Dr A

A Report by the
Deputy Health and Disability Commissioner

(Case 21HDC00157)

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Contents

Complaint and investigation

1. The Health and Disability Commissioner (HDC) received a complaint from Ms B about the services provided by Dr A. The following issue was identified for investigation:

   - *Whether Dr A provided Ms B with an appropriate standard of care from 14 June 2019 to 11 May 2020 (inclusive).*

2. This report is the opinion of Deborah James, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

3. The parties directly involved in the investigation were:

Ms B	Consumer
Dr A	Surgeon

4. Further information was received from:

General practitioner (GP)
Health New Zealand|Te Whatu Ora (Health NZ)
Medical centre
Private surgical hospital
Mr C (Ms B's support person)

5. Information was also received from the Accident Compensation Corporation (ACC).

6. Independent clinical advice was obtained from Dr David Moss, a general surgeon (Appendix A).

Background

7. On 24 May 2019 Ms B presented to her GP with diffuse swelling on the front and right side of her neck after having commenced a mood-stabilising medication six weeks previously. The GP requested a blood test and an ultrasound of Ms B's neck and advised Ms B to return if her symptoms worsened.

8. Ms B's TSH[1] blood test taken on 24 May 2019 showed normal thyroid[2] activity. An ultrasound performed on 28 May 2019 reported that Ms B had 'no thyroid tissue appreciated in her left thyroid bed' and that her right thyroid lobe was prominent and 'largely replaced by a thyroid nodule [abnormal tissue growth]'.

[1] Thyroid stimulating hormone (a hormone produced by the pituitary gland).
[2] The thyroid gland is located in the front of the neck and has a right and a left lobe. The gland is responsible for regulating blood pressure, metabolism, and body temperature by secreting hormones.

9. The ultrasound report also noted several different possible Thyroid Imaging Reporting and Data System (TI-RADS) designations.[3] The report stated:

> '[E]chogenic foci[4] were not felt to be present (TIRADS designation would be TR3). On several images, however, non-shadowing echogenic foci do appear contained within the mass (TIRADS designation would be TR5).'

10. An (undated) addendum to the report noted: 'Correction: if the right sided nodule is considered to have echogenic foci, the TR category is TR4, not TR5.'

11. The report recommended a fine needle aspiration (FNA),[5] and Ms B's GP referred Ms B to the public general surgical clinic on 29 May 2019.

Preoperative investigation and discussion

12. On 14 June 2019 Dr A saw Ms B in the general surgical clinic and wrote a clinic letter to her GP. The letter noted the mass on the right thyroid lobe but did not comment on the lack of tissue noted on the left thyroid lobe.

13. In his response to HDC, Dr A stated:

> 'Inexplicably, which I can only put down to human error, I did not note the comment regarding the left lobe in the ultrasound report. Because of this I did not document this in my letter.'

14. As the ultrasound comment about the size of Ms B's left lobe was not documented, Dr A 'did not consider this at subsequent visits and therefore assumed the left side was normal throughout the preoperative workup'.

15. Dr A told ACC that Ms B did not have a history of thyroid surgery, and no previous neck surgery was documented in her health records or questionnaire. Her thyroid function tests were normal, and she had no symptoms to suggest an over- or under-active thyroid.

16. Dr A documented that the nodule had 'some suspicious findings on FNA; he could 'feel the [right thyroid] nodule easily' and he did a freehand[6] FNA of Ms B's right thyroid nodule at the appointment on 14 June 2019. Dr A told HDC that notwithstanding the ultrasound report amendment to a TIRADS 4 nodule, 'the features on the ultrasound suggested the lesion should probably be rated closer to a TIRADS 5'. Dr A documented that he 'told [Ms B] that it

[3] Ultrasound features of thyroid nodules are used to classify the TI-RADS level (1–5) correlating to potential malignancy. TIRADS 3: with features mildly suspicious of malignancy; TIRADS 4: with features moderately suspicious of malignancy; TIRADS 5: nodules highly suggestive of malignancy. See: https://www.thyroid.org/patient-thyroid-information/ct-for-patients/september-2018/vol-11-issue-9-p-7-8/ American College of Radiology Thyroid Imaging Reporting and Data System (ACR TI-RADS) chart:gr1_lrg.jpg (3167×2507) (acr.org).

[4] Bright spots within the thyroid nodule, which is indicative of higher risk for malignancy.

[5] A procedure used to collect a small sample of cells, fluid, or tissue from an abnormal area or lump in the body.

[6] Non-ultrasound guided.

is likely she will need a [right] thyroid lobectomy [removal of the lobe] given the size and appearance of this nodule' with the plan dependent on whether the results of the FNA were benign or malignant.

17. On 28 June 2019 Dr A documented that Ms B was followed up in the general surgical clinic following FNA results that were 'consistent with a benign colloid nodule' (build-up of thyroid cells).[7] Dr A told HDC that he discussed with Ms B the treatment options of either a right thyroid lobectomy or monitoring of the nodule, and recommended surgery given the suspicious features on the ultrasound, the size of the nodule, and the possibility of an undiagnosed tumour. Ms B considered the option of surgery through the private health sector.

18. On 10 July 2019 a third consultation was arranged at Dr A's private rooms at the private surgical hospital for Ms B to consider treatment options. The clinic letter for the appointment on 10 July 2019 notes that Ms B had a 'large nodule which is causing obstructive symptoms and two inconclusive FNAs for this large TR-4 nodule'.

