ENT Specialist, Dr D

District Health Board
(now Te Whatu Ora)

A Report by the
Deputy Health and Disability Commissioner

(Case 20HDC00719)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a woman by an ear, nose, and throat (ENT) specialist and head & neck surgeon at a public hospital in 2019 and 2020.

2. In late December 2018, the woman was diagnosed with cancer in the thyroid gland. There was suspicion that the cancer had spread to her lymph glands. She had a nodule in her chest, but the precise nature of it was unclear.

3. The surgeon removed the woman's thyroid gland and performed a central neck dissection (excision of the lymph nodes).

4. The woman believes that the informed consent process was inadequate, and that she underwent unnecessary surgery. The woman has had ongoing complications, particularly relating to her use of her voice, which is of significant personal importance to her.

Findings

5. The Deputy Commissioner considered that the surgeon discussed the woman's condition and her options at a time when effective communication was impaired by her being affected by sedation. The surgeon was found to have breached Right 5(2) of the Code.

6. The Deputy Commissioner was critical of the surgeon's record-keeping, and also commented on his management of the woman's refusal of consent to having a sternotomy and not obtaining specific consent to perform a stroboscopy.

7. The Deputy Commissioner reminded Te Whatu Ora of the importance of the treating team taking a holistic view of a patient's needs. For the woman, this involved taking into account the personal significance of the use of her voice.

Recommendations

8. The Deputy Commissioner recommended that Te Whatu Ora review the thyroid multi-disciplinary documentation with a view to including specific comments about an individual patient's voice requirements, and audit a selection of the surgeon's clinical records with a view to assessing his compliance with the Medical Council of New Zealand guideline.

9. The Deputy Commissioner also recommended that Te Whatu Ora continue to engage with HDC's Director Māori and the woman to bring closure to this complaint through a hohou te rongo restorative process, after which, if still requested by the woman, the surgeon provide a written apology to the woman for his breach of the Code.

Complaint and investigation

10. The Health and Disability Commissioner (HDC) received a complaint from Ms A about the services provided by Dr D at a district health board (DHB) (now Te Whatu Ora Health New Zealand).[1] The following issues were identified for investigation:

- *Whether Dr D provided Ms A with an appropriate standard of care in 2019 and 2020.*
- *Whether the DHB provided Ms A with an appropriate standard of care in 2019 and 2020.*

11. This report is the opinion of Deputy Health and Disability Commissioner Vanessa Caldwell, and is made in accordance with the power delegated to her by the Commissioner.

12. The parties directly involved in the investigation were:

Ms A	Consumer
Ms B	Consumer support
Dr C	Provider/general practitioner (GP)
Dr D	Provider/ENT specialist and head & neck surgeon
Dr E	Provider/cardiothoracic surgeon
District health board	Provider

13. Further information was received from:

Dr F	Provider/laryngologist
DHB2	Provider
Medical centre	Provider

14. Also mentioned in this report:

Dr G	General and endocrine surgeon
Dr H	Registrar
Ms I	Speech and language therapist

15. Independent expert advice was obtained from an otolaryngologist, Dr Catherine Ferguson (Appendix A).

[1] On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, resulting in all district health boards being disestablished. Their functions and liabilities were merged into Te Whatu Ora — Health New Zealand. All references to the district health board in this report now refer to Te Whatu Ora.

Information gathered during investigation

Introduction

16. This report concerns the care provided to Ms A by an ear, nose, and throat (ENT) specialist and head & neck surgeon, Dr D, and the DHB, at Hospital 1 in 2019 and 2020.

17. In late December 2018, Ms A was diagnosed with papillary thyroid carcinoma (cancer in the thyroid gland — a butterfly-shaped gland located at the base of the neck). There was suspicion that the cancer had spread into the mediastinum (the area of the chest that separates the lungs). She had a nodule in her chest, but the precise nature of it was unclear. She was referred to Dr D, and was offered a total thyroidectomy (removal of the thyroid gland) and central neck dissection stage 6 (excision of the level 6 lymph nodes), with or without a sternotomy (a vertical incision along the sternum, after which the sternum is divided).

18. Ms A said that she was a performer.

19. Ms A said that her voice, particularly her upper register, was an important part of her life. She considers that her concerns were not addressed in a culturally appropriate manner, in that any loss of her voice would potentially impact her mana within her kapa haka group. She considers that Dr D under-appreciated these issues.

Multi-disciplinary meeting 24 January 2019

20. Ms A's case was discussed at a multi-disciplinary team meeting (MDM) on 24 January 2019, during which the members at the MDM reviewed the results of CT and ultrasound scans, as well as a pathology report from 24 December 2018, which showed that Ms A had:

1. a 20mm lesion on her right thyroid lobe that was a papillary thyroid carcinoma; and
2. a multinodular goitre on her left thyroid lobe, which extended into her upper chest.

21. The MDM members proposed a surgical treatment plan for Ms A comprising a total thyroidectomy (removal of the entire thyroid gland) and central neck dissection (removal of lymph nodes from the neck). Further investigation (imaging and biopsy) and referral to the Cardiothoracic Department was recommended regarding the mass in Ms A's chest.

22. Dr D was not present at the MDM because he was on leave. There is no evidence that the cultural issues relating to Ms A's voice were discussed.

23. In response to the provisional opinion, Ms A said that general and endocrine surgeon Dr G later told her that the recommendation for treatment is made by group discussion at the MDM, but the lead surgeon is responsible for ensuring that the decision is clinically appropriate, and has the responsibility to inform the patient.

Appointment 28 February 2019

24. On 28 February 2019, Ms A and a support person, Ms B, travelled to Hospital 1. Ms A had a fine needle aspiration (FNA[2]) to obtain a biopsy of the mass in her chest, and an endobronchial ultrasound (EBUS) bronchoscopy (a procedure used to diagnose different types of lung disorders, including inflammation, infections, or cancer).[3]

25. Ms A was given sedation before the procedures. The records show that she was given 100mcg of fentanyl and 5mg of midazolam between 10.50am and 11.40am on 28 February 2019. The consent form for the EBUS procedure specifically states that patients must not make critical decisions for 12 hours after the sedation for the procedure.

26. Ms A and Ms B initially saw registrar Dr H and then met with Dr D. The appointment time was 12.52pm.

27. In response to the provisional opinion, Ms A said that she and Ms B told Dr H that Ms A had just come out of the EBUS procedure. Ms A stated that she and Ms B do not recall the content of the discussion with Dr D.

28. Dr D told HDC that he discussed the fact that Ms A had a nodule in her right thyroid gland, confirmed to be a papillary thyroid cancer, and that there was a large left thyroid goitre (an irregular growth of the thyroid gland) extending into her upper chest. He said that they talked about the need to remove the entire thyroid gland because of the confirmed cancer in one lobe and the enlarged multinodular lobe on the other side. They also discussed the fact that Ms A's case was complicated by her having a mass in her chest (a mediastinal lymph node) that was thought to have originated in the thyroid, and there was a concern that it could be a malignancy that had spread from the thyroid gland.

29. Dr D said that the Cardiothoracic Department was managing treatment of the mass in Ms A's chest, and he was aware that cardiothoracic surgeon Dr E was considering whether it might be possible to remove the mediastinal node in conjunction with the proposed thyroid surgery.

30. Dr D said that he explained to Ms A that, as the mass in her chest was thought to have originated from the thyroid cancer, there was a concern that the cancer may have spread to the lymph nodes in her central neck compartment before it reached her chest. A neck dissection was therefore intended to remove this cancer. He said that he cannot recall everything that he said to Ms A but, in accordance with his "invariable practice", he would have advised her that thyroid cancer is primarily treated with surgery, and it was intended that the thyroidectomy and neck dissection would remove the cancer and achieve a cure. He stated that he would also have advised Ms A that not proceeding with the surgery would pose a real risk of the cancer growing and spreading.

[2] A fine needle aspiration (FNA) is a type of biopsy. It uses a very thin needle and syringe to remove a sample of cells, tissue, or fluid from an abnormal area or lump in the body.
[3] An EBUS bronchoscopy uses a flexible tube that is passed through the mouth and into the windpipe and lungs.

31. In response to the provisional opinion, Ms A said that she was not given the results from the preoperative imaging (CT[4]/PET[5]/chest scans), even though the results were available to Dr D prior to the meeting on 28 February. She stated that she was not aware that there was no evidence to support the need for a prophylactic lymph node neck dissection, or that generally it would not be recommended. She also said that she was not told that she would have to take calcium pills and vitamin D for the rest of her life, which has resulted in substantial expenses for prescriptions and doctor's visits. Ms A also told HDC:

> "I was not given sufficient information about the possible side effects of the surgical procedures, especially the complications that I have suffered over the past year. Furthermore, I was unaware that the central neck dissection was a preventative measure. If I knew that, I would have refused consent. I was denied the opportunity to make an informed decision and give informed consent."

