placing" the candidate. The agency's process was less than reliable. Dr A accepted Dr Hasil on face value and failed to make any independent enquiries regarding his suitability and background.

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<sup>62</sup> Credentialling is defined as a process used to define specific clinical responsibilities (scope of practice) of health professionals on the basis of their training, qualifications, experience, and current practice, within an organisational context. The context includes the facilities and support services available in the service the organisation is funded to provide. Credentialling is part of a wider organisational quality and risk management system designed primarily to protect the patient. Ministry of Health, *Toward Clinical Excellence — A framework for the credentialling of senior medical officers in New Zealand* (March 2001) 1.1.

<sup>63</sup> See Appendix 10, Independent Advice to Commissioner

The credentialling committee then simply “rubber-stamped” the application and failed to adequately scrutinise the documentation. The committee did not make any independent checks, nor satisfy itself that Dr A had done so thoroughly or indeed at all. In many ways, the process was effectively delegated to the Medical Council.

These deficiencies may have been a result of the matter being considered under urgency, but that is no excuse for circumventing the credentialling process. The whole point of a credentialling system is to safeguard against mistakes being made when there is pressure to appoint a clinician.

I also note that the credentialling process at the time did not involve defining specific clinical responsibilities (scopes of practice). The clinical director/head of department had this responsibility. While I note my advisor’s view that this was not unusual at the time, credentialling should involve defining scopes of practice. Middlemore Hospital led the way in introducing credentialling in the early 1990s. The Ministry of Health has provided specific and clear guidance on credentialling. The need for effective credentialling was also highlighted in my *Tauranga Hospitals Inquiry* report.

The evidence discloses a general lack of rigour on the part of the DHB in the appointment of Dr Hasil. In my view, the referees selected by Dr Hasil should have been independently checked and Dr Hasil’s last known employer and/or supervisor should have been contacted, especially in light of Dr Hasil’s disclosure of his difficult relationship with the consultants at Lismore Base Hospital. The DHB failed to take these steps.

The Medical Council, to its credit, did make further enquiries and checked the references provided and sought more current references prior to registering Dr Hasil. However, the Council did not directly contact the relevant registration authorities or Dr Hasil’s previous employer. I consider that there were sufficient flags regarding the documentation in this case to have made such enquiries prudent.

In my view, reasonable enquiries at the time would likely have revealed Dr Hasil’s difficult past and triggered further scrutiny. This would have provided some early warning as to Dr Hasil’s limitations. Appreciation of Dr Hasil’s lack of candour alone would likely have made the Council and DHB think carefully about whether he was a suitable person for appointment or registration.

#### *Performance management*

A DHB has a duty to monitor the performance of its employed doctors with reasonable care and skill, and to manage poor performance appropriately. Hospitals must have in place an effective mechanism for identifying and dealing decisively with concerns about an employee. Although employees are entitled to be treated fairly, hospitals cannot allow patient safety to be jeopardised.<sup>64</sup>

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<sup>64</sup> For authority on the need to put safety before employment concerns, see *Air New Zealand v Samu* [1994] 1 ERNZ 93, 95.

When concerns about a doctor's practice come to light, the doctor's employer (ultimately the chief executive officer) must ensure that patient safety is the paramount consideration, and that someone takes responsibility for addressing the concerns. Where a thorough investigation has been undertaken and recommendations have been made, there needs to be a monitoring mechanism to ensure that recommendations are implemented.

If a hospital has (or, in light of the information available to it, should have) reason to believe that a doctor may pose a risk of harm to patients, it has a duty to respond immediately to minimise the risks. This may include placing appropriate conditions on the doctor's practice pending further inquiries. The decision to limit a doctor's practice may be based on a pattern or a single incident of substandard care or misconduct. It will always be a matter of judgement when that threshold has been reached, and what action is necessary to protect the health and safety of the public.

The interests of patients and doctors will be better served if issues relating to competence and fitness are dealt with firmly and fairly in the workplace, before they escalate, patients (and the doctor's reputation and health) are harmed, and external agencies become involved.<sup>65</sup>

The DHB submitted that the "granting of registration, and the subsequent issuing of a practising certificate, can be taken as an unequivocal statement by the Medical Council to the New Zealand public (including prospective employers) that a practitioner is competent and safe to practise in New Zealand". The Council accepts responsibility for the registration of Dr Hasil. However, the fact that the Council is responsible for registering doctors and ensuring their competence does not detract from an employer's obligation to ensure that a doctor is providing services of a safe and appropriate standard to patients. The employer's obligation to assess and monitor its employees' performance exists independently of the Council processes.

I endorse the comment of my advisor, Dr Brown, that it is the DHB's role to facilitate the supervision process by ensuring that enough time and resources are set aside for this to happen. This requires DHBs to size jobs appropriately to allow sufficient time for this activity and to provide appropriate technical support for audit, peer review etc. I acknowledge that where there are already considerable staff shortages, this is very difficult to achieve.

*Recognition of and response to Dr Hasil's performance issues*

Dr A was primarily responsible for supervising clinical staff in the Department of Obstetrics and Gynaecology, including Dr Hasil. Clinicians taking up such responsibilities require protected time to recognise and respond to problems in their area of responsibility. Dr A was a busy doctor with a high clinical load as well as an administrative load. It was inevitable that without considerable support Dr A would not be able to recognise the extent of Dr Hasil's deficiencies. Sadly this proved to be the

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<sup>65</sup> Cf *Tauranga Hospitals Inquiry: Opinion 04HDC07920* (Health and Disability Commissioner, 18 February 2005), pp 40–41.

case, as discussed above. The general manager, medical advisor, service managers, human resource manager, and quality and risk personnel all had some responsibility to support the oversight and monitoring of clinical staff by Dr A as clinical director/head of department.

In my view, it was the responsibility of the hospital management team, and ultimately of the chief executive officer, to ensure that the quality assurance policies and processes were well understood and implemented. It is not appropriate to leave the matter in the hands of an overworked doctor/clinical director, with no further assistance, oversight or monitoring from the hospital management team and the chief executive officer.

The DHB knew or ought to have known that Dr Hasil might pose a risk of harm to patients well before his resignation. In my view, the DHB hesitated too long in the face of clear information that Dr Hasil might pose a risk of harm to patients. There was a history of concern about Dr Hasil during his employment in Australia, and more recently at Wanganui Hospital. These concerns have been set out earlier in this report. In summary, staff and patients made a number of complaints about Dr Hasil in the course of his 14 months working at Wanganui Hospital. They varied in seriousness, but began with strident criticism from a well-regarded and experienced nurse and ended with a complaint about a failed sterilisation, in circumstances where the hospital knew or ought to have known (if it had put together available information known to its staff) that it was the fifth such failure. The gravity of the situation was self-evident.

A number of features of this case are striking. First, none of the four known sterilisation failures were reported in accordance with the DHB incident reporting policy (Appendix 5). Only one of the four known sterilisation failures was reported to management (Patient J's).<sup>66</sup>

It is unacceptable that the sterilisation failures were not exposed by any of the systems for quality assurance, such as incident reporting, audit, peer review and supervision. Chance played a large part in exposing the high number of sterilisations. Had Patient A not met Patient B in late 2006 and learnt of her failed sterilisation, she may never have realised that her own pregnancy might be part of a pattern of treatment failures. But for Patient A's complaint, the cluster of failed sterilisations may never have been exposed and investigated. The DHB accepts that a well-developed quality assurance and audit system ought to have identified the trends in Dr Hasil's failed sterilisation procedures. It is no wonder many people in Wanganui felt let down by their hospital.

Secondly, it was obvious to certain staff (including Dr A and Dr B when they did case reviews in late 2006), and later to the consultant obstetrician and gynaecologist with whom Dr Hasil worked at MidCentral DHB, and to my advisor, Dr Brown, and ACC advisor Dr Ngan Kee, that Dr Hasil's practice was not safe. Each of these doctors considered a sample of Dr Hasil's patients, and although the range of patients and nature of the reviews differed markedly, the conclusions did not. Each found that the care provided by Dr Hasil fell well below the standard of reasonable care and skill expected.

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<sup>66</sup> See page 45.

The third feature is that the DHB was perceived as being unresponsive. That view is hardly surprising. It was unresponsive. While DHB management were aware of the problems regarding Dr Hasil, they did not appreciate the seriousness of this situation, make the links between the incidents and the problems identified, and take effective action early enough.

Management responsibility for the complaints or incidents was dispersed among a number of staff, including Quality and Risk Management and Human Resources. However, Dr A was the common link. Although it was Quality and Risk Management's role to identify concerning patterns, there is very little evidence of how this was translated into practice. DHB management tended to judge the events in isolation, without consideration of their combined significance.

Investigations were fairly narrow and had a strong medico-legal focus. The challenge of balancing public protection with the need to act fairly can result in a silo effect, whereby single events are judged in isolation, making it difficult for a pattern of concern to be illuminated. This appears to have happened in this case. While it can be difficult to know whether a complaint or incident reflects a one-off lapse or raises a red flag to a pattern of recurrent failure, the DHB failed to consider the combined significance of the concerns raised — which we now know were the tip of the iceberg. At a minimum, the concerns should have triggered a more comprehensive assessment of Dr Hasil's competence and fitness to practise.

Finally, the DHB did not ensure that appropriate action was taken to minimise or eliminate the risk of incidents recurring in the future. There is no evidence of any system for monitoring the implementation of recommendations and agreed actions. I accept that Dr A discussed complaints and other concerns with Dr Hasil, and on occasion undertook more extensive case reviews with him. Dr A and others made recommendations about Dr Hasil's clinical practice — for example, the use of lithotomy in clinical examinations, the use of options other than hysterectomy to manage gynaecology problems for post-menopausal women, and the need to improve his documentation. Dr A was aware of at least one sterilisation failure and counselled Dr Hasil on his sterilisation practice. However, there is no evidence of any steps being taken to follow up these recommendations or to actively monitor Dr Hasil's practice to ensure that remedial action had been taken and that patients were not being put at risk.

In March 2006, when Dr Hasil was found using alcohol while on call, he was given a formal warning and offered support. Given that the incident was not reported to the Medical Council, it was essential that the DHB took appropriate steps to protect patients, and to support Dr Hasil. There is no evidence of any follow-up to ensure Dr Hasil had obtained assistance for his "social problems" that precipitated the "one-off occurrence". In my view, this was a lost opportunity to support a vulnerable doctor and minimise the risk he posed to his patients.

Dr Brown advised that following the first alcohol incident, there should have been more active, ongoing support. In his view, the DHB did not respond adequately to the issues, particularly as there did not appear to be a plan for ongoing support and monitoring.



Dr Brown also commented that there was no clear evidence of improvement in response to the individual and systemic issues raised by the complaints.

Of particular note, in May 2006, a well-regarded nurse warned that Dr Hasil would make a grave mistake. The response to the May alcohol incident was inconsistent with DHB policy and practice. Dr Hasil was not formally investigated. Dr A also reported patient safety concerns to the DHB in about August 2006. Dr B reported his own concerns a few months later when Dr Hasil was expected to return to work at Wanganui Hospital. It is startling how little was done in response to the various concerns.

However, in reviewing the actions taken following the incidents or complaints, it would be wrong to say that the DHB failed to take any action. Internal investigations were generally carried out. Staff were interviewed. Apologies were offered. In a limited way, the concerns were addressed with Dr Hasil — competence issues by way of informal feedback and training, and health issues via a disciplinary process (with the exception of the May incident). When the situation began to unravel, the DHB took appropriate actions. Examples include the prompt response to Patient A's complaint, the comprehensive audit undertaken by Dr B and Dr A under urgency, the prompt disclosure of the situation to the relevant authorities and the follow-up provided to the affected patients. But it was all too little, too late.

#### *International context*

The causes and characteristics of major health care failure are remarkably similar throughout the world. The findings in this inquiry echo many of those made in similar inquiries in New Zealand and abroad.<sup>67</sup> The following observation by health services researcher Kieran Walshe is particularly apt:<sup>68</sup>

“On the face of it, the problems often centre on an individual clinician or small team and seem to contradict the conventional belief that most threats to patient safety result from systems failure rather than from individuals' behaviour. However, the organisations where these failures occur usually lack fundamental management systems for quality review, incident reporting, and performance management, or those systems have been bypassed with ease. They frequently show little collaboration between managers and clinicians and a lack of coherent clinical leadership. They are often isolated and inward-looking organisations, unwilling to learn from elsewhere.”

The tendency in many organisations is to use informal mechanisms to deal with problems of poor performance or failure, such as finding a way for a “problem doctor” to exit

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<sup>67</sup> Hon Geoffrey Davis (30 November 2005) “Queensland Public Hospitals Commission of Inquiry”, Queensland Government, accessed at [http://www.qphci.qld.gov.au/final\\_report/Final\\_Report.pdf](http://www.qphci.qld.gov.au/final_report/Final_Report.pdf), 25 January 2008 and Healthcare Commissioner (August 2006) “Investigation into 10 maternal deaths at, or following delivery at, Northwick Park Hospital, North West London Hospitals NHS Trust, between April 2002 and April 2005”, accessed at [http://www.healthcarecommission.org.uk/\\_db/\\_documents/Northwick\\_tagged.pdf](http://www.healthcarecommission.org.uk/_db/_documents/Northwick_tagged.pdf), 25 January 2008.

<sup>68</sup> Kieran Walshe et al, “When things go wrong: How major health care organisations deal with major failures”, *Health Affairs*, 2004 23:3, p 103.

quietly without any formal action. The result is that problems get moved around the health system rather than being tackled and resolved.

### *Conclusion*

The overall impression of the elements of Whanganui DHB's obstetric and gynaecology service scrutinised in this inquiry is of a service marked by an ongoing sense of crisis, where expected standards of practice had been eroded. There were so many organisational shortcomings that quality of care for obstetric and gynaecology patients was inevitably compromised. The risk of harm to patients was not managed effectively.

Outside metropolitan centres, there will always be tension between providing a less than optimal service and providing no service at all. In my view, a DHB must put patient safety first. It is short-sighted to struggle on with substandard arrangements in the hope that disaster will be averted and things will eventually get better. It may be preferable to bite the bullet and face potential community outrage if a service is closed, rather than "muddle on" and cause long-term harm to community confidence, and to a DHB's committed staff, when patients are harmed and the inevitable external inquiries follow. The board itself must play a key role in tackling these difficult issues.

I consider that by mid-2006 Whanganui DHB had reason to believe that Dr Hasil might pose a risk of harm to patients, and therefore had a duty to respond immediately to minimise that risk. Although the DHB did respond to each isolated incident or complaint, it did not carry out a retrospective audit of his clinical practice to assure itself that patients were not at risk. It did not take any steps to restrict or systematically monitor Dr Hasil's practice. It was unreasonable for the DHB to wait until October 2006 (in relation to the health issues) and February 2007 (in relation to competence concerns) before involving the Medical Council.

Evidence of alcohol abuse by a health practitioner is a serious issue. An employer should have a high index of suspicion about any "one-off" incidents. Firm action must be taken to ensure that the employee obtains any necessary support but understands that *no* alcohol abuse will be tolerated. There should be a low threshold for notifying a registration body that the practitioner has a health concern.

While fairness and collegial support are important factors when dealing with concerns about a doctor's competence, patient safety must come first. Employers have an ethical duty to report any concerns about a doctor's competence to the Medical Council.<sup>69</sup> The delay in taking active steps to respond to the emerging pattern of concerns about Dr Hasil's health and competence put patients at risk. Whanganui DHB had a responsibility to the public to respond to the serious concerns about Dr Hasil's competence in a decisive and timely manner. It failed to respond appropriately.

I conclude that Whanganui DHB failed in its duty of care by allowing the situation to continue as it did. The DHB continued to deny the existence of any patient safety

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<sup>69</sup> Medical Council of New Zealand, *Employer Guidelines for Providers* (April 2002).

concerns regarding Dr Hasil and avoided taking any decisive action to address his shortcomings and the endemic workforce shortages in the department.

In summary, Whanganui DHB breached Right 4(1) of the Code by its lack of care in employing Dr Hasil, by failing to have a system in place to monitor Dr Hasil's practice effectively and failing to respond to his health issues and competence concerns in a timely and effective manner.

## **OTHER MATTERS**

### *Medical Council of New Zealand*

The terms of reference for this investigation did not include the Medical Council. As Health and Disability Commissioner, I have jurisdiction only in respect of actions of healthcare or disability services providers as defined in section 2(1) of the Health and Disability Commissioner Act 1994. The Medical Council is not such a provider.

Registration of any medical practitioner and renewal of their annual practising certificate are key actions by a regulatory body. I have commented on the process of Dr Hasil's registration and the failure to make further enquiries.<sup>70</sup> I am also concerned that Dr Hasil's annual practising certificate was renewed in mid-March 2006, shortly after a health report was received from the New South Wales Medical Board.

I acknowledge that the report was reassuring and, given Dr Hasil's satisfactory supervision report, concerns may have been allayed. I also appreciate that a health report raising issues would not automatically preclude renewal of a doctor's practising certificate. But the NSW Board's report was a flag that all might not be well, and that further enquiries regarding his current fitness to practise were warranted.

In response, the Council submitted that the information it received from the NSW Board did not reach the threshold for notifying Dr Hasil's employer under section 35(1)(d) for three reasons. First, the information including the psychiatrist's report stated that no further action needed to be taken. Secondly, although the Council is responsible for collating and assessing information that it receives regarding concerns that a doctor's health might affect public health and safety, it is not Council's responsibility to distribute this information to the employer (which would then in turn be obliged to assess the situation and determine whether or not to notify the Council). Finally, any breach of confidentiality by the Council when dealing with health concerns (except where there is a clear concern about public health and safety) will undermine confidence in the process and make early referral less likely.

I acknowledge that these are delicate matters that need to be considered on a case-by-case basis. There can be no blanket approach to reporting performance and health issues, although it would seem reasonable for the supervisor working on behalf of the Medical Council to have been informed in confidence.

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<sup>70</sup> See pp 80–81.

However, there were further steps that could (and in my view should) have been taken on receipt of the NSW Board's information about Dr Hasil. The Medical Council could have contacted Dr Hasil in the first instance and made its own independent assessment of the current situation. It is likely that the Council would then have unearthed concerning information and felt obliged to alert the DHB.

In hindsight, had such information been communicated to the DHB, the first alcohol incident may well have been handled quite differently, and the risk of further harm minimised. The DHB gave evidence that it responded to the first incident on the basis it was a one-off occurrence. The DHB advised that it would have appreciated knowing such information.

Certainly, the DHB would have realised that Dr Hasil was lying about his use of alcohol and a different course would probably have been taken, such as instigating the rehabilitative path eventually taken in October 2006. This is also Dr Brown's independent view. Such support, provided earlier, might have avoided the harm that transpired and also prevented the demise of Dr Hasil's health and career.

It is reassuring that since these events took place, the Medical Council has reviewed its processes of registering doctors. In particular, the Council is taking steps to ensure it obtains all relevant information about a doctor from recruitment agents and employers. Furthermore, the Council is working with DHBs and doctors to ensure that its health programme is better understood and that referrals are made promptly. The Council is also working with DHBs to develop and provide a training programme for regulatory supervisors and an orientation programme for international medical graduates. These are all sensible initiatives.

#### *Professional responsibilities*

The current Medical Council guidelines note that consultants are encouraged to provide supervision to new doctors and that they may not "unreasonably refuse to provide a colleague with supervision". The New Zealand health service depends on the willingness of consultants to undertake clinical supervision of junior doctors, and regulatory supervision of doctors who are provisionally registered (such as international medical graduates).

