Bay of Plenty District Health Board

A Report by the

Health and Disability Commissioner

(Case 16HDC01120)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. In October 2011, Dr B at Bay of Plenty District Health Board (BOPDHB) made a plan to repeat Mr A's hepatoma ultrasound in November 2011, and for Mr A's next hepatoma ultrasound to be ordered at the time of his planned three-yearly surveillance endoscopy, which was due in 2012. Dr B wrote to Mr A's general practitioner, Dr D, at his medical centre and stated that Mr A would receive a hepatoma ultrasound in November 2011, and then the management plan was to follow up in June 2012 at the time of Mr A's surveillance endoscopy. Mr A received his hepatoma ultrasound in November 2011.

2. In 2012, BOPDHB put all surveillance endoscopies on hold owing to resource constraints, the resignation of a staff member, and the death of another staff member within the Gastroenterology team.

3. On 18 April 2012, the Medical Services Department at BOPDHB wrote to Mr A's GP, Dr D, and stated that BOPDHB would not be able to complete endoscopy surveillance for any patients. BOPDHB also told HDC that, in 2012, a notice was placed on the BOPDHB website stating that surveillance endoscopies had been put on hold.

4. On 22 May 2012, it is documented in Mr A's GP clinical notes that a staff member of the clinic telephoned Mr A to inform him that BOPDHB was not doing surveillance screening endoscopies. Dr D documented that Mr A said this was a three-year recall for repeat screening and that he wanted to "leave at this stage — does not want private screening or [faecal occult blood tests] — not symptomatic".

5. In July 2015, Mr A consulted with GP Dr E. Dr E arranged an appointment at BOPDHB at which Mr A was referred for a scan, which identified a 7.5cm tumour in his liver. It was discovered that Mr A's hepatoma ultrasound due in 2012 was not carried out as it was to have been scheduled at the time of the endoscopy surveillance appointment that had been cancelled by BOPDHB. Mr A is now receiving palliative care.

Findings

6. By failing to continue Mr A's hepatoma ultrasounds as was intended, BOPDHB did not provide services to Mr A with reasonable care and skill, and breached Right 4(1) of the Code.

Recommendations

7. It was recommended that BOPDHB provide a written apology to Mr A. It was also recommended that BOPDHB provide this Office with a copy of the newly developed standardised protocol for follow-up arrangements for all patients with cirrhotic liver disease, confirm the implementation of the standardised protocol for follow-up arrangements for all patients with cirrhotic liver disease, conduct a review of the effectiveness of these policies, and report back to this Office. In addition, it was recommended that BOPDHB consider implementing a database for patients on dual surveillance programmes and report back to this Office within six months of the date of this report.

Complaint and investigation

8. The Commissioner received a complaint from Mr A about the services provided by Bay of Plenty District Health Board. The following issue was identified for investigation:

- *Whether Bay of Plenty District Health Board provided Mr A with an appropriate standard of care between 2011 and 2015.*

9. The parties directly involved in the investigation were:

Mr A	Consumer
Bay of Plenty District Health Board	District Health Board

10. Information was reviewed from:

Dr B	Gastroenterologist
Dr C	General practitioner
Dr D	General practitioner
Dr E	General practitioner

11. Independent expert advice was obtained from Gastroenterologist Professor Murray Barclay **(Appendix A).**

Information gathered during investigation

Background

12. In 2005, Mr A attended the Gastroenterology[1] Department at BOPDHB and was reviewed by Gastroenterologist Dr B. Dr B ordered a liver biopsy and it was identified that Mr A had cirrhosis of the liver.[2] Dr B advised Mr A that he was at high risk of developing liver cancer, and needed to have hepatoma ultrasound scans of his abdomen at six monthly intervals which would monitor his condition. Mr A was also receiving three yearly endoscopies[3] as a patient involved in the endoscopy surveillance program at BOPDHB.