32. Dr D said that he did not inform Ms A that the central neck dissection was a preventative measure because he did not consider that this was the case. He stated: "To my mind, both the neck dissection and thyroidectomy were intended to be curative of existing cancer."

33. Dr D told HDC that he discussed the potential complications associated with both procedures, including the risk of injury to the nerves supplying the larynx and the four glands (parathyroid) that control calcium metabolism. He said that he explained that damage to the nerves supplying the larynx could cause vocal cord paralysis, resulting in temporary or permanent hoarseness. With respect to the potential for damage to the parathyroid, he explained that this could cause decreased levels of calcium in her blood (hypoparathyroidism) which, in turn, could cause her to experience a tingling sensation, muscle cramps, or convulsions. He said that he assured Ms A that, after the surgery, she would be monitored for hypoparathyroidism and, if this occurred, it would likely be a temporary complication that could be treated with calcium supplementation.

34. Dr D stated that he remembers briefly discussing with Ms A that if Dr E attempted to remove the mediastinal node at the same time as the proposed surgery, there was a small risk of a major bleed, and, if this occurred, it would be necessary to open her sternum in order to access the chest cavity (a sternotomy) to address the bleed. Dr D also explained that a sternotomy could damage her laryngeal nerve and therefore her voice, and he told Ms A that Dr E would discuss with her the chest component of the surgery, including the possibility of a sternotomy, in greater detail. He said that Ms A told him that she wanted to avoid a sternotomy. He told HDC: "As the possibility of a sternotomy was unrelated to the thyroidectomy and neck dissection, I did not discuss this in further detail with [Ms A]." In response to the provisional opinion, Ms A said that she did not tell Dr D on that day that she wanted to avoid a sternotomy. She stated that she signed the consent form to have the sternotomy as well as the other procedures.

[4] A computerised tomography (CT) scan combines a series of X-ray images taken from different angles around the body, and uses computer processing to create cross-sectional images.
[5] Positron emission tomography (an imaging test to check for disease).

35. The consent form Ms A signed on 28 February 2019 states the procedure as "total thyroidectomy & neck dissection +/- sternotomy". The risks listed are "bleeding, infection, scar, hypocalcaemia, recurrent nerve injury-hoarseness, further treatment, lifelong thyroid hormone replacement".

36. Ms A said that she was asked to sign the consent form for the surgery not long after she had been sedated for the EBUS procedure. Ms B said that Ms A seemed to be "a bit incoherent", as she had just finished the EBUS procedure, but Ms A did question Dr D about how the operation would affect her voice and singing. Dr D told HDC that Ms A did not exhibit any signs of conscious sedation at the time he saw her, but he accepts that Ms A would still have been under the influence of her morning sedation at that time, so he should not have suggested that she sign some of the consent paperwork for the proposed surgery. He said that he did so to prevent her having to make another return trip from her home to Hospital 1. In response to the provisional opinion, Ms A said that she was not told that if she signed the consent to surgery procedures, she would save herself a return trip to the hospital.

37. Dr D stated that he assured Ms A that signing the paperwork did not preclude her from changing her mind about the surgery, and subsequently she asked questions about the surgery (in her emails of 8 March 2019 and 1 April 2019, and in their preoperative discussion on 8 April 2019).

38. Ms A said that she explained to Dr D the importance of her voice to her. She said that she was told that the cancer had spread from her thyroid gland, and, as a result, she gave consent for a thyroidectomy and central neck dissection, but she refused consent for the sternotomy and mediastinal clearance, as the risk to her voice was high. In response to the provisional opinion, Ms A said that she would not have consented to the surgery if she had not been sedated and if she had been given the correct information.

39. Dr D said that the consent documentation was completed by the registrar, Dr H, and he agreed that there is a lack of detailed documentation recording the risks that he discussed with Ms A, and the unique importance of her voice to her, both professionally and culturally. Dr D stated: "With the benefit of hindsight, I accept that this is the case and regret my contribution to this lack of documentation."

Preoperative work-up

40. Ms A said that as part of the preoperative work, she had a CT scan, EBUS, positron emission tomography and computed tomography (PET-CT) scan, and a trans-tracheal biopsy, none of which showed any suggestion of cancer spread outside the thyroid lobe, or concern regarding lymph node disease, and no lymph node disease was suspected at the time of surgery. Ms A said that she did not know any of this prior to the surgery, and she listened to what Dr D told her. Ms A said that Dr G later told her that "[t]he CT, CT/PET and endobronchial USS +FNA all showed confidence that the mediastinal nodule was benign".

41. Ms A believes that she was subjected to unnecessary tests, because PET imaging is not used in the algorithm of differentiated thyroid cancer, and the known papillary thyroid cancer did not have uptake on the PET scan.

MDM meeting 7 March 2019

42. Ms A was discussed at a second MDM on 7 March 2019, attended by Dr D. The results of the EBUS and FNA were available, as well as CT and PET-CT scans from mid-February 2019. The EBUS and the FNA of the mediastinal node came back negative for malignancy. Dr D said that it is not uncommon for an FNA to have a false negative result, and the cytology report for Ms A's FNA referred to the presence of occasional lymphocytes (white blood cells), which indicated a poor cellular aspirate. He said that lymphocytes are found in nodes, and can harbour cancer cells.

43. When the MDM reviewed the recent CT and PET-CT scans, it was thought that the chest mass may have originated in the thyroid. The MDM considered that the sample of the chest mass that had been biopsied might not accurately reflect the overall mass, as the cytology did not tie in with the clinical and radiological findings. Consequently, the MDM maintained its previous conclusion that the appropriate treatment plan for Ms A was a total thyroidectomy and central neck dissection, with the Cardiothoracic Department to consult on the possible surgical excision of the mediastinal node.

44. In response to the provisional opinion, Ms A said that subsequently when she sought a second opinion from Dr G, he told her that the preoperative imaging (CT/PET/chest scans) from 11 January 2019, 18 February 2019, and 20 February 2019 showed no evidence of extra thyroid disease and no evidence of pathological lymph nodes.

45. Dr D said that even if the MDM had been made aware of the importance of Ms A's voice to her, the advice would have been unlikely to have been different in order to avoid any risk to Ms A's voice, given the papillary thyroid cancer and the suspicion of metastatic carcinoma.

Contact with Dr D

46. On 8 March 2019, Ms A emailed Dr D. She stated:

> "... I understand that I gave consent to have a full removal of my thyroid. However yesterday I was told by [a nurse at DHB2] that I would also be having [an] exploratory operation. The issue that I have is that this was not what we discussed."

47. Dr D telephoned Ms A. He said that he explained to her that she had consented to a full thyroidectomy and central neck dissection, and that these procedures were not exploratory, as they were intended to cure her cancer by removing the thyroid gland and lymph nodes in her neck. In response to the provisional opinion, Ms A said that she did not talk to Dr D about a full thyroidectomy and central neck dissection, and they only spoke about the exploratory surgery, the sternotomy.

48. Dr D stated that Ms A asked for more information about the chest component of the operation. She indicated that this was the exploratory operation that she had queried in her email. He said he told her that Dr E would discuss this aspect of the surgery with her when she met with him later in the month.

49. In response to the provisional opinion, Ms A said that she communicated her views to Dr D in an email on 8 March and confirmed her refusal of the sternotomy on 1 April 2019. She said that Dr D could have told her the MDM meeting outcome on 8 March 2019 but he did not do so. She said that there were further opportunities to do so on 1 and 8 April 2019 but he did not inform her. She stated that these were relevant clinical notes that she should have been told about before signing/confirming the consent. She said that as a result she was not able to make an informed decision regarding the thyroidectomy and central neck dissection.

Consultation with Dr E — 28 March 2019

50. Ms A attended a consultation with Dr E on 28 March 2019 to discuss management of the chest mass, following which Dr E wrote to Dr D:

> "Today we had a look at her CT scan together and I explained to her that the endoscopic biopsy of the shadow in front of the trachea shows no cancer cell in itself but it is likely that, that area of the lump is continuous with the thyroid but we cannot be sure as the CT scan does not show any continuity."

51. Dr E told Dr D that he and Ms A had agreed that he would attempt to remove the mediastinal node through the neck incision as a combined procedure with the thyroid operation. Dr E said that he would abandon the procedure if the mass was very adherent to surrounding structures to avoid damage to the recurrent laryngeal nerve[6] and surrounding vessels.

52. On 1 April 2019, Ms A emailed Dr E about their consultation, stating that she did not consent to him removing the lump but she did consent to a sample being taken and for him to "see if there are any other lumps that you may foresee to be a future issue". Ms A wrote the following to Dr E and copied in Dr D:

> "… 1) I would like to confirm the following points in our meeting. I do not give permission to remove the lump beneath the thyroid because it has not been confirmed as benign or a major problem that would affect my long term health and wellbeing. 2) I do not give permission to remove the lump because the risks outweigh the benefits. The risks as explained are a long term raspy voice, and possible injury to veins and major blood vessels. 3) I give permission to take a sample of the contents of the lump so that we can confirm the status of its contents."