I wish to acknowledge Dr A's willingness to provide supervision, particularly when no one else was available or willing to do so. When Dr A resigned in September 2006, Dr B was not prepared to assist with supervision of Dr Hasil other than in emergencies. His stance followed advice from the Medical Protection Society. Dr B had a "sense of disquiet" about Dr Hasil's practice, and expressed this to the Medical Council in November 2006. Yet he was not willing to document his concerns, as requested.

In New Zealand there has always been an ethical obligation to take prompt action in the face of concerns about a colleague's performance. Professionalism requires nothing

less.<sup>71</sup> The New Zealand Medical Association *Code of Ethics* (2002) states: “Doctors have a general responsibility for the safety of patients and shall therefore take appropriate steps to ensure unsafe or unethical practices on the part of colleagues are curtailed and/or reported to relevant authorities without delay.” This obligation should be well understood by every doctor. Performance issues should be addressed locally in the first instance, but if that approach fails, the “relevant authorities” (usually the Medical Council) must be notified.

The role of the Council is supportive, not punitive. The obligation to alert a registration body to the risk of harm posed by a colleague/health practitioner’s practice is necessary so patients can have faith that health professions will tackle poor performance, and that practitioners themselves know that problems will not simply be “swept under the carpet”.

Dr B was reluctant to provide on-site support for Dr Hasil. If he was unwilling to provide onsite support or supervision, and he had concerns about Dr Hasil’s unsupervised clinical practice, Dr B should have formally notified the DHB and the Medical Council of his concerns.

Dr B submits in response that he is aware of his ethical obligation to take prompt action if there are doubts about a colleague’s performance in relation to patient safety. However, there is a considerable difference between expressing a sense of disquiet and reporting concerns to the Medical Council. While I accept that performance issues should be addressed locally in the first instance, I note that the Council had asked Dr B to put the concerns he voiced by telephone in writing. At this point, the Council was on notice of concerns about Dr Hasil. The Council took no action but chose to await written confirmation from Dr B before taking action. Dr B did not provide this.

Dr B clearly had doubts about Dr Hasil well before he reported them to the DHB. Substantive evidence of poor performance is not required. In my view, Dr B should have reported his doubts to the DHB earlier, and to the Council as requested. It is the Council’s role to investigate such concerns to establish whether there is any substance to the concern. Dr B did not formally report his concerns until the evidence of incompetence was uncontrovertible. By that stage it was too late.

## **THE WAY FORWARD**

Whanganui DHB has been subject to a great deal of media attention, public criticism, and external review, particularly during 2006–07. The DHB is now taking a wide range of actions to improve its systems, following the catalogue of problems. These are heartening developments.

Whanganui DHB’s services will remain vulnerable to problems of recruitment and retention of staff because of its size. Many of the problems at Whanganui DHB are predictable and result from isolated practice. Isolation is the “kiss of death” for a

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<sup>71</sup> “Charter of medical professionalism: Medical professionalism in the new millenium: a physicians’ charter”, *Lancet* 2002; 359:520–522.

clinician, a department and a DHB. There is a risk that patients will be harmed, clinicians will breach professional standards, and communities will lose local services.

These issues are not confined to the Whanganui district. Lack of effective service planning across DHBs, and of effective co-ordination and collaboration to maintain services that are safe for patients and clinicians, is a national problem. It is disappointing that there has been a failure to mobilise the medical profession to find ways to provide more equitable care across the country. Greater co-ordination and collaboration across DHBs should not be left to serendipity, nor should they be forced by a clinical failure or a rushed reaction to adverse publicity. There must be a more proactive, facilitated approach to ensure that services can be provided safely in a sustainable way across DHBs. Planning should occur at a regional and national level and should tackle areas of known risk. Typically these are the acute services.

Planning and support for staff will continue to be essential. Both clinical staff and the services in which they work should be properly credentialled. These challenges are not insurmountable, as larger DHBs and smaller DHBs become involved in regional collaboration and form alliances to improve service quality and access for consumers. For obstetrics and gynaecology services, such formal alliances allow obstetricians and gynaecologists and other professionals to become part of a wider peer group and provide opportunities for continuing education and collegial support.

I endorse the comments in the *Wanganui Hospital Clinical Review: Report to Whanganui District Health Board and Ministry of Health* about service models and, in particular, that rejecting regionality concepts is unsustainable in both obstetrics and gynaecology and general surgery (and other specialities) for Whanganui DHB.<sup>72</sup>

In short, the future lies in collaboration. It is the only practical way to respond to the challenges of workforce and training, limited financial resources, safety and quality improvement and demography faced by the health sector. There is a crucial need for a regional and national service planning and good leadership. The Ministry of Health seems best placed to take a national lead but it must engage fully and effectively with sector leaders in DHBs and the colleges.

This inquiry has also highlighted the lack of time that clinical directors and other senior doctors have for supervision, quality improvement initiatives, and monitoring over and above their clinical work. Clearly this problem is linked to the shortages in the medical workforce in New Zealand. I believe there is a role for the Medical Council, the Quality Improvement Committee and district health boards to work together to clarify the appropriate scope and necessary support for clinical leadership roles.<sup>73</sup> This should be achievable without compromising clinical services.

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<sup>72</sup> David Sage and others, *Wanganui Hospital Clinical Review: Report to Whanganui District Health Board and Ministry of Health* (July 2007) p 21.

<sup>73</sup> I have focused on medical leadership roles in public hospitals, but similar comments could be made in relation to nursing and midwifery leadership.

I commend Whanganui DHB for the steps it is taking, with support from the Ministry of Health and neighbouring DHBs, to address current (and foreseeable) workforce shortages and the difficulties posed by its size and geographical location.

## RECOMMENDATIONS

I endorse the recommendations in the reports, *Wanganui Hospital Clinical Review: Report to Whanganui District Health Board and Ministry of Health* (July 2007) and *Joint Review of Whanganui District Health Board* (29 August 2007). As most of the actions arising from the previous reports are in the process of being implemented, my recommendations are limited to the following:

### *Apologies*

I recommend that Dr Hasil and Whanganui DHB apologise to Patient A, Patient B and Patient C for their breaches of the Code by **31 March 2008**.

### *Whanganui DHB*

#### *— Reviews already under way*

I recommend that Whanganui DHB advise the Commissioner by **31 May 2008** of the steps taken to:

- implement the proposed actions as a result of the failed sterilisations regarding human resources, complaints and incident management systems, and service audit and peer review (see pages 59–60)
- implement the following recommendations set out in the *Wanganui Hospital Clinical Review*:
  1. that confidential verbal reference checking be included in the standard recruitment process for senior medical officers
  2. that the Credentialling Committee further refine their credentialling processes within specialty categories
  3. that fitness to work policy and decision-making be reviewed, including access to resources for expert assessment
- ensure robust systems are in place for monitoring the quality and performance of obstetric and gynaecology services.

#### *— Further reviews*

I recommend that Whanganui DHB further review its provision of obstetric and gynaecology services in light of this report and, with support from RANZCOG and the Ministry of Health, discuss with neighbouring DHBs collaboration towards a regional service.

*Royal Australian and New Zealand College of Obstetricians and Gynaecologists*

I recommend that RANZCOG develop guidelines on the process for laparoscopic tubal ligation quality audit, with consumer input, and consider whether photographs are an effective quality tool and, if so, when and how they should be used.

*Council of Medical Colleges*

I recommend that the Council of Medical Colleges review the role of medical colleges in the supervision and oversight of medical officers working in specialty areas, and the accreditation of provincial hospitals as a training post suitable for trainee registrars.

## **FOLLOW-UP ACTIONS**

- A copy of this report will be sent to the Minister of Health, the Director-General of Health, the Medical Council of New Zealand, the Medical Council of Tasmania, the New South Wales Medical Board, the Medical Practitioners Board of Victoria, the Medical Board of Queensland and Queensland Health.
- A copy of this report will also be sent to the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, the Council of Medical Colleges in New Zealand, the New Zealand Medical Association, the Association of Salaried Medical Specialists, the New Zealand Nurses Organisation, the New Zealand Resident Doctors Association, Quality Health New Zealand, the Quality Improvement Committee, the Medical Training Board, the District Health Boards New Zealand Workforce Group, District Health Boards New Zealand, and all district health boards, as well as being placed on the Health and Disability Commissioner website, [www.hdc.org.nz](http://www.hdc.org.nz), for educational purposes.

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## **NON-REFERRAL TO DIRECTOR OF PROCEEDINGS**

Having found that Dr Hasil and Whanganui DHB breached the Code of Health and Disability Services Consumers' Rights, I am required to consider whether either party should be referred to the Director of Proceedings to decide whether further proceedings are warranted.

When a provider breaches the Code of Health and Disability Services Consumers' Rights, and in doing so has fallen well short of the mark, a referral to the Director of Proceedings may well be indicated. Accordingly, I invited further comment on the matter.

*Dr Hasil*

Dr Hasil's lawyers stated:

“There is, it is submitted, very little that would be achieved by referring Dr Hasil to the Director of Proceedings. He has no intention of practising in New Zealand, and it is not in the public interest to do so. The effect on Dr Hasil's health, of such proceedings, would be substantial.”



Dr Hasil is believed to be residing in Australia. Accountability of health practitioners via disciplinary proceedings is an important consideration. But Dr Hasil has already suffered the ignominy of media exposure and the public sanction of this inquiry and the findings that he breached the Code. I can see little point in expending public resources in pursuing disciplinary proceedings against a doctor who is no longer resident in New Zealand and is unlikely to work here again. Accordingly, I have concluded that the public interest does not require referral of Dr Hasil to the Director of Proceedings.

*Whanganui District Health Board*

In this case, there is major corporate responsibility for the deficiencies in the care provided to patients at Wanganui Hospital. Systems flaws at the DHB were a significant cause of the sluggish identification of and response to Dr Hasil's shortcomings.

The DHB submitted that it should not be referred to the Director of Proceedings, and noted:

- “• Whilst there have been areas where WDHB has fallen short, a further consideration by the Commissioner of this matter, including taking into account the matters referred to in [the DHB's response to the provisional opinion], ought to lead the Commissioner to conclude that the failings are not sufficiently serious to warrant referral for consideration of further action;
- There is no public interest in further investigation. There is ample opportunity for WDHB and other DHBs to learn from this case from considering the Commissioner's detailed final report, without the circumstances being traversed in detail further in another forum;
- The public interest is best served by allowing WDHB to move forward and concentrate on the delivery of quality health services to the people of the Whanganui region;
- Patients A, B and C will be able to take great comfort from the Commissioner's final report insofar as learning more about the circumstances relating to their treatment, and from WDHB's acceptance that they did not receive services of an acceptable standard. These patients have clear avenues open to them, either through the Accident Compensation Corporation or through the courts, if they wish to pursue other entitlements.”

Whanganui DHB has been subject to extensive reviews. It has acknowledged its shortcomings in relation to Dr Hasil, and is taking appropriate steps to address the deficiencies. It seems that many of the systems and practices at Whanganui DHB were no different than those of other DHBs at the time.

In my view, the public criticism of the DHB's systems in this report and the finding that the DHB breached the Code is a sufficient form of accountability. I do not consider that the public interest requires referral to the Director of Proceedings for potential further proceedings.

Nonetheless, many women of Wanganui have been deeply affected by the substandard care provided by Dr Hasil, and some women have been harmed. This report clearly acknowledges that. These women may wish to pursue other entitlements on their own initiative. I am aware that there is the threat of a class action being taken against the DHB. Patients A, B and C may also bring their own proceedings before the Human Rights Review Tribunal in light of my breach opinion. In the event of further proceedings, I encourage the DHB to do the right thing and resolve any such claims promptly and fairly.

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## **APPENDIX 1: TERMS OF REFERENCE**

The terms of reference for the inquiry are as follows:

1. *The adequacy and appropriateness of the services provided by Dr Roman Hasil to patients at Wanganui Hospital, including the services provided to:*
  - (a) *Patient A, on whom Dr Hasil performed an unsuccessful laparoscopic sterilisation in September 2006*
  - (b) *Patient B, on whom Dr Hasil performed an unsuccessful sterilisation procedure in January 2006*
  - (c) *Patient C, on whom Dr Hasil performed a bilateral salpingo-oophorectomy and adhesiolysis in September 2005.*
2. *The adequacy and appropriateness of the steps taken by Whanganui District Health Board to ensure that Dr Hasil was competent to practise, including the steps taken to credential, supervise and audit his practice, and the steps taken when concerns were raised about Dr Hasil's practice.*
3. *The adequacy and appropriateness of the steps taken by Dr A to ensure that Dr Hasil was competent to practise, including the steps taken to supervise and audit Dr Hasil's practice, and the steps taken when concerns were raised about his practice.*

## APPENDIX 2: INVESTIGATION PROCESS

This investigation was overseen by Chief Legal Advisor Nicola Sladden and Senior Legal Advisor Dr Deanne Wong. Independent expert advice was obtained from Dr Ian Brown, formerly an obstetrician and gynaecologist, and Director of Medical Services at Northland District Health Board. I am grateful for their capable assistance and wise counsel.

Information was obtained from Whanganui DHB and a number of individuals and organisations. The investigation team visited Whanganui on 3–4 April and 7–8 June 2007. During this time, interviews were conducted with key hospital staff and other individuals involved in the inquiry.

The interviews, together with evidence from patients' clinical records and other documents and information provided by individuals and organisations, were used as the source material for this report. Having reviewed all the evidence and my independent expert advice, I formed a provisional view on the quality of care provided by Dr Hasil, the steps taken by his supervisor to ensure that Dr Hasil was competent, and the steps taken by the DHB to identify and respond to concerns about Dr Hasil's competence and fitness to practise. I sent a copy of my provisional opinion to each of the providers adversely commented upon, to give them a reasonable opportunity to respond. Their responses were carefully weighed in forming my final opinion.

Information was provided by the following individuals and organisations:

(a) *Whanganui DHB staff*

- Dr Roman Hasil
- Whanganui DHB
- Dr A
- Dr B
- Dr C
- Dr D
- General Manager, Human Resources
- Service Manager A
- Service Manager B
- Manager C
- Theatre Nurse Manager
- Clinical Nurse Manager
- Clinical Audit Co-ordinator
- RMO Co-ordinator
- Nurse A
- Dr Hasil's support person
- Personal Assistant for the Service Manager, Surgical and Support Services

(b) *Consumers/complainants*

- Patient A
- Patient B

- Patient C
- Patient D
- Patient E
- Patient F
- Patient G
- Patient H
- Patient I
- Patient J
- Patient K's mother
- Patient L
- Patient M

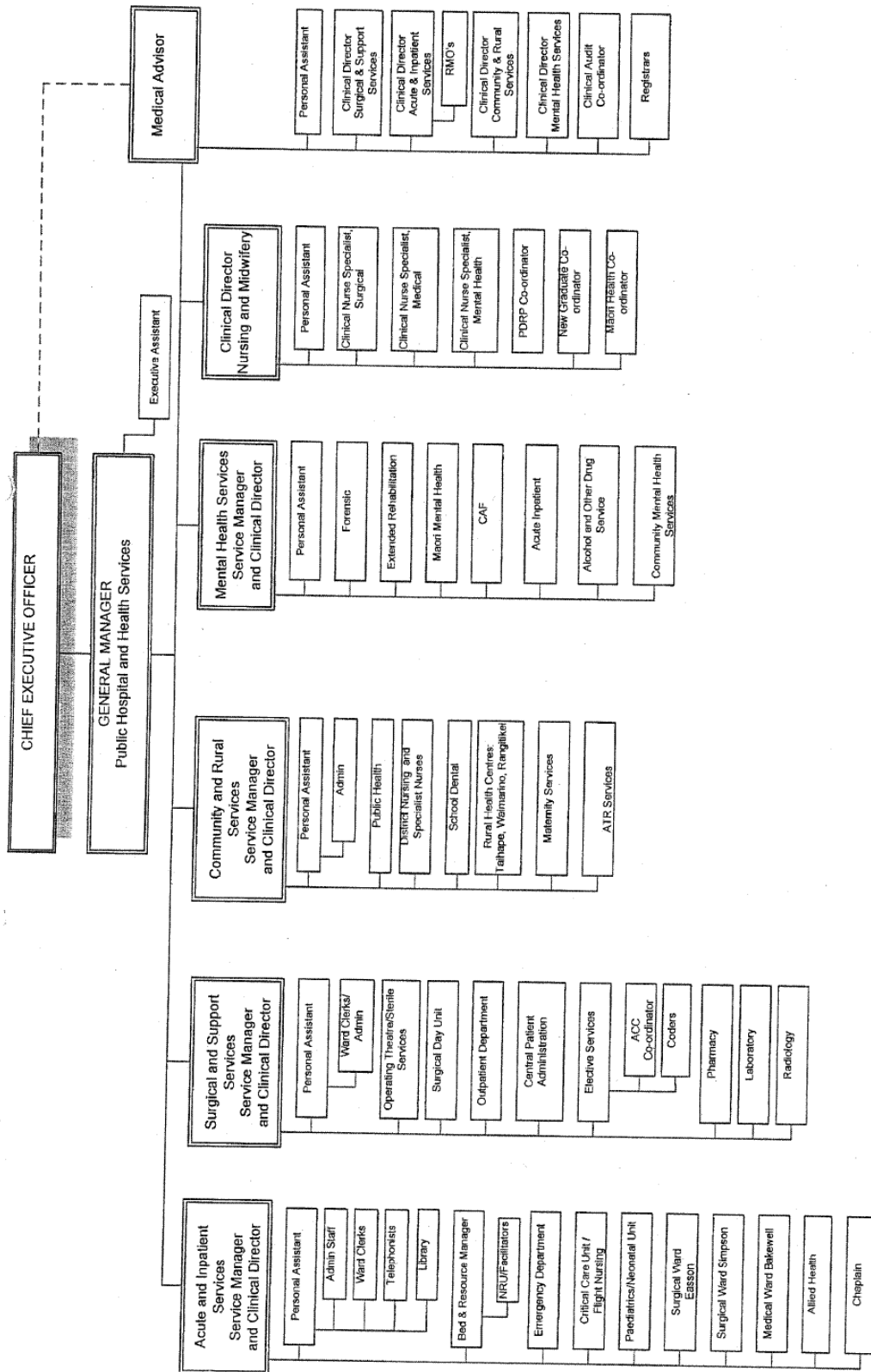
(c) *Other agencies/individuals*

- Ministry of Health
- Medical Council of New Zealand
- Accident Compensation Corporation (ACC)
- MidCentral DHB
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists
- a medical recruitment agency
- New South Wales Medical Board
- Medical Practitioners Board of Victoria
- Medical Council of Tasmania
- Royal Hobart Hospital, Tasmania
- Lismore Base Hospital, New South Wales
- Midwife A
- Midwife C
- Midwife D