13. In October 2011, Dr B made a plan to repeat Mr A's hepatoma ultrasound[4] in November 2011, and for Mr A's next hepatoma ultrasound to be ordered at the time of his planned three yearly surveillance endoscopy which was due in 2012. Dr B wrote to Mr A's general practitioner, Dr D, and stated that Mr A would receive a hepatoma ultrasound in November 2011, and then the management plan was to follow up in June 2012 at the time of Mr A's

[1] A branch of medicine concerned with the structure, functions, diseases, and pathology of the stomach and intestines
[2] Widespread disruption of normal liver structure that is caused by any of various chronic progressive conditions affecting the liver.
[3] The use of an illuminated usually fiber-optic flexible or rigid tubular instrument for visualising the interior of a hollow organ or part (such as the bladder or oesophagus) for diagnostic or therapeutic purposes
[4] Ultrasound scans of the liver to check for cancer.

surveillance endoscopy. Mr A received his hepatoma ultrasound on 18 November 2011 as planned.

14. This report focuses on the care provided by BOPDHB to Mr A following that hepatoma ultrasound.

Postponement of surveillance endoscopies

15. In 2012, BOPDHB put all surveillance endoscopies on hold due to resource constraints, the resignation of a staff member, and the death of another staff member within the Gastroenterology team.

16. On 18 April 2012, the Medical Services Department at BOPDHB wrote to Dr D and stated:

> "Bay of Plenty [DHB] will not be able to complete surveillance [endoscopy] for any of your patients; therefore we advise that patients be monitored for the development of concerning bowel symptoms … Surveillance patients may choose to seek a [endoscopy] in the private sector."

17. BOPDHB also told HDC that, in 2012, a notice was placed on the public hospital's website stating that surveillance endoscopies had been put on hold.

18. On 22 May 2012, it is documented in Mr A's GP clinical notes that a staff member of the clinic telephoned Mr A to inform him that BOPDHB was not doing surveillance screening endoscopies. Dr D documented that Mr A said this was a three year recall for repeat screening and that he wanted to "leave at this stage — does not want private screening or [faecal occult blood tests] — not symptomatic."

19. Mr A told HDC that he later consulted (during his three monthly visit) with Dr D, who enquired whether he had recently consulted with Dr B. Mr A told HDC that he informed Dr D that he had not. Mr A told HDC that Dr D told him that he would seek an appointment with Dr B for him. However, Dr D left the medical centre and Mr A did not hear anything further about this. Dr D told HDC he does not recall this discussion.

20. Following Dr D's departure from the medical centre, GP Dr C took over Mr A's care and carried out liver function tests on a regular basis. Mr A told HDC that Dr C asked him if he had been to see Dr B, and when Mr A said he had not, Dr C advised him not to worry, as "if he had liver cancer it would show up in the blood test." Dr C told HDC that while he does not have any specific memory of the discussion that day, he does not believe he would have made this statement.

21. In July 2015, Mr A transferred to another medical centre and consulted with GP Dr E. Dr E asked Mr A about his cirrhosis and why his appointments with Dr B had ceased. Dr E arranged an appointment at BOPDHB at which Mr A was referred for a scan which identified a 7.5cm tumour in his liver. It was discovered that Mr A's hepatoma ultrasound due in 2012 was not carried out as it was to be ordered at the endoscopy surveillance appointment that was cancelled by BOPDHB. Mr A is now receiving palliative care.

Response from BOPDHB

22. The CEO at the time of events stated:

> "In terms of [Mr A's] case, it was always intended that he would continue to have his ultrasounds [for his cirrhosis] but the plan at the time was to do the next one with his surveillance endoscopy. Unfortunately there was no process in place at the time for [Mr A] to be recalled for each individual procedure which resulted in him being lost to follow up."

23. Dr B told HDC: "It is unfortunate that rather than book [Mr A] another outpatient appointment, I opted to be 'efficient' and see him at the time of the surveillance endoscopy, planning to order the hepatoma surveillance ultrasound at that time."