53. Dr E emailed Dr D stating that there was no reason to take a further sample of the mediastinal node (given the FNA that had been carried out previously) and, unless removal of the node was to be attempted, there was nothing for him to do. Dr D emailed Dr E to say that he would contact Ms A and get back to him.

54. Dr D told HDC that he decided to confirm Ms A's instructions regarding the removal of the mediastinal node in person when he sought her consent to proceed with the thyroidectomy and neck dissection.

[6] The recurrent laryngeal nerves supply sensation to the larynx below the vocal cords.

Surgery 8 April 2019

55. Ms A told HDC that on 8 April 2019, Dr D asked her for the fourth time to consent to having the sternotomy and mediastinal lump removal. She said that this caused her to feel highly stressed minutes before her surgery. Dr D said that he explained to Ms A that although she needed to consent to a sternotomy before Dr E could attempt to remove the mediastinal node, it was highly unlikely that a sternotomy would actually be required because Dr E would attempt to remove the node endoscopically via the neck incision, and would abandon the attempt if the node could not be excised easily. Ms A again said that she did not consent to a sternotomy.

56. Dr D said that he explained to Ms A that there was little point having Dr E take a sample of the mediastinal node, as this had been done previously by FNA with inconclusive results. Ms A decided that Dr E would not perform any chest procedure to diagnose the origin of the mass during the operation, and Dr D informed Dr E of this. Ms A said that she felt "bullied and harassed to undergo a procedure [she] had already declined earlier".

57. Dr D told HDC that at the end of their discussion in the preoperative waiting area, he was satisfied that Ms A had provided informed consent for him to proceed with the thyroidectomy and neck dissection, and they reviewed the consent paperwork. Dr D signed the consent form confirming the consent. The form still refers to the sternotomy.

58. In response to the provisional opinion, Ms A said that Dr D did not explain the surgery, and she actually spoke to Dr H. Dr D said that if he had had any doubts about Ms A's understanding of her diagnosis and the consequences of the proposed surgery, he would not have gone ahead.

59. Dr D performed Ms A's total thyroidectomy and central neck dissection. His operation report states that the recurrent laryngeal nerve was identified and dissected and a small cuff of thyroid tissue was left behind at the nerve entry, as the nerve was quite "plastered down".

60. Dr D said that the surgery was challenging because the tissues were stuck down and the left-sided goitre was large and extended into the upper chest.

Postoperative care

61. Following the surgery, Ms A's voice was hoarse, and a flexible nasoendoscope[7] examination confirmed that she had a paralysed left vocal cord. Dr D said that she also developed hypoparathyroidism[8] and a seroma[9] (not a haematoma,[10] as Ms A alleged in her complaint),

[7] A thin, flexible tube called a nasendoscope with a small video camera on the end is passed into the nostril and backwards. This allows the practitioner to view a number of areas in the nasal passage, the back of the tongue, the larynx, and the vocal cords.

[8] A condition in which parathyroid glands, which are in the neck near the thyroid gland, produce too little parathyroid hormone. This makes blood calcium levels fall and blood phosphorus levels rise. Treatment for hypoparathyroidism involves taking supplements, usually for life, to restore calcium and phosphorus levels.

[9] A seroma is a collection of fluid that builds up under the surface of the skin. Seromas may develop after a surgical procedure, most often at the site of the surgical incision or where tissue was removed.

[10] A haematoma is a collection of blood outside a blood vessel.

from which 10ml of fluid was aspirated. He said that seromas are not uncommon following the removal of large neck masses, including thyroid goitres. In response to the provisional opinion, Ms A said that prior to the surgery she was not informed of the risks of the complications she experienced.

62. Ms A was discharged on 23 April 2019.

Follow-up and speech therapy

63. Ms A's first postoperative follow-up appointment was on 16 May 2019 with registrar Dr H and Dr D. Ms A was on calcium supplementation and still had a hoarse voice. She was re-referred to Dr E for further management of the chest mass.

64. The pathology report from the operation was available, and indicated that despite the concerns that Ms A's thyroid cancer had spread, there was no evidence of metastatic carcinoma in the lymph nodes in the central neck compartment.

MDM discussion

65. On 23 May 2019, Ms A was discussed at a third MDM. As the surgery had not treated the chest mass, the members at the MDM recommended that she be offered the option of ongoing monitoring, or further investigation and surgical treatment of the mediastinal node.

Consultation with Dr E — 30 May 2019

66. On 27 May 2019, Dr E wrote to Dr G asking for an opinion on the histology. Dr G replied with a detailed assessment, and concluded that it was highly unlikely that the mediastinal nodule represented a metastasis. On 30 May 2019, Ms A attended a consultation with Dr E, and it was decided to monitor the chest mass with regular CT scans.

Follow-up

67. Ms A's second postoperative follow-up appointment was on 1 July 2019 with Dr H. Ms A's voice was improving slowly, and a flexible nasoendoscopic examination showed signs of movement in the left vocal cord.

68. Ms A was very concerned about her singing, as she was actively engaged in kapa haka and was concerned that she would not be able to participate in an upcoming annual event. She said that she would like to initiate an ACC treatment injury claim and receive further follow-up treatment from ENT specialists and speech therapists in her home town. She told Dr H that she would be happy to see her local GP, Dr C, for ongoing monitoring and treatment with regard to her thyroid and calcium levels.

69. Subsequently, Ms A received follow-up treatment from ENT specialists, and ongoing monitoring and follow-up treatment for her thyroid and calcium levels. Dr C referred Ms A to a speech therapist, and she attended speech therapy sessions with local speech therapists.

70. Dr D said that he had not referred Ms A to a speech therapist previously because vocal cord paralysis tends to recover within three months of surgery. However, as almost three months

had elapsed since the surgery, and her cord paralysis was resolving but Ms A was still finding it difficult to sing, he supported her decision to undertake speech therapy.

ACC claim

71. Ms A said that when she saw Dr H on 1 July 2019, she requested an ACC claim from him, and he said that he would inform Dr D about this. She stated that Dr D called her to say that he had never submitted an ACC claim previously.

72. On 4 July 2019, Ms A emailed Dr D about making an ACC treatment injury claim. On 5 July 2019, he emailed a medical house officer to ask her to assist him with Ms A's claim. The house officer replied on the same day to advise that she had spoken with Ms A and the relevant claim forms had been prepared and submitted.

73. On 15 July 2019, Ms A emailed Dr D to ask for the house officer's name. Before he had responded to Ms A, she copied him into an email that she had sent to ACC, on 16 July 2019, asking to withdraw her claim. Ms A's email did not indicate any reason for the withdrawal. Ms A stated:

> "I started to feel guilty and I withdrew the claim because I was not sure if it was my fault or not. I knew that the cancer was my responsibility and I needed to own my healing journey. After all, I arrived at [Hospital 1 unwell] and [Dr D] tried to help me, and now he's submitting a claim."

74. On 17 July 2019, Ms A copied Dr D into a further email to ACC that acknowledged that her request for withdrawal of the claim was being processed by ACC. Dr D told HDC that he emailed Ms A to ask her why she had withdrawn her ACC claim, and if everything was all right. Ms A's reply stated: "Yes, everything is perfectly ok. Thank you for asking."

75. Dr D told HDC that he did not call Ms A to say that he had never submitted an ACC claim previously, as Ms A claimed. He said that she never gave him any reasons for the withdrawal of her claim, and he denies saying anything to her to make her feel guilty about submitting the claim.

Third postoperative follow-up 13 August 2019

76. Ms A's third postoperative follow-up was with Dr D on 13 August 2019. He stated that Ms A's speaking voice had returned to its preoperative state, but she reported that her full singing voice had yet to return, and she was increasingly concerned about her inability to reach high notes. Ms A confirmed that she was attending speech therapy sessions locally, and that this was making a difference, but the speech therapist was finding it hard to improve her current singing voice. In response to the provisional opinion, Ms A said that she never stated that her voice was back to its preoperative state, nor did any of the evidence support that.

77. Dr D carried out a flexible nasoendoscopic examination, which confirmed normal mobility of Ms A's left vocal cord, but he detected a new cyst on her right vocal cord. He said that he suggested that Ms A continue her speech therapy to see if her singing ability improved, and

that failing this, the cyst could be removed surgically if there were persisting issues. He provisionally scheduled surgery to remove the cyst for 15 November 2019.

78. Dr D said that he told Ms A the provisional surgery date, but explained that he was hoping that her voice would improve and it would be possible to avoid surgery, as further surgery would be likely to regress her voice recovery.