(d) *Referees*

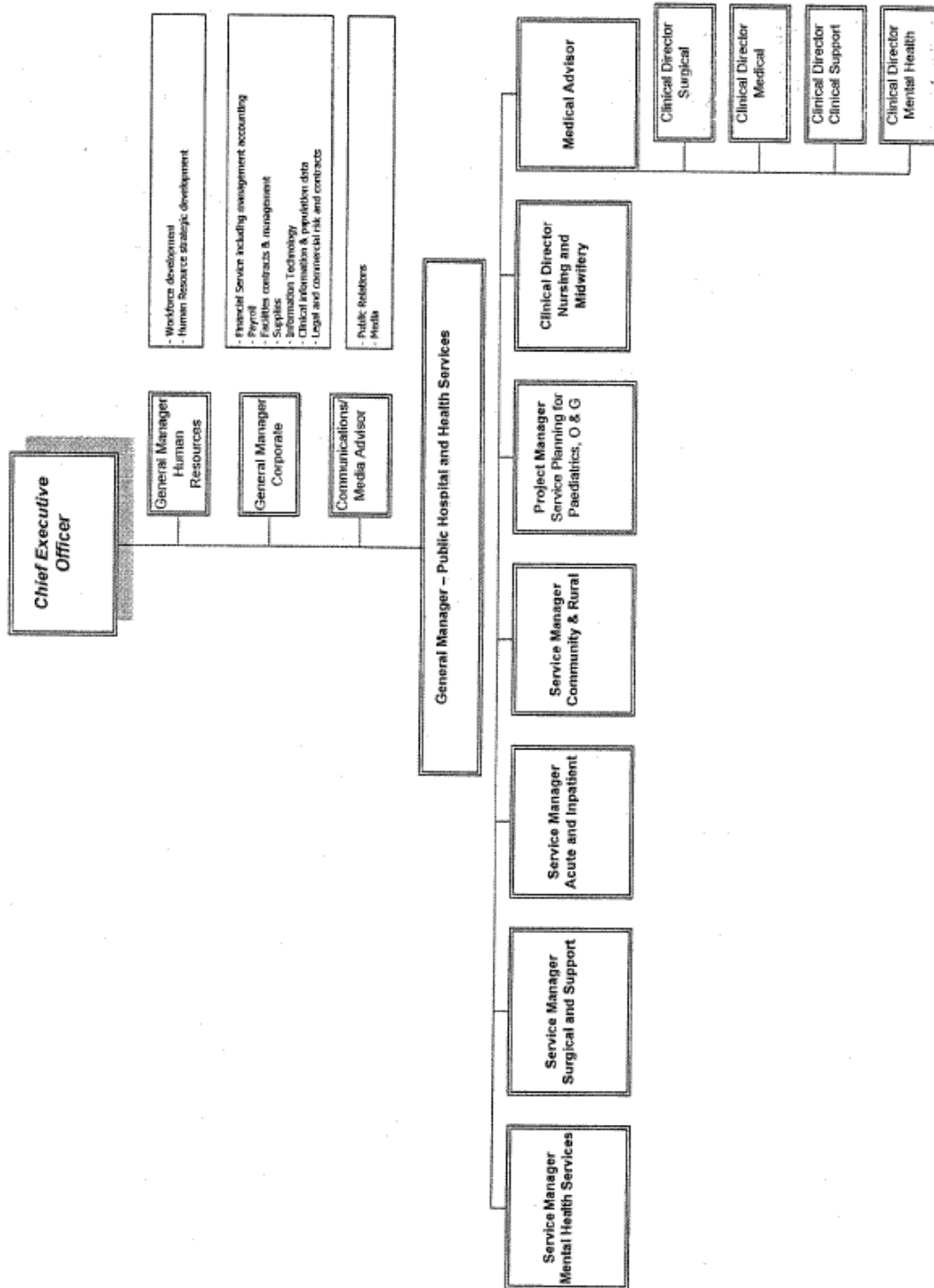
- Referee A
- Referee B
- Referee G
- Referee H

### APPENDIX 3: ORGANISATION CHART



Whanganui District Health Board, Provider Arm -- Good Health Wanganui

September 2005



April 2007



## APPENDIX 4: KEY PERSONNEL

The **General Manager, Public Hospital and Health Services** oversees the management of the Provider Division, which provides secondary and community specialist health services including Surgical and Support Services, and Acute and Inpatient Services.

The **Medical Advisor** provides clinical advice concerning the health and disability support services and reports to the General Manager, Public Hospital and Health Services and the Chief Executive Officer. The Medical Advisor was Dr C.

The **Clinical Director, Surgical and Support Services** manages the clinical aspects of the Surgical and Support Services and works closely with the Service Manager, Surgical and Support Services. The Clinical Director reports to the Medical Advisor and the General Manager. Dr A, obstetrician and gynaecologist (until September 2006) and Dr D, anaesthetist (from November 2006) served as Clinical Director, Surgical and Support Services.

The **Head of Department, Department of Obstetrics and Gynaecology** manages the obstetric and gynaecology work of the hospital and reports to Service Manager, Surgical and Support Services and the Clinical Director, Surgical and Support Services. Dr A, obstetrician and gynaecologist, served as Head of Department, Department of Obstetrics and Gynaecology.

The **Service Manager, Surgical and Support Services** oversees the management of Surgical and Support Services, including the operating theatres for gynaecology and obstetric services: the Surgical Day Unit, and Outpatient Services. The gynaecology service falls within Surgical and Support Services while the obstetric service falls within the Maternity Service. The Service Manager reports to the General Manager. From 14 November 2005, this role was filled by Service Manager A.

The **Service Manager, Community and Rural Services** manages the Community and Rural Services, which provides maternity and other services to individuals and families of the Whanganui region. Maternity services provided by Wanganui Hospital include antenatal education, facilities for Lead Maternity Carers, primary services, including midwife only continuity service, labour and birth care for women with no identified Lead Maternity Carer, and outpatient services, including family planning clinics. The Service Manager reports to the General Manager, Public Hospital and Health Services. Service Manager B served as the Community and Rural Services Manager.

The **Clinical Quality and Risk Advisor** is part of the Quality and Risk team and is responsible for overview of patient complaints and incident reports. Manager C is the Clinical Quality and Risk Advisor.

The fixed term position of **Project Manager, Service Planning for Paediatrics, Obstetric and Gynaecology** was established in late 2006. Manager C served in this role and prepared the *Laparoscopic Sterilisation Audit Report* (1 March 2007).

A **Consultant Obstetrician and Gynaecologist** is primarily responsible for the delivery of clinical care to patients requiring obstetrics and gynaecology treatment/services. The specialist reports to the Clinical Director, Surgical and Support Services, through the Head of Department, Department of Obstetrics and Gynaecology.

A **Medical Officer, Obstetrics and Gynaecology** assists specialist consultants to deliver clinical care to patients requiring obstetrics and gynaecology treatment/services. A Medical Officer works either under supervision or in a collegial relationship. Medical Officers are not registered within a vocational scope of practice (ie, are not specialists) nor are they in a formal specialist training programme. The Medical Officer reports to the Clinical Director, Surgical and Support Services, through the Head of Department, Department of Obstetrics and Gynaecology. Dr Roman Hasil was employed as a Medical Officer, Obstetrics and Gynaecology.

## APPENDIX 5: RELEVANT POLICIES

### CODE OF CONDUCT

Whanganui  
District Health Board

# Code of Conduct

<b>Reviewed by:</b>	[...] Human Resources Advisor	<b>Gazette date:</b> 21 July 2006
<b>Date:</b>	13 July 2006	
<b>Approved by:</b>	[...] Chief Executive officer	
<b>Date:</b>	18/07/06	

**A STATEMENT**

This policy provides a set of expectations for behaviour and a framework for disciplinary procedures to ensure the efficient and successful operation of Whanganui District Health Board, and to ensure that expectations are understood and met by all employees of Whanganui District Health.

**B POLICY****1 Jurisdiction**

This policy is applicable to all employees of Whanganui District Health Board.

**2 Whanganui District Health Board expects all its employees to:**

- Perform to the best of their ability, and be committed to a high quality of work performed in a safe manner
- Be professional in both their manner and attitude to fellow employees, managers, clients/patients and members of the public. This applies when on Whanganui District Health Board premises and whilst on Whanganui District Health Board business
- Adhere to professional standards and work within the scope of practice as set by their professional regulatory body
- Take the initiative and be creative in resolving problems, seeking improved productivity and responding to opportunities within their areas of responsibility
- Make decisions and be responsible for those decisions and the actions that flow from them
- Treat all Whanganui District Health Board assets with due care and respect
- Be supportive of their work teams, and accept their responsibilities as team members
- Be supportive of those changes in work processes and attitudes that are necessary to ensure Whanganui District Health Board's continued success.
- Be honest and loyal to the organisation.
- Treat any material/information they acquire through their work with absolute confidentiality.
- Not engage in any private activity, without the employer's prior agreement, which could have an effect on their ability to carry out the duties as an employee
- Not compromise Whanganui District Health Board integrity either inside or outside work.

Note: These expectations apply to all employees regardless of their role in the organisation.

- 2.1 Whanganui District Health Board employees can expect Whanganui District Health Board to adhere to some basic principles underlying good disciplinary procedure. These include:

**Timeliness:** Action will be taken as soon as practicable after the event.

**Impartiality:** Disciplinary procedures will be applied in an equitable and fair manner - every employee must be treated equally.

**Consistency:** Similar disciplinary action will be taken in respect of similar offences.

**Non-punitive approach:** The purpose of disciplinary action is to prevent recurrence. It will not be to exact revenge or inflict punishment for its own sake.

**Fairness:** The degree of discipline will be related to the nature of the employee's work record, the circumstances, and any extenuating circumstances. The procedure used in each case must be fair and follow the principles of natural justice.

Whanganui District Health Board will also:

- Treat all employees with respect and integrity
- Be a good employer
- Fully investigate any complaints
- Promptly draw any unsatisfactory aspects of their work to the attention of the employee
- Ensure employees are aware of the standards of performance and behaviours required of them
- Ensure employees are given adequate counselling, advice and training necessary to enable them to reach the required standards
- Ensure employees are given time to modify or correct their behaviour and/or attain and maintain an acceptable standard of work performance where appropriate
- Ensure that the appropriate disciplinary action occurs where unacceptable behaviours or work performance persist.

### **3 RULES**

#### **3.1 Misconduct**

The following are examples of the type of actions and behaviour, which Whanganui District Health Board considers to be misconduct. They may, after warnings, result in dismissal:

1. Wasting time or materials.
2. Misuse, unauthorised use or defacing of Whanganui District Health Board property.
3. Failure to observe safety, health or hygiene protocol/instructions, working in an unsafe manner, or failing to make proper use of safety equipment when such equipment is installed or provided.
4. Lateness or poor performance.
5. Preventing or interfering with another employee carrying out their work functions.
6. Failure to follow defined Whanganui District Health Board policies and procedures.
7. Reporting for work in such a condition as to be unable to perform the required duties in a safe and proper manner.
8. Posting offensive notices/pictures on notice boards, computer screens or elsewhere on the premises.
9. Unauthorised absence from work including leaving work without permission, and without good reason failing to notify the supervisor of unavailability to commence work at the specified starting time.
10. Unacceptable, unsafe and/or disruptive behaviour at the place of work.
11. Failure to promptly report any workplace accident.
12. Sleeping during working hours. (This does not include situations where employees are on-call for immediate availability).
13. Unauthorised gambling on Whanganui District Health Board premises.
14. Where an employee is negligent, careless, indolent, inefficient or incompetent in the performance of his or her duties.
15. Being in a department without proper purpose after normal working hours.
16. Using abusive or offensive language, while at work.
17. Unreasonable refusal to attend a doctor nominated by the employer for the purpose of an assessment of the employee's fitness for work.
18. Having a standard of dress that is below required standards of professionalism.
19. Smoking in a smoke-free area or in a vehicle belonging to the organisation.
20. Deliberate incompatibility with other employee(s), manager(s) or reporting employee(s).
21. Acts otherwise falling within the category of serious misconduct, but where the particular case is such as to fall short of requiring dismissal in the particular instance.

*This list is not exhaustive and may be amended from time to time as Whanganui District Health Board deems necessary. Where an act is carried out by an employee which is not specifically covered by the above misconduct, but is of a similar nature, Whanganui District Health Board reserves the right to implement disciplinary procedures.*

#### 4 Serious Misconduct

The following are examples of the type of actions/behaviour which Whanganui District Health Board considers to be serious misconduct and which, after investigation, may lead to dismissal without notice or formal warning:

1. Conduct injuring the business, reputation or goodwill of Whanganui District Health Board or its employees.
2. Unauthorised possession or removal of property belonging to Whanganui District Health Board, the public at large, another employee or a client.
3. Intentional damage or grossly negligent damage to property belonging to Whanganui District Health Board, the public at large, or another employee.
4. Physical or verbal violence against other people including members of the public, clients, fellow employees, or management, on Whanganui District Health Board premises during work hours or whilst on Whanganui District Health Board business.
5. Falsification of any record of Whanganui District Health Board including time sheets, submitting false claims for expenses.
6. Bringing on to Whanganui District Health Board property, firearms or other offensive weapons or being in possession of an offensive weapon whilst on Whanganui District Health Board business.
7. Bringing on to or consuming on Whanganui District Health Board premises, non prescribed drugs, intoxicating liquor or other dangerous substances without prior authorisation (This excludes items bought over the counter for headaches or coughs and colds).
8. Reporting for work in such a condition, as to be unable and/or unfit to perform designated duties effectively and/or safely. Being under the influence of alcohol or illegal drugs while on duty.
9. Unauthorised use of fire protection or safety equipment.
10. Deliberate acts detrimental to the quality and/or efficiency of Whanganui District Health Board services or detrimental to the safety of employees, clients or visitors.
11. Sleeping during working hours in situations having the potential to affect the safety of clients or employees. (This does not include situations where employees are on-call for immediate availability).
12. Any unauthorised access and/or disclosure to unauthorised persons of any confidential information belonging to Whanganui District Health Board or concerning any clients/patients or employees.
13. Failure to record and report any accident affecting clients/patients, visitors or employees.
14. Without authorisation, entering a restricted area of Whanganui District Health Board premises.
15. Harassment, as defined in the Whanganui District Health Board Policy on Harassment.
16. Accepting any personal fee, reward, gift, gratuity or remuneration other than normal salary or attempting to extract the same on account of any services provided in the normal course of duty. Unsolicited gifts of token value are an exception.
17. Refusal to carry out the lawful instruction of a Manager or supervisor, including refusal to perform work, or walking off the job, except where working conditions are unsafe.
18. Professional misconduct or breach of professional code of conduct, scope of practice or ethics.
19. Not being in possession of an annual practising certificate or any other professional practising requirement where required by legislation and/or falsely claiming reimbursement from the Board.
20. Failure to notify the Board of a change in your scope of practice that may have an

effect on your ability to carry out the duties and functions of your position.

21. Removal, copying, falsification, destruction or disclosure of computer software, records or confidential information belonging to Whanganui District Health Board.
22. Failure to account for cash, or failure to follow correct procedures for the handling of money.
23. Failure to follow safety requirements where the safety of other employees, clients/patients or customers is put at risk. This includes the use of and failure to wear or use safety equipment and/or protective clothing.
24. Absence from work, without good cause, including during a period for which a request for leave of absence has been denied.
25. Being absent for three consecutive days without reporting.
26. Submission of false sick leave claim.
27. Lending keys/electronic cards, identity cards, or giving details of combination locks, or access passwords to persons not authorised to hold these items or have this information.
28. Misuse of Whanganui District Health Board vehicle fleet cards.
29. Acts otherwise falling within the category of misconduct as outlined under 1 above where the particular case is so serious a breach as to warrant dismissal in the particular instance.

***This list is not exhaustive. Where an act is carried out by an employee which is not specifically covered by the above serious misconduct but is of a similar nature, Whanganui District Health Board reserves the right to implement disciplinary procedures.***

#### **4.1 Conduct Detrimental to the best interests of Whanganui District Health Board**

The following are examples of the type of actions/behaviour that are considered to be conduct detrimental to the best interests of Whanganui District Health Board. They may be regarded as Serious Misconduct and following investigation may therefore be likely to lead to summary dismissal without notice or formal warning:-

1. Conviction in a court of law
2. Off duty behaviour which brings the organisation or the standing of the employee's profession into disrepute
3. Failure to follow Whanganui District Health Board procedures for resolving an ethical dilemma that brings the organisation into disrepute.

***This list is not exhaustive. Where an act is carried out by an employee which is not specifically covered by the list above but is of a similar nature, Whanganui District Health Board reserves the right to implement the disciplinary procedure.***

## **5 WHEN EXPECTATIONS ARE NOT MET**

Sometimes things go wrong and corrective action is required. The formal disciplinary procedures outlined below provide the means to correct a problem which exists and inform the employee what is expected of them for their continued employment with Whanganui District Health Board.

It is acknowledged that in some cases it may be appropriate to use more informal approaches to resolve a problem, eg Employee Assistance Programme counselling, monitoring or training. Such options may be utilised at the manager's discretion or employee's request with management approval.

In cases of professional misconduct or breach of professional code of conduct or ethics, the matter may be referred to the appropriate professional body, eg Medical Council of New Zealand.

*Under the Health Practitioners Competence Assurance Act, when an employee employed as a*

*health practitioner resigns or is dismissed for reasons relating to competence, the employer must promptly give the responsible authority, ie appropriate relevant registration body, written notice of the reasons for that resignation or dismissal [clause 34 (3)].*

#### **FORMAL PROCEDURES**

Refer Appendix A and B.

##### **5.1 Misconduct**

There are three steps in the formal disciplinary procedure, which will generally be followed depending on the nature of the offence and relevant facts of the matter.

- A first formal warning
- A final formal warning
- Dismissal.

This procedure is not limited to repetitions of a similar form of offence, but may be applied to offences of different nature.

##### **5.2 Serious Misconduct**

Offences, which constitute serious misconduct may result in:

- suspension from duties (on pay) whilst the alleged offence is investigated, and/or
- dismissal without notice, without prior warnings being issued.

In some instances serious misconduct may result in a first or final warning rather than dismissal, depending upon all the relevant facts of the matter.

