MidCentral District Health Board

General Surgeon, Dr B

Anaesthetist, Dr C

Medical Centre

General Practitioner, Dr D

A Report by the

Health and Disability Commissioner

(Case 14HDC00294)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. In 2012, in Month1[1], Mr A (62 years old at that time) was diagnosed with oesophageal cancer.

2. Following several sessions of chemotherapy, on 10 Month5 Mr A underwent an Ivor Lewis oesophago-gastrectomy procedure ("Ivor Lewis") and had a percutaneous feeding jejunostomy tube inserted. Dr B performed the surgery, and the anaesthetist was Dr C. The histology showed that the cancer remained and that some of the lymph nodes contained metastatic tumour. Mr A underwent two further rounds of chemotherapy.

3. On 17 Month9, Dr B's registrar wrote to Mr A's general practitioner (GP), Dr D, noting that there were no further treatment options if the cancer recurred, and that while they did not normally follow up with serial imaging, Dr D could get back in touch and request a surveillance scan, which could be arranged at the six- or 12-month mark.

4. From around Month11, Mr A's condition began to decline. On 17 Month13, he attended an appointment with Dr D with, among other things, severe constipation and abdominal pain, and requested a scan.

5. On 22 Month13, Dr D sent a request for a CT scan to the surgical clinic at Hospital 1. Dr D did not provide any information regarding Mr A's current physical symptoms or any assessment findings. Unfortunately, the referral was not actioned by MidCentral District Health Board (MidCentral DHB).

6. On 27 Month14, Mr A reported to Dr D that he was waking up with a "sharp burn" at the base of his throat and was experiencing fatigue and shortness of breath on exertion. Dr D considered these to be new symptoms that could be attributable to the re-emergence of cancer, but he did not inform Mr A of this.

7. On 24 Month15, at the request of Mr A, Dr D re-sent the CT referral letter of 22 Month13. He did not make any additions or amendments to the original request. As there was no indication on the referral letter as to the declining health of Mr A or of the urgency of the request, the referral letter was left to be reviewed by Dr B when he returned from leave.

8. On 22 Month16, Dr B returned from leave. The following day he sent a request for a CT "to look for recurrent disease". He indicated a priority for the scan as less than two weeks.

9. On 4 Month17, Mr A underwent a CT scan at Hospital 2. No obvious metastasis was reported, but it was noted that oesophageal distension was indicative of recurrent disease, and follow-up was suggested.

10. On 18 Month17, Mr A underwent a gastroscopy at Hospital 1. Mr A was admitted to that hospital for follow-up treatment regarding a blockage in his oesophagus and, on 27 Month17, Mr A underwent a barium swallow, which showed a blockage in his upper abdomen.

[1] Relevant months are referred to as Months 1-18 to protect privacy.

11. Mr A was scheduled for laparoscopic surgery on 4 Month18 in order to attempt to unblock his digestive tract, and to confirm whether his cancer had returned.

12. Prior to the laparoscopy, Mr A had signs of a chest infection including shortness of breath, and underlying acute lung disease.

13. On the morning of 4 Month18, Mr A underwent his laparoscopic procedure. However, Dr B was unable to complete the procedure owing to the distribution of the recurrent cancer.

14. Following the termination of the anaesthesia, it took Mr A over an hour to begin breathing spontaneously. Mr A did not show any neurological response or wake from the anaesthesia. He was re-intubated but later became intolerant of his endotracheal tube. Given Mr A's condition, long-term ventilation and life support measures were not appropriate. Sadly, Mr A did not regain consciousness and died at 1.13pm.

Findings

Dr D

15. Dr D did not provide sufficient information in the initial referral on 22 Month13. Neither did he proactively offer Mr A the option of private CT scanning or review by Dr B in private at that stage. Further, Dr D did not provide updated information about Mr A's worsening symptoms in the 24 Month15 referral, discuss the possibility of private referral with Mr A, or contact Hospital 1 or Dr B about the delay. Accordingly, Dr D failed to provide Mr A with services with reasonable care and skill, and breached Right 4(1)[2] of the Code of Health and Disability Services Consumers' Rights (the Code).

16. Adverse comment is made that Dr D did not have a conversation with Mr A about his symptoms, likely prognosis, and options available to him when he presented with symptoms that were consistent with the return of cancer.