79. Dr D's reporting letter to Dr C about this consultation states:

> "... I am pleased to note that her voice has improved dramatically to her pre-operative state. [Ms A] mentions that her pitch is improving however she has not reached her full singing voice as yet. She is attending her speech therapy sessions and feels this is making a difference ...
>
> I have explained to her that in view of the fact that her voice is normal, we do not need to address this vocal cord cyst. The only indication to address this would be if her voice is not good enough for singing, then phonosurgery [an operation for the improvement or restoration of voice] would be recommended to remove the cyst. I have advised that she continue her speech therapy and I have given her until November to assess whether her singing voice returns."

80. Ms A said that Dr D was inaccurate and deceptive when he wrote to her GP that the left vocal cord palsy had resolved and that her voice had improved dramatically to its preoperative state. She stated:

> "I have never described my voice as normal. I felt that I was not being heard and was told that my voice was normal when it was not. His opinion excluded me from my own health journey. Prior to the surgery, I could sing 3 octaves and now, I could only sing 5 out of 7 notes in an octave. Significant drop in vocal range."

81. Dr D said that it is not true that he incorrectly advised Dr C that Ms A's voice had returned to the preoperative condition. He stated that his letter makes it clear that while her speaking voice had returned to its preoperative condition, there were ongoing concerns about her singing ability.

Speech therapy

82. Ms A told HDC that Dr D "did absolutely nothing to support [her] recovery". In response to the provisional opinion, she said that she initiated the post-surgery care herself, including contact with Dr F and Dr G, and Dr D did nothing.

83. On 21 August 2019, Ms A emailed Dr D requesting referral to the speech therapist at Hospital 1. He emailed a speech and language therapist at Hospital 1, to enquire about speech therapists with expertise in professional singing. On 23 August 2019, he received an email from a colleague of the speech and language therapist, who advised that the DHB does not accept referrals for singing voice only.

84. Ms A said that Dr D knew that speech therapists do not focus on professional voice, because she had told him that prior to his email. She stated that she was denied access to speech therapy when she was entitled to it, which left her in the position of having to be her own advocate. She said that she complained to DHB2 and was referred to Ms I, who identified that she should have a stroboscopy.[11]

85. The colleague of the speech and language therapist sent Dr D links for singing teachers who might be able to assist. He forwarded the email to Ms A. On 4 September 2019, Ms A emailed Dr D about her recent speech therapy sessions with Ms I, saying that Ms I had recommended that she be referred to Dr F, a laryngologist in a main centre, and that Ms I had said that surgery followed by voice therapy is the recommended treatment for vocal cord cysts. Ms A asked whether the phonosurgery to remove the cyst could be moved to an earlier date.

Referral to Dr F

86. Ms A said that by that stage it had been four months since the surgery, and Hospital 1 had not initiated a referral to any specialists despite her having several postoperative complications. In response to the provisional opinion, Ms A said that she self-referred to Dr F in his private practice to have a stroboscopy for a second opinion.

87. On 30 August 2019, Ms I referred Ms A to Dr F at Ms A's request. The letter of referral asked Dr F to assist Ms A with an assessment with stroboscopy and rehabilitation for her singing voice after the cyst on her vocal cord had been removed surgically. On 4 September 2019, Ms A sent an email to inform Dr D of her scheduled appointment with Dr F, and said that a videostroboscopy had been requested.

Concerns about surgery

88. On 6 September 2019, Ms A copied Dr D into an email she sent to Dr E about her decision not to proceed with surgery to remove the mediastinal node during the surgery on 8 April 2019. Dr D said that he became aware from this that:

- Ms A's decision not to proceed with removal of the mediastinal node by Dr E was informed by an apparent misunderstanding of the procedure and the need to consent to a sternotomy;
- Ms A considered that Dr D had operated poorly and caused damage to her voice; and
- Ms A felt that Dr D had harassed her when discussing her unwillingness to consent to a sternotomy.

89. On 30 September 2019, Dr D emailed Ms A to remind her that she was due to have her calcium levels checked and to enquire whether she had made a decision to proceed with phonosurgery. In her email reply on the same date, Ms A suggested making a decision on

[11] Stroboscopy is used to visualise vocal fold vibration. It uses a synchronised, flashing light passed through a flexible or rigid telescope.

the surgery at their follow-up appointment on 7 November 2019, once he had assessed her vocal cords.

90. In October 2019, the DHB2 ENT team submitted a new ACC treatment injury claim for Ms A. Once Ms A's ACC claim had been approved, Ms I sent a new letter of referral to Dr F at his private practice.

91. On 22 October 2019, Dr D called Ms A to discuss her referral to Dr F. Dr D said that he explained that Dr F is a highly respected laryngologist, and he (Dr D) would value Dr F's opinion on her case before carrying out surgery to remove the cyst on her vocal cords. Dr D said that he told Ms A that he would cancel her phonosurgery that had been provisionally scheduled for 15 November 2019, and await Dr F's opinion. Dr D stated: "[Ms A] appeared to accept this approach." In response to the provisional opinion, Ms A said that she did not agree to cancel the phonosurgery, as that was not what she wanted.

92. Dr D also called Dr F to discuss Ms A's referral and his (Dr D's) preference to defer phonosurgery until after Dr F's consultation with Ms A. Dr F agreed with this approach and asked Dr D to send him a referral for Ms A (as he wanted a referral from a specialist rather than a speech therapist). Dr D emailed Dr F on 22 October 2019 regarding Ms A's referral. In response to the provisional opinion, Ms A said that at no point did she ask Dr D to contact Dr F, and the appointment had already been booked by her before this contact. Ms A now considers that it was a breach of her privacy for Dr D to talk to Dr F (although her email correspondence with Dr D at the time of these events does not express concern about this contact).

93. Dr D stated that he exchanged three further emails with Ms A on 24 October 2019, in which she noted that she was booked to see Dr F on 26 November 2019 and was looking forward to having a stroboscopy performed, and receiving Dr F's report. Ms A asked who would be performing the phonosurgery, why Dr D did not want to do it, and the purpose of their follow-up appointment on 7 November 2019.

94. On 4 November 2019, Ms A sent a further email querying her phonosurgery and appointment on 7 November 2019. Dr D sent Ms A an email confirming that her surgery had been cancelled for now, but the appointment was going ahead.

Fourth postoperative appointment — 7 November 2019

95. Ms A's fourth and final postoperative appointment with Dr D took place on 7 November 2019. In response to the provisional opinion, Ms A said that the appointment was to prepare for the surgery to remove the cyst. She said that while she was driving to the appointment, she received a call saying that her surgery had been rescheduled to 18 November. She said that on 7 November 2019, after an examination, Dr D told her that the cyst had disappeared, and the surgery was cancelled. Her calcium levels were normal and she was not on any supplementation. Her speaking voice was also normal, but she was still unable to reach the higher notes when singing.

96. Dr D carried out a flexible nasoendoscopic examination to assess the recovery and mobility of Ms A's vocal cords. Ms A said she thought that it was part of her preparation for surgery to remove the cyst. Dr D said that he planned to show Ms A a recording of her vocal cords taken with the camera on the flexible nasoendoscope. Ms A consented to the procedure and the recording before he began.

97. Dr D said that the flexible endoscope he uses has a stroboscopy option that provides a different means of recording vocal cord movement to that of the standard recording mode. To do a stroboscopy with a flexible nasoendoscope, a switch is clicked and no other instrumentation is needed. From a patient perspective, there is nothing to distinguish a flexible nasoendoscopy from a stroboscopy other than the recording that is produced. He stated that when he carried out the flexible nasoendoscopic examination he clicked the switch to make the recording in strobe mode. Ms A asked why he was carrying out a stroboscopy when she had not given permission for that. He said that he immediately switched the strobe button off and abandoned the recording in strobe mode.

98. Dr D stated:

> "I apologised to [Ms A] for mistakenly assuming that she had no objection to the use of strobe mode as part of the flexible nasoendoscopic examination. I am sorry that I did not make it clear to [Ms A] at the outset that I intended for the flexible nasoendoscopic examination to include a stroboscopy."

99. Ms A said that Dr D did not apologise, and when she asked, "What was that? Was that a stroboscopy?" he did not reply.

100. Dr D told HDC that the flexible nasoendoscopic examination confirmed that Ms A's right vocal cord cyst was still present but it had decreased in size.

101. Ms A emailed Dr D on 8 November 2019 to complain about his failure to obtain her informed consent to carry out the stroboscopy. In her email of 8 November, Ms A stated that in her emails prior to the appointment she had told Dr D that she refused to have a stroboscopy because Dr F was going to do one. She provided HDC with a copy of an email to Dr D in which she mentioned that she was having a stroboscopy with Dr F.

102. In contrast, Dr D told HDC that he did not discuss the stroboscopy with Ms A in advance, and that she had not told him that she did not wish to undergo the procedure because Dr F was going to do one. In response to the provisional opinion, he said that the email Ms A sent him on 24 October 2019 in which she advised him that she was booked to see Dr F on 26 November 2019 and was looking forward to having a stroboscopy and receiving his reports did not alert him that Ms A had strong feelings against him switching the nasoendoscope to strobe mode two weeks later. However, he regrets that he did not make it clear to Ms A at the outset that he intended the flexible nasoendoscopic examination to include a stroboscopy.

