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 *Wanganui 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.