19. Ms B told HDC that the reference to obstructive symptoms and a second FNA in the clinic letter were incorrect. Dr A acknowledged that he 'incorrectly stated there were two inconclusive FNAs and pressure symptoms from the nodule (these were not indications for surgery)' and these were errors made while dictating the letter.

20. Dr A told HDC that he discussed the 'rationale, outcomes and risks' of surgery with Ms B at the appointment on 10 July 2019. He could not recall giving Ms B any written information, as they had discussed this information at previous consultations, and he considered that Ms B had 'expressed a clear understanding' of the procedure, rationale, and risks. The risks discussed included postoperative hypothyroidism (underactive thyroid gland) requiring thyroid replacement hormones. However, this was based on the assumption that Ms B had a normal left thyroid lobe. Dr A told HDC that if the size of Ms B's left thyroid as noted on the ultrasound report had been taken into account, the risk of hypothyroidism would have been higher, and this would have been an important piece of information for her to take into consideration when deciding whether to have surgery.

21. Mr C was Ms B's support person at her appointments with Dr A in his private rooms. Mr C recalls Dr A describing the thyroid lobectomy and saying that having half the thyroid removed would not significantly affect Ms B's wellbeing as the remaining lobe was 'intact and functioning'. Ms B told HDC that Dr A told her at a consultation prior to surgery that he 'hope[d] that the left side thyroid lobe [would] pick up the job of a complete thyroid and no thyroid replacement medication [would] be required'.

22. Ms B told HDC that Dr A 'did not mention the state of the left side of [her] thyroid gland to [her] at all'. She said that she asked 'valid questions prior to surgery' and considers that Dr A responded 'arrogantly'. She told HDC that due to the small chance of cancer (while being

[7] Ms B's cytology specimen of 14 June 2019 was reported as: 'The appearance is that of a benign colloid nodule.'

unaware of the ultrasound findings of the left thyroid lobe), she decided to proceed with the option of surgery to remove the right thyroid lobe.

23. Ms B had a right thyroid lobectomy on 7 August 2019 at the private surgical hospital. An initial postoperative thyroid function test taken on 8 August 2019 was within normal range, which documented a TSH result of 0.44 (reference range being 0.4–4m0mlU/L).

Postoperative follow-up

24. On 21 August 2019, at Ms B's postoperative consultation, Dr A wrote to Ms B's GP outlining that Ms B '[would not] require any ongoing follow-up' and that he would arrange a repeat thyroid function test in two to three months' time. Dr A told HDC that the follow-up plan was based on the assumption that Ms B had a normal left thyroid lobe, and that repeat thyroid function tests at three months was his usual practice at the time. Ms B told HDC that Dr A told her that she would have a repeat thyroid function test in 12 weeks' time.

25. Ms B requested a follow-up appointment with Dr A on 18 September 2019 as she had 'a very swollen face and other issues'. She told HDC that she did not have swelling in her neck but that the swelling was under her chin and around the jaw and sides of her face (described by Ms B as a 'moon face'). She said that Dr A examined her and reassured her that the swelling in her face was normal and would go down. Ms B told HDC that 'a swollen face can be one of the most common symptoms of hypothyroidism', and Dr A did not order a thyroid function blood test.

26. In his clinic letter to Ms B's GP about the appointment on 18 September 2019, Dr A documented that Ms B was concerned about swelling around her neck above the scar and 'extending up to the angle of the jaw at both sides'. Dr A noted subcutaneous tissue[8] swelling and his impression that this probably represented tissue oedema (fluid build-up) as a result of scarring and swelling from the surgery.

27. Dr A told HDC that he considered that Ms B's symptoms were expected following thyroid surgery, and he arranged follow-up in six weeks from the 18 September appointment to ensure that Ms B's symptoms were settling and to check her thyroid function. The clinic letter to the GP of 18 September 2019 notes a plan to see Ms B after her repeat blood tests in early November. Whilst there is no documentation that safety-netting advice was provided to Ms B on 18 September 2019, Dr A told HDC that his usual practice is to encourage a patient to return if they have any deterioration in their symptoms, and he believes he would have done this.

28. On 6 October 2019 Ms B presented to a GP on duty, who noted that Ms B had reported 'constant pain' in her left neck area and 'heavy feet', and that pain-relief medications did not help these symptoms. Ms B subsequently presented to her GP on 9 October 2019 with fatigue, a stiff/swollen neck, and feeling 'not right since surgery in early August'. The GP provided a blood test form at this appointment. Ms B's blood test taken on 21 October 2019

[8] Under the skin.

(10–11 weeks after her operation) showed a critically abnormal TSH level.[9] The GP's clinical notes of 22 October 2019 document: 'Rang Dr A; advised starting on 100mcg [thyroid replacement therapy]; send note and have [follow-up] blood [test] in 6–8 weeks.'

29. Dr A told HDC that he was in the operating theatre at the time he received the phone call from Ms B's GP, and he did not appreciate how unwell Ms B was. Dr A said that he recognises that he missed an opportunity to support Ms B by not arranging an immediate review in his clinic.