103. Dr D said that nasoendoscopic examination is minimally invasive. Minor side effects include nasal discomfort, sneezing, and slight nasal bleeding. From a patient perspective, the only

appreciable difference between the use of the strobe mode and the normal mode is the type of recording produced, with the differences to be explained by the clinician performing the procedure. He said that the scope and nature of information that must be provided for informed consent to be obtained effectively in respect of a procedure is assessed with reference to what the reasonable consumer would expect to be informed about. This centres around a patient being properly informed as to their condition, the reason for the procedure and alternative options, and the relative risks and benefits involved.

104. Dr D submitted that there was not a deficiency in the informed consent process in that Ms A was not informed that an additional mode of recording was to be used in the course of a procedure that she was otherwise fully informed about. He stated: "There is no additional risk in this scenario, just additional information produced, which in most circumstances would be most easily interpreted/explained for the patient after it had been obtained."

Appointment with Dr F — 26 November 2019

105. On 26 November 2019, Dr F saw Ms A. Dr F found that her voice quality was "mildly dysphonic (hoarse) and mildly rough" and her pitch was "slightly low". Dr F assessed that more than one potential issue had caused her voice to change following her surgery. His reporting letter to Dr D states:

> "[Ms A] has had a marked voice change following her surgery. I think that this is most likely multifactorial. She does indeed have a right vocal fold lesion which I clinically think is a vocal fold polyp … I think there is most likely an underlying paresis secondary to recurrent laryngeal nerve dysfunction. The fact that she has had a total thyroidectomy also raises the possibility that she had superior laryngeal nerve dysfunction as well … However having said that [Ms A's] voice certainly did not sound like someone with bilateral superior laryngeal dysfunction."

106. Dr F reported that he had explained to Ms A that it was a complicated situation as she had more than one potential issue causing her voice change. He stated that it was imperative that she have continued voice therapy input, and he recommended that she have vocal coaching for her singing.

107. Dr F recommended that Ms A have a microlaryngoscopy.[12] He said that she should have the right vocal fold lesion excised and consider augmenting the left vocal fold.

Further contact with Dr D

108. Dr D said that he did not have any further involvement with Ms A until 28 January 2020, when she emailed him asking why he had performed the central neck dissection. He called Ms A on 4 February 2020 to discuss her email and arrange a further follow-up appointment. Dr D told HDC that she informed him that she did not want to deal with him anymore, and he accepted that.

[12] Microlaryngoscopy is a procedure performed through an instrument called a laryngoscope that is placed through the mouth to expose the vocal folds. A microscope is used to examine the vocal folds in detail.

109. On 8 February 2020, Ms A emailed Dr D and said that she was concerned about the diagnoses and treatment that she received under his care, and sought his response to seven issues. On 9 February 2020, he emailed Ms A to suggest that they discuss her concerns in person at her next follow-up. The next day, she replied seeking his response in writing so that she could share it with her whānau. On 13 February 2020, Dr D responded in writing.

110. On 21 February 2020, Dr C wrote to Dr D on behalf of Ms A, requesting an explanation for carrying out the central compartment neck dissection, and Dr D responded on 12 March 2020.

111. On 20 March 2020, Dr D emailed Dr C querying Ms A's response to his letter. Dr D told Dr C that Ms A had advised his clinic nurse that she did not want to follow up with him anymore. Dr D asked Dr C to ensure that Ms A was seeing someone for follow-up of her cancer, and noted that he had colleagues with thyroid experience who could see her.

112. Dr D said that he did not hear anything further from Dr C or Ms A, and, over the next month, he became increasingly worried about Ms A's ongoing care, in particular the surveillance of her thyroid cancer.

113. Dr D said that he called Ms A on 20 April 2020, to make sure that her recovery was progressing and that she was aware of the importance of having regular follow-ups with a specialist, and to tell her that although she did not wish to see him, there were other doctors available who could assist. This call caused considerable distress to Ms A. Dr D told HDC that after the call, he emailed Dr C to advise him of the call with Ms A and to ask him to speak with her about specialist follow-ups.

114. Later that evening, Ms A emailed Dr D asking him not to contact her via phone or email again.

Subsequent events

115. Ms A's ongoing cancer surveillance was performed by general surgeon Dr G.

116. On 28 July 2020, Dr F performed a microlaryngoscopy and excision of the right vocal fold lesion. Ms A remained under the care of Dr F. In response to the provisional opinion, Ms A said that she has had to have three surgeries performed by Dr F to correct the injury from the thyroidectomy and central neck dissection.

Rationale for central neck dissection

117. Ms A had a CT scan on 8 September 2021. On 15 September 2021, Dr E wrote to her to tell her that the shadow in her chest had remained the same since it was first noted in January 2019. Ms A told HDC that this showed that Dr D, who told her in February and April 2019 that the cancer had spread, had made an incorrect diagnosis and performed unnecessary central neck dissection surgery on her.

118. Dr D told HDC that Ms A had a confirmed cancer in her right lobe but also an enlarged left thyroid goitre that was extending into her upper chest. The differential diagnosis included

metastasis or ectopic thyroid tissue. The decision for the central neck dissection was based on the rationale that if the chest mass was malignant, then it was likely that it had originated in the thyroid and passed through the first station of lymphatic drainage, which is in the central neck. A central neck dissection was thus intended to address this first station of lymphatic drainage by removing the lymph glands that were suspected of harbouring micro deposits of cancer cells.

Hui with Ms A

119. In June 2022, Ms A was invited to meet with Te Whatu Ora Director Māori and HDC's Director Māori. At this hui, Ms A discussed and shared her experience as a patient at Hospital 1.

120. An outcome from the hui was for a face-to-face hui with Hospital 1 clinicians to bring to closure this complaint through a hohou te rongo restorative process.

Responses to provisional opinion

121. The provisional opinion was provided to the parties, and their comments have been included in the "information gathered" section where appropriate. In addition, the following comments were made.

Dr D

122. Dr D expressed his sympathy for Ms A and his disappointment that she had not regained full use of her singing voice following the surgery, particularly in light of the importance of her singing voice to her daily life, her practise of kapa haka, and to her mana. He said that throughout his involvement in Ms A's care he was doing his best to facilitate a good outcome in her cancer treatment and follow-up care; to keep her at all times well informed about her condition, treatment options, and their associated risks/benefits; and to mitigate, as best he could for her particular circumstances, the challenges patients invariably face during cancer treatment.

123. Dr D stated that with the benefit of hindsight, he can see that he did not place sufficient weight on the unique value Ms A's voice had for her, both in his discussions with her and in his documentation.

124. Dr D said that he has reviewed the Medical Council of New Zealand's practice standards, including the standard on patient records and its statement on "The maintenance and retention of patient records", and he understands the importance of keeping clear and accurate patient records that report relevant clinical findings, decisions made, information given to patients, and any drugs or other treatment prescribed, and he will ensure that his documentation complies with these standards.

125. Dr D told HDC that since he treated Ms A in 2019, he has undertaken a cultural competency course provided by the DHB, and continues to develop his understanding of the ways in which partnership obligations under Te Tiriti o Waitangi inform treatment of Māori patients. He said:

> "I will continue to look for further opportunities to improve my cultural competency as well as my understanding of the partnership obligations mandated by Te Tiriti o Waitangi."

126. Dr D also said that he has published an article in the *ANZ Journal of Surgery* titled "Ethnic disparities for thyroid surgery".

Ms A

127. Ms A said that the DHB had an organisational responsibility to provide bicultural support to an overseas-trained doctor who, although qualified as a surgeon, did not understand the Māori cultural context. She said that the DHB was responsible to make Dr D's provision of care "culturally safe", but he was not aware of his deficit.

128. Ms A said that she had the right to be treated with respect, and have services provided that took into account the needs, values, and beliefs of different cultural, religious, social, and ethnic groups, including the needs, values, and beliefs of Māori. She said that Dr D's employers should have ensured that this right was met.

129. Ms A said that Dr D denied her the right to exercise her rangatiratanga under Te Tiriti o Waitangi. She stated that the loss of her voice has had a negative cultural impact, and the impact of the surgery was not only physical, but also emotional and mental. She said that it has affected her ability to perform with her community as she had in the past.

130. Ms A stated that there was no rational reason to have performed a central neck dissection. She said that when she obtained a second opinion from Dr G, with regard to the central neck dissection, he stated: "… I have explained that certainly for advanced papillary thyroid cancer, this would be considered standard practise however for a small early stage papillary thyroid cancer with no radiological evidence of lymph node metastasis, this would generally not be recommended."