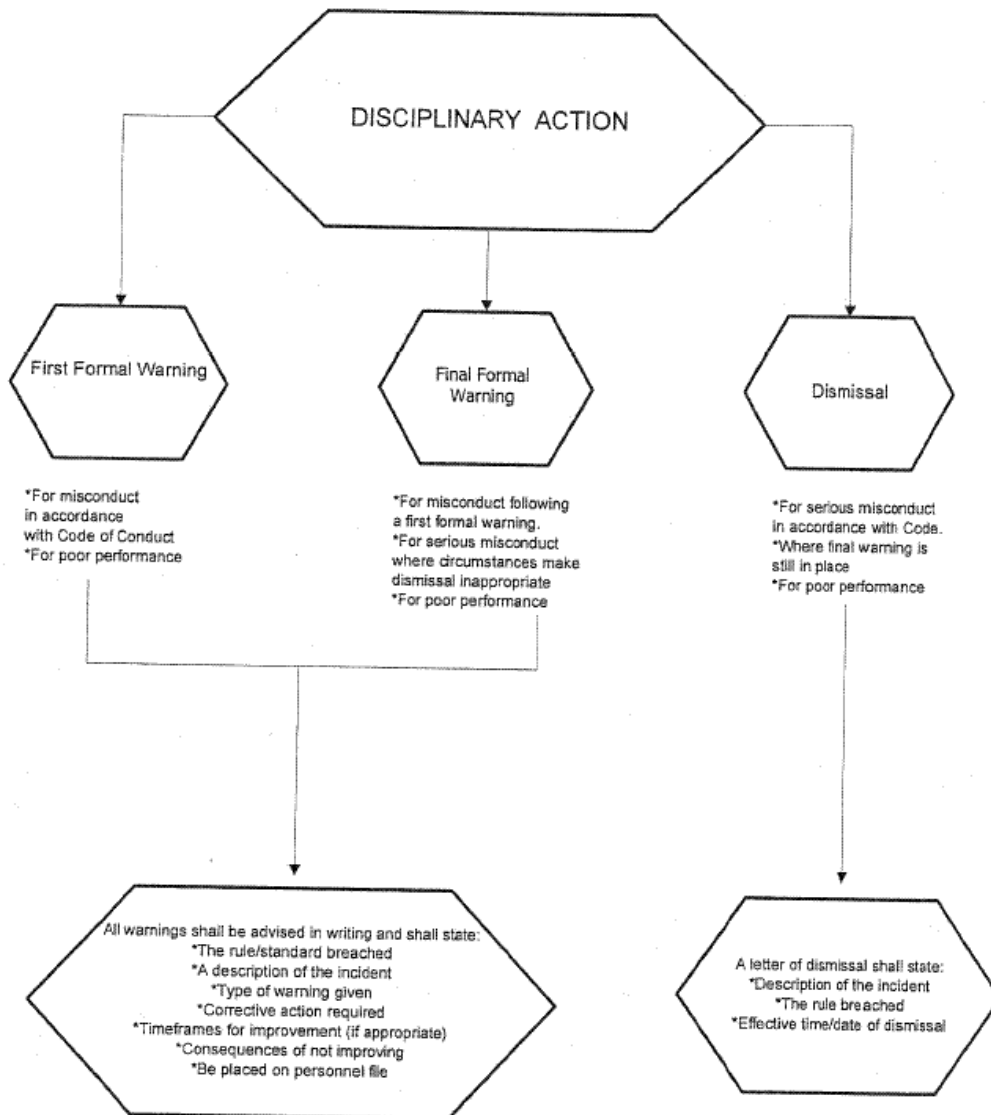
#### **6 EMPLOYEES RIGHTS**

The employee is entitled to:

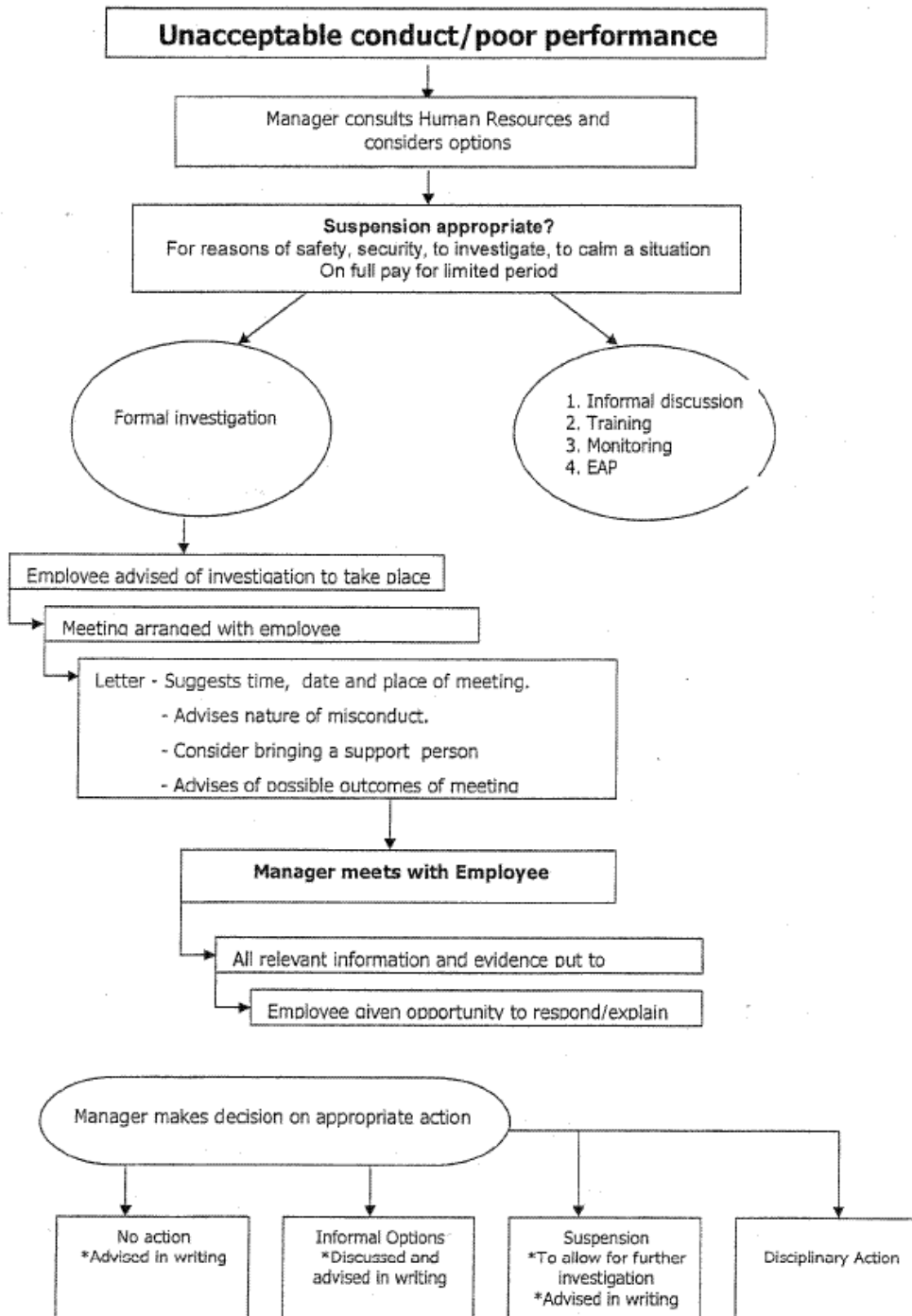
- Representation or assistance in disciplinary or dismissal situations
- Representation/assistance of their own choice
- To know what the specific issue(s) causing concern are
- Be given an opportunity to explain
- Where appropriate, to be given time and if appropriate, training to improve
- Where appropriate, given a copy of any warning issued. This warning will contain the date the warning will expire. In some serious cases the warning may be issued for an indefinite period. Warning letters will remain on the personnel file as a record of employment.



Appendix A



Appendix B



## SUPERVISION POLICY

Whanganui  
District Health Board

# Supervision Policy

<b>Reviewed by:</b>	[..] Service Manager, Maternal, Child and Public Health	<b>GAZETTE DATE</b> 31 December 2004
<b>Date:</b>	6 October 2004	
<b>Recommended by:</b>	[..] Acting General Manager Public Hospital and Health Services	
<b>Date:</b>	20 October 2004	
<b>Approved by:</b>	[..] Chief Executive Officer	
<b>Date:</b>		

**A STATEMENT**

This policy reflects Whanganui District Health Board's commitment to support and resource supervision consistent with relevant statutory and professional body requirements.

**B POLICY BACKGROUND**

Health Practitioners Competence Assurance Act 2003  
Treaty of Waitangi – Whanganui District Health Board  
Social Work Registration Act 1993  
Privacy Act 1993

**C DEFINITIONS**

**Supervision:** is a process in which the supervisor enables, guides and facilitates the supervisees in meeting certain organisational, professional and personal objectives. These objectives are: competency; accountable practice; continuing professional development and education; personal support (Australian, New Zealand Association of Social Workers 1997 adapted from Morrison, 1993: 13).

**Mentoring:** partnership between experienced and less experienced staff to support and guide junior staff.

**Supervisor:** someone who has undertaken supervision training as recognised by Good Health Wanganui and has a minimum of two years graduate practice experience. Good Health Wanganui staff already providing mandated supervision within the organisation are recognised by this Policy.

**Supervisee:** a person who participates in a Good Health Wanganui recognised supervision or mentoring process and has been prepared for this role through a process of orientation. A supervisee is not necessarily a less experienced practitioner than his / her supervisor.

**D POLICY**

**1. Principles of Supervision**

- The best interest of the patient/client must always come first except where there are threats to safety
- Supervision is mandated by organisation policy
- Supervision is culturally safe and gender appropriate (where possible) for the participants
- Supervision is a shared responsibility
- Supervision is based on a negotiated agreement at commencement which has provision for conflict resolution
- Supervision promotes competent, accountable empowered and anti-discriminatory practice
- Supervision is based on an understanding of how adults learn
- Supervision provides for appropriate consultation when needed in special circumstances.

**2. Purposes of Supervision**

- To ensure the supervisee is clear about roles and responsibilities
- To encourage the supervisee to meet their profession's responsibilities
- To encourage quality of service to patients/clients
- To encourage professional development and provide support
- To identify and manage workload and related issues
- To consider the resources the supervisee has available to do their job and discuss issues arising from resource allocation

- To provide a positive environment within which practice can be discussed and reviewed

### 3. Forms of Supervision

The structure of supervision can vary to suit the needs of each discipline, for example it may be:

- Individual
- Peer
- Group (facilitated)
- External
- Cross- disciplinary
- Reciprocal
- Mentoring.

## E PROCEDURE

Each service area where supervision is undertaken will develop and resource area specific supervision procedures consistent with this Supervision Policy.

Procedural detail, including minimum frequency of supervision, forms of supervision, limits of confidentiality, supervision records management, review processes, and supervision orientation for new supervisees will be covered in area specific protocols.

A template for this purpose is attached. This is to be completed for each supervision contract and a copy forwarded to Human Resources.

Where cultural supervision is being considered this is to be discussed with the Maori Health Co-ordinator.

**SUPERVISION CONTRACT**

Supervisee: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Venue: \_\_\_\_\_ Frequency: \_\_\_\_\_

Length of Session: \_\_\_\_\_

Goals of supervision (be specific): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Supervisee Responsibilities:**

- To identify practice issues to address in supervision
- To identify ways of dealing with these issues from their perspective
- To be open to feedback
- To develop the ability to work out what feedback is useful.

**Supervisor Responsibilities:**

- To help to explore, clarify thinking, feelings and concerns underlying their practice
- To give clear feedback
- To share information, experience, and skills appropriately
- To challenge personal and professional blind spots.

**Disputes Process**

- Issues in dispute to be discussed between the contracting parties in the first instance and referred to Team Leader for follow up in the event of non-resolution.

**Confidentiality Statement**

The content of supervision is to be treated as confidential by both parties involved.

Should a situation occur where either party feel the need to discuss an issue, arising from supervision, with a third party this is to be discussed before disclosure.

**Record keeping arrangement (how, by whom, who has access)**

\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ Review Date \_\_\_\_\_

Signed: \_\_\_\_\_  
Supervisee Supervisor

**PATIENT COMPLAINTS**

Whanganui  
District Health Board

# Patient Complaints

<b>Reviewed by:</b>	Quality and Risk [...]	<b>Gazette Date:</b> 29 July 2005
<b>Date:</b>	23 June 2005	
<b>Approved by:</b>		
<b>Date:</b>	Chief Executive Officer	

Ombudsman's Office, or the Coroner, the complaint investigation will be managed by the Quality and Risk Management department.

## **E PROCEDURES**

Refer to complaints process flow chart in Appendix A.

### **1 Receiving a Complaint**

- 1.1 (a) Any employee can receive a complaint from a patient or their representative. The employee receiving a complaint must document the circumstances of the complaint, the issues the complainant would like resolved. The employee has a responsibility to advise the complainant about advocacy and the Code of Health and Disability Services Consumers' Rights where the complaint is about health services and the Privacy Commissioner where the complaint is about health information
- (b) Any employee who is made aware of a complaint must inform their Supervisor/Manager during their shift.
- (c) The person receiving the complaint must forward the complaint within 24 hours to the Customer Relations Officer for logging and tracking.
- (d) The Customer Relations Officer must acknowledge in writing receipt of the complaint to the complainant within five working days.

The written acknowledgement must inform the complainant of their rights to advocacy and the option of referring the matter to the Health and Disability Commissioner or the Privacy Commissioner.

- 1.2 Within 10 working days of giving written acknowledgement of a complaint, Whanganui District Health Board must:
- (a) Decide whether or not it accepts whether the complaint is justified; or
- (b) If more time is needed to investigate the complaint, Whanganui District Health Board must:
- (i) Determine how much additional time is needed; and
- (ii) If that additional time is more than 20 working days, inform the patient (or the patient's representative) of the need for more time, and the reasons for it.

### **2 Investigating A Complaint**

- 2.1 **Responsibility for Investigation** The Service Manager is responsible for the co-ordination of the investigation. Where a health professional is cited in the complaint, clinical leaders must be involved in leading the investigation in conjunction with the relevant Service Manager. Those who investigate a complaint must ensure that the complaint is resolved in a speedy and fair manner.
- 2.2 **Reportable Events Assessment** All complaints, after preliminary investigation, should be screened to assess whether they meet Reportable Events Committee referral criteria (refer 2.8).
- 2.3 **Employee cited in a complaint** An employee cited in a complaint will be notified by Quality and Risk that this has occurred, advised of their support options and that the full details have been forwarded to the investigator. An employee cited in a complaint must be notified by the manager investigating the complaint as soon as possible and given the full details of the complaint. The employee must be given the opportunity to respond to the complaint and must be informed of the complaint outcome. All employees cited in a complaint must do what they can to ensure the complaint is resolved in a speedy manner.



**4 Support for Employees**

Whanganui District Health Board recognises that complaints and complaint investigations can be stressful for those who are cited in complaints. Whanganui District Health Board is committed to providing support to employees cited in complaints. The following people, departments and organisations are available, and employees cited in complaints are encouraged to utilise one or more of these mechanisms:

- (a) Clinical Directors, Heads of Department and other clinical leaders
- (b) Direct line managers
- (c) Quality and Risk Management
- (d) Employee Assistance Programme; and
- (e) Professional advisers and representatives (for example, New Zealand Nurses Organisation, New Zealand College of Midwives, Medical Protection Society and Public Service Association).

**5 Audit**

Quality and Risk Management will screen complaints against the following criteria and include results in monthly reporting

- (a) Reporting compliance
- (b) The thoroughness of investigations
- (c) The quality of replies to the complainant
- (d) Whether remedial action to rectify the complaint has been taken.

**6. Cultural Responsiveness**

Appropriate cultural input and resources need to be obtained. If English is not the first language, official interpreter services need to be obtained. If requested, the Maori Liaison Officer is available to support families and staff to address cultural needs. If a request is not made, then staff should inform whanau that a liaison service is available. If a nominated spokesperson is identified within whanau, then that person should be consulted for mutual communication and clarification of any procedures.

**7 Interpreters**

A list of interpreters is available from either the Customer Relations Officer or the Telephonists.

**ENDS**

**APPENDIX B**

***Patient Complaints Checklist***

Patient's name: \_\_\_\_\_

Complainant's Name - if different from above, consent given by patient for complainant to make complaint on patient's behalf? Yes/No: \_\_\_\_\_

Relationship of complainant to patient: \_\_\_\_\_

Complaint number: \_\_\_\_\_


1. Investigator has confirmed the circumstances, issues and desired outcome of complaint with complainant	YES/NO
2. Investigation is documented (file notes and statements included where appropriate)	YES/NO
<b>Investigation:</b>	
1. Copy of complaint given to and discussed with employee/s cited in complaint if applicable and support offered	YES/NO
2. Identified and clarified all the complainant's issues	YES/NO
3. Considered whether the care provided was delivered to an acceptable standard of care	YES/NO
4. Considered whether the complainant received sufficient information to make an informed decision regarding the care delivered	YES/NO
5. Avoided some of the complainants issues/issues identified as a result of the investigation	YES/NO
6. Findings of investigation communicated to complainant by telephone or at a meeting	YES/NO Telephone/Meeting
<b>Written response:</b>	
1. Acknowledges circumstances of complaint	YES/NO
2. Acknowledges relevance of complaint	YES/NO
3. Identifies clearly each issue and provides an explanation of investigation findings and actions taken as a result of the investigation	YES/NO
4. Identified issues have not been avoided in response	YES/NO
5. Accords the complainant respect	YES/NO
6. Written in plain factual English and is not defensive	YES/NO
7. Position titles used unless person identified in complaint	YES/NO
8. Letter is the Whanganui District Health Board's complete response – avoids departmental finger pointing	YES/NO
9. Response is credible	YES/NO
10. Final response shown to employee/s cited in complaint (if applicable) prior to being sent to CEO for sign off	YES/NO
<b>Performance issues:</b>	
1. Performance issues identified	YES/NO
2. Appropriately addressed	YES/NO

Declaration: I have completed this investigation using my professional knowledge and to the best of my ability.

Investigator: \_\_\_\_\_

Date: \_\_\_\_\_

## INCIDENT REPORTING



Whanganui  
District Health Board

*Incident Reporting*

Reviewed By	Quality & Risk Management	GAZETTE DATE: 11.02.03
Date:	22 01.03	
Recommended by General Manager Public Hospital and Heath Services	[...]	
Date	11.02.03	
Approved by Chief Executive Officer :	[...]	

**A POLICY SUMMARY**

This policy describes Whanganui District Health Board's Incident Reporting requirements and covers all incidents occurring on Whanganui District Health Board property and any incident in the community associated with delivery of care or where an employee was present, during the course of their duties.

The purpose of reporting incidents is to monitor and improve the quality of healthcare delivery. Patient safety is the primary focus for the reporting and consistent investigation of incidents. Reporting of incidents provides the opportunity to identify and correct causal factors, redesign systems and processes and share the learning gained throughout the organisation.

This policy is to be read in conjunction with Health and Safety Policy reporting and investigation requirements and the Reportable Events Committee terms of reference.

**B POLICY BACKGROUND**

- (b) Ministry of Health Guidelines for Reporting and Reviewing Incidents, December 1995
- (c) Ministry of Health guidelines for Reportable Events, September 2001
- (d) Towards Clinical Excellence: Learning from experience – Report to the Director General of Health from the Sentinel Events Project Working Party 2001
- (e) Standards New Zealand Process for standardised investigation and reporting in the Health Sector. SNZ HB 8152:2001

**C DEFINITIONS****Incident**

An undesired event that occurs within the organisation that could have, or does result in harm to people, damage to property or loss to process. Harm includes physical or emotional harm that is unrelated to the natural course of the patient's illness or underlying condition.

**Incident categories**

The following non-exhaustive list must be reported:

- a) Incidents that have resulted in harm to patients, visitors and employees that are discovered upon entry to a service or occur during service provision
- b) Serious harm suffered by employees/visitors/contractors as defined in the Health and Safety in Employment Act 1992
- c) Incidents that reflect an unsatisfactory situation in terms of the quality of clinical practice, quality of operational management or quality of service delivery systems that require reporting to managers. This may include incidents related to the organisations interface with other organisations/service providers
- d) Incidents that have resulted in, or could have resulted in, damage to the environment
- e) Restraint, either personal or mechanical
- f) Abuse or illicit possession of drugs/alcohol/firearms/offensive weapons
- g) Error in legal status, including incorrect Mental Health Act papers

- h) Incidents that could have caused harm/serious harm/damage/loss if:
- (i) the situation had not been rescued in time to prevent harm occurring
  - (ii) employees foresee that a recurrence of the event could result in harm.

### Critical Incidents

These incidents include Serious events and Sentinel Events as defined by the Ministry of Health's "*Reportable Event Guidelines*"

The characteristics of a critical incident include:

- (i) system failures that result in reduction of service
- (ii) significant deviation from the organisation's usual practice
- (iii) did not result in, but has the potential to result in significant harm
- (iv) an event that must be reported to regulatory bodies under statute
- (v) an event that needs to be reported to the organisations insurer
- (vi) the potential for adverse media attention

an event that has the potential to result in death or major permanent loss of function, not related to the course of the patient's illness or underlying condition.