30. Dr A saw Ms B at his private rooms on 20 December 2019. He documented in his clinic letter to Ms B's GP that he had reviewed Ms B's preoperative ultrasound and noted that she had 'quite a small thyroid on the left side', so he wondered whether her hypothyroidism had been 'uncovered by removing the [right] lobe'. Dr A wrote in this clinic letter that he had apologised[10] to Ms B for not having identified the small left thyroid lobe earlier (although this is disputed by Ms B, who told HDC that she was not informed until 9 March 2020). He also noted that normally he would have ordered (thyroid) blood tests 2–3 months after surgery but he has now changed his practice and requests blood tests 2–3 weeks after surgery with a follow-up test three months after surgery. Dr A wrote that he planned a further ultrasound for Ms B once the surgical inflammation and scarring had settled.

31. Ms B's thyroid function tests were reviewed at her appointment with Dr A on 20 December 2019. Dr A documented in a further letter to Ms B's GP dated 24 January 2020: 'I will get the ultrasound between now and my next clinic to see what kind of thyroid remnant she has on the left side.'

32. Ms B told HDC that during her ultrasound on 14 February 2020, she 'realised what had happened' when the sonographer could not locate her left thyroid lobe, and at the following appointment (on 9 March 2020) she 'demanded Dr A to explain … why he failed to tell [her] that [her] left lobe was non-existent'. Her support person at the appointment told HDC that following the second ultrasound when Ms B 'realised that Dr A either did not know or did not recall that she had no left side thyroid tissue … Dr A left the room for some time to consult or review notes [and] [Ms B] was very upset'. Mr C told HDC that from their perspective, 'Dr A apologised but also seemed to try to minimise the error'.

33. Dr A documented in his clinic letter to Ms B's GP on 9 March 2020 that the ultrasound showed that Ms B had a 'thin thyroid remnant on the left side with a small nodule' and that he had apologised to Ms B 'for not picking this up preoperatively'. Dr A told HDC that while this probably would not have changed the management of her right thyroid lobe, it would have prompted earlier thyroid function testing and treatment. In response to the provisional opinion, Ms B told HDC that this appointment was the first time the left thyroid issue was discussed with her, and the first and only verbal apology she received.

[9] TSH controls the way other hormones function. Ms B's TSH result was 0.44mIU/L on 8 August 2019, and 78mIU/L on 21 October 2019 (reference range 0.40–4.00mIU/L).

[10] In her response to the provisional opinion, Ms B stated that this apology did not occur on this date, contrary to what is stated in this letter.

34. Dr A continued to be involved in Ms B's care until 28 April 2020. In clinic letters to Ms B's GP on 20 December 2019, 24 January 2020, and 9 March 2020, Dr A noted Ms B's blood results and discussed her thyroxine[11] dosage. The clinic notes document that Dr A was making thyroxine dose recommendations and communicating this to Ms B's GP, and the thyroid blood test taken on 7 April 2020 (after Ms B's last consultation with Dr A) was within normal range.[12] This result was documented in a (non-contact) clinic letter to Ms B's GP on 28 April 2020, with a copy to Ms B by email.

35. Dr A sent an email to Ms B on 14 May 2020 acknowledging that she had requested no further communication with the practice but wrote to offer a written apology for failing to recognise her risk of hypothyroidism after surgery and saying that he should have recognised these symptoms at her first postoperative visit. Dr A wrote that he would be 'happy to provide advice directly to [her] GP' regarding Ms B's thyroxine dose.

36. Ms B told HDC that she questioned Dr A's record-keeping and the reason for overlooking the radiology finding concerning her left thyroid lobe. She is concerned that Dr A 'mixed [her] up with another patient'.

37. Ms B said that the right thyroid lobectomy has had a significant negative impact on her health and wellbeing. She is concerned that she was dismissed when she requested a follow-up with Dr A on 18 September 2019 when she told him that she had 'a swollen face (like a moon)', which is 'one of the most common symptoms of hypothyroidism'. She told HDC that she is not satisfied that she received a genuine or timely apology from Dr A when she raised her concerns with him.

Further information

Health NZ

38. Health NZ outlined Dr A's workload during the period 14 June 2019 to 11 May 2020, which included oversight/supervision of multiple clinicians. Dr A said that since this time, Dr A has used a new clinic template that specifies a reduced number of patients.

Dr A

39. Dr A told HDC:

> 'I sincerely apologise to Ms B for the chain of events arising from an oversight in my care. It has affected her greatly and required a long and difficult recovery. I would not wish this experience on anybody and deeply regret this. I have taken this matter very seriously and have taken this as an opportunity to reflect and learn from the events surrounding this case.'

[11] Medication used to treat an underactive thyroid gland.
[12] 7 April 2020 results TSH = 3.6 (reference range 0.4–4.0mIU/L) and FT4 = 12 (reference range 10–24pmol/L).

Responses to provisional opinion

40. Ms B was provided with an opportunity to comment on the 'information gathered' section of the provisional opinion. Her comments have been incorporated into this report where relevant.

41. Dr A was provided with an opportunity to comment on the provisional opinion, and he confirmed that he had no further comments.

Opinion: Dr A — breach

42. Ms B was referred to the general surgical clinic by her GP following an ultrasound that reported that her right thyroid was 'largely replaced' by a nodule and recommended an FNA because of the size of the nodule. At Ms B's initial appointment, she was seen by Dr A, who reviewed her ultrasound report and overlooked the finding that 'no thyroid tissue is appreciated in the left thyroid bed'. Dr A told HDC that as he did not notice or document the finding, Ms B's left thyroid lobe was assumed to be normal at subsequent appointments.