Medical centre

17. The medical centre did not breach the Code.

Dr B

18. Adverse comment is made about the scheduling error by Dr B on 3 Month5, the follow-up arrangements in place after the Ivor Lewis procedure, and that Dr B did not document the discussion he had with Mr A regarding the risks and benefits of undergoing laparoscopic surgery.

Dr C

19. Dr C's record-keeping was inadequate in a number of areas and, accordingly, it was found that that he breached Right 4(2)[3] of the Code for failing to keep clear and accurate patient records in accordance with his professional obligations.

[2] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."
[3] Right 4(2) of the Code states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

20. Adverse comment is made about Dr C's statement that he did not think that he discussed the risk of perioperative death with Mr A.

MidCentral District Health Board

21. MidCentral DHB's system for management of referrals was inadequate, as Mr A's initial referral was not tracked sufficiently in order to ensure that triage occurred. Accordingly, it was found that MidCentral DHB breached Right 4(5)[4] of the Code.

Recommendations

22. It is recommended that Dr D organise an independent GP peer to conduct a random audit of 10 referrals to specialist secondary services that Dr D has instigated within the last 12 months, to check that appropriately documented requests have been performed and appropriate reminders have been put in place to follow up such referrals. Dr D is to provide a copy of the audit to HDC within three months of the date of the final report.

23. It is recommended that Dr D attend training on communication and report to HDC within three months of the date of the final report with evidence of attendance and a report on the content of the training.

24. It is recommended that, within three months of the date of the final report, MidCentral DHB review the effectiveness of the following measures it implemented as a result of its internal review:

- The criteria and process of follow-up oesophagectomy.
- The plan for communication between cancer support nurses, GPs and specialists.
- The centralised referral process with regard to tracking and triaging of referrals.
- The guidelines for management of communication regarding life-threatening events in the operating theatre.

25. It is recommended that MidCentral DHB report to HDC on the implementation of the remaining recommendations from the internal review within three months of the date of the final opinion.

26. It is recommended that Dr C undergo further training on record-keeping within six months of the date of this opinion, and report to HDC with evidence of the content of the training and attendance.

27. It is recommended that Dr B, within three months of the date of the final opinion:

a) Review the effectiveness and appropriateness of his approach taken to follow-up.

b) Review the effectiveness of the written information provided to patients on discharge from hospital.

[4] Right 4(5) of the Code states: "Every consumer has the right to co-operation among providers to ensure quality and continuity of services."

c) Report to HDC on the implementation of his post-oesophagectomy treatment plan, which he intends to provide to GPs when a patient is referred back into their care.

28. It is recommended that Dr D, Dr C and MidCentral DHB each provide a written apology to Mrs A for their breaches of the Code, within three weeks of the date of the final opinion. The apologies are to be sent to HDC for forwarding.

Complaint and investigation

29. The Commissioner received a complaint from Mrs A about the services provided to her late husband, Mr A, by MidCentral District Health Board, Dr D, Dr B, and Dr C. The following issues were identified for investigation:

- *Whether MidCentral District Health Board provided an appropriate standard of care to Mr A in 2012 and 2013.*
- *Whether Dr B provided an appropriate standard of care to Mr A in 2012 and 2013.*
- *Whether Dr C provided an appropriate standard of care to Mr A in 2012 and 2013.*
- *Whether the medical centre provided an appropriate standard of care to Mr A in 2012 and 2013.*
- *Whether Dr D provided an appropriate standard of care to Mr A in 2012 and 2013.*

30. An investigation was commenced on 25 September 2014 and extended on 18 November 2014.

31. The parties directly involved in the investigation were:

Mrs A	Complainant
MidCentral District Health Board	Provider
Dr B	General surgeon/provider
Dr C	Anaesthetist/provider
Medical centre	Provider
Dr D	General practitioner/provider

Also mentioned in this report:

Dr F	Doctor
Dr G	Registrar
Dr H	Registrar
Dr I	Anaesthetist

32. Information was also reviewed from:

Primary Health Organisation	Provider
RN E	Cancer Support Nurse

33. Expert advice was obtained from HDC's in-house clinical advisor, general practitioner Dr David Maplesden (**Appendix A**), and independent expert advice was obtained from general surgeon Dr Patrick Alley (**Appendix B**) and anaesthetist Dr Malcom Futter (**Appendix C**). Expert advice was also provided by HDC's in-house nursing advisor, registered nurse Dawn Carey **(Appendix D)**.