### Examples of critical incidents include

- Missed or misdiagnosis
- Incorrect or incorrectly performed procedure/medication
- Self harm attempts
- Arson or any occurrence of fire
- Riot situations
- Hospital acquired infections
- Intruder activity or breach of security
- Unauthorised media involvement
- Contraction of a blood borne notifiable disease
- Harm resulting in admission to intensive care from a ward or transfer to another provider
- Employment of a person fraudulently posing as a registered health professional
- Absence without leave of a patient who may be seen as a danger to themselves or others
- Serious harm involving staff
- Failure in emergency management procedures resulting in major disruption to patient care
- Deaths requiring reporting to the coroner as defined in the Coroner's Act 1988
- Infant abduction or discharge to the wrong family
- Invasive procedure or intervention on the wrong patient or wrong body part
- Attempted or alleged sexual abuse or rape
- Errors of omission or commission that result in significant additional treatment or care or are life threatening e.g. medication errors, iatrogenic injury, recall of patients

**Root cause analysis:** A systematic process that uses information gathered during the investigation of a critical incident to determine the underlying reason or the fundamental root cause and considers both the localised and systemic problems that may create deficiencies that cause incidents

**Supervisor:** The person in charge of the area at the time of the incident

**Multi-disciplinary:** Those disciplines directly involved in the incident

**D POLICY**

**1 Jurisdiction**

This policy covers all incidents occurring on Whanganui District Health Board property and any incident in the community associated with delivery of care or where an employee was present, during the course of their duties.

**2 Notification**

**2.1 Internal notification requirements**

The incident must be reported immediately to the Team Leader/Supervisor and any other relevant staff member (see incident involving a patient). All incidents must be documented on the shift in which the incident occurs or is discovered. The General Manager is to be notified of all critical incidents by the appropriate service manager or manager on call. The General Manager will notify the Chief Executive Officer, as chair of the Reportable Events Committee, of all critical incidents. The General Manager will co-ordinate the investigation of the critical incident and will ensure mandatory reporting requirements are met. In the case of Mental Health Services, a critical incident must be reported to the Director Area Mental Health Service (DAMHS) as well as the Service Manager and General Manager. *Incident reporting is to follow the incident reporting management process (see Section E).*

**1.2 Mandatory external notification requirements**

Incident	Notification Agency
Breach of hospital licensing requirements	Ministry of Health – Manager Licensing
Misadministration of radioactive materials	Ministry of Health – National Radiation Laboratory
Events relating to the safety of electrical equipment	Ministry of Commerce – Chief Electrical Engineer
Gas accidents	Ministry of Commerce - Chief Gas Engineer
Deaths requiring reporting to the Coroner	Wanganui Police and the Coroner

### **3 Investigation**

The Team Leader/Supervisor is to conduct at least a preliminary investigation on the shift in which the incident occurs or is discovered. An investigation is to be completed within 72 hours of the incident occurring, except where exceptional circumstances exist and the Service Manager has granted a time extension.

#### **3.1 Investigation of critical incidents/**

The Service Manager is responsible for appointing the investigation team. These incidents must be investigated according to a standard process. The investigation team is responsible for

- planning the investigation
- determining the sequence of events
- identifying causal factors and root causes
- developing corrective action plans
- monitoring the implementation of action plans
- evaluating effectiveness of actions

The investigation is to be recorded on the approved investigation form. Additional documentation is to be appended.

### **4 Multidisciplinary debriefing**

A multidisciplinary debriefing will be held within 48 hours of any critical incident. The General Manager or an appropriately skilled person appointed by the General Manager will chair the debriefing session. The Service Manager in the area in which the incident has occurred will co-ordinate this meeting. All staff involved directly in the incident will be required to attend the debriefing. The purpose of the debrief is to allow the staff involved to express their reactions to the incident and to identify any further support measures that may be required for both patients and staff. *Refer to section support section 6.*

### **5 Reportable Events Committee**

The Committee will maintain oversight of the incident reporting management process, particularly the frequency and cause of incidents. The Committee will review the adequacy of investigations for all critical incidents. The Committee may collectively or individually request further investigations or provide further recommendations.

### **6 Support following critical incidents**

Following all critical incidents, for example suicide or serious injuries (see definition), those obviously affected by the incident, including family/whanau, should be advised of and offered support by Whanganui District Health Board staff.

#### **6.1 Patient/client/family/whanau**

The support may include counselling, home visit by the key worker/senior clinician/manager, discussion with the patient's Responsible Clinician or such other interventions of a supportive nature as indicated as being useful by the patient/family/whanau, and within the means of Whanganui District Health Board.

**6.2 Employees**

The support may include Employee Assistance Programme, other counselling, leave or such other interventions of a supportive nature as indicated as being useful by the employee and agreed by the General Manager

**E PROCEDURES**

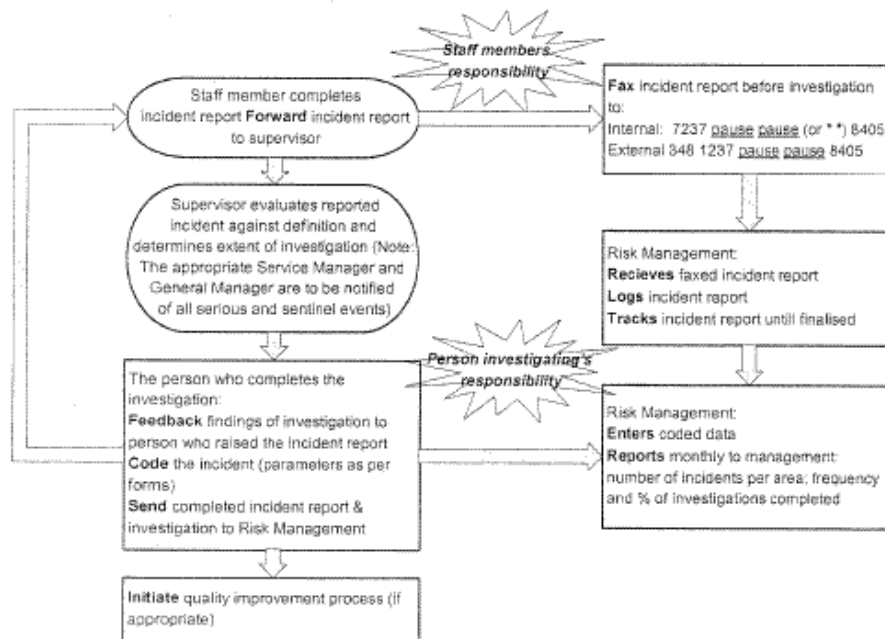
**1 Incident report forms**

All incidents must be reported on the approved Incident Report forms.

Investigations must be completed on an approved investigation form. Where an incident involves solely a clinical review of a patient's care and there are no system failures the investigator may record the investigation in the patient's record providing the incident is clearly documented in the notes, including incident number, and the investigator has reviewed the record and determined that there is no incident pattern.

In the above circumstances the following statement may be recorded on the Incident Report "No further investigation required, incident recorded in patient's notes".

**2 Incident reporting management process**





### **3 Completing incident report form**

#### **3.1 Incident involving a patient**

- When a patient is involved in an incident, the person responsible for their care at the time of the incident, must complete the incident report form, as soon as they are certain all people involved in the incident are safe
- Notify the responsible on-duty medical officer to arrange a medical examination, as soon as possible and document their instructions and response to the incident in the progress notes
- Notify the Team Leader/Supervisor/After Hours Facilitator, as soon as possible
- Make an entry of the incident in the Patient Health Record, including incident number, within the shift in which the incident occurs
- Mental Health Service Maori patient, regardless of incident severity notify Te Whanau Hauora as soon as possible.

#### **3.2 Incident/ causing harm to a staff member**

- The person(s) involved in the incident must ensure an incident Report Form/s is completed. When a staff member is incapacitated and unable to complete the form, Nurse in Charge/Supervisor must ensure that the form is completed.
- When a staff member suffers an incident involving blood or body fluids, eg: needle stick injury, a pink 'Blood/Body Fluid Accident Form' must be completed and sent to Infection Control.
- When injured on duty, the staff member should complete an Accident Insurance Certificate (completed by you and your health provider), the employer's copy should be forwarded to "Quality and Risk Management".
- In cases where symptoms of an injury are suspected at the time of the incident the injury or symptoms must be reported and documented immediately. When an injury is suspected at a later stage, the incident must be documented as soon as an injury becomes apparent.

#### **3.3 Incident involving allegations of inadequate staff performance/breach of professional practice standards or the organisation's Code of Conduct**

- The incident report is to be investigated by the staff member's line manager and the investigation handled according to the Code of Conduct Guidelines for Managers. The relevant Clinical Director must be involved for events that relate to professional practice.

### **4 Responsibility of Team Leader/Supervisor**

- #### **4.1**
- Ensure that incidents involving patients have appropriate post incident clinical management and all clinical management is documented in the patient health record.
- #### **4.2**
- The patient is informed if the incident affects their care and treatment and the outcome of the investigation. Where a patient is not competent their representative is to be informed of the incident.
-

- 4.3 Following any alleged assault occurring on Whanganui District Health Board's property or any alleged assault in the community where an employee was present, during the course of their duties, the attending medical officer must contact the police as part of their immediate response. For additional clinical guidance refer to "Management of Suspected Abuse of Clients" policy.
- 4.4 Ensure severity of incident is identified so that appropriate resources and investigations can be mobilised. (Health and Safety serious harm incidents must immediately be notified on extension 8100) Serious and Sentinel Critical incidents must be immediately notified to the General Manager through the appropriate service manager/on call manager.
- 4.5 Ensure debriefs and reviews of all incidents are arranged (see paragraph 7) or facilitated when thought appropriate by the team leader/supervisor or requested by staff member.
- 4.6 When applicable, ensure police involvement is initiated.
- 4.7 When Mental Health Service patients (Turoro Maori) and whanau, are involved in an incident/event, the appropriate Maori Mental Health Worker (te whanau hauora) is notified as soon as practicable.
- 4.8 When incidents involve the Mental Health Act, ensure that the Director of Area Mental Health Services is notified as soon as practicable.

## **5 Responsibilities of Senior Medical Officer**

- 5.1 Ensure that incidents involving patients have appropriate post incident clinical management and all clinical management is documented in the patient health record.
- 5.2 Ensure that there is medical officer attendance at the site of incidents involving patient violence and subsequent injury, or when further patient/client assessment and review is indicated.
- 5.3 Ensure that there is appropriate physical assessment of patient and/or mental status examination within two hours of the incident occurring.
- 5.4 Following any alleged assault occurring on Whanganui District Health Board property or any alleged assault in the community where an employee was present, during the course of their duties, the attending medical officer must contact the police as part of their immediate response. For additional clinical guidance refer to "Management of Suspected Abuse of Clients" policy.
- 5.5. Ensure that all deaths that require notification to the Coroner are notified to the Wanganui Police, the Coroner and Risk Management.

**ENDS**

## TERMS OF REFERENCE FOR CREDENTIALLING COMMITTEE



### Terms of Reference for Credentialling Committee

#### 1. Authorisation of the Committee

- 1.1 The Credentialling Committee is authorised by the Chief Executive Officer, Whanganui DHB.
- 1.2 The Credentialling Committee is a Chief Executive Officer committee.

#### 2. Purpose of the Committee

- 2.1 The Credentialling Committee is the instrument for delineating the clinical activities of all doctors working in the hospital. This includes full-time salaried senior staff, part-time medical practitioners, general practitioners, locum tenens, and visiting medical staff. Junior staff are excluded from the activity of this committee as they have their own supervision.
- 2.2 The principal aim is to ensure that all work carried out by medical practitioners is consistent with their qualifications, training, experience and competence, and has regard to the available resources.
- 2.3 The Committee will consider applications by medical practitioners for clinical activity approval in association with their appointment initially and thereafter on a regular triennial basis.
- 2.4 The Committee will also evaluate matters relating to the clinical activity of a medical practitioner referred to the Chair of the Credentialling Committee and accepted by the Committee, which relate to the professional standards of individuals as documented by a pattern of performance over time.
- 2.5 The Committee shall develop policies and procedures for credentialling for recommendation to the Chief Executive Officer and shall implement such procedures as the Chief Executive Officer approves.

Terms of Reference may need to be changed from time-to-time.

#### 3. Committee Membership

- 3.1 The Committee will have a broad based speciality representation including five medical practitioners. The Medical Advisor and the Chair of the Medical Staff Association will be automatic appointees.
- 3.2 Members will be appointed by the Chief Executive Officer from candidates nominated by the Medical Staff Association.

- 3.3 Members of the Committee will serve for two years and will be eligible for renomination and reappointment by the Chief Executive Officer.
- 3.4 A member of the Committee can be removed from membership of the Committee, on the recommendation of two thirds (2/3) of the membership of the Committee when he/she fails to attend 3 consecutive meetings without adequate reason, or when the member's behaviour has been such as to be inconsistent with the aims and objectives of the Credentialling Committee. Such removal must be endorsed by the Chief Executive Officer.
- 3.5 In the case of a vacancy on the Committee due to death or resignation, the Medical Staff Association will nominate candidates to the Chief Executive Officer, who will appoint a replacement to serve the remainder of the two-year term.
- 3.6 The Chair of the Committee shall be elected annually from among the members of the Committee.
- 3.7 The Committee has the power to co-opt other medical practitioners. Co-opted members, including outside assessors from other disciplines and specialities, will sit on the Committee only until the task for which they were co-opted has been completed. The role of outside assessors is to provide objectivity and specialist knowledge.

#### **4. Meetings**

- 4.1 A quorum for the Committee to begin and to continue to transact business is three (3) members.
- 4.2 Where physical presence of members is not possible, teleconference will be a recognised mechanism.
- 4.3 Where a member of the Committee is the subject of a submission to the Committee, or is in the position of being an applicant for re-appointment or privileges, or for any other circumstances where there may be a conflict of interest, real or apparent, he/she must absent him/her self from the deliberations of the Committee.
- 4.4 The business of the Committee shall be formally conducted and all decisions properly recorded.
- 4.5 An agenda shall accompany a notice of regularly scheduled meetings, and it shall be distributed prior to the meeting.
- 4.6 Minutes will be distributed a week prior to the next meeting.
- 4.7 The Committee shall meet monthly or at such other frequency as decided by the Committee. However, the Chair, or in his/her absence, any two members, may call for an emergency meeting of the Committee, without notice or agenda being distributed prior to the meeting.
- 4.8 Matters coming before the Committee shall be decided by majority view.

#### **5. Process**

##### **5.1 Applications for Clinical Activity**

- 5.1.1 All medical practitioners wishing to practise in the hospital must make application to the General Manager of the Hospital setting out their training, qualifications and experience and, in addition, must define the details of clinical work they wish to perform.
-

- 
- 5.1.2 The General Manager and/or the delegated Service Manager will forward applications with a written comment to the Chair of the Credentialling Committee.
  - 5.1.3 The Committee shall consider applications by medical practitioners for clinical activity in association with their appointment, and routinely every 3 years.
  - 5.1.4 Applications for New Activities must follow the same process as for full credentialling.
  - 5.1.6 The decision of the Credentialling Committee must be put in writing to the Medical Practitioner and to the General Manager immediately following the decision being made.
  - 5.1.7 The delineated clinical activities of individual clinicians may be reviewed and altered from time to time. This may happen at the request of the individual clinician, the general manager or the MSA Chair. In considering these changes, the Credentialling Committee will address issues relating to the professional standards of the individual as documented by a pattern of performance over a period of time. The Committee will respond to information that there is evidence of repeated episodes of lack of skill or an unacceptably high rate of adverse events or inappropriate professional behaviour. All information will be in strict confidence and the "Laws of Natural Justice" will apply. Such requests must be acted upon promptly by the Credentialling Committee.

## 5.2 *Process Considerations of the Committee*

- 5.2.1 The Committee will in the course of its activities, derive documented information concerning individual medical practitioner's performance.
- 5.2.2 The Committee will ensure that all its decisions are objective, without malice and have constant regard for the Law of Natural Justice.
- 5.2.3 The criteria to be used by the Committee shall be solely the competence of the practitioner under consideration to provide high quality care with the resources and services which the hospital will make available for such care.
- 5.2.4 The decisions and actions of the Committee will at all times have regard to the hospital policies and relevant regulations/legislation.
- 5.2.5 Confidentiality of the business of the Committee shall at all times be paramount. Members will only discuss the Committee's business with other members and such other persons who are authorised to provide or receive such information.
- 5.2.6 The Committee will, in the course of its activities, derive documentation concerning an individual SMO's Annual Practising Certificate/Indemnity Insurance.

## 5.3 *Exclusions*

The Committee will not be involved in the following:

- 5.3.1 Matters pertaining to employment contracts.
  - 5.3.2 Setting resource standards or requirements.
  - 5.3.3 The development of proposals with respect to any contracts or tenders undertaken or negotiated by the Whanganui DHB.
-

5.4 ***Committee Recommendations and Reporting***

- 5.4.1 The Committee reports to the Chief Executive Officer. Reports will be the minutes of the meeting or such other form as required by the Chief Executive Officer from time to time.
- 5.4.2 Decisions of the Committee shall be in the form of recommendations to the Chief Executive Officer.
- 5.4.3 Under ordinary routine circumstances, in the case of appointments, or in the case of routine review, recommendations shall go to the general manager.
- 5.4.4 Under emergency situations, such as the need to limit a practitioner's clinical activity immediately, the Committee may make such recommendations for action to the general manager who shall act according to the powers delegated to him/her by the Chief Executive Officer.
- 5.4.5 The Committee shall at all times act in a diligent manner and shall endeavour to ensure that it does not unnecessarily delay any proceedings or action where such delays may have the effect of causing undue stress inconvenience or harm to any party.