Preoperative assessment

43. Dr A acknowledged that he overlooked Ms B's preoperative ultrasound finding of a small left thyroid lobe. He told HDC that it was important to consider Ms B's opposite thyroid lobe in the management of her abnormal right thyroid nodule and said that usually he is very careful when reviewing radiology reports for incidental or unexpected findings relevant to the care of a patient. He is unable to explain why he missed this finding but considers that the most likely explanation is that he focused his concern on the possibility of a thyroid tumour. He also identified that human and work factors may have contributed to the error.

44. My independent clinical advisor, general surgeon Dr David Moss, noted that when surgery for thyroid nodules is being contemplated, 'the standard of care when assessing a thyroid nodule is to clearly establish the nature of the other/contralateral lobe of the thyroid'. Dr Moss considers that the finding of an abnormal left thyroid lobe 'stand[s] out quite clearly' in Ms B's ultrasound report, and that Dr A's failure to assess Ms B's left thyroid lobe represents a moderate departure from accepted practice.

45. I accept Dr Moss's advice and note that Dr A accepts that overlooking Ms B's abnormal ultrasound finding was a moderate departure. Dr A told HDC that he was 'disturbed as to how easy it was for this oversight to have occurred and [is] devastated for the effect this had on Ms B'. I acknowledge that Dr A emailed a written apology to Ms B on 14 May 2020 for this lapse in his care.

Recommendation for surgery and information given preoperatively

46. Dr A told HDC that during his preoperative consultation with Ms B they discussed the options of a right thyroid lobectomy to remove the nodule or monitoring of the nodule with imaging

and a repeat FNA. Surgery was recommended because of the size of the nodule, suspicious features on ultrasound, and the possibility of an undiagnosed tumour.

47. Dr A said that if he had noted Ms B's left thyroid lobe findings, he still would have recommended the surgical removal of her right thyroid lobe but would have been more cautious in recommending the surgery due to the need to balance the risk of missing a cancer versus the risk of hypothyroidism. He said that he would also have been able to discuss Ms B's risk of postoperative hypothyroidism more completely and acknowledged that this was 'an important piece of information for Ms B in considering the possible outcome and therefore the decision to proceed with the surgery'.

48. Dr Moss considered that the decision to perform a right hemithyroidectomy was appropriate.

49. However, in terms of information provided preoperatively having overlooked the finding relating to Ms B's left thyroid lobe, Dr A did not discuss the implications of that with her. Ms B therefore did not receive information that would have been important to her decision whether to proceed with surgery (namely, the information about her left thyroid lobe and the associated risks and alternatives).

50. Dr Moss considers that the remainder of the information provided to Ms B was appropriate, although he also noted that if the left thyroid lobe abnormality had been documented, alternative non-surgical treatment options such as a repeat scan and biopsies could have been discussed.

51. I have considered these issues carefully. I acknowledge that from Ms B's perspective she did not receive information that would have been important to her decision whether to proceed with surgery (namely, the information about her left thyroid lobe and the associated risks and alternatives). I also note that the lack of information about the ultrasound findings prior to the surgery flows from Dr A having overlooked this information in the report, and I acknowledge that regrettably it was not possible for Dr A to share and act on information of which he was unaware. Having found that overlooking the ultrasound finding was a departure from accepted practice (as discussed above), I do not consider it appropriate to be further critical of a provider for failing to share and act on information of which they were unaware.

Postoperative care — diagnosis of hypothyroidism

52. Following Ms B's operation on 7 August 2019 she had a blood test taken on 8 August 2019 and the results were within normal range.

53. Dr A told HDC that his practice at the time was to check for hypothyroidism three months after a routine thyroid lobectomy, as it can take several weeks for postoperative blood levels to stabilise.

54. Dr Moss considered this acceptable and advised that there are no clear guidelines for following up a patient's thyroid tests in the postoperative period and that 'provided the

patient is well this can indeed wait a number of months'. I accept Dr Moss's advice, and I am not critical of Dr A's initial plan for follow-up blood tests in three months' time.

55. Ms B had a follow-up appointment with Dr A scheduled for three months after her surgery. However, when she became unwell and had facial swelling 4–5 weeks after the operation, she arranged an earlier appointment. Dr A saw Ms B on 18 September 2019, but he did not request a thyroid function blood test at that time. Ms B told HDC that at this appointment, after Dr A examined her, he reassured her that her swollen face was 'normal' and that it '[would] go down'.

56. Dr A told HDC that because he overlooked the comment about the left thyroid lobe on the ultrasound report, he did not consider this finding at subsequent visits. Dr A said that the symptoms he documented on 18 September 2019 (swelling in the neck above the scar and extending up to the angle of the jaw on both sides, and a feeling of tightness when swallowing) are common after thyroid surgery. Dr A said that he told Ms B that her symptoms should settle with time and planned for thyroid function tests three months after surgery on the 'assumption of a normal left lobe'.

57. Dr Moss noted that the failure to assess Ms B's left thyroid lobe adequately 'would have potentially changed the post-operative management and indeed quite probably as Dr A points out, have resulted in Ms B's hypothyroidism being detected at an earlier stage'.