Information gathered during investigation

Introduction

34. In Month1 Mr A, 62 years old at that time, was diagnosed with oesophageal cancer. In Month18, Mr A died following a surgical procedure. This opinion relates to the care provided to Mr A between 2012 and 2013 by the following health providers: general practitioner (GP) Dr D and the medical centre; MidCentral DHB; general surgeon Dr B; and anaesthetist Dr C.

Background

35. Mr A and his wife, Mrs A, consulted Mr A's GP, Dr D, at his medical centre.[5] Mr A told Dr D that he had been suffering from difficulty swallowing and impaired digestion for the previous two months. Mr A weighed 62 kilograms (kg) at the time, and previously his father had suffered from oesophageal cancer.

36. Dr D ordered blood tests (the results of which were normal) and referred Mr A to general surgeon Dr B[6] for a gastroscopy.[7]

37. Mr A was booked in for an appointment with Dr B on 1 Month1.

38. On 1 Month1 Mr A attended his appointment with Dr B at Hospital 3. Dr B performed a gastroscopy with biopsies, and referred Mr A for blood tests and a CT scan.[8]

39. On 3 Month1 Dr B wrote to Dr D, advising him of the outcome of Mr A's CT scan. Dr B's letter stated: "There is no evidence of distant metastatic[9] disease. There is thickening of the distal oesophagus consistent with cancer." Dr B, who was to be away from 4 to 20 Month1,

[5] Dr D is vocationally registered in general practice.
[6] Dr B is a vocationally registered general surgeon. Dr B is a Fellow of the Royal Australasian College of Surgeons.
[7] A procedure using an endoscope (a flexible instrument with a video camera at one end), developed for investigating disorders of the oesophagus, stomach and the first part of the small bowel.
[8] A computed tomography scan is an X-ray that produces cross-sectional images of the body.
[9] The spread of cancer from one part of the body to another.

referred Mr A for a repeat gastroscopy and biopsies, as well as a PET-CT scan,[10] at Hospital 3, and these were booked for 22 Month1.

40. Dr B also arranged for Mr A's case to be discussed at the next multidisciplinary forum for gastrointestinal and intra-abdominal cancer, which occurred on 14 Month1. At the conclusion of that meeting, the consultant surgeon noted:

> "… Histology … shows Barretts Oesophagus[11] with at least a high grade dysplasia and no overt invasion was seen."

Diagnosis of oesophageal cancer

41. On 22 Month1 Mr A attended his appointment with Dr B at Hospital 3. Investigations confirmed cancer of the lower end of the oesophagus. Dr B recorded in the postoperative report:

> "At upper endoscopy, the [cancer] can be clearly seen from 39cm to 41cm … Post-Operative Diagnosis: Adenocarcinoma[12] distal[13] oesophagus ..."

42. Dr B advised Mr A of the outcome of the investigations and referred him for chemotherapy in preparation for an Ivor Lewis oesophago-gastrectomy procedure ("Ivor Lewis")[14] scheduled in Month5. Mr A underwent three cycles of chemotherapy[15] on 7 Month2, 4 and 27 Month3.

Ivor Lewis procedure

43. Mr A was originally scheduled for an Ivor Lewis procedure on 3 Month5. On 3 Month5 Mr A presented at Hospital 1 and was prepared for surgery and taken to theatre. However, Dr B was not available to perform the surgery as he was away. Mr A's procedure was rescheduled for the following week, on 10 Month5.

44. Dr B explained that he had made an error in scheduling the procedure for 3 Month5 as he had believed he would be back at work on 2 Month5. However, he did not return to work until the following week, and Mr A was not contacted and advised of the scheduling problem.

45. On 10 Month5 Mr A underwent the Ivor Lewis procedure and had a percutaneous jejunostomy feeding tube[16] inserted. Dr B performed the surgery, and the anaesthetist was Dr C.[17]

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[10] "Positron emission tomography–computed tomography" (PET-CT) is a medical imaging technique using a device that combines a PET scanner (which produces a 3D image) and an X-ray CT scanner, so that images acquired from both devices can be taken sequentially, in the same session, and combined into a single image.
[11] "Barretts Oesophagus" refers to abnormal cells that line the oesophagus. The main cause is long-standing reflux of acid from the stomach into the oesophagus. People with Barrett's oesophagus have an increased risk of developing cancer of the oesophagus.
[12] A type of cancer that forms in mucus-secreting glands throughout the body.
[13] The point farthest away from the centre of the body.
[14] A procedure whereby the abdomen and right chest is opened to remove the upper part of the stomach as well as part of the oesophagus affected by cancer.
[15] Treatment using anti-cancer drugs.