[...]  
*Chief Executive Officer*  
*September 2006*

ENDS

**APPENDIX 6: SUPERVISION AND INDUCTION PLAN AND  
SUPERVISION REPORTS**



# **Supervision and Induction Plan**

**Doctor:** Dr Roman Hasil

**Specialty:** Medical Officer, Obstetrics & Gynaecology

**Overseen by:** [...]  
of Department, Department  
of Obstetrics & Gynaecology

## Supervision Plan

1. Direct Supervision will be provided on site by Consultants in the Department of Obstetrics & Gynaecology
2. A weekly formal Department of Obstetrics & Gynaecology Team meeting is held every Monday morning.
3. Peer Review is held on the third Tuesday of every month.
4. Obstetrics Standards Review Committee meet every month
5. Peri-natal Review Meeting is held quarterly



## Induction Plan

Time	Area	Venue	Contact	Extn	Signed off as Completed
<b>Monday:</b>					
0745	Meet with [...] Clinical Director, Surgical Services	4 <sup>th</sup> Floor	[...]	Page 109	
0830	Laboratory [...]	Main Entrance	[...]		
0930	Photo ID, Human Resources	Lambie, Ground Floor	[...]	8412	
0945	Infection Control Quality Services Privacy Issues	Lambie – 2 <sup>nd</sup> Floor	[...] [...] [...]	8163 8202 8380	
1030	Radiology Department	1 <sup>st</sup> Floor	[...]	8221	
1100	Pharmacy	1 <sup>st</sup> Floor	[...]	8289	
1130	Outpatient Department Surgical Day Unit / Pre-admission	Ground Floor & 3 <sup>rd</sup> Floor	[...] [...]	Page 007 8075	
1400	Hand in completed papers	4 <sup>th</sup> Floor	[...]	8165	
1500	Library / computer suite	Tunnel – Ground floor	[...]	8142	
1530	Info Services / Network access / pin number	4 <sup>th</sup> floor	[...]	8026	
<b>Tuesday:</b>					
0830	Coronor's Cases	Laboratory	[...]	8271	
0930	Cultural Awareness	4 <sup>th</sup> Floor	[...]	8158	
1100	Neonatal Resuscitation	Delivery Suite	[...]	Page 076	
1330	Death Certification ACLS	Emergency Department	[...]	Page 125	
<b>Wednesday:</b>					
0800	Emergency Department		[...]	Page 125	
0930	Delivery Suite	Delivery Suite	[...]	8176	
1130	Central Patient Admin (CPA) to meet Gynaecology Administration Team	Ground Floor Offices	[...] [...] [...]	7283 7276 7276	
1300	Physiotherapy Dept Occupational Therapy Dept	1 <sup>st</sup> Floor		8126	

<b>Thursday:</b>					
0830	Informed consent / Theatre	Theatre	[...]	8039	
<b>Friday:</b>					
0800	<p><b>Report to Maternity Ward (Mollie Christie)</b></p> <p><b>O&amp;G Services</b>  Mollie Christie Ward ; Meet with:-</p> <ul style="list-style-type: none"> <li>▪ [...] Head of Department, Obstetrics &amp; Gynaecology</li> <li>▪ [...] Obstetrician &amp; Gynaecologists</li> <li>▪ [...] Clinical Team Leader</li> </ul> <p><b>Paediatric Services</b>  Alexander &amp; Bruce Ward : Meet with:-</p> <ul style="list-style-type: none"> <li>▪ [...] Head of Department, Paediatrics</li> <li>▪ [...] (Clinical Nurse Leader)</li> </ul> <p><b>Emergency Department :</b>  Meet with:-</p> <ul style="list-style-type: none"> <li>▪ [...] Director, Emergency Department</li> <li>▪ [...] (Clinical Nurse Leader)</li> </ul> <p><b>Service Manager, Surgical Services</b>  Meet with:-</p> <ul style="list-style-type: none"> <li>▪ [...] Service Manager, Surgical Services</li> </ul> <p><b>Service Manager, Maternal, Child and Public Health</b>  Meet with:-</p> <ul style="list-style-type: none"> <li>▪ [...] Service Manager, Maternal, Child and Public Health</li> </ul> <p>Plus please contact:</p> <p><b>Critical Care Unit</b> (located at the end of Easson Ward, 2<sup>nd</sup> Floor)</p> <ul style="list-style-type: none"> <li>▪ [...] Clinical Nurse Leader Extn 8267, Page 039</li> </ul> <p><b>Surgical Ward - Simpson Ward</b></p> <ul style="list-style-type: none"> <li>▪ [...] Clinical Nurse Leader Extn 8237,</li> </ul> <p><b>Clinical Nurse Specialist</b></p> <ul style="list-style-type: none"> <li>▪ [...] (Surgical) Extn 8164, Page 107</li> <li>▪ [...] (Medicine) Extn 8012, Page 105</li> </ul>				




## Orientation Day – Tuesday 02 August 2005

### Mr Roman Hasil, Medical Officer, Obstetrics and Gynaecology

Time	Person	Department	Location
9.30am		Surgical Services	4 <sup>th</sup> Floor, Ward Block
9.35am		Human Resources for ID Card Photo	Lambie, 1 <sup>st</sup> Floor
9.40am		Quality and Risk	Lambie, 1 <sup>st</sup> Floor
10.00am		Health and Safety	Lambie, 1 <sup>st</sup> Floor
10.30am		Pharmacy	1 <sup>st</sup> Floor, Opposite HR
11.00am		Outpatient Department	Ground Floor, Ward Block
11.15am		Radiology : Clinical Team Leader	1 <sup>st</sup> Floor, (above ED)
11.30am		Receptionist Therapy Services	1 <sup>st</sup> Floor, along from Radiology
11.40am		Emergency Department	Ground Floor
<b>Lunch</b>			
1.00pm		Library	Ground Floor, Tunnel
1.10pm			Ground Floor, Tunnel
1.20pm		Neonatal (Paediatrics)	Ground Floor, Maternity Block
1.30 - 1.40pm		Maternity	1 <sup>st</sup> Floor, Maternity Block
2.00pm		Theatre Co-ordinator	1 <sup>st</sup> Floor, Ward Block
Rest of the day will be spent in Theatre			

Orientation completed: 02/08/2005

4 AUG 2006

	<h1>Supervisors Report</h1>	RP3 – Sept 2004 Registration No:
	<input checked="" type="checkbox"/> Provisional general scope <input type="checkbox"/> Special purpose scope <input type="checkbox"/> Temporary registration	40499

Level 13 Mid City Tower, 139-143 Willis Street, P O Box 11 649 Wellington, New Zealand  
 Telephone 64-4-384 7635, Fax 64-4-385 8902

- A supervision report is to be completed and forwarded (via medical staffing office if employed in a hospital) to the Council office every three months, or as requested by the Medical Council.

Name: DR ROMAN HASIL

Employer/training host: Whanganui DHB - Whanganui Hospital

Report covers work/training done from: 10, 3, 06 to 9, 6, 06

Doctor is working in vocational scope of: Provisional General

Appointment ends on: Ongoing

Doctor is being considered for re-employment as: MOSS O+G

Until: .....

Current supervisor: [...]

**Supervision report**

- KEY: 1 Unsatisfactory-performs significantly below that generally observed for this level of experience  
 2 Below expectation-requires further development  
 3 Meets expectation-performs at a satisfactory level  
 4 Above expectation-performs at a level better than that which would be expected for the level of experience  
 5 Exceptional-performs at a level beyond that which would be expected for the level of experience  
 N/A Not applicable

Clinical Knowledge and Skills		1	2	3	4	5	N/A
1	Clinical knowledge (eg. knowledge of common symptoms, drug doses and side effects, drug interactions, etc)				✓		
2	Professional knowledge (knowledge of hospital procedures, policy, medico legal aspects)			✓			
3	Clinical clerking (adequacy of detail in written records, legibility, accurate drug charting)			✓			
4	History taking (ability to take history and perform physical examination, powers of observation)			✓			
5	Relevant procedural skills (eg. venesection, arterial blood gases, peak flows, etc)				✓		
Clinical Judgement		1	2	3	4	5	N/A
6	Diagnostic skills (Identifies and prioritises patient problems)			✓			
7	Patient management (Synthesises data, makes appropriate management decisions, responds appropriately to call outs and provides emergency care as required)			✓			
8	Time management (Plans and organises work, sets goals and meets them, prioritises calls, seeks advice on priorities if needed)				✓		
9	Recognising limits (accurate assessment of own skills, refers and consults with others as required, takes responsibility for actions, notifies staff if expecting to be absent from duty)			✓			

Patient Communication		1	2	3	4	5	N/A
10	<b>Communication skills</b> (communicates effectively in English, clarity, logic of expression, quality of case presentation etc)			✓			
11	<b>Ability to communicate with patients and families</b> (listening skills, respect, avoidance of jargon, coping with antagonism)			✓			
12	<b>Sensitivity, ethical and cultural awareness</b> (is aware of options and networks available to patients, treats patients as individuals, responds appropriately to different cultures encountered)			✓			
Communication and Teamwork		1	2	3	4	5	N/A
13	<b>Ability to communicate with other healthcare professionals</b> (ability to work in a multidisciplinary team and with all team members irrespective of gender, contributes effectively to teamwork)			✓			
14	<b>Initiative and enthusiasm</b> (gets involved, able to identify needs of the job, follows up without being prompted, thinks and plans ahead, shows commitment, asks questions of supervisors)			✓			
15	<b>Takes responsibility for own learning</b> (evidence of reading up on cases, attends seminars and teaching sessions, asks questions)				✓		
Professional Attitudes and Behaviour		1	2	3	4	5	N/A
16	<b>Reliability and dependability</b> (punctual, carries out instructions, fulfils obligations, complies with hospital policies, keep up to date with work including letters, arranging meetings)				✓		
17	<b>Ability to cope with stress, emotional demands and emergency situations</b> (reports when stressed, shows coping skills)			✓			
18	<b>Personal manner</b> (approachability, warmth, openness, rapport etc)				✓		

Comments (Please use a separate sheet if necessary)

Supervisor *Dr Hazel is a reliable member of the team. He is making good progress in adapting to the New Zealand System*

This report should be discussed with the doctor being reported on. Please tick if you have done so

If you have not done so, please explain why not:

Supervisor's signature: *[Signature]* Date: *4.8.2006*


Doctor

Signed: *[Signature]* Date: *4/8/06*

Chief Medical Advisor/Employer

Name: *[Signature]*

Signed: *[Signature]* Date: *4 AUG 2006*

	<h1 style="margin: 0;">Supervisors Report</h1>	RP3 – Sept 2004 Registration No: <span style="font-size: 1.2em; font-family: cursive;">40499</span>
<input checked="" type="checkbox"/> Provisional general scope <input type="checkbox"/> Special purpose scope <input type="checkbox"/> Temporary registration		

Level 13 Mid City Tower, 139-143 Willis Street, P O Box 11 649 Wellington, New Zealand  
 Telephone 64-4-384 7635, Fax 64-4-385 8902

- A supervision report is to be completed and forwarded (via medical staffing office if employed in a hospital) to the Council office every three months, or as requested by the Medical Council.

Name: Mr Roman Hecil

Employer/training host: Whanganui DHB - Whanganui Hospital

Report covers work/training done from: 10.6.06 to 9.9.06

Doctor is working in vocational scope of: Provisional General

Appointment ends on Ongoing

Doctor is being considered for re-employment as: MOSS O&G

Until: ...../...../.....

Current supervisor: [...]

**Supervision report**

- KEY:
- 1 Unsatisfactory-performs significantly below that generally observed for this level of experience
  - 2 Below expectation-requires further development
  - 3 Meets expectation-performs at a satisfactory level
  - 4 Above expectation-performs at a level better than that which would be expected for the level of experience
  - 5 Exceptional-performs at a level beyond that which would be expected for the level of experience
  - N/A Not applicable

Clinical Knowledge and Skills		1	2	3	4	5	N/A
1	<b>Clinical knowledge</b> (eg. knowledge of common symptoms, drug doses and side effects, drug interactions, etc)				✓		
2	<b>Professional knowledge</b> (knowledge of hospital procedures, policy, medico legal aspects)			✓			
3	<b>Clinical clerking</b> (adequacy of detail in written records, legibility, accurate drug charting)			✓			
4	<b>History taking</b> (ability to take history and perform physical examination, powers of observation)			✓			
5	<b>Relevant procedural skills</b> (eg. venesection, arterial blood gases, peak flows, etc)				✓		
Clinical Judgement		1	2	3	4	5	N/A
6	<b>Diagnostic skills</b> (Identifies and prioritises patient problems)			✓			
7	<b>Patient management</b> (Synthesises data, makes appropriate management decisions, responds appropriately to call outs and provides emergency care as required)			✓			
8	<b>Time management</b> (Plans and organises work, sets goals and meets them, prioritises calls, seeks advice on priorities if needed)			✓			
9	<b>Recognising limits</b> (accurate assessment of own skills, refers and consults with others as required, takes responsibility for actions, notifies staff if expecting to be absent from duty)			✓			

Patient Communication		1	2	3	4	5	N/A
10	<b>Communication skills</b> (communicates effectively in English, clarity, logic of expression, quality of case presentation etc)				✓		
11	<b>Ability to communicate with patients and families</b> (listening skills, respect, avoidance of jargon, coping with antagonism)			✓			
12	<b>Sensitivity, ethical and cultural awareness</b> (is aware of options and networks available to patients, treats patients as individuals, responds appropriately to different cultures encountered)			✓			
Communication and Teamwork		1	2	3	4	5	N/A
13	<b>Ability to communicate with other healthcare professionals</b> (ability to work in a multidisciplinary team and with all team members irrespective of gender, contributes effectively to teamwork)				✓		
14	<b>Initiative and enthusiasm</b> (gets involved, able to identify needs of the job, follows up without being prompted, thinks and plans ahead, shows commitment, asks questions of supervisors)			✓			
15	<b>Takes responsibility for own learning</b> (evidence of reading up on cases, attends seminars and teaching sessions, asks questions)				✓		
Professional Attitudes and Behaviour		1	2	3	4	5	N/A
	<b>Reliability and dependability</b> (punctual, carries out instructions, fulfils obligations, complies with hospital policies, keep up to date with work including letters, arranging meetings)				✓		
17	<b>Ability to cope with stress, emotional demands and emergency situations</b> (reports when stressed, shows coping skills)				✓		
18	<b>Personal manner</b> (approachability, warmth, openness, rapport etc)				✓		

Comments (Please use a separate sheet if necessary)

Supervisor

— Dr Haei continues to provide satisfactory service and to show a willingness to develop his practice.

This report should be discussed with the doctor being reported on. Please tick if you have done so

If you have not done so, please explain why not: — Doctor on leave

Supervisor's signature: [...]

Date: 29.8.2006

Doctor

Signed: [Signature]

Date: 3/9/06

Chief Medical Advisor/Employer

Name: [...]

Signed: [...]

Date: 4/9/06

## **APPENDIX 7: MEDICAL COUNCIL OF NEW ZEALAND HEALTH COMMITTEE ASSESSMENT**

On 16 October 2006 the Medical Council received Dr C's letter which provided details of the incident regarding Dr Hasil being under the influence of alcohol in a workplace and the outcome of the meeting.

The MCNZ Health Committee arranged for Dr Hasil to be assessed by an independent psychiatrist on 27 October 2006. The Health Committee endorsed the independent psychiatrist's recommendations.

In a letter dated 20 November 2006, the MCNZ asked Dr Hasil to:

- Arrange for his general practitioner to refer him to an alcohol service that provides ongoing treatment rather than an acute response service. CADS in another region was suggested as a possibility.
- Establish a therapeutic relationship with a clinical psychologist to address developing management strategies for stress including support with addressing the current stressors related to family and work, a relapse management plan and, as part of that insight into the early warning signs for relapse.
- Discuss with this general practitioner and his treatment team, the monitored use of disulfiram (known as Antabuse, which is a deterrent to alcohol consumption).
- Arrange with his general practitioner to have full blood count and liver function test immediately and thereafter two-monthly, and arrange for the results to be copied to the committee.

Dr Hasil was also advised to remain off work until the Health Committee received assurance by way of the signed voluntary undertaking, that the appropriate structures and safeguards provided by his supervision, monitoring and treatment were in place before a return to work would be endorsed. Further, that the undertaking must include a well-managed limited return to work plan that included:

- Arrangements to undergo monitored breath testing before starting medical duties each day. In the event of a positive test, he must agree not to work and make an appointment with his general practitioner. The results of the testing to be forwarded to the committee.
- Confirmation of the appropriate level of supervision of his practice and his practice supervisors being fully informed of his health concerns.
- Limited work hours with his employer to incorporate dedicated time off to attend treatment appointments and supervision.

The MCNZ Health Committee also requested that Dr Hasil have further review of his progress by the independent psychiatrist at the end of January 2007.

On 17 November 2006, the independent psychiatrist informed the MCNZ that he received the New South Wales Board-nominated psychiatrist's report from the New South Wales Medical Board dated 12 January 2006 and that he did not need to change any of his earlier findings or recommendations.



**APPENDIX 8: LAPAROSCOPIC STERILISATION AUDIT  
REPORT**



**LAPAROSCOPIC STERILISATION  
AUDIT REPORT**

**1 MARCH 2007**

Laparoscopic sterilisation audit – March 2007

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## Executive Summary

This audit was conducted as a result of a patient complaint regarding failed sterilisation. The purpose of the audit was

- to identify how many patients had become pregnant following laparoscopic sterilisation by a particular obstetrician and gynaecologist
- to assess the standard of documentation in relation to evidence of counselling, informed consent and comprehensive operation records
- to determine where possible using photographic evidence that the filshie clips were correctly placed

The audit was conducted by two consultant obstetrician and gynaecologists and identified that five women had become pregnant following the procedure. Four of these women had terminated their pregnancy, three had been re-sterilised by other obstetrician and gynaecologists and one was considering termination. One woman continued with the pregnancy and was re-sterilised after the birth of her child. The audit established that the obstetrician had performed 32 procedures giving a failure rate of 16.25%. This is well outside the accepted failure rate of 0.2% for sterilisations using filshie clips.

## Audit methodology

Two independent obstetricians and gynaecologists conducted the audit on 24 and 25 February 2007 using an audit checklist which had been agreed with them prior. The audit checklist was based on the Royal College of Obstetricians and Gynaecologists (United Kingdom) recommendations for non negligent sterilisation. The auditors assessed each women's health record looking for evidence of clear contemporaneous documentation including adequate counselling regarding failure rates, provision of written patient information regarding sterilisation, evidence that both tubes were clearly identified and that the filshie clips were applied at the tubal mid isthmic site, perpendicular clip alignment, complete tubal lumen encapsulation, clear documentation of checking the procedure after clip application. At the conclusion of their audit the auditors met and compared findings.

## Audit Findings

The table below illustrates the findings.

The audit established that there were 5 failures occurring within a post surgery timeframe of 3-10 months. As these failures occurred within 12 months this indicated that operator error was the most likely cause<sup>1</sup>.

Five of the thirty two women's initial outpatient assessment had been conducted by other medical officers. Mr Hasil then took over these women's care and performed their sterilisations. There were significant deficits in Mr Hasil's documentation. Only 33% of the records completed by Mr Hasil had evidence that the women had been counselled. 60% of the records had evidence of informed consent. All of the operation notes described both tubes were identified, however four the photos indicated that the clips were incorrectly placed. None of the operation notes indicated that the clips were placed correctly. The auditors noted that the clips appeared to be placed very laterally. The standard of the photos was variable resulting in the auditors being unable to reach a conclusion as to correct placement of the clips in ten cases.

Documented evidence of:	Yes	No	Uncertain
Counselling re: failure rate	9 = Mr Hasil 5 = other medical officer	18	
Informed consent	16 = Mr Hasil 5 = other medical officers	11	
Operation note describes both tubes identified	31		
Operation note states clips placed correctly	0	31	
Photo shows correct placement* <b>one record no photos</b>	17	4	10

1. "Failed sterilisation: Evidence Based Review: Medico Legal Ramifications" British Journal of Obstetrics and Gynaecology, December 2004, Vol. 111, pp.1322-1332

Laparoscopic sterilisation audit – March 2007

---

## **Conclusion**

The audit established that there were significant deficits in this practitioner's documentation and that this practitioner's laparoscopic sterilisation failure rate is well outside the accepted range. Due to the high risk of failure the 27 women who had not conceived to date were to be individually contacted, advised to discuss contraception with their primary care provider and offered an urgent outpatient consultation with a gynaecologist.

[...]

Project Manager Obstetrics and Gynaecology  
1.3.2007

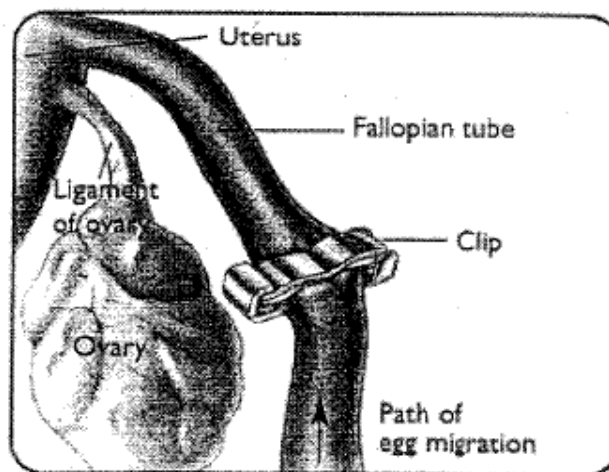
## APPENDIX 9: LAPAROSCOPIC STERILISATION OVERVIEW

Laparoscopic sterilisation surgery (or tubal ligation) is a procedure carried out on women who want permanent contraception. It is generally regarded as a relatively straightforward procedure with a small risk of failure.<sup>74</sup>

The Gynaecology clinic at Wanganui Hospital hands out information on sterilisation, which includes the Family Planning Association's pamphlet on sterilisation and the RANZCOG pamphlet, "Tubal Occlusion and Vasectomy: A Guide about Female and Male Sterilisation"<sup>75</sup> (see extract below). The RANZCOG pamphlet states that for every 1,000 women who have a tubal occlusion, about one or two may become pregnant over the next year, and the failure rate for each method is about the same. The United Kingdom Royal College of Obstetricians and Gynaecologists states that the risk of failure at ten years is 2 to 3 per 1,000 procedures when using the Filshie clip.<sup>76</sup>

### *Extract*

Laparoscopic tubal occlusion is a permanent method of birth control for women. It is achieved by an operation to permanently block both Fallopian tubes, which prevents sperm from fertilising an egg.