58. Dr Moss advised:

> 'It is impossible at this stage to ascertain exactly what the examination findings and interpretation of these by [Dr A] were. I think the symptoms of hypothyroidism are very non-specific and challenging. Certainly in my experience it is difficult to make a clinical diagnosis of hypothyroidism, however my personal view is that in a patient who has had recent thyroid surgery who presents with unwellness which has no clear other cause, hypothyroidism for whatever reason must be one of the first problems to be excluded.'

59. Dr Moss concluded that not considering hypothyroidism as a reason for Ms B presenting postoperatively was a mild departure from the expected standard.

60. Dr A told HDC that with the benefit of hindsight he recognises that Ms B's early return to his private rooms with postoperative swelling on 18 September 2019 should have alerted him to the need to consider alternative diagnoses for her symptoms. He said that not considering the possibility of an alternative cause for Ms B's postoperative symptoms was the most important learning he has taken from this event. He said that he is 'truly sorry that [he] appeared dismissive in this clinic and missed this as an opportunity to manage her hypothyroidism earlier'. He accepts Dr Moss's assessment that this is a mild departure from the accepted standard of care.

Documentation

61. Ms B told HDC that she is concerned that Dr A incorrectly noted that she had an FNA taken prior to the appointment on 14 June 2019, and also incorrectly noted that she had reported

pressure (obstructive[13]) symptoms in her clinical record (discussed in paragraph 18]. Ms B considers that these errors occurred because she was 'mixed up with another patient'.

62. Dr A has acknowledged these errors in his documentation. I also note (below) that there is a lack of documentation regarding the provision of postoperative safety-netting advice given to Ms B.

63. Accurate documentation is fundamentally important and is relied upon when providing ongoing patient care and when communicating with other members of the healthcare team (such as GPs). I am critical that Dr A made errors with his clinical documentation. However, I note that Dr A has acknowledged these errors, regardless of the specific human and work factors that may have contributed, and he has made changes to his practice to avoid future errors.

Safety-netting advice

64. It is unclear whether Dr A provided Ms B with safety-netting advice. There is no documentation that Dr A told Ms B to contact him if she had any further concerns after the operation. Dr A told HDC that his usual practice would be to discuss symptoms for patients to look for postoperatively and what action they should take if these develop, but he acknowledged that he did not document this. I note, however, that Ms B contacted Dr A's rooms for an early appointment as she was experiencing postoperative swelling.

65. On balance, I find it more likely than not that safety-netting advice was discussed.

66. Dr A has made several changes to his practice, including the provision of safety-netting advice (outlined below), and I accept Dr Moss's advice that he does 'not think any further specific recommendations are required to prevent this from happening in the future'.

Conclusion

67. Dr A overlooked the finding of an abnormal contralateral thyroid lobe on Ms B's ultrasound report. I accept Dr Moss's clinical advice that this was a moderate departure from the relevant standard of care. I also accept Dr Moss's advice that Dr A departed from the acceptable standard of care when he did not consider hypothyroidism as a potential diagnosis at Ms B's follow-up appointment on 18 September 2019. I am also critical of errors in Dr A's documentation, particularly noting that Dr A relied on his clinical documentation at subsequent appointments with Ms B and was sending clinic letters to Ms B's referring GP.

68. In my view, when considered together, these errors amount to a failure to provide services to Ms B with reasonable skill and care. Accordingly, I find Dr A in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[14]

[13] An enlarged thyroid may cause obstructive symptoms such as breathing or swallowing issues.
[14] Right 4(1) states: 'Every consumer has the right to have services provided with reasonable care and skill.'

Communication — other comment

69. The communication of clinical matters between Ms B and Dr A has been addressed above. I now turn to consider the manner of Dr A's other communications.

70. There is conflicting evidence regarding when Ms B was made aware of Dr A's error in reading the ultrasound report. Dr A's clinic letter to Ms B's GP on 20 December 2019 documented his awareness that the preoperative ultrasound scan showed 'quite a small thyroid on the left side' and said that he 'apologised [to Ms B] for not picking this up earlier' (I note that Ms B was not copied into this letter). However, the accounts of Ms B and her support person are that she was not made aware of the missed radiology finding until her second neck ultrasound on 14 February 2020, and Dr A offered a verbal apology at the follow-up appointment on 9 March 2020.

71. I am unable to reconcile these accounts or make a finding as to whether Ms B was made aware of the error on 20 December 2019.

72. The manner of Dr A's other communication has also been raised. Ms B told HDC that she felt that Dr A was 'arrogant' when she tried to ask questions preoperatively and was dismissive of her postoperative concerns, and she considers that the apology she received from Dr A was 'not as genuine as it should have been'.

73. Ms B told HDC that while Dr A offered her a verbal apology on 9 March 2020, she did not feel that this was genuine, and he 'looked more worried for himself'. She also did not receive a written apology from Dr A until 14 May 2020 after sending an email asking to be removed from his patient contact list.

74. Dr Moss noted that the relationship between Ms B and Dr A seems to have broken down to some degree, and he is unable to comment on the manner of Dr A's communication.

75. Dr A told HDC that he is concerned that he came across as dismissive and that his apologies were not regarded as genuine. He stated that he recognises that his 'communication did not meet Ms B's needs at times', and, while he attempted to apologise to Ms B with the best intentions, 'it is clear from her letter that [his] apologies were neither adequate nor timely'.

76. I am pleased that Dr A has reflected on his communication with Ms B and intends to attend communication workshops to address this.