131. Ms A said that, in her opinion, Dr D's belief that the chest mass looked to be thyroid in origin should not have resulted in a central neck dissection. She further added that in her opinion a surgeon should not perform a central neck dissection just because there is suspicion of cancer.

132. Ms A stated that she understands the results of the preoperative tests and the postoperative results go against the "suspicion of metastatic carcinoma" and, at the very least, a less invasive procedure should have been discussed with her.

133. Ms A provided some ideas as to how the service could better engage with Māori, including use of face-to-face meetings and being included in MDT meetings. These have been forwarded to the DHB.

134. Ms A said that a doctor should not ask a patient to sign the consent form until the patient has had sufficient time to understand the implications of the proposed surgery, and the consent form should not be signed while the patient is under sedation.

Opinion: Dr D — breach

Introduction

135. It is clear that Ms A's voice is of considerable importance to her — particularly her ability to participate in kapa haka — and it affects her mana. Her vocal difficulties have caused her significant distress. I express my sympathy to her for the effect this has had on her life.

Communication — breach

Effect of sedation

136. On 28 February 2019, Ms A and Ms B travelled to Hospital 1. Ms A was given sedation before having an EBUS. She was administered 100mcg of fentanyl and 5mg of midazolam between 10.50am and 11.40am. The consent form for the EBUS procedure states that patients must not make critical decisions for 12 hours after the sedation for the procedure.

137. Ms A and Ms B met with Dr H and then saw Dr D for the appointment that was scheduled for 12.52pm. Ms A said that she was asked to sign the consent form for the surgery not long after she had been sedated for the EBUS procedure. Ms B said that Ms A seemed to be "a bit incoherent" as she had just finished the EBUS procedure, but Ms A did question Dr D about how the operation would affect her voice and singing.

138. Dr D said that Ms A did not exhibit any signs of conscious sedation at the time he saw her, but he accepts that Ms A would still have been under the influence of her morning sedation at that time he saw her, so he should not have suggested that she sign consent paperwork for the proposed surgery. He stated that he did so to prevent her having to make another return trip from her home to Hospital 1. Ms A said that he did not discuss this with her.

139. My advisor, otolaryngologist Dr Catherine Ferguson, considered that as Ms A would still have been under the influence of her morning sedation, she should not have been asked to sign a consent form at that time. Dr Ferguson stated: "In this regard I consider that there has been a serious departure from the standard of care."

140. Dr D said that he told Ms A that signing the paperwork did not preclude her from changing her mind about the surgery, and that subsequently she did ask questions about the surgery (in her emails of 8 March 2019 and 1 April 2019 and their preoperative discussion on 8 April 2019).

141. I appreciate that informed consent is a process. However, on 28 February 2019, Dr D discussed Ms A's condition and her options at a time when effective communication was impaired by Ms A's sedation. Accordingly, I find that Dr D breached Right 5(2) of the Code of Health and Disability Services Consumers' Rights (the Code).[13]

[13] Right 5(2) states: "Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively."

Information regarding condition, options, and risks

142. In terms of what was discussed on 28 February 2019, Dr D and Ms A have differing recollections, perhaps because Ms A was still experiencing the effects of sedation.

143. Dr D said that he told Ms A that she had a nodule in her right thyroid gland, confirmed to be papillary thyroid cancer, and that there was a large left thyroid goitre extending into her upper chest. He said that they talked about the need to remove the entire thyroid gland, that her case was complicated by the mass in her chest thought to be thyroid in origin, and there was a concern that it could be a malignancy that had spread from the thyroid gland. Dr D said that he explained to Ms A that, as the lesion in her chest was thought to have originated from the thyroid cancer, there was a concern that the cancer might have spread to the lymph nodes in her central neck compartment before it reached her chest. A neck dissection was therefore planned.

144. Dr D cannot recall everything he said to Ms A, but he stated that in accordance with his "invariable practice", he would have advised her that thyroid cancer is primarily treated with surgery, and it was intended that the thyroidectomy and neck dissection would remove the cancer and achieve a cure. He said that he would also have advised Ms A that not proceeding with the surgery would pose a real risk of the cancer growing and spreading.

145. Ms A said that she was not told that she would have to take calcium pills and vitamin D for the rest of her life. She also stated:

> "I was not given sufficient information about the possible side effects of the surgical procedures, especially the complications that I have suffered over the past year. Furthermore, I was unaware that the central neck dissection was a preventative measure. If I knew that, I would have refused consent. I was denied the opportunity to make an informed decision and give informed consent."

146. Dr D said that he did not inform Ms A that the central neck dissection was a preventative measure because he did not consider that this was the case. He stated: "To my mind, both the neck dissection and thyroidectomy were intended to be curative of existing cancer."

147. Dr D told HDC that he discussed the potential complications associated with both procedures, including the risk of injury to the nerves supplying the larynx and the four glands that control calcium metabolism. He said he explained that damage to the nerves supplying the larynx could cause vocal cord paralysis, resulting in temporary or permanent hoarseness. With respect to the potential for damage to the parathyroid, he explained that this could cause hypoparathyroidism which, in turn, could cause her to experience a tingling sensation, muscle cramps, or convulsions. He said he assured Ms A that after the surgery she would be monitored for hypoparathyroidism, and, if this occurred, it would likely be a temporary complication that could be treated with calcium supplementation.

148. Dr D said that he remembers briefly discussing with Ms A that if Dr E attempted to remove the mediastinal node at the same time as the proposed surgery, there was a small risk of a major bleed and, if this occurred, it would be necessary to open her sternum in order to

access the chest cavity and address the bleed. He also explained that a sternotomy could damage her laryngeal nerve and therefore her voice, and he told Ms A that Dr E would discuss with her the chest component of the surgery, including the possibility of a sternotomy, in greater detail.

149. Dr Ferguson advised that it is usual to emphasise the risks to the recurrent laryngeal nerve when consenting for any thyroid or central compartment surgery. The signed document refers to the risks of bleeding, infection, hypocalcaemia, recurrent laryngeal nerve injury with resulting hoarseness, and the need for lifelong thyroid hormone replacement. Dr Ferguson advised that as far as she could ascertain from the limited documentation, there was adequate information provided to Ms A regarding the possible implications and complications associated with sternotomy. I accept this advice but do have concerns about the adequacy of Dr D's record-keeping, as discussed below.

Record-keeping — adverse comment

150. The signed consent form refers to the risks of bleeding, infection, hypocalcaemia, recurrent laryngeal nerve injury with resulting hoarseness, and the need for lifelong thyroid hormone replacement.

151. Dr Ferguson noted that there is no mention of the importance of Ms A's voice to her in the documentation, and she questioned whether that may have been given less significance in light of the concern over the cancer diagnosis.

152. Dr D agreed that there is a lack of detailed documentation recording the risks that he discussed with Ms A and the unique importance of her voice to her, both professionally and culturally. He stated: "With the benefit of hindsight, I accept that this is the case and regret my contribution to this lack of documentation."

153. Dr Ferguson advised:

> "As far as the medical record keeping is concerned I consider that there has been a moderate departure from the standard of care and recommend that all preoperative discussion and counselling be clearly documented in a typed record for the clinical records."

154. As a registered medical practitioner, Dr D must comply with the Medical Council of New Zealand's practice standards, including the standard on patient records in place in 2019. The Medical Council of New Zealand's statement, "The maintenance and retention of patient records", states that doctors "must keep clear and accurate patient records that report relevant clinical findings; decisions made; information given to patients [and] any drugs or other treatment prescribed". Matters that should be recorded include concerns discussed during a consultation, in this case Ms A's expressed concerns about the potential for damage to her voice.

155. In my view, Dr D did not ensure that the discussion on 28 February was recorded sufficiently to include information relevant to Ms A's priorities.

Refusal of consent to sternotomy — other comment

156. On 28 February 2019, Ms A told Dr D that she wanted to avoid a sternotomy. On 28 March 2019, Dr E and Ms A agreed that Dr E would attempt to remove the mediastinal node through the neck incision as a combined procedure with the thyroid operation.

157. Dr D said that he explained to Ms A that although she needed to consent to a sternotomy before Dr E could attempt to remove the mediastinal node, it was highly unlikely that a sternotomy would actually be required, because Dr E would attempt to remove the node endoscopically via the neck incision and would abandon the attempt if the node could not be excised easily.

158. Ms A told HDC that she felt harassed by Dr D asking her repeatedly to consent to a sternotomy, and that on 8 April 2019 he asked her for the fourth time to consent to having the sternotomy and mediastinal lump removal. She said that she refused again, but being asked again caused her to feel highly stressed minutes before her surgery.

159. Ms A decided not to have Dr E perform any chest procedure to diagnose the origin of the mass during the operation, and Dr D informed Dr E of this.

160. Dr Ferguson noted that it would appear that a degree of pressure was put on Ms A to consent to a sternotomy, as at the time this was considered to be very important in terms of diagnosis and appropriate treatment, but being fully appraised of the increased risks to her voice with this procedure, she refused, and this was accepted.