After tubal occlusion, each fallopian tube is permanently blocked, and sperm cannot reach an egg.

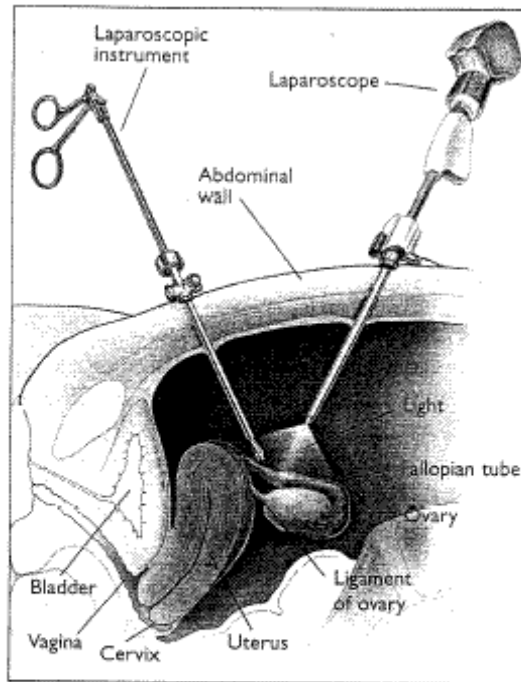
<sup>74</sup> In November 2007, the RANZCOG Women's Health Committee published guidelines on Filshie Clip sterilisation, available on RANZCOG's website at <http://www.ranzcog.edu.au/publications/statements/C-gyn22.pdf>.

<sup>75</sup> The Royal Australian and New Zealand College of Obstetricians and Gynaecologists *Tubal Occlusion and Vasectomy: A Guide about Female and Male Sterilisation*, Australia, RANZCOG, 23 February 2004, p 2.

<sup>76</sup> The Royal College of Obstetricians and Gynaecologists *Male and Female Sterilisation* (London, RCOG Press, 2004) cited in Royal College of Obstetricians and Gynaecologists, "Failed sterilisation: evidence-based review and medico-legal ramifications" *BJOG: An International Journal of Obstetrics and Gynaecology*, (2004) 111: 1322–1332.

The gynaecologist makes a small incision close to the lower edge of the navel and inserts a long, thin instrument with a light and viewing lens called a laparoscope. The laparoscope allows the gynaecologist to see inside the abdomen. This is often called “key-hole surgery”. The bladder may be emptied with a urinary catheter placed in the urethra.

Carbon dioxide gas is passed into the abdominal cavity to slightly inflate the abdomen. This lifts the abdominal wall so the Fallopian tubes, uterus, ovaries and other organs are separated and can be seen clearly. An instrument is usually placed in the uterus, through the vagina, so pelvic organs can be manipulated during the procedure.



A laparoscope is inserted through a small cut in the abdomen and passed into the abdominal cavity. Surgical instruments are inserted into the abdomen, and clips, rings or diathermy are used to block the fallopian tubes. The skin incision is then closed.

The gynaecologist may insert an instrument for closing the tubes, usually through a second small incision near the pubic hairline. Several methods may be used to block both Fallopian tubes during laparoscopy:

- clamping each with a clip
- applying plastic rings around the tubes
- using diathermy to burn the full thickness of the tubes and close them.

After removing the laparoscope and any other instruments, the gynaecologist may close the skin incisions with a few stitches or clips. Because the incisions are small, the scars will be hardly noticeable. Laparoscopic tubal occlusion usually takes about 30 minutes.

*Dr Hasil's usual practice*

Dr Hasil explained his usual practice in performing laparoscopic sterilisation surgery. He stated:

“My procedure for performing these operations was as follows:

1. I would check the papers to identify the patient.
2. I would make a 2 portal laparoscopic entry with a 10mm Troacar in the umbilical region, and inflate the abdomen. I would make small incisions using a 5mm Troacar approximately 2cm above that. Unfortunately I found, when performing the laparoscopic procedures, that there was always something missing — usually the 5mm or 10mm Troacar. These would be then located and the procedure would continue.
3. In Australia, before putting the Filshie clips into the applicator, the nurses would demonstrate to me that the clips were closing properly. In Wanganui the nurses did not follow this procedure, but put the clips straight into the applicator. In Australia they would check this in front of me.
4. The application of the clip would be watched by all in theatre. In order to effectively clip the tube, you have to get to the end of the tube and then follow it on until you get to the uterus and then clip the Filshie clip on.
5. My practice is to apply the clip on the right side first approximately 2.5cm from the uterine cords, and perpendicular. When I squeeze the applicator and it clips on, I would then lift the applicator. I cannot undo it. Once I have applied the clip I check it, and then move to the other side, and complete the same routine. I have not had anything but a normal failure rate either in Europe or Australia. At the end of the application of the clips, I would take a photo on both sides. I would then remove the applicator and close and finish. The gas would then be released, and often the junior doctors would close the wound. Sometimes there was no paper in the camera, and a photograph could not be taken, but it was certainly standard practice for me to do so.
6. When I gave informed consent to a patient, I would advise them that they could get pregnant and that the risk rate was 1:200. I also advised patients that if they missed a period they were to immediately go to their GP, and/or come back to me. I also, as part of my usual practice, advised the patient to go and get a pregnancy kit if pregnant and to come back to Whanganui DHB because the pregnancy could be outside the uterus.”

*Further comments*

Dr A noted that the technical difficulty of the tubal ligation procedure is the laparoscopy and not putting the clips on the Fallopian tubes. However, unless there have been previous complications in the pelvis, it is relatively straightforward, but takes a degree of care to ensure that the clips are placed correctly.

Dr A explained that photographs are taken during the operation so that if a woman falls pregnant, it can be determined whether the clip is in the correct place. Dr B explained that the photograph is “to document medico-legally that the clips are properly applied”, but that “there’s no real clinical reason for doing it”. If the photograph defines the anatomy, it is possible to see exactly where the clip has been placed. Dr B’s usual practice during the operation is to take a close-up photograph of the Fallopian tube and clip, and then turn the Fallopian tube up the other way to demonstrate that it has been completely occluded by the clip. Dr B takes four photographs in total, two on each side — two close-up and two panoramic shots.

Dr B often asks other members of the operating team to view the monitor to look at the placement of the clips. He explained that, whether or not a photograph is taken, the pause gives the surgeon some extra time to carefully check the placement of the clip.



## APPENDIX 10: INDEPENDENT ADVICE TO COMMISSIONER

The following expert advice was obtained from Dr Ian Brown, a former obstetrician and gynaecologist then working as Director of Medical Services at Northland District Health Board.

“I have been asked to provide an opinion to the Health and Disability Commissioner on case number 07/03504.

I have read and agree to follow the Commissioner’s Guidelines for Independent Advisors.

My qualifications are:

MB.BS	1967, London
MRCOG	1972
FRCOG	1983
FRANZCOG	1998
MRACMA	2004

My employment history following vocational registration is outlined below:

Aug 2005–Present	Director Medical Services Northland District Health Board
2001–2005	Chief Medical Officer Counties Manukau District Health Board
1999–2001	Deputy Chief Medical Officer Counties Manukau District Health Board
1997–2001	Clinical Director — Women’s Health Counties Manukau District Health Board
	Honorary Associate Professor University of Auckland
1993–1997	Clinical Director — Obstetrics & Gynaecology King Fahad Armed Forces Hospital, Saudi Arabia
1992–1993	Visiting Professor, Department of Obstetrics & Gynaecology University of Bristol, United Kingdom
1985–1992	Obstetrician & Gynaecologist Private Practice, Harare, Zimbabwe
	Honorary Senior Lecturer, University of Zimbabwe

1979–1984	Professor of Obstetrics & Gynaecology University of Zimbabwe
1973–1979	Lecturer and then Senior Lecturer University of Zimbabwe

I have reviewed the supporting information supplied on 7 August 2007 and 6 September 2007 (attached).

### **Supporting Information**

The supporting information is as follows:

#### **Part A** (pages 1–191)

- summary of key events (1–11)
- complaint from [Patient A] (sent to you on 28 March 2007)
- complaint from [Patient B] (sent to you on 28 March 2007)
- complaint from [Patient M] regarding lack of follow-up care (12–14)
- Whanganui DHB’s response to the inquiry dated 12 April 2007 (sent to HDC on 16 April 2007)
- information from Whanganui District Health Board following interviews conducted on 3 and 4 May 2007 and 8 June 2007 (15–130)
- information from Whanganui DHB regarding the staffing issues in the Department of Obstetrics and Gynaecology between 8 August 2005 and 5 March 2007 (131–180)
- Dr Hasil’s response to the inquiry dated 27 July 2007 (181–189)
- [Dr A’s] response to the inquiry dated 21 May 2007 (190–191)
- information from the Medical Council of New Zealand (sent to HDC on 30 April 2007)
- information from the Medical Council of New Zealand’s Health Team (sent to HDC on 1 May 2007)

#### **Part B** (pages 1–427)

- record of interview with:
  - [...], Elective Services Manager (1–24)
  - [...], General Manager Human Resources (25–53)
  - [Nurse A] (54–103)
  - [Manager C], Project Leader — Paediatrics, Obstetrics and Gynaecology (104–126)
  - [Clinical Nurse Manager, Operating Theatre] (127–158)
  - [Service Manager A], Surgical and Support Services Manager (159–190)
  - [Dr C], Medical Advisor (191–224)
  - [Clinical Audit Co-ordinator] (225–235)
  - [Midwife D at a nearby rural health centre ] (236–250)

- [Dr D], Anaesthetist and Clinical Director of Surgical and Support Services (251–278)
- [...], Clinical Nurse Manager, Outpatient Department and Surgical Day Unit (279–297)
- [Service Manager B], former Service Manager, Community and Rural Services (298–316)
- [Dr A], Obstetrician and Gynaecologist (317–362)
- [Midwife A] (363–371)
- [Dr Hasil's support person] (372–382)
- [Midwife C], Registered Midwife (383–390)
- [Dr B], Obstetrician and Gynaecologist (391–418)
- [Referee A] (419)
- [Referee C] (420–421)
- [Referee H] (422–423)
- [Referee B] (424–425)
- [...], Executive Officer, Lismore Base Hospital (426–427)

### **Part C (pages 1–1442)**

- Whanganui District Health Board's clinical records of the [patients who had a laparoscopic sterilisation performed by Dr Hasil]:

### **Supporting Information**

#### **Patient C**

- Letter from Whanganui DHB dated 31 July 2007 enclosing copies of memoranda and other documentation from [Dr A] and others to management and/or the Board between 8 August 2005 and 5 March 2007 regarding the staffing issues in the Department of Obstetrics and Gynaecology (pages D1–50)
- Letter from Whanganui DHB dated 20 August 2007 enclosing minutes of the obstetric and gynaecology departmental meetings, the obstetric and gynaecology department/management meetings, and the Maternal and Perinatal Review Committee meetings held in 2005 and 2006 (pages D51–134)
- Complaint from [Patient C] dated 2 July 2007 and file notes of subsequent telephone conversations with [Patient C] (3 July and 4 September 2007) (pages D135–138)
- Whanganui DHB's response to [Patient C's] complaint and clinical records of [Patient C] (pages D139–209)
- Letter from [Patient C's general practitioner] dated 24 August 2007 and relevant clinical records (pages D210–219)
- File note of telephone conversation between HDC and [Referee B] dated 16 May 2007 (pages D220–221)
- File note of meeting with [the recruitment agent] on 7 May 2007 and subsequent correspondence between HDC and [the recruitment agent] (pages D222–225)

## **Expert Advice Required**

### **Dr Roman Hasil**

#### *[Patient A]*

1. Was Dr Hasil's preoperative assessment of [Patient A] appropriate?

Dr Hasil's initial outpatient assessment was inadequate, with minimal clinical history, and no details of examination.

2. Please comment on the appropriateness and adequacy of the information provided to [Patient A] about the laparoscopic sterilisation procedure.

A general consent form was signed at the assessment visit but there is no evidence on the form related to specific complications, including failure. It is normal practice to document the key complications of the procedure — in particular, the risk of failure. I understand that there are information pamphlets available which outline the complications, but there is no evidence of this being provided to the patient.

3. Did Dr Hasil perform [Patient A's] laparoscopic sterilisation operation with reasonable care and skill in accordance with professional standards?

In retrospect, the probable answer to this question is no. However at the time the clinical record describes an uncomplicated process and there are clinical photographs available of the tubes, although it is not possible to be certain that both tubes are occluded. It should also be noted that nursing staff and observing doctors commented that his surgery tended to be rushed — an issue that had been noted by his supervisor, and raised in discussion with him.

#### *[Patient B]*

4. Was Dr Hasil's preoperative assessment of [Patient B] appropriate?

The initial outpatient assessment was very poorly documented but there is evidence of a very brief history and examination.

5. Please comment on the appropriateness and adequacy of the information provided to [Patient B] about the laparoscopic sterilisation procedure.

The Request and Agreement to Consent form was signed by Dr Hasil and [Patient B], but there is no mention of a discussion related to complications — including failure. There is however a comment in the nursing assessment notes on the day of surgery, commenting on a good understanding of the procedure and of the laparoscopic sterilisation booklet.

6. Did Dr Hasil perform [Patient B's] laparoscopic sterilisation operation with reasonable care and skill in accordance with professional standards?

The operation was not straightforward as it was noted during the procedure that the right Filshie clip was partly on the meso-salpinx and not positioned correctly. The clip was removed and this was associated with some bleeding.

The bleeding was stopped and a second clip was placed on the tube. There is no evidence in the notes of any other complications during the procedure. We do not know however that the second clip was also not applied correctly as this was clear when the second procedure was undertaken on 26 February 2007. The first procedure was therefore not undertaken with reasonable care and skill.

7. Was Dr Hasil's postoperative care of [Patient B] appropriate?

[Patient B] was kept in hospital overnight in view of the bleeding and ongoing discomfort. She was discharged the following morning. This was appropriate.

*Laparoscopic sterilisation procedures*

8. Overall were the laparoscopic sterilisation operations performed with reasonable care and skill in accordance with professional standards? (Please note patient operation records and photographs taken during operation.)

As we now know from the review undertaken by Whanganui DHB, and the high failure rate of the procedures undertaken by Dr Hasil, he did not perform these procedures with the appropriate skill. Interviews with theatre nursing staff show that he was rather rushed in his procedures and the operative photographs show that he tended to apply the clips more distally than recommended.

9. Please comment on Dr Hasil's failure rate of sterilisation procedures.

The review undertaken by Whanganui DHB of the sterilisations undertaken by Dr Hasil shows a failure rate of 25%. This is way above the accepted failure rate of 0.2% for sterilisations using Filshie clips.

*Other*

10. Please comment on the appropriateness and adequacy of Dr Hasil's record-keeping.

Dr Hasil's record-keeping was inadequate and did not meet the standard expected in New Zealand. Good Health Whanganui has a standard clinical record sheet for gynaecology patients which gives a clear structure for record-keeping. This was not utilised properly in any of the patient charts that I have reviewed.

11. Was the care provided by Dr Hasil of the standard expected in New Zealand?

See above.

12. Please comment on any other aspects regarding the adequacy and appropriateness of the care provided by Dr Hasil to patients at Whanganui Hospital, which you consider warrant additional comment.

The overall care that was provided by Dr Hasil was not adequate in the context of a New Zealand District Health Board. His record-keeping was poor and his decision making and treatment inconsistent. He was employed as a MOSS (Medical Officer) but was essentially functioning as a specialist or senior medical officer. He was under supervision as required of a provisional general

registrant, but he was not a trainee. His anticipation on employment was to study and learn so as to achieve his fellowship. The requirements of the hospital were for an obstetrician and gynaecologist to maintain the service requirements. The shortages of available SMO staff essentially forced him into the latter role.

### **Whanganui District Health Board**

1. Was Whanganui DHB's recruitment process of Dr Hasil appropriate? Please comment on the appropriateness of the interview and reference checking process.

The Whanganui District Health Board recruited Dr Hasil through a recruiting agency. There was no formal interview by the DHB but verbal reference reports were undertaken by the agency, who also advised and arranged for the Medical Council of New Zealand interview.

An interview with [Dr A] was held on 21 June to assess Dr Hasil's suitability. I note that no record was made of this interview, but this would not be unusual. At Whanganui DHB it was then the role of the Credentialling Committee to verify Dr Hasil's qualification, training, experience and competence. This assessment occurs before appointment, and on paper.

It is unclear whether the reference checking occurred but it should have been done. The fact that the references were old and that they were, in the main, not from obstetricians should have been questioned.

There is also evidence that one verbal reference was given to the recruiting company from an obstetrician, and that the reference was not forwarded to the District Health Board. I would have expected that all references received by the agency would have been submitted to the District Health Board.

2. Was Whanganui DHB's credentialling of Dr Hasil appropriate? Please comment on the adequacy of the information he was credentialled on and whether further enquiries should have been made.

Whanganui DHB credentialling processes were appropriate as part of a recruitment and appointment exercise but essentially only approved him as credentialled with a broad scope of practice which, in Dr Hasil's case, was a provisional general scope working in obstetrics and gynaecology under supervision. The Credentialling Committee confirms the registration status of the doctor and reviews the references, but does not meet with the doctor on appointment and did not, at the time of Dr Hasil's appointment, undertake a more detailed procedural credentialling process which would have given an opportunity to assess specific procedures and identify areas where further training or specific supervision may be needed — in other words, a specific procedural scope of practise within the organisation. The process of credentialling throughout New Zealand is still evolving and the process in place in Whanganui in 2005 would have been similar to that of many other DHBs in New Zealand.

3. Was Whanganui DHB's induction and orientation of Dr Hasil appropriate?

The induction and orientation plan included a week long process covering most of the key issues relevant to a new international graduate. This would be a more thorough process than that used in many other DHBs. However there is no evidence that it actually happened. I suspect that this would have been a resourcing issue and that the demands of service got in the way of the week. Clearly this is unsatisfactory but the situation is the same in many other hospitals.

4. Did Whanganui DHB provide appropriate and adequate supervision of Dr Hasil? Please comment on the adequacy of the supervision reports.

The DHB has a supervision policy and there was a simple supervision plan outlined for Dr Hasil. It is important to note however that the responsibilities for doctors working under supervision lie with the supervisor, and the doctor working under supervision. The DHB's role is to facilitate this process by ensuring that enough time and resource is set aside for this to happen. This can be facilitated by DHBs with appropriate job sizing to allow time for this activity and by providing the appropriate technical support for audit, peer review, etc. Where there are already considerable staff shortages, this is very difficult to achieve. This is a problem for all DHBs, and Whanganui DHB would be in line with many others in this respect.

5. Did Whanganui DHB provide [Dr A] with appropriate and adequate support to allow [Dr A] to ensure that Dr Hasil was competent to practise?

I do not think that the DHB provided as much support as was needed to support [Dr A] in his supervisor's position, but again, this is a generic issue across DHBs rather than specific to Whanganui DHB. It is particularly difficult in small and medium sized DHBs to balance the clinical work required to provide service with the non-clinical time to provide adequate supervision (and other non-clinical activity).