46. The procedure went well, but the histology showed cancer of the oesophagus with 13 out of 28 of the lymph nodes containing metastatic tumour.[18]

Post Ivor Lewis procedure — improvement in Mr A's condition

47. According to Mrs A, following the Ivor Lewis procedure, Mr A's condition appeared to improve. He was in relatively good health, eating six small nutritious meals a day and walking for an hour every day.

48. On 11 Month6 Mr A attended a follow-up appointment at Hospital 1 and was reviewed by Dr B's registrar, Dr G. Dr G noted that Mr A was doing well, with no abdominal pain, reflux or dysphagia.[19] It was noted that Mr A had lost 1kg since his Ivor Lewis procedure.

49. From 8 Month7 Mr A underwent two further rounds of chemotherapy. On 30 Month7 Mr A received his fifth and final cycle of chemotherapy treatment.

50. Mr A was discharged from the oncology service at Hospital 1 to be followed up by Dr B in his surgical clinic.

51. On 4 Month9 Mr A saw Dr D for a review. Mr A had fatigue, weight loss, muscle wasting, hair loss, reduced sensation in his right anterior ribs, and fingertip paresthesia,[20] all of which were improving slowly.

Advice regarding postoperative imaging or clinical follow-up

52. On 17 Month9 Mr A and Mrs A attended a follow-up appointment with Dr B and Dr G. Dr B told HDC that he advised Mr A that routine clinical or imaging follow-up was not his usual practice because imaging can be either falsely reassuringly negative, or can show recurrence in a patient who is otherwise feeling well, "in which case a difficult clinical management scenario would arise" because there is almost never a second chance for a cure.

53. Dr G wrote to Dr D stating:

> "[Mr A] is looking well and is decidedly upbeat. He has put on a bit of weight. He denies any reflux symptoms.
>
> We had a pragmatic discussion in the presence of his wife about ongoing surveillance for his cancer. As you know, there are no further treatment options if there is recurrence. We usually do not follow people up with serial imaging in [Hospital 1]. However if [Mr A] decides he would like a surveillance scan, please get back in touch and we can arrange one for him at the 6 month or 12 month mark."

[16] A tube that is inserted into the jejunum (small intestine) for feeding. The tube is used to give liquids or medicines into the small intestine to help prevent feeding from backing up, or to remove fluids and gas from the stomach.
[17] Dr C is employed by MidCentral District Health Board and is a Fellow of the Royal College of Anaesthetists. He is a member of the Australian and New Zealand College of Anaesthetists.
[18] As Mr A's cancer affected more than seven of the nearby lymph nodes, his cancer was categorised as stage three.
[19] Difficulty swallowing.
[20] An abnormal sensation, typically tingling or pricking ("pins and needles"), caused chiefly by pressure on, or damage to, peripheral nerves.

54. Dr B told HDC that with regard to post-Ivor Lewis patients, it is his usual practice to see patients for review on just one occasion before transferring care to the patient's GP. Dr B said that he advises all of his patients who have undergone similar cancer treatments, including Mr A, that after they have recovered from initial surgery (in this case the Ivor Lewis procedure) he does not routinely offer clinical follow-up, but that he can be contacted by telephone or by letter either by the patient personally, or through the patient's GP. Dr B stated that he "definitely" advised Mr A of this in his final clinic visit.

55. In response to my provisional opinion, Mrs A advised that "[Dr B] said nothing about contacting him personally should [Mr A] become symptomatic."

56. According to Dr B, his usual practice is to inform patients that it is very unlikely that cancer recurrence can be treated successfully and, therefore, he does not routinely advise surveillance imaging, as this can result in false reassurance or alternatively detect untreatable disease that was not currently symptomatic. He further stated:

> "[Patients are advised that] appropriate investigations would be arranged in the event of any relevant symptoms developing, and that development of symptoms does not necessarily mean the cancer has returned — it may be a problem due to the treatment rather than the cancer itself, or a problem totally unrelated to the cancer or its treatment.
>
> …
>
> Although the clinic letter [dated 17 Month9 written by Dr G] does not outline the above in the same way as I have, this is exactly what I advise ALL of my patients at the last clinic following completion of and recovery from upper digestive tract cancer treatment/surgery."