161. I acknowledge that it is Ms A's experience that Dr D placed pressure on her to consent to the sternotomy. It has been difficult to make a factual finding as to whether Dr D pressured Ms A about this issue inappropriately, but I acknowledge that there were several communications initiated by Ms A about these procedures and seeking clarification, and that Dr D was required to ensure repeatedly that she understood and was giving consent or not. I accept that he considered that it was in Ms A's best interests to obtain her consent to the sternotomy.

Stroboscopy — other comment

162. On 7 November 2019, Ms A had a follow-up appointment with Dr D. She told HDC that prior to the appointment she had told Dr D that she refused to have a stroboscopy because Dr F was going to perform one. In contrast, Dr D said that he did not discuss the stroboscopy with Ms A in advance, and she had not told him that she did not wish to undergo the procedure. I accept that the email Ms A sent Dr D on 24 October 2019 in which she advised him that she was booked to see Dr F on 26 November 2019 and was looking forward to having a stroboscopy and receiving Dr F's reports did not alert Dr D that Ms A had refused consent to his switching the nasoendoscope to strobe mode on 7 November 2019.

163. Dr D said that Ms A consented to the procedure but she had not been informed that an additional mode of recording was to be used in the course of the procedure. He stated:

> "There is no additional risk in this scenario, just additional information produced, which in most circumstances would be most easily interpreted/explained for the patient after it had been obtained."

164. Dr D said that when he carried out the flexible nasoendoscopic examination he clicked the switch to make the recording in strobe mode. When Ms A asked why he was carrying out a stroboscopy when she had not given her permission, he immediately switched off the strobe button and abandoned the recording in strobe mode.

165. Dr D stated:

> "I apologised to [Ms A] for mistakenly assuming that she had no objection to the use of strobe mode as part of the flexible nasoendoscopic examination. I am sorry that I did not make it clear to [Ms A] at the outset that I intended for the flexible nasoendoscopic examination to include a stroboscopy."

166. Dr Ferguson advised that if specific mention was not made of the intent to perform stroboscopy this would constitute a minor departure from the standard of care, as consent was not obtained before commencement of the procedure. I agree, but I note that Ms A consented to the flexible nasoendoscopic examination, and I think it not unreasonable for Dr D to have considered that a reasonable consumer in these circumstances would not expect to be informed about a technique used solely to obtain additional information. I acknowledge that he discontinued recording in strobe mode once he became aware of Ms A's wishes.

Treatment plan — other comment

167. Dr D said that Ms A had a confirmed cancer in her right thyroid lobe and an enlarged left thyroid goitre that was extending into her upper chest. He said that the differential diagnosis included metastasis or ectopic thyroid tissue, and the decision for the central neck dissection was based on the rationale that if the chest mass was malignant, then it was likely that it had originated in the thyroid and passed through the first station of lymphatic drainage, which is in the central neck. A central neck dissection was intended to address this first station of lymphatic drainage by removing the lymph glands that were suspected of harbouring micro deposits of cancer cells.

168. Dr Ferguson advised that this was a complicated case with known thyroid cancer in the thyroid gland in Ms A's neck, and ongoing concern about the possibility of spread of the cancer into ectopic thyroid cancer in the mediastinum. She said that despite a number of investigations, the precise nature of the nodule in Ms A's chest remained unclear.

169. Ms A's case was discussed twice at MDM meetings prior to the surgery, and a treatment plan was established. Dr Ferguson advised that the MDM was the appropriate forum for the discussion and formulation of the plan. On 24 January 2019, the members at the MDM reviewed the results of Ms A's CT and ultrasound scans, as well as a pathology report from 24 December 2018, which showed that Ms A had a papillary thyroid carcinoma on her right thyroid lobe and a multinodular goitre on her left thyroid lobe, which extended into her

upper chest. The MDM members proposed a surgical treatment plan for Ms A comprising a total thyroidectomy and central neck dissection. Further imaging and biopsy, and a referral to the Cardiothoracic Department, was recommended regarding the mass in Ms A's chest.

170. Ms A's treatment plan was discussed again at an MDM on 7 March 2019. When the MDM reviewed the recent CT and PET-CT scans, the MDM members thought that the chest mass looked to be thyroid in origin. They considered that the sample of the chest mass that had been biopsied might not reflect the overall mass accurately, as the cytology did not tie in with the clinical and radiological findings. Consequently, the MDM maintained its previous conclusion that the appropriate treatment plan for Ms A was a total thyroidectomy and central neck dissection, and consultation with the Cardiothoracic Department on the possible surgical excision of the mediastinal node.

171. Dr Ferguson advised that the process involving the MDM was appropriate, but she suggested that if the MDM had been made aware of the importance to Ms A of her voice, its advice may have been different. In response, Dr D said that even if the MDM had been made aware of the importance of Ms A's voice to her, it is unlikely that the advice would have been any different in order to avoid any risk to Ms A's voice, given the papillary thyroid cancer and the suspicion of metastatic carcinoma.

172. I accept that it was reasonable and appropriate for Dr D to adopt the plan formulated by the MDM, although he remained responsible for his clinical decision-making.

173. Ms A believes that as the shadow in her chest has remained the same since it was first noted in January 2019, this means that Dr D, who told her in February and April 2019 that the cancer had spread, had made an incorrect diagnosis. The pathology report from the operation indicated that there was no evidence of metastatic carcinoma in the lymph nodes in the central neck compartment. This has resulted in Ms A considering that the central neck dissection was unnecessary. Dr Ferguson advised:

> "It is easy to comment with the benefit of hindsight that the central neck dissection was not necessary, but the final cancer staging is only available once pathological results have come to hand. However, it should be recognised that all the same outcomes might have occurred with a total thyroidectomy alone, and indeed if there has been superior laryngeal nerve injury, this is a complication of thyroidectomy and not of central compartment neck dissection."

174. I accept this advice and consider that the treatment plan was reasonable in light of the information known at the time.

Performance of surgery — other comment

175. Dr D performed Ms A's surgery on 8 April 2019. Dr Ferguson advised that the operation note is detailed, and it appears that all care and skill were taken during the surgery. She stated: "I do not consider that there has been a departure from the standard of care." I accept this advice.

176. Ms A experienced a number of issues following her surgery. Dr Ferguson advised that the adverse outcomes experienced by Ms A (wound seroma, hypocalcaemia, recurrent laryngeal nerve injury, and possible superior laryngeal nerve injury) are recognised risks of the procedures undertaken, either with or without central neck dissection. Dr Ferguson said that it is impossible to determine whether the injury to Ms A's recurrent laryngeal nerve was a result of the thyroidectomy or of the central neck dissection.

Opinion: District health board — educative comment

177. Ms A's case was complex, and various services and clinicians at the DHB were involved in her care. Following her surgery, Ms A had follow-up appointments with Dr D and/or Dr H. She was referred back to Dr E for consideration of treatment of the node in her chest, and it was decided to monitor it by way of CT scans. However, Ms A considered that in the four months after her surgery, Hospital 1 had not initiated a referral to any specialists despite her having several postoperative complications.

178. Dr Ferguson advised that the level of follow-up was careful and thorough, and multiple people were involved, particularly regarding the concerns about possible spread of the cancer to Ms A's chest and involvement with the cardiothoracic surgeons, and follow-up discussion after surgery with recommendations for ongoing surveillance. Dr Ferguson said that there was early involvement of speech-language therapists, and efforts to assist with identifying appropriate singing rehabilitation experts.

179. Dr Ferguson advised that an endocrinologist did not need to be involved in the management of the calcium and parathyroid hormone levels or thyroid replacement therapy unless problems were experienced in achieving optimal levels, but usually that would be managed by the treating surgical team in the first instance. She stated: "I do not consider that there has been a departure from the standard of care."

180. I accept this advice, and remind the treating team, including the MDM, of the importance of taking a holistic view of a patient's needs in their deliberations. For Ms A, this involved taking into account the personal significance of the use of her voice. As Dr Ferguson stated, the concerns were over the nature of possibly very advanced cancer, and appropriately attention was focused on achieving the best possible oncological outcome.

Recommendations

Te Whatu Ora

181. I recommend that within three months of the date of this opinion, Te Whatu Ora:

a) Review the thyroid multi-disciplinary documentation with a view to including specific comments about an individual patient's voice requirements, and report the outcome and provide any amended documentation to HDC.

b) Audit a selection of Dr D's clinical records with a view to assessing his compliance with the Medical Council of New Zealand guideline and, in particular, his documentation of preoperative discussions in the clinical record. Te Whatu Ora is to provide the findings to HDC.

182. I also recommend that Te Whatu Ora continue to engage with HDC's Director Māori and Ms A to bring closure to this complaint through a hohou te rongo restorative process. Following the conclusion of this process, Te Whatu Ora should report back to HDC on the outcome and any additional steps to be taken.