6. Did Whanganui DHB respond appropriately and adequately to the concerns about Dr Hasil and, in particular, to the following:

- 1.1 The incidents involving Dr Hasil's use of alcohol;
- 1.2 Staff concerns;
- 1.3 Patient complaints;
- 1.4 The number of failed sterilisation procedures?

6.1 The first incident related to Dr Hasil's use of alcohol occurred on 24 March 2006. This was addressed promptly by the DHB and was discussed with the Medical Council through a phone call for advice from the [Medical Advisor]. The action taken by the DHB was also appropriate, considering the information known to them. It is however of concern that the Medical Council was on notice of the alcohol incident in Australia in April 2005 and this information was not shared at this point. The action of the DHB may have been different if they

had had this information. I believe that the initial action taken by the DHB was appropriate under the circumstances, but there should have been more active, ongoing support.

A further alcohol incident occurred on 31 May 2006. This was reported, but no action taken. In view of the previous incident in March, I think that further supportive action should have been taken at this point.

The third alcohol incident occurred on 5 October 2006. Following this incident, Dr Hasil was placed on sick leave and received the appropriate treatment.

I do not believe that Whanganui DHB did respond adequately to the earlier alcohol issues — particularly as there did not appear to be a plan for ongoing support and monitoring following the first incident. It is likely that his inappropriate alcohol use significantly contributed to his clinical judgement.

- 6.2 Staff concerns — there were several concerns about Dr Hasil raised by staff through incident reports and through discussion with [Dr A]. These issues covered both technical and behavioural aspects of his care. There were particular concerns raised by Outpatients. Although note seems to have been taken about these issues there was no evidence of a systematic response to address them.
- 6.3 Patient complaints — specific patient complaints were responded to appropriately, but there is no clear evidence of processes to improve the issues — both individual and systematic — raised as a result of the complaints.
- 6.4 The number of failed sterilisation procedures — there does appear to be a failure to identify a pattern of failed sterilisation procedures, beginning in April 2005.
  - [Dr A] was aware of the first failure [Patient H] on 10 April 2006, and arranged for her to be seen by Dr Hasil. She did not proceed with a second operation.
  - The second case was identified on 11 April 2006 and was followed up by [Dr A]. He met with Dr Hasil and discussed the issue with him.
  - The third case was identified by [Dr B] via a letter from the patient's GP in July 2006.
  - The fourth case was referred to Whanganui DHB by her GP for a repeat sterilisation on 10 November 2006. She was subsequently seen by [Dr B] on 9 February 2007.
  - Finally, the fifth case [Patient A] made a verbal complaint after recently discovering she was pregnant after a tubal ligation performed by Dr Hasil. Whanganui DHB began its investigation shortly after this complaint.

There was enough evidence through this process to have identified the failed procedures earlier. The first two cases were identified by [Dr A] in 2006 and he did follow up with Dr Hasil emphasising the importance of correct clip application. The second two cases were referred to [Dr B] from GPs in July and



November, although not seen by him until later. There is no evidence to suggest that [Dr B] was aware of the first two failures. In the absence of regular review and audit of procedures, the pattern of failed tubal occlusion was not appreciated until the DHB received a complaint related to a failed procedure in mid-February 2006. At this stage a full investigation was instigated, which was entirely appropriate.

7. Please comment on the appropriateness and adequacy of the systems in place to deal with performance issues, complaints and incidents regarding Dr Hasil.

Whanganui DHB has a clear and robust patient complaints policy, and it appears from the material available to me that in general this process is adhered to. The internal incident reporting process also appears to be functioning satisfactorily, although I have not seen the policy.

8. Did Whanganui DHB appropriately monitor Dr Hasil's performance during his employment?

There was not a formal process in place to monitor Dr Hasil's performance. He was supervised and had the opportunity to attend the regular obstetric and gynaecology quality and team meetings, but his attendance at these were irregular and formal peer review did not occur. An assumption was made that he was capable of functioning at an SMO level, and in effect was functioning as an SMO. No formal performance or quality objectives were established, but in fairness, this does not occur regularly at SMO level nationally.

9. Did Whanganui DHB appropriately audit Dr Hasil's procedures during his employment?

Whanganui DHB did not audit Dr Hasil's procedures until the issues related to his performance were raised. During his employment there was discussion with his supervisor, and he met with his superior to discuss issues of appropriateness of diagnoses and treatment, but it was not until he had stopped working that a more formal assessment was made by [Dr B].

10. Did Whanganui DHB appropriately contact the Medical Council of New Zealand when concerns about Dr Hasil came to light?

Whanganui DHB did contact the Medical Council when the concerns related to alcohol were raised. The DHB also contacted the Medical Council when the issue of failed sterilisations came to light.

11. Whanganui DHB became aware of four failed sterilisation procedures by November 2006. Please comment on the adequacy and timeliness of Whanganui DHB's response.

Although individuals in the DHB were aware of the failed sterilisations, I can find no evidence that the DHB was aware at that stage. [Dr A] was aware of two cases and had discussed the first of these with Dr Hasil. [Dr B] was also

aware of two others via communication from GPs from September 2006, but I cannot find any evidence that he was aware of those known to [Dr A] (see 6.4).

12. Was there appropriate clinical and social support available to Dr Hasil during his employment at Whanganui DHB? Please comment on the adequacy of the steps taken to provide support.

Overall I don't believe that there was enough clinical and social support available under the circumstances. It is important to note that Dr Hasil was working under considerable stress, with social and family problems, and that his work load was considerable. He was also working a 1 in 2 roster for much of the time. He was provided with good professional advice and support from [Dr A] in the early part of his employment, but in retrospect it would have been preferable to have had a greater level of support once some issues (particularly the use of alcohol) had been identified.

13. Was the care provided by Whanganui DHB in relation to the laparoscopic sterilisation procedures performed by Dr Hasil of the standard expected in a New Zealand hospital?

The equipment and staffing in theatre was of an appropriate standard, and the recalibration process was up to date, with the next service due by 24 August 2007. The theatre staff were experienced and all new staff orientated to laparoscopic surgery.

14. Please comment generally on the systems in use at Whanganui DHB, and whether there are any systemic issues you believe contributed to the failed laparoscopic sterilisation procedures. Please comment on the timeliness of Whanganui DHB's response.

Overall I think that the systems used in Whanganui DHB are satisfactory, although (as in many other DHBs) strengthening the clinical governance systems would reduce the possibility of recurrence of such incidents. It is likely that the failures of the sterilisation procedures themselves were related to the impairment of the surgeon himself. I have commented [in relation] to the timely identification of the pattern of failures, and I think that these would have been identified earlier if the appropriate audit procedures were in place. The DHB's response was appropriate once the issue was appreciated but the trend could have been picked up earlier.

15. Were the steps taken by Whanganui DHB to identify and follow up Dr Hasil's patients appropriate?

The steps taken to follow up the patients who had been sterilised by Dr Hasil were appropriate, in my view.

16. Please comment on the appropriateness of the changes that have been made to Whanganui DHB's systems as a result of the failed sterilisation procedures.

The response from Whanganui DHB following the audit of Dr Hasil's laparoscopic sterilisation procedures was prompt and appropriate, and follow-

up actions were taken for all patients. The processes undertaken in theatre were outlined during the review and appeared appropriate. I am unable to identify any specific changes which have been implemented as a result of the review.

17. Please comment on any other matter you consider relevant regarding the adequacy and appropriateness of the steps taken by Whanganui DHB to ensure that Dr Hasil was competent to practise.

I have previously commented on the issues of credentialling and supervision, which are the key issues in this context. Both of these processes need to be appropriately resourced and this is extremely difficult in an environment of significant workforce shortages. Whanganui DHB had processes for both of these activities and the supervision provided in the early part of Dr Hasil's employment was close and effective. As the workforce issues became more acute, the stresses on those still working increased, and effective supervision became more difficult for all parties. The only practical solution was to take a more regional approach to the workforce, which I understand is now under way.

**[Dr A]**

1. Please comment on the appropriateness and adequacy of the steps taken by [Dr A] to recruit Dr Hasil and to ensure that he was competent to practise.

[Dr A] did take appropriate steps to recruit Dr Hasil, and these issues are further considered under Whanganui DHB question 1. He did have a phone interview with Dr Hasil but did not personally phone the referees. This had been done by the recruitment agency. The Credentialling Committee also reviewed his qualifications and referee reports, and 'credentialled' him to work in the hospital. [Dr A's] role was ensuring that Dr Hasil was competent to practise relates to his supervisory role, which is covered in the next question.

2. Please comment on the appropriateness and adequacy of the steps taken by [Dr A] to supervise Dr Hasil.

Supervisors are agents of the Medical Council and are required to take appropriate steps to do the things that the Council expects of them. If they become aware of deficiencies in a doctor's practice they have a responsibility to report these to the Council and take steps to ensure that patients are not put at risk. The Council has guidelines related to the supervisor's responsibilities as well as the doctor who is under supervision. The supervisor is expected to meet the doctor daily for the first week, weekly for the first three weeks, and monthly thereafter. [Dr A] did supervise even more frequently than this in the early months of the supervision, holding regular meetings and spending time with Dr Hasil in theatre, observing and assisting with procedures. Dr Hasil worked with him on at least six lists and with [Dr B] and [the third consultant] on at least two occasions. His contact in Outpatients was less frequent and there is less evidence of close supervision as time goes by. His involvement was within the Council guidelines but there is no doubt that close and more consistent supervision would have been ideal. However in the context of acute staff

shortages and other supervision responsibilities undertaken by [Dr A], I think that the level of supervision would be much the same as that provided in many other DHBs.

3. Please comment on the appropriateness and adequacy of the steps taken by [Dr A] to audit Dr Hasil's practice.

In the role of supervisor, [Dr A] would not specifically audit Dr Hasil's practice but rather endeavour to ensure that his supervision plan was effectively implemented. This would have involved a weekly team meeting, peer review over a month, the Obstetric Standards Review Committee meeting and the quarterly Perinatal Review meeting. Although these meetings should have run regularly, it seems that they did not always occur and not all staff were able to attend.

4. Did [Dr A] respond appropriately and adequately to the concerns about Dr Hasil and, in particular, to the following:
  - 4.1 The incidents involving Dr Hasil's use of alcohol;
  - 4.2 Staff concerns;
  - 4.3 Patient complaints;
  - 4.4 The number of failed sterilisation procedures?

I have responded to these issues under the Whanganui DHB section.

5. Please comment on any other aspects regarding the adequacy and appropriateness of the steps taken by [Dr A] to ensure that Dr Hasil was competent to practise, which you consider warrant additional comment.

### **Patient C**

...

1. Was Dr Hasil's pre-operative assessment of [Patient C] appropriate?

[Patient C] was referred to Dr Hasil by the surgeons with ongoing and progressing iliac fossa pain. She was seen by him on 25 August 2005. There is a very brief clinical history in the clinical notes. The recording of the past clinical history is inadequate, and little comment is made related to the nature of the pain. He found no obvious abnormalities on pelvic examination. He commented in his letter to the GP that a CT scan had identified a cystic lesion measuring 8 x 6cm in the left pelvis. On the basis of these observations he appropriately asked for an ultrasound scan and tumour markers. The ultrasound finding showed a cyst on the left ovary measuring 5 x 4 x 3cm with high vascularity and although the tumour markers were negative, I think on balance that it was reasonable to proceed with a laparoscopy/laparotomy and adhesiolysis, and possible bilateral oophorectomy.

2. Please comment on the appropriateness and adequacy of the information provided to [Patient C] about the bilateral salpingo-oophorectomy and adhesiolysis procedure. What information should Dr Hasil have provided [Patient C] about the procedure?

There is no evidence in the notes related to a detailed discussion with [Patient C] of the effects of bilateral oophorectomy at any stage. It would be standard practice to inform any patient undergoing bilateral oophorectomy of the side effects, and this discussion would also involve the options for hormone replacement. The standard organisation consent form signed by both [Patient C] and Dr Hasil confirms the procedure as laparotomy/laparoscopy +/- bilateral oophorectomy but it is not possible to say whether any discussion occurred related to the consequences. There is also no comment in the follow-up notes related to the issue of the effects of removing both ovaries, and no comment related to hormone replacement therapy.

Dr Hasil should have discussed the potential outcomes of the procedure in more detail. These should have included:

- (a) the likelihood of improving her main complaint (left iliac fossa pain)
- (b) the details of the operation to be performed
- (c) the possible risks of the procedure, including bleeding and possible damage to other organs in view of the known adhesions
- (d) the effects of removing the ovaries.

3. Did Dr Hasil perform [Patient C's] operation with reasonable care and skill and in accordance with professional standards?

The technical aspects of the operation appear to have occurred appropriately and have been carried out with appropriate care and skill.”

*Additional advice*

I sought clarification from Dr Brown on a number of points. He provided the following additional expert advice:

- “1. I refer to question 16 (page 13 of your advice) and the letter from Whanganui DHB dated 12 April 2007 in response to the inquiry. Under request 11, Whanganui DHB discusses changes to its systems as a result of this incident in the areas of human resources, complaints and incident management systems, and service audit and peer review. Do you have any additional comment in this regard?

Apart from the review directly related to the failed tubal ligations and the actions taken as a result of the review, the DHB has also commented on changes made (or that they are considering to make) as a result of the incident.

In the area of human resources, their proposals for centralising the administration of medical recruitment are appropriate but as I have mentioned elsewhere, the strengthening of the credentialling system is as important. The strengthening of the clinical governance system and increased support for IMGs [international medical graduates] is also welcomed.

An electronic Complaints & Incidents management system has already been introduced and appears to be functioning well now.

I note that some suggestions have been made for Service Accreditation and peer review. In fact, regular peer review meetings have been held in the past and I have seen the Minutes of these meetings. The key issue seems to me to ensure that all clinical staff can attend these meetings. It would also be very helpful to link with nearby DHBs for clinical meetings when possible. I assume that the development of a policy on the use of Alcohol/Drugs is underway, as suggested by the CEO.

2. Please comment on the appropriateness of a doctor registered within a general scope of practice providing specialist services and, in particular, Dr Hasil who was employed as a MOSS and providing specialist services at Wanganui Hospital.

The only doctor who can call himself a specialist must be registered with the Medical Council of New Zealand, within a vocational scope of practice. Hospital doctors who are not vocationally registered and are not in a formal specialist training programme are either non-training registrars or hospital medical officers. These doctors are registered under a general scope of practice and are either under supervision (as was Dr Hasil) or in a collegial relationship as prescribed by the Medical Council of New Zealand. Dr Hasil was employed as a MOSS (hospital Medical Officer) within a scope of practice of Obstetrics and Gynaecology. It would be appropriate for him to undertake the activities and procedures for which he was credentialled, but he could not be considered a specialist.”

## APPENDIX 11: DEVELOPMENT OF MEDICAL WORKFORCE IN NEW ZEALAND

New Zealand, like other western countries, is facing an increase in demand for doctors. This is primarily caused by the effects of population aging and changes to employment conditions. Most countries are using two broad strategies to address these issues — train more doctors and recruit doctors trained overseas.<sup>77</sup>

A substantial amount of work has been, or is being, undertaken on the health workforce in New Zealand. The Health Workforce Advisory Committee (HWAC) was set up under the New Zealand Public Health and Disability Act 2000 to advise the Minister on workforce issues.

District Health Boards New Zealand (DHBNZ) has developed a collaborative workforce development framework based on a workforce action plan that focuses on information, relationships and strategic capability. The DHB/DHBNZ Future Framework (developed in 2005) has identified future workforce need and priorities for action. Work has also been done in the education sector, notably by the Tertiary Education Commission (TEC) on the funding of undergraduate medical programmes and the Clinical Training Agency (CTA) on vocational training for general practitioners.<sup>78</sup>

During 2005–2006 the Medical Reference Group of HWAC and the Doctors in Training Workforce Roundtable undertook extensive work on the medical profession which concluded in two reports to the Minister of Health, *Fit for Purpose and for Practice* and *Training the Medical Workforce 2006 and Beyond*.<sup>79</sup>

Key points from these two reports are set out below:<sup>80</sup>

- There is an overall shortage of medical practitioners, evidenced by the use of locums and reliance on overseas-trained doctors, which will be exacerbated in the future as the population ages and competition for medical practitioners increases in the international market.
- There is a “misdistribution” of the available medical workforce, with rural and non-metropolitan areas finding it increasingly difficult to recruit and retain doctors. Maori and Pacific Peoples are currently under-represented in the medical profession in New Zealand. Those from lower socio-economic backgrounds are also under-represented.

<sup>77</sup> Medical Reference Group, Health Workforce Advisory Committee (2006) *Fit for Purpose and for Practice: Advice to the Minister of Health on the issues concerning the medical workforce in New Zealand*, Wellington, Health Workforce Advisory Committee, p 3.

<sup>78</sup> See Ministry of Health (2006), *Health Workforce Development: An overview*, Wellington, Ministry of Health, which draws together an overview of health workforce development in New Zealand since 2000.

<sup>79</sup> Medical Reference Group, Health Workforce Advisory Committee, op cit; Ministry of Health (2006) *Training the Medical Workforce 2006 and Beyond*, Wellington, Ministry of Health.

<sup>80</sup> Workforce Taskforce (2007) *Reshaping medical education and training to meet the challenges of the 21<sup>st</sup> century: A report to the Ministers of Health and for tertiary education from the Workforce Taskforce*, Wellington, Ministry of Health.

There is a need for strategies to increase recruitment into medical schools from these groups.

- New Zealand needs to train more medical practitioners locally to meet the demand. To achieve this, the level of the cap on funded undergraduate medical places should be raised and further clinical training positions made available.
- The quality and relevance of medical education and training could be improved by greater continuity between undergraduate medical education and subsequent clinical training and increased responsiveness of the whole system to the needs of the health sector.
- The health sector is complex, and there are many players involved in educating and training medical practitioners. There is a need for a central body to co-ordinate and oversee medical education and training.
- The difficulties for training and clinical settings created by the inherent tension between service delivery and training needs, the changing service delivery patterns in public hospitals and the implications of industrial agreements over the last 20 years are putting pressure on the current apprenticeship model.

In September 2006, the Minister of Health established the Workforce Taskforce as a standing committee to provide the Minister with advice on the implementation of actions needed to improve the capability of the health workforce to deliver services in the future. The initial task of the Taskforce was to advise the Minister of Health and the Minister for Tertiary Education on how to streamline the current medical education and clinical training arrangements to produce medical practitioners who are fit for purpose and for practice in the minimum time period.

The Taskforce considered the recommendations of the reports from the Medical Reference Group and the Doctors in Training Workforce Roundtable. The Taskforce received submissions and invited presentations from a range of interested parties.

In its report, the Taskforce indicated that most of the problems identified were not new, but were becoming more apparent and needed to be addressed more urgently as pressures on the health system increased. The Taskforce looked at why, given the consistency of expert advice, there have been no effective changes.

The Taskforce concluded that faced with the uncertainties inherent in long-term workforce development, it is important to have effective and responsive leadership. The report made five recommendations as the first step toward making changes that will result in a sustainable medical education and training system to produce medical practitioners who are fit for purpose and for practice in the minimum time period. The recommendations cover the following areas:

1. oversight and implications of the continuum of learning
2. commitment to ongoing self-sufficiency for the medical workforce
3. new roles and interprofessional collaboration



4. accountability for clinical training
5. increasing focus on generalism.

The Taskforce recommended that a Medical Training Board, involving providers of education and training and health care, be established to oversee medical education and training in New Zealand. The Taskforce's report was published in May 2007. In October 2007, the Minister of Health appointed Len Cook as Chair of the Medical Training Board. Mr Cook is a former Government Statistician of New Zealand and National Statistician of the United Kingdom, and was a member of the Workforce Taskforce.





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