Changes made

77. Dr A told HDC that he has reflected on Ms B's experience and has made several changes to his practice that he believes will prevent similar events from occurring in the future. Specifically, he has:

- Conducted a review of the last 100 radiology reports he signed off to look for missed findings;
- Researched cognitive and human factors that can influence decision-making, including recognising the importance of unexpected presentations, and is more aware of how these factors affect his practice;
- Reduced distractions and interruptions to his workflow during Health NZ clinics and reduced the time pressures within the clinic by allocating additional time between patients for dictation with protected dictation sign-off time each week. He has also stepped down from a role that was affecting his time available for clinical work;
- Ensured that clinical history and investigations are checked off against dictated letters, and random letters are routinely audited against patient results. No significant discrepancies have been recognised in the audit over the last two years;
- Planned to enrol in communication workshops focusing on communication skills following an adverse event or challenging interaction;
- Planned to enrol in a 'Mastering your risk' workshop and to lead a session at the departmental audit meeting;
- Developed a discharge planning document that includes follow-up tests, prescriptions, and safety-netting information;
- Researched best practice regarding blood tests following thyroid lobectomy and now checks blood tests six weeks after the operation, or more frequently (two, six, and eight weeks) for high-risk patients. This has been developed as a written protocol and will be communicated to patients as part of their discharge plan;
- Ensured that patients are now copied into any GP letters written prior to surgery that discuss the rationale and risks for surgery. This presents an opportunity for patients to review these discussions and present with further questions;
- Established a regular endocrinology/surgery multidisciplinary meeting (which will include radiology) to discuss challenging cases; and
- Planned to present this case (in a fully anonymised form) along with learnings to colleagues and trainees.

Recommendations

78. I acknowledge the significant changes Dr A has made to his practice following these events and consider that he provided a comprehensive apology to Ms B on 14 May 2020. In addition, I recommend that Dr A:

a) Report back to HDC with the result of the audit of radiology reports, and, if the audit has identified any further overlooked findings, provide HDC with a plan for follow-up

and remedial actions. Dr A is to provide the audit results and any plan within three months of the date of this report.

b) Provide a copy of the postoperative blood-testing protocol and discharge-planning document, within three months of the date of this report.

c) Report back to HDC regarding his enrolment in communication workshops and the Mastering Risk workshop, and presentation on the risk topic at the departmental audit meeting, within three months of the date of this report.

d) Confirm to HDC that the anonymised case study and learnings have been presented to Dr A's colleagues, within three months of the date of this report.

e) Consider copying patients into all clinic letters so that any discrepancies in the documentation of the consultation can be identified and resolved in a timely manner, and report back to HDC within three months of the date of this report.

Follow-up actions

79. A copy of this report with details identifying the parties removed, except the advisor on this case, will be sent to Health NZ, the relevant Health NZ district, and the Medical Council of New Zealand, which will be advised of Dr A's name.

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

Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from Dr David Moss:

> 'My name is David Philip Moss. I am a vocational registered general surgeon employed by Counties Manukau District Health Board. I graduated from Auckland Medical School in New Zealand in 1993 and completed the general surgical training programme of the Royal Australasian College of Surgeons, obtaining fellowship in 2003. I underwent further training in breast and endocrine surgery at the Glasgow Royal Infirmary in 2003 and 2004. I commenced consultant practice at Counties Manukau District Health Board in October 2004 as a consultant general breast and endocrine surgeon. As mentioned above I have a special interest in endocrine surgery which involves surgery to the thyroid, parathyroid and adrenal glands, and now have nearly 20 years of consultant surgical practice. I have been asked to provide an opinion to the Commissioner on the above case. I have read the HDC guidelines for independent advisors and will endeavour to follow them. I declare no conflict of interest in this case.
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> In brief summary, [Ms B] was referred to the public hospital in May 2019 following detection by her GP of a right thyroid nodule. She had an ultrasound in May which suggested a large nodule in the right lobe of the thyroid with some suspicious features for malignancy (initially reported as TIRADS5, subsequent addendum downgraded this to TIRADS4). She was seen in the outpatient clinic at the public hospital in June 2019 where she was seen by [Dr A]. The ultrasound was reviewed and given the concerns raised by the radiologist he performed a fine needle aspiration of the palpable lump himself. This showed benign changes. Given the size of the nodule and the suspicious ultrasound report the recommendation was made to [Ms B] that she undergo surgery in the form of a diagnostic right hemithyroidectomy. The operation itself was uncomplicated however subsequently [Ms B] developed quite profound hypothyroidism which was not detected until October 2019, some 3 months following the operation. She was commenced on thyroid replacement tablets appropriately and the most recent blood tests that I have seen show that she is adequately replaced with Thyroxine. This is a brief summary of her case and in fact there are two further excellent summaries of this which I have read, one from [Dr A] himself and the second one provided to me by [HDC] in the request to provide an expert opinion. I have been asked to comment on ten specific questions.
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> **Question 1. Whether [Dr A's] review of the radiology report was carried out to an appropriate standard.**
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> The radiology report is quite unusual in that it comments in the second line of the report about an absence or near absence of the left lobe of the thyroid. This is an unusual situation as normally the initial body of a report would focus on the nodule in question rather than the other lobe of the thyroid. My assumption is that this was an unusual and dramatic finding and therefore the radiologist chose to mention this early in the report, and certainly reading the report in retrospect it does stand out quite clearly. When surgery for thyroid nodules, whether they are benign or malignant, is contemplated it is a fundamental part of the assessment to establish the nature of the

other lobe of the thyroid (in this case the left lobe). This is both to decide the extent of surgery (if there were nodules present on the other side the recommendation could be for a total thyroidectomy rather than a hemithyroidectomy) and also to establish whether any further investigation is required on this side. Therefore I would conclude that the standard of care when assessing a thyroid nodule is to clearly establish the nature of the other/contralateral lobe of the thyroid. [Dr A's] failure to do this does represent a departure from accepted practice, which I would consider to be moderate. In this particular case this departure did not change the decision to perform surgery, but certainly would have potentially changed the post-operative management and indeed quite probably as [Dr A] points out, have resulted in [Ms B's] hypothyroidism being detected at an earlier stage. I believe all experienced thyroid surgeons like [Dr A] would regard this as a departure from the standard of care. Certainly it seems from [Dr A's] subsequent correspondence that as a result of this he has indeed instituted a number of measures to prevent a similar event occurring in the future and I have no doubt that this has been a very profound experience for [Dr A] from which he has likely learned a great deal.

Question 2. Whether you would have expected [Dr A] to carry out further investigations on 14/6/19.

[Dr A] performed a history and a clinical examination as well as a fine needle aspirate and I would not expect any further investigations to be performed at this stage. Specifically the letter of referral and [Dr A's] letter do not comment on anything that would suggest the thyroid was enlarged to a degree that imaging such as a CT scan would have been required.

Question 3. Whether [Dr A's] decision to perform a right hemithyroidectomy was appropriate.

I believe this was an appropriate decision given the concern of the radiologists. It is difficult to speculate on what decision would have been made had the ultrasound scan findings of a virtually absent left lobe of the thyroid been documented. Certainly alternative strategies could have been discussed such as repeating the ultrasound and fine needle aspirate at a later date to check if any growth in the nodule had occurred. Thyroid cancer is generally a very indolent tumour and a delay of many months in diagnosis is unlikely to affect prognosis therefore even for nodules that have suspicious characteristics on ultrasound, it is not unreasonable to survey these with a number of scans and fine needle aspirates if it is the desire to avoid surgery.

Question 4. What information would you have expected [Ms B] to have seen before she underwent a right hemithyroidectomy.

I think the expectation would be that she would understand the reasons for the procedure being performed (risk of malignancy) and the alternatives (observation with or without repeat fine needle aspirate). In my experience I would expect information about where the incision was to be made, that a general anaesthetic would be required, the expected time that the surgery would take and the duration of hospitalisation.

General and specific complications related to the procedure should be discussed including wound infection which is rare, bleeding which is very rare but potentially catastrophic, voice change either related to nerve injury or other causes, and injury to the parathyroid glands which in the setting of a hemithyroidectomy would be exceedingly low. I think it is reasonable to discuss with patients that even though not all of the thyroid is being removed, there is still a risk of requiring thyroid replacement in the future as hypothyroidism is relatively common even in those people who have never had thyroid surgery and therefore it is important to educate the patient about what the potential symptoms of hypothyroidism are. From my reading of the notes it seems that the information provided by [Dr A] was of an acceptable standard.

Question 5. Whether [Dr A's] post-operative management was appropriate.

It seems the operation was uncomplicated and [Ms B's] initial post-operative course was very straightforward. She was discharged at the appropriate time and followed up at an appropriate time with a discussion of histology. [Dr A] did mention that a plan should be made to check [Ms B's] thyroid function tests in the post-operative period. There was some discussion or dispute about the timing of this although I do not think there are any clear guidelines about this, and certainly provided the patient is well this can indeed wait a number of months. The specific aspect of the post-operative management that requires discussion, in my view, is what happened in relation to when [Ms B] was seen subsequently with complaints of swelling in the neck. It is impossible at this stage to ascertain exactly what the examination findings and interpretation of these by [Dr A] were. I think the symptoms of hypothyroidism are very non-specific and challenging. Certainly in my experience it is difficult to make a clinical diagnosis of hypothyroidism, however my personal view is that in a patient who has had recent thyroid surgery who presents with unwellness which has no clear other cause, hypothyroidism for whatever reason must be one of the first problems to be excluded. I accept that in the early post-operative period there can be a number of symptoms which can be hard to sort out, however the difference in [Ms B's] condition between her first post-operative review and the subsequent one seems quite profound, and this is certainly not a normal course of recovery, cannot be explained by other causes such as wound infections, and therefore I think exclusion of hypothyroidism at least should have been something that should have been considered. For this reason I do believe that there has been a mild departure from the standard of care here. As mentioned above, I imagine the actions of [Dr A] subsequent to discovering [Ms B's] hypothyroidism and his subsequent correspondence and other efforts that he has made suggests to me that this case has indeed had a profound effect on him and I do not think any further specific recommendations are required to prevent this from happening in the future.

Question 6. Would you have expected any further action from [Dr A] on 21 August, 18 September and/or 21 October 2019?

As mentioned above, once the diagnosis of hypothyroidism was established, then the advice to commence Thyroxine was appropriate. While if [Dr A] had decided to review [Ms B] in person when the diagnosis was first made this may have smoothed the

relationship subsequently, I do not think there is any additional therapy that would have been suggested at this stage, therefore I would not have expected any further action. I do not believe that in this setting [Dr A's] care was a departure from the standard of care.