57. Dr B ordered blood tests for Mr A, which showed that his blood count was improving, but that his iron level had dropped.

Decline in Mr A's condition

58. From around Month11, Mr A's condition began to deteriorate. On 24 Month11 Mrs A emailed Dr D and noted that Mr A had persistent pain in the abdominal area affected by his surgery. Mrs A explained that the pain occurred most often after eating. On 27 Month11, Dr D prescribed Mr A an anti-spasm medication[21] to take before meals to check whether food was causing spasm or cramping around the surgical site.[22]

59. On 17 Month13, Mr A attended an appointment with Dr D with severe constipation and abdominal pain, and said that he was unable to eat. Mrs A attended the appointment with her husband. Mr A brought with him to the consultation a list of symptoms and questions for Dr D, which Dr D included in his consultation notes. According to his list, Mr A was experiencing the following symptoms:

> "Muscle aches including neck aches, 'right lung area', left shoulder and midsection.

[21] Mebeverine hydrochloride, an anti-spasm medication for abdominal cramps that works by relaxing the muscles in and around the gut.
[22] Dr D responded to Mrs A's email informing her that he had sent the prescription to a local pharmacy for Mr A to pick up. He did not review Mr A.

> Nerve damage including right lung and thorax, difficulties interpreting whether he was hungry/in pain/needed the toilet.
>
> Ringing/hissing in ears.
>
> Gas and full bladder, (painful).
>
> Constipation."

60. Mrs A told HDC that Mr A wrote a list of questions, which included whether his symptoms were normal for someone who had had an Ivor Lewis procedure, and asked, "At what point should we request a CT or PET?" According to Mrs A, Mr A asked Dr D to send a referral to Dr B for a CT scan, as outlined in Dr G's letter of 17 Month9.

61. With regard to this appointment, Dr D noted:

> "Drinking OK but tends to limit fluids because bladder feels too full too soon — though this feeling is upper-mid abd[omen]. Pain across upper abd[omen] — nil on waking. Assoc[iated] w[ith] eating. Present when not but worse when constipated … Worried no follow up planned w positive nodes. Surg Reg offered scan at 6 or 12 mth mark. Surg was [Month5].
>
> Worried advised no [treatment] if recurs. I suggested solitary peripheral [metastasis] might be excised but lung or central multiple liver [metastasis] not amenable to [treatment].
>
> Request scan
>
> [Discuss] situation w dietitian — apt for advice?
>
> Connect w [cancer support nurse]."

Referral for CT scan

62. On 22 Month13, following his consultation with Mr A, Dr D sent a request for a CT scan to the surgical clinic at Hospital 1. Dr D stated in his referral letter:

> "I enclose a copy of the last Clinic letter of 17 [Month9], indicating that routine follow-ups don't influence outcome but offering a surveillance scan if requested.
>
> [Mr A] is keen to take up this offer of a 6 month scan, given that his chemo finished 30 [Month7]."

63. Dr D did not provide any information regarding Mr A's current condition, including the physical symptoms he was currently suffering. Dr D said that that was because the symptoms in Month13 appeared to be a continuation of the symptoms he noted on 4 Month9, which he said "the surgical clinic [would] have been aware of when discharging [Mr A] [at the last surgical outpatient's review] on 17 [Month9] and [Month11]". Dr D told HDC that he "felt the message would be clear that [Mr A] would like the scan arranged immediately given that [he was] then close to the 6-month point".

64. On 22 Month13, Dr D also requested an X-ray for Mr A to be undertaken at Hospital 1.

65. In addition, Dr D wrote a referral to cancer support nurse (CSN) RN E at the Primary Health Organisation (PHO) requesting her support. The role of a CSN is to provide knowledge and support to the consumer navigating the health system. The CSN assists consumers with access to services and with managing their own health. The CSN can work alongside both primary and secondary services supporting the consumer.

66. In the referral to RN E, Dr D enclosed a copy of Mr A's list of questions and requested her assistance in responding to them. Dr D also enclosed a copy of Dr G's letter to Dr D dated 17 Month9. RN E told HDC that this letter "did not state that [Mr A] had a terminal condition".