Dr D

183. I encourage Dr D to participate in the hohou te rongo restorative process, after which, if still requested by Ms A, that Dr D provide a written apology to Ms A for his breach of the Code. The apology is to be sent to HDC, for forwarding to Ms A, within three weeks of the date of the conclusion of the hohou te rongo restorative process.

Follow-up actions

184. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Medical Council of New Zealand, and it will be advised of Dr D's name.

185. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Royal Australasian College of Surgeons, Te Aka Whai Ora — Māori Health Authority, Manatū Hauora — Ministry of Health, Te Whatu Ora Health New Zealand, and the Health Quality & Safety Commission, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to Commissioner

The following expert advice was obtained from otolaryngologist Dr Catherine Ferguson:

"To: Health and Disability Commissioner Complaint: [Dr D], [the] District Health Board Reference Number: C20HDC00719

My name is Dr Catherine Ferguson, and I am a registered Otolaryngologist, Head and Neck Surgeon practising in Wellington, New Zealand. I have been asked to provide expert advice to the Health and Disability Commissioner on the care provided by [Dr D] to [Ms A] between 28 February 2019 and 4 February 2020. I have no personal or professional conflict in this case. I have reviewed a copy of the HDC's guidelines for independent advisors and I have read the following documents:

1. Letter of complaint dated 25th April 2020.
2. [Dr D's] response dated 3rd July 2020.
3. Clinical records from [the DHB] covering the period of 2019 to 2020.
4. Clinical records from [the] DHB covering the period 2019 to 2020.
5. Clinical records from [the medical centre].
6. [Ms A's] comments on [Dr D's] response to 12th August 2020.
7. Copy of EBUS records and outpatient letter 28th February 2019.

I have been asked a number of questions which I will address.

1. I have been asked to comment on whether [Ms A] was adequately informed as to her condition, possible treatment options, and the risk associated with the proposed surgical treatment plan. There is not a large amount of information regarding this. There is a signed consent form and damage to the recurrent laryngeal nerve is documented in that consent form, but it is not clear whether the true implications of this was explained and communicated to [Ms A]. I also note that in all the preliminary documentation that has been made available to me, there is no mention of the importance of [Ms A's] voice to her and I wonder if this may have been given less significance in light of the concern over the cancer diagnosis. However, as far as I can ascertain from the documentation, there was adequate information provided regarding the possible implications and complications associated with sternotomy. [Ms A] states that she was asked to sign the consent form for surgery not long after she was sedated for an EBUS procedure. The consent form for this procedure specifically states that patients must not make critical decisions for 12 hours after sedation for such a procedure. The records confirm that [Ms A] was given 100mcg of Fentanyl and 5mg of Midazolam between 10.50am and 11.40am on 28th February. She was then seen that same afternoon to discuss her planned surgical procedure and was placed on the waiting list for surgery. It is not specified that the written surgical consent form was signed that day but it appears that this is when the discussion regarding surgery took place. [Ms A] would still have been under the influence of her morning sedation at that time and should not have been

asked to sign a consent form at that time. In this regard I consider that there has been a serious departure from the standard of care and would strongly recommend that practitioners be reminded of the requirements when obtaining informed consent for any procedure. As far as the medical record keeping is concerned I consider that there has been a moderate departure from the standard of care and recommend that all preoperative discussion and counselling be clearly documented in a typed record for the clinical records.

2. I am asked whether the surgical treatment plan implemented was clinically appropriate given the diagnostic/screening information available. This was a complicated case with known thyroid cancer in the thyroid gland in the neck but ongoing concern despite a number of investigations as to the possibility of spread of the cancer into ectopic thyroid cancer in the mediastinum. This is a complex situation and despite a number of investigations, it remained unclear as to the precise nature of the nodule in the chest. I note that the case was discussed at two thyroid multidisciplinary meetings (which is the appropriate forum) and despite ongoing investigation, it was still felt that a plan of total thyroidectomy and central compartment neck dissection was the appropriate treatment because of the uncertainty about the possibility of mediastinal spread. There was appropriate consultation with the Cardiothoracic service. This is appropriate treatment although had the MDM been made aware of the importance of [Ms A's] voice in this situation, the advice might have been different. That said, it is impossible to determine whether the injury to the recurrent laryngeal nerve was a result of the thyroidectomy or of the central neck dissection. I do not consider that there has been a departure from the standard of care.

3. I have been asked whether an appropriate process for obtaining informed consent for each of the surgical procedures was followed. As detailed above, it is uncertain as to the level of detail and implications that were discussed. The documentation is brief, but it is usual to emphasise the risks to the recurrent laryngeal nerve when consenting for any thyroid or central compartment surgery. The signed document refers to the risks of bleeding, infection, hypocalcaemia, recurrent laryngeal nerve injury with resulting hoarseness and the need for lifelong thyroid hormone replacement. It would appear that a degree of pressure was put on [Ms A] to consent to a sternotomy (as at the time this was considered to be very important in terms of diagnosis and appropriate treatment), but being fully appraised of the increased risks to her voice with this procedure, she refused and this was accepted. In this regard I am unable to comment if there has been a departure from the standard of care, apart from the issues already discussed in regards to sedation and obtaining consent.

4. I have been asked whether the surgical procedures were undertaken with reasonable care and skill. I have read the dictated operation note, which is detailed, and it appears that all care and skill were taken. It does note that dissection of the left lobe of the thyroid gland was difficult with attachment to some of the significant surrounding blood vessels, but a note was made that the recurrent laryngeal nerve was appropriately identified and followed. I do not consider that there has been a departure from the standard of care.

5. I have been asked whether the adverse outcomes (wound seroma, hypocalcaemia, recurrent laryngeal nerve injury and possible superior laryngeal nerve injury) experienced by [Ms A] are recognised risks of the procedures undertaken. These outcomes are all recognised risks in this situation (with or without central neck dissection).

6. I have been asked about [Dr D's] explanation of instruments used when performing the flexible nasoendoscopic examination. It appears that the flexible endoscope he was using has the ability to perform stroboscopy, which is commonly used when assessing vocal fold function. However, it also appears that [Ms A] was not happy for this function to be used, and when [Dr D] was made aware of this, he immediately ceased stroboscopic examination. I cannot comment further on this question, although when asked to stop, it appears that he did. If specific mention was not made of the intent to perform stroboscopy this would constitute a minor departure from the standard of care, as consent was not obtained before commencement.

7. I have also been asked whether follow-up care was appropriate including coordination of care with other providers. It appears that the level of follow-up has been careful and thorough and multiple people have been involved particularly regarding the concerns about possible spread to the chest and involvement with the cardiothoracic surgeons, and follow-up discussion after surgery with recommendations for ongoing surveillance. There was early involvement of speech-language therapists within 3 weeks of surgery, and efforts to assist with identifying appropriate singing rehabilitation experts. I do not consider that an endocrinologist needs to be involved in the management of calcium and parathyroid hormone levels or thyroid replacement therapy unless there are problems experienced in achieving optimal levels, but this would usually be managed by the treating surgical team in the first instance. I do not consider that there has been a departure from the standard of care. As I have said initially, it does not appear that the team including the Multidisciplinary Clinic Team were fully apprised of the extent of [Ms A's] voice use and the importance of her voice to her. The concerns were over the nature of possibly very advanced cancer and appropriately attention was focused on achieving the best possible oncologic outcome. It is easy to comment with the benefit of hindsight that the central neck dissection was not necessary, but the final cancer staging is only available once pathological results have come to hand. However, it should be recognised that all the same outcomes might have occurred with a total thyroidectomy alone, and indeed if there has been superior laryngeal nerve injury, this is a complication of thyroidectomy and not of central compartment neck dissection. It is obvious that the poor voice outcomes have had a devastating effect for [Ms A] and I think it is very appropriate that her voice care has been taken over by [Dr F]. It is also appropriate that her ongoing cancer surveillance is being performed by [Dr G] because of the breakdown in the professional relationship with [Dr D]. However, I would like to commend [Dr D] for his willingness to respond rapidly to [Ms A's] requests for information via e-mail and his level of commitment to her case in this situation.

In summary, most of the initial documentation does not cover the full range of implications for voice. There is a lack of dictated documentation about the discussion of risks particularly in light of the complainant being a professional voice user, and the cultural significance of voice in this case. It does not appear that the cultural implications of potential voice change were considered at all. I would recommend that the thyroid multidisciplinary documentation be adjusted to provide specific comments about an individual patient's voice requirements so that this is well documented and understood, and I would recommend that [Dr D] specifically documents the extent of all preoperative discussion in the clinical record. I also suggest that [Dr D] undergo further education and training in cultural competence and his obligations under the principles of Te Tiriti o Waitangi, and that [the DHB] ensures that cultural competency training is appropriate to vocational scope.

Please contact me if you have any further questions.

Kind regards,

Dr Catherine Ferguson"