Question 7. Whether the safety netting advice provided to [Ms B] on 18/9/19was adequate.

From reading the notes from the 1809/2019 appointment and [Dr A's] response from 25/3/21 it is unclear as to exactly what safety netting advice was discussed. It is certainly common for surgeons to advise patients that if they have further concerns then they should be contacted, however there is no information within the documentation provided whether this occurred, although I think it is likely it did. As to if a departure from the standard of care has occurred. At the very worst I would consider it a mild departure and once again as stated previously I believe that [Dr A's] actions subsequent to this case indicate to me that this is very unlikely to occur in the future again and so I would not suggest any further specific action.

Question 8. The adequacy of [Dr A's] communication

I would regard [Dr A's] communication with [Ms B] to be excellent. Obviously the detection of her post-operative hypothyroidism could have occurred at an earlier stage, but [Dr A's] communication before surgery and afterwards following the hypothyroid diagnosis I find him to be responsive to her problems and certainly I am impressed by the character of this communication once it was apparent that [Ms B] had developed hypothyroidism. I do not think there is any departure from the standard of care here.

Question 9. What information would you have expected [Ms B] to have received in relation to the post-operative issues concerning her left thyroid lobe.

I presume this really relates to the information that would be provided once it was apparent her thyroid lobe was very small and inadequate in size to provide enough thyroid function for her to continue without supplementation. I would expect the communication to include that this is an incredibly rare situation where a lobe of the thyroid is almost absent. Secondly thyroid supplementation is a common situation and the supplementation provides the exact same chemical as the body produces therefore it is reasonable to expect entirely normal function once adequate replacement has occurred. Thirdly I advise patients that Thyroxine has a very long half-life before wearing off and missing a single tablet is not of concern. Also is meant to take some time for the levels to be corrected and if [Ms B] was aware of this it may have helped with her understanding of the condition once hypothyroidism was diagnosed. Once again the correspondence provided does not specifically relate to exactly what information was provided and as an experienced thyroid surgeon I would expect it is likely all of this would be covered by [Dr A]. I do not think there is a clear departure from the standard of care here.

Question 10. Any others matters in this case you consider warrant comment.

This case represents a very rare situation where the patient has almost complete absence of left lobe of thyroid and thus became profoundly hypothyroid following what was thought to be resection of only a part of a normally functioning thyroid gland. As mentioned previously there seemed to have been a number of clear signals that could have resulted in this being picked up before surgery and [Dr A] I think has adequately discussed this as to potential reasons why this may have occurred. He also has made a series of changes to his practice both in terms of education and audit but also specific elements were added to thyroid surgery. I believe that once hypothyroidism was discovered [Dr A's] efforts to provide comprehensive care were excellent however at this point it seems like the relationship had indeed broken down to some degree and while there are a number of administrative shortcomings that have occurred, these in my opinion do not really relate to any serious departure from the standard of care and probably did not impact on the quality of care but clearly in my view contributed to an ongoing sense of frustration from [Ms B] about her care. As mentioned on a number of occasions I believe [Dr A] has undertaken considerable actions to both apologise to [Ms B] and also to ensure that such a similar situation would not occur in the future, and I do not believe any further clinical actions are required. Seemingly [Dr A] has apologised for all of the shortcomings and I am unsure whether any further apology is required although further acknowledgement of all these matters may assist in closure of the case.

I hope this information is satisfactory and I would be very happy to be contacted if more clarification is required.'

Further advice

Dr Moss provided the following further advice on 30 September 2022:

'*In response to a request for clarification:*

Question 8
Could you please note the source of your finding regarding [Dr A's] communication: eg was this finding from a review of the documentation, or [Dr A's] response to HDC;

Also, could you please note whether you are referring to the content of the information that is documented, or the manner in which it appears to have been communicated.

Question 9
Please advise why it seems likely that this information would have been covered by [Dr A].

Question 8 — I guess on reflection I would describe [Dr A's] communication as adequate.

I think from the point of first contact through to theatre and initial post op visit was acceptable perhaps even above average.

As previously stated once the diagnosis of hypothyroidism was made the efforts at communication was also of the standard expected.

From the point of [Ms B] beginning to feel unwell until the diagnosis of hypothyroidism was made there was not a lot of communication between the 2 parties.

She was seen once and reassured that her post op course was not abnormal and the next contact was from her GP with the diagnosis of hypothyroidism.

Based on the documentation received all I can say is that the letter from 18/9/2019 does not specify that [Ms B] can/should make contact if she has concerns and that would be the only suggestion I would make about communication.

This conclusion is made from examining the content of the communication, can't really comment on the manner.

Question 9
This conclusion is made based on my experience of professional interactions with [Dr A] as a fellow New Zealand Endocrine surgeon.

There are only small numbers of Endocrine surgeons in New Zealand, and as a metropolitan surgeon I receive regular communication for advice or for patient care from other New Zealand surgeons.

During this time I have been referred a number of patients by [Dr A] for advice and my experience is that these referrals are of excellent quality and appropriate.

The information that would need to be provided is basic advice about the nature of Thyroxine replacement and the time it takes to return to normal levels. This is communicated routinely after the operation of Total Thyroidectomy (effectively the surgery [Ms B] had).

As mentioned without knowing exactly what was discussed it's hard to comment further.'