Referral for CT scan received — not actioned

67. MidCentral DHB advised HDC that on 25 Month13 there is a note in the Patient Information Management System (PIMS) that a letter dated 22 Month13 was received and registered on PIMS with the comment "[GP letter]22 Month13 — [Consultant] TO VIEW". However, the referral for the CT scan was not actioned, and MidCentral DHB has not been able to locate the original letter.

On-going care

68. On 28 Month13 Mr A had an X-ray as ordered by Dr D. On the same day, Dr D wrote to Mr A advising him that the X-ray results showed "significant constipation", and that "[d]ealing with this should take a lot of pressure off the operation site". Dr D prescribed Laxol (a treatment for constipation) and recommended follow-up if symptoms persisted.

69. On 5 Month14 RN E recorded in Mr A's progress notes that she had received a phone call from Dr D's GP practice, asking her to contact Mr A as he had "quite a few questions". RN E noted that she contacted Mr A and arranged to see him on 7 Month14. RN E recorded: "[Mr A] has quite a few questions which I feel I may need to ask for some assistance from the colorectal team."

70. On 7 Month14 RN E visited Mr A at his home. She recorded that Mr A weighed 48.6kg, that he had not had any input from the surgical team since Month8 and that further input was required. RN E recorded that Mr A was having ongoing problems with constipation, and recommended that he double his dose of Laxol every second day. RN E noted:

> "[I] have expressed that [Mr A] is doing and has done really well to get this far he is aware that the [majority] of patients do not do well …"

71. RN E told HDC that her impression of Mr A was that he was well informed about his condition and his medical history. According to RN E, Mr A told her that he was aware that most patients having had an Ivor Lewis procedure have an average life expectancy of two years following the procedure.

72. On 14 Month14 Mr A had a follow-up appointment with Dr D, which he attended with his wife. Dr D noted that Mr A's constipation had "improved" but that he was experiencing nerve pain just below his ribs, on his right-hand side. Dr D told HDC that he considered that Mr A's constipation was causing him to have a reduced appetite.

73. Mrs A told HDC that, as they had not yet received a referral for a CT scan, she and Mr A enquired at this appointment about a private CT scan, and said that they would be willing to pay for a scan.

74. In this respect, Dr D told HDC that if Mrs and Mr A had requested a private scan, he would have completed the appropriate referral form and provided it to Mrs and Mr A to take to a private radiology service to arrange an appointment, as was his standard practice. Dr D said that he never posts these forms for patients, and has "no reason to think that [he] would have agreed to arrange a private CT scan" without following his usual practice. There is no record in the clinical notes of a discussion on 14 Month14 regarding the possibility of a private CT scan.

75. Mrs A told HDC that she and her husband asked RN E about the cost of a private scan on a number of occasions, and that she was unable to answer them.

76. RN E told HDC:

> "As a community cancer nurse my role is to be an advocate and support for the patient and family. I am unable to request or incite that the GP do a referral for a scan or incite that they send the patient back for review by [the] surgical clinic. This is beyond both my job description and scope of practice."

77. The PHO told HDC that a cancer support nurse would not be expected to know the cost of a private CT scan. Furthermore, the PHO stated: "[I]t could place the Cancer Support Nurse in a position of conflict of interest if they were perceived to be recommending any private provider over another."

78. On 24 Month14 RN E recorded that she spoke to Mr A by telephone. Mr A told RN E that he had been getting acid reflux and experiencing symptoms similar to a cold. Following her discussion with Mr A, RN E reported to Dr D that Mr A was experiencing reflux and that he had experienced these symptoms previously but "not for many years". RN E referred Mr A to a dietitian at the outpatient clinic at Hospital 1. RN E marked the referral as "semi urgent" and noted:

> "Please could I ask you to get in contact with this gent. He had an Ivor Lewis oesophagectomy done [Month5].
>
> He is currently doing very well. Pain improved constipation improved, has slight reflux. Please could you assist him with his dietary needs, he is currently having six small meals a day. Current weight 48.6kg. He has always been a slight man. I am not sure if he needs supplements, but he does need some advice."