24. BOPDHB told HDC:

> "There are no 'standard practice' guidelines for endoscopies to be scheduled alongside follow up appointments for hepatoma reviews, however at BOPDHB and internationally, healthcare providers are attempting to improve the patient experience by streamlining multiple appointments when this is a valid option. In [Mr A's] case however, the delay in the delivery of his [endoscopy] surveillance procedure had the unintended consequence of his next ultrasound for hepatoma review not being scheduled."

25. BOPDHB told HDC: "The circumstances of a patient being on dual surveillance programmes within the gastroenterology service … is relatively unusual and this was identified as the key issue for the system failure that led to [Mr A] not being recalled for his hepatoma surveillance ultrasound."

26. BOPDHB told HDC that it has reviewed all patients on surveillance programmes for cirrhotic liver disease to ensure that no other patients were impacted. BOPDHB also told HDC that a database has been developed for all hepatology patients and that BOPDHB is currently developing a standardised protocol for follow up arrangements for all patients with cirrhotic liver disease to prevent such incidents in the future.

27. BOPDHB stated: "In terms of [Mr A's] experience, we again want to apologise to him and his family that our system and process failures in 2012 resulted in the delay in his diagnosis and caused distress in an already difficult situation."

Response to provisional opinion

28. Mr A was provided with an opportunity to respond to the information gathered section of the provisional opinion. Mr A told HDC that he appreciated Dr B's acceptance of the procedural failure at BOPDHB.

29. BOPDHB was provided with an opportunity to respond to the provisional opinion. BOPDHB accepted the findings and recommendations of the provisional opinion.

Opinion: Bay of Plenty District Health Board — breach

30. The key facts in this case are not in dispute. In short, Mr A did not receive the hepatoma ultrasounds he needed from BOPDHB to monitor his liver after November 2011 because of a process failure that resulted in his ultrasounds being ordered when he attended endoscopy surveillance, and once the endoscopy surveillance was halted, his hepatoma ultrasounds were not followed up on.

31. District Health Boards are responsible for the operation of the clinical services they provide, and are responsible for service failures. DHBs have an organisational duty to facilitate continuity of care and are also responsible for ensuring that they have robust systems in place to provide an appropriate standard of care to consumers.

32. Expert advice was obtained from gastroenterologist Professor Barclay. Professor Barclay advised:

> "The sequence of events in this case seems to have been primarily caused by significant resource constraints which led to altered patient care practices that are departures from accepted standards of care. In this case, the departure from accepted standard of care occurred when surveillance endoscopy was placed on hold, which led to a cancelled appointment, which led to failure to continue hepatocellular cancer surveillance resulting in missing a cancer that might have been curable if detected at an earlier time."

33. Professor Barclay advised that this amounted to a significant departure from accepted standards. While I note that BOPDHB informed general practitioners that the endoscopy surveillance program was on hold, and placed a notice to that effect on their website, this information only applied to endoscopies and not other ultrasound procedures. When BOPDHB cancelled Mr A's scheduled endoscopy in 2012, it did not have a system in place to allow it to recognise that Mr A's hepatoma ultrasound scan was due to be ordered at this appointment.

34. Further, while Mr A's general practitioners were placed on notice in relation to monitoring Mr A for any concerning bowel symptoms, they were not placed on notice for their need to monitor Mr A's liver condition. In addition, whilst Mr A was provided with the option to go privately for endoscopy scans, he was not aware of the DHB's failure to schedule his hepatoma ultrasound and was unable to act as a partner in his own healthcare.

35. I note BOPDHB's statement that there was no standard practice regarding scheduling different follow up reviews at the same time but that "Healthcare providers are attempting to improve the patient experience by streamlining multiple appointments when this is a valid option." This is what Dr B sought to do in this case.

36. While I accept that streamlining patient appointments is a result of BOPDHB's attempt to improve the patient experience, it is entirely unacceptable that BOPDHB did not have systems in place to ensure that Mr A's requirement for a hepatoma ultrasound scan was identified when it placed a hold on the endoscopy surveillance program and cancelled Mr A's scheduled appointment. This failure resulted in Mr A going without a hepatoma ultrasound to monitor his liver for three years which is also entirely unacceptable.

37. In my view, by failing to continue Mr A's hepatoma ultrasounds as was intended, BOPDHB did not provide services to Mr A with reasonable care and skill, and breached Right 4(1) of the Code.

38. I note that BOPDHB has ensured all patients on the hepatoma surveillance program have been reviewed to ensure they were not lost to follow up. I also note that BOPDHB is reviewing the policies in place, and establishing a database of hepatology patients, with the aim of preventing such an incident from occurring in the future.

39. Professor Barclay advised: "The information provided to me indicates that there is now a robust process in place for monitoring patient surveillance procedures at Bay of Plenty DHB." I am satisfied that BOPDHB has put processes in place to minimise the risk of this occurring in the future.

Recommendations

40. I recommend that Bay of Plenty District Health Board:

a) Provide a written apology to Mr A. The apology is to be sent to HDC within three weeks of this report.

b) Provide a copy of the newly developed standardised protocol for follow up arrangements for all patients with cirrhotic liver disease to HDC within three months of the date of this report.

c) Confirm the implementation of the standardised protocol for follow-up arrangements for all patients with cirrhotic liver disease, conduct a review of the effectiveness of these policies and report back to this Office within six months of the date of this report.

d) Consider implementing a database for patients on dual surveillance programmes and report back to this Office within six months of the date of this report.

Follow-up actions

41. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Bay of Plenty District Health Board, will be sent to the New Zealand Society of Gastroenterology.

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

Appendix A: Independent expert advice to the Commissioner

The following expert advice was obtained from Gastroenterologist Professor Murray Barclay:

> "I am writing in response to your request for an opinion on this case. I am a consultant Gastroenterologist and Clinical Pharmacologist at Christchurch Hospital, Clinical Professor of Medicine with the University of Otago and a past President of the New Zealand Society of Gastroenterology.
>
> In preparing this opinion, I have reviewed the information supplied to me including your summary background to the complaint, a copy of the complaint dated 27 July 2016, a copy of the response from Bay of Plenty DHB dated 26 August 2016, [Dr C's] response dated 24 August 2016, clinical records from Bay of Plenty DHB covering the period 1 July 2009 onwards, clinical records from [another] DHB covering the period 1 July 2015 onwards, and Guidelines for independent advisors. As I am a general gastroenterologist and not a specialist hepatologist, I also sought specialist hepatologist advice in providing this opinion.
>
> I was asked to advise on whether I consider the care provided to [Mr A] by Bay of Plenty DHB and [Dr C] of [the medical centre] was reasonable in the circumstances and why. In particular I was asked to comment on the following regarding what is [the] standard of care/expected practice, if there has been a departure from the standard of care or accepted practice and how significant any departure is considered to be, how it would be viewed by my peers, and recommendations for improvement that may help to prevent a similar occurrence in the future:
>
> **1) The overall standard of [Mr A's] management by the Bay of Plenty DHB gastroenterology service given his diagnosis of hepatic cirrhosis secondary to NAFLD (including face-to-face review, hepatocellular carcinoma surveillance and surveillance endoscopy)?**
> The standard of care for surveillance in patients with cirrhosis, when this surveillance testing is accessible, is currently 6-monthly ultrasound scan of the liver looking for evidence of hepatocellular carcinoma, and upper gastrointestinal endoscopy to assess for development of oesophageal, or gastric, varices. When cirrhosis was diagnosed in [Mr A] in 2005 however, 6-monthly ultrasound was not routine and a frequency of 12-monthly would have been more common in New Zealand, partly due to debate about the best interval and partly due to limited access to timely ultrasound in many parts of New Zealand. Upper gastrointestinal endoscopy can be up to annual if significant varices have been found, but would usually be less frequent than this and may not be required if a patient is on a beta-blocker medication with no significant varices found. Routine testing for serum α-fetoprotein is not recommended in major guidelines such as the American Association for the Study of Liver Disease guidelines, but is sometimes used for surveillance in New Zealand. In approximately 30–40% of patients with hepatocellular cancer the α-fetoprotein concentration remains normal however.
>
> Between 2005 and November 2011 [Mr A] had regular clinic review, 6-monthly ultrasound and α-fetoprotein concentration measurement, and 3-yearly upper gastrointestinal endoscopy looking for evidence of portal hypertension and varices.

Therefore, up until November 2011, [Mr A's] management by Bay of Plenty DHB gastroenterology service (including face-to-face review, hepatocellular carcinoma surveillance and surveillance endoscopy) was fully according to accepted standards of care for that period. The correspondence also indicates an intention for his management to continue in the same manner after 2011. The reason that his surveillance beyond 2011 was interrupted was that his endoscopy was cancelled due to resource constraints. This led to a lack of follow-up as it was planned for a clinic appointment and ultrasound request to be arranged at the time of the endoscopy. At this point, [Mr A's] management departed from accepted standards of care as he was no longer having regular clinic follow-up and surveillance for hepatocellular carcinoma, or oesophageal or gastric varices. This is a significant departure from expected practice and would be viewed by peers as unacceptable even considering resource constraints.

2) The manner in which Bay of Plenty DHB handled resource constraints in relation to endoscopy services in 2012, including the notification sent to GPs (mentioning colonoscopies but not upper GI endoscopies)?

The correspondence available to me suggests that there were 2 main drivers for cancelling surveillance endoscopies in 2012 including, (a) a shortage of endoscopists that was compounded by one gastroenterologist resigning and another dying, and (b) financial constraint and inappropriately low endoscopy contract volumes. At this time, surveillance endoscopy was halted to allow endoscopies for symptomatic patients where the yield for abnormal findings is higher. Long delays for surveillance endoscopy in New Zealand are not unique to Bay of Plenty DHB and in other DHBs the main driver has been financial constraint and inappropriately low contract volumes, compounded by an insufficient number of endoscopists. Notification to GPs is common although there is also an option to notify patients individually which increases the chances of all affected patients receiving appropriate information regarding their endoscopy surveillance. This information then gives the patient the choice to have an endoscopy in private or wait until surveillance endoscopy is again available in the public hospital. Your summary of this case indicates that [Mr A's] GP received the notification that was sent to GPs and that this was passed on by the GP to [Mr A] who decided to wait until surveillance endoscopy was again available through the public hospital. However, I can find no indication in the information provided that this discussion occurred between [Mr A] and his GP. From my reading it appears that there was in fact no letter sent to GPs regarding surveillance endoscopies and the only notification to GPs was via the [hospital] website. Neither was a letter sent to patients. On the website, patients were advised to contact their GP if they were symptomatic, which in many cases would have been too late to prevent treatable cancer, as in the case of [Mr A]. The website notification indicated that surveillance colonoscopy was placed on hold but there was no mention of surveillance upper GI endoscopies also being [placed] on hold. Therefore, there was no indication available to [Mr A] or his GP that his surveillance upper GI endoscopies were placed on hold. Furthermore, neither [Mr A] nor his GP would have realised that missing the endoscopy in 2012 would have resulted in an end to his hepatocellular carcinoma surveillance also.

Clearly, in the website notification to GPs in Bay of Plenty DHB, it would have been preferable to state that the halt on surveillance endoscopy services applied to both colonoscopy and upper GI endoscopy so that neither GPs nor patients would assume

that upper GI endoscopy surveillance was continuing, and therefore giving patients the option for alternative private surveillance.

One question is how much effort was made by Bay of Plenty DHB to obtain locum endoscopists, or recruit permanent gastroenterologists, to cover the shortfall in 2012. It is not possible to determine this from the available information provided to me. However, there is an acknowledged ongoing shortage of endoscopists nationally and this may have led to difficulty in obtaining locums or permanent staff in 2012.

Overall, there do appear to be some inadequacies in how Bay of Plenty handled resource constraints in 2012. The first probable error was relying on a website notification to GPs regarding placing surveillance endoscopies on hold. There was a risk of GPs not seeing the notification and also not knowing which patients were affected. It would have been preferable to write to GPs directly in relation to each patient affected, and even more preferable if patients had been notified directly also. It was also a probable mistake not informing GPs that surveillance upper GI endoscopies were placed on hold in addition to surveillance colonoscopies. It is difficult to categorise this into level of accepted standard of care/expected practice because withholding surveillance endoscopies due to resource constraints is not really accepted practice, even though it has become common in New Zealand due to resource constraints.

3) Would you expect Bay of Plenty DHB to have had, in 2011, robust processes for detecting when patient surveillance being undertaken by District Health Board clinicians (such as monitoring for hepatocellular carcinoma) was due to became overdue?

In the late 2000s, surveillance protocols for hepatocellular carcinoma and oesophageal varices were gradually becoming standardised and embedded in international guidelines and by 2011, most centres in New Zealand were likely using these guidelines. However, it would have been common at that time for follow-up to be planned at outpatient clinics or endoscopy appointments and usual procedures for recalling patients would have applied. Therefore if patients missed a [follow-up] appointment, it would be quite variable whether they were recalled a second or third time, in the same way as for appointments for other conditions. Some gastroenterology services at DHBs in New Zealand now keep a registry of patients who require surveillance procedures, usually in the larger hospitals where it is more likely that there are specialist nursing staff who can run the registry and keep track of patient surveillance procedures and results. Overall, in 2011, the processes for detecting when patient surveillance being undertaken by DHB clinicians was due to become overdue were not likely to be robust in many DHBs, and likely less robust in smaller DHBs such as Bay of Plenty DHB, and therefore Bay of Plenty DHB's processes were probably no worse than might be expected. The information provided to me indicates that there is now a robust process in place for monitoring patient surveillance procedures at Bay of Plenty DHB.

4) Would you expect [Mr A's] lack of gastroenterology monitoring and follow-up to have been noted at his Emergency Department visit on 7 September 2013, noting the visit was for right upper quadrant pain and it is apparent that previous blood test results were reviewed at this time?

The paperwork related to [Mr A's] attendance at [the public hospital] on 7 September 2013 seems to be limited to a 6 line discharge letter from [a house surgeon] and in the

discharge letter it is stated that [Mr A] was actually assessed by [another doctor]. It appears [Mr A] presented with upper abdominal pain that settled with 'Pink Lady' which is usually a combination of antacid and topical anaesthetic. Response to this treatment suggests an oesophageal or gastric cause of pain. The discharge letter indicates that previous clinical records were assessed because there is a comment, 'Multiple previous endoscopies and USS, NAD'. In viewing the clinical notes it seems likely that the previous diagnosis of cirrhosis would have been seen, along with clinical notes indicating that [Mr A] had been in a surveillance program. During hospital admission, it appears that [Mr A] had a chest X-ray performed and blood tests including white bood cell count, CRP, and liver function tests. Although there were abnormalities in the liver function tests, there was apparently no significant change from previous results that would indicate a cause of the pain and so it is likely that the tests were thought to be reassuring.

In summary, it appears that the doctor or doctors that assessed [Mr A] on 7 September 2013 were focussed on the cause of his presenting pain, and were reassured by test results and the response to 'Pink Lady'. It seems likely that they missed the significance of the previous surveillance program and the fact that there had been no recent surveillance tests or clinic follow-up. In the setting of assessing and treating upper abdominal pain in an Emergency Department setting, with reassuring test results and response to treatment, it is likely a matter of chance whether the gap in surveillance testing would be picked up as an important issue at the time. I would not consider it to be particularly unreasonable, therefore, that this was missed.

However, I would be interested to know if there is more information related to this hospital encounter. All that was provided was a short discharge summary, whereas I note for earlier emergency department attendances in 2011 there are many other available documents including nursing notes, patient recordings, ambulance notes, doctors clinical notes and test results. It would be helpful to see more thorough case records for the 2013 encounter to better answer question 4.

Of particular relevance, there is a copy of a letter written from Elective Services Bay of Plenty DHB to [Mr A] 3 days before his hospital attendance, ie dated 4 September 2013, asking him if he still required endoscopy since his surveillance endoscopies were halted in 2009. It appears that [Mr A] first ticked the box stating that the procedure is no longer required, with the handwritten reason 'No problem since, See Attached Discharge Letter' which I assume refers to the Discharge letter written 3 days later. It then appears that a decision was made to cross out the choice 'The procedure is no longer required' and instead tick the box 'The procedure is still required'. I cannot tell if [Mr A] made this change himself or whether this change was made by someone else. However, this is important because this paperwork suggests that [Mr A] could have been placed back on the list for surveillance endoscopy in 2013, in which case why did this not proceed? This question needs to go back to Bay of Plenty DHB.

5) Please comment on the adequacy of the remedial measures undertaken by Bay of Plenty DHB in relation to this complaint.

There is no correspondence from Bay of Plenty DHB directly addressing the remedial measures undertaken in relation to this complaint but there are passages of text from [Dr B] that give some information in this regard. It appears that significantly more effort has

been put into dealing with the surveillance endoscopy shortfall in the past 2–3 years compared with the previous few years, with a recruitment drive resulting in more gastroenterologist FTE, now up to 4.5 and with the possibility of a further gastroenterologist being employed. Further, an extra endoscopy room has been made available, there are extra weekend endoscopy lists, and the procedures for monitoring surveillance endoscopy times have been made more robust in an effort to comply with national surveillance guidelines. A gastroenterologist with a liver interest has been employed and has been tasked with identifying all patients with cirrhosis and ensuring that all surveillance scanning is undertaken appropriately.

These remedial measures appear appropriate and adequate although is has been acknowledged that there remain patients with overdue surveillance endoscopies.

6) Please provide any further comments you feel are relevant to this case.
With regard to the care provided to [Mr A] by [Dr C], there is no specific question asked. From the information provided, [Dr C] was likely made aware of the hold on surveillance colonoscopies via the [hospital] website but it is unclear whether he realised that this also applied to surveillance gastroscopy as there was no notification to this effect. It appears that at no stage was he informed by Bay of Plenty DHB that [Mr A] had also dropped off the surveillance program for hepatocellular carcinoma and he would have likely assumed that Bay of Plenty DHB were continuing surveillance until such time as it became clear that [Mr A] had received no appointments for a long time. When this happened, it is not clear whether [Dr C] informed Bay of Plenty DHB as there is no record of the DHB receiving this correspondence. It could be argued that [Dr C] should have been more persistent in trying to re-establish hospital follow-up but I am not aware of the relationship or communication between GPs and the department of gastroenterology at that time, which may have been difficult due to understaffing in gastroenterology. Again it is difficult to judge whether there were departures from accepted standards of care/accepted practice because standard of care would be ongoing surveillance arranged and monitored by the DHB gastroenterology service which was disrupted due to lack of endoscopy resource. Therefore [Dr C] was dealing with an abnormal situation and it was probably not clear where his responsibilities lay in relation to the DHBs responsibilities.

The sequence of events in this case seems to have been primarily caused by significant resource constraint which led to altered patient care practices that are departures from accepted standards of care. In this case, the departure from accepted standards of care occurred when surveillance endoscopy has placed on hold, which lead to a cancelled appointment, which lead to failure to continue hepatocellular cancer surveillance resulting in missing a cancer that might have been curable if detected at an earlier time. The situation was likely exacerbated for this case by suboptimal communication by Bay of Plenty DHB to GPs and patients in 2012 regarding surveillance endoscopy but the primary problem was the halt on surveillance endoscopy.

I trust that this opinion is useful and I am happy to expand further on this opinion if required.

Yours sincerely

Clinical Professor Murray Barclay MB ChB, MD, FRACP, AGAF
Gastroenterologist and Clinical Pharmacologist”