Symptoms consistent with return of cancer

79. On 27 Month14 Mr A attended a follow-up appointment with Dr D. Mr A reported that he was waking up with a "sharp burn" at the base of his throat and was experiencing fatigue and shortness of breath on exertion. Dr D told HDC that he considered these to be new symptoms and considered that they could be attributable to the re-emergence of cancer. Dr D did not

inform Mr A of this. Dr D told HDC that he understood that the surgical clinic had advised that if Mr A's cancer returned, nothing more could be done for him, other than palliative care.

80. Dr D ordered blood tests, which showed that Mr A's C-reactive protein[23] level was mildly raised and his total protein was slightly low. Dr D started Mr A back on omeprazole for his reflux and suggested that Mr A raise the head of his bed for sleeping.

81. On 5 Month15 RN E visited Mr A at his home. Mr A's weight was approximately 50kg and he told RN E that he was concerned regarding broken veins underneath his toes. RN E referred Mr A to Dr D. RN E told HDC that Dr D did not inform her of his concerns that Mr A's cancer had returned.

82. The same day, Mr A attended Dr D's practice and was seen by Dr F,[24] who arranged blood tests for Mr A to try to ascertain the cause of the broken veins under his toes.

Follow-up of initial referral

83. On 9 Month15 Mr A again attended an appointment with Dr D, as his condition was deteriorating. Mr A enquired about Dr D's referral for a CT scan, which he had not yet heard back about. On 10 Month15 Dr D wrote to Mr A advising him of the outcome of the blood tests ordered by Dr F. The results were normal, with no sign of infection or inflammation, and no explanation was found for the broken veins underneath his toes. In his letter, Dr D told Mr A that he wanted to see him again if his symptoms progressed, and queried whether he had heard from the surgical clinic regarding a CT scan appointment. Dr D told HDC that he did not receive a response from Mr A to this letter.

84. On 15 Month15 RN E recorded that she spoke with Mr A on the telephone and arranged to see him on 19 Month15. She recorded that he was still experiencing reflux, and that he was now experiencing poor sleep due to pain from constipation. She also noted, "[F]eet are slightly better, not infected, remain slight dusky[25] in colour but bloods are fine," and that he had not lost weight (which remained 51.8kg) but was concerned at his loss of muscle.

85. Following her appointment with Mr A, RN E sent a referral to the dietitian service at the PHO. The PHO received the referral on 17 Month15.

86. On 19 Month15 RN E visited Mr A at his home as arranged.

87. Following her appointment with Mr A, RN E wrote to Dr D advising that Mr A was concerned about his weight (now 51.8kg). She noted that while Mr A had not lost weight since her last visit, he was concerned about loss of muscle. RN E further noted in her letter to Dr D:

> "I also noted his feet this morning noting that they are a lot less discoloured, remaining dusky but over all have improved, good blood return on slight pressure to the toes, good

[23] A protein made by the liver and released into the blood within a few hours after tissue injury, the start of an infection, or other cause of inflammation.
[24] Dr F is vocationally registered in general practice.
[25] "Dusky" refers to having a bluish tinge. There can be a number of causes including peripheral vascular disease.

pulse. I did note that he has an increased number of petechial haemorrhages[26] to the base of his toes. Please could I ask you to look at these again?"

Initial referral for CT scan re-sent

88. On 24 Month15, Dr D received an email from Mr A stating: "It is now 10 months since my Ivor Lewis procedure, so I guess the 6-month scan is overdue!" Mr A further stated that his constipation was "letting up" and that there had been "very little reflux" lately.

89. Dr D wrote to Mr A and noted that he would "re-send the letter to the surgical clinic requesting the CT scan". Dr D re-sent his referral letter of 22 Month13. He did not make any additions or amendments to his original request. In this respect, Dr D told HDC:

> "The reason for [simply] re-sending the letter was my belief that I simply needed to remind the surgical clinic team that a CT scan had been promised and the appointment was outstanding and needed to be authorised … had I believed that the CT scan was not imminent or that my [24] Month15 letter would not be a sufficient reminder to expedite this, I would have included information about [Mr A's] recent symptoms … "

Referral letter received (second time)

90. On 26 Month15 MidCentral DHB received a copy of the 22 Month13 referral letter for Mr A's CT scan. MidCentral DHB advised HDC that this copy of the referral letter was placed in the triage folder for the surgical clinic to triage. The triage consultant noted, "Show [Dr B]."[27] However, at this time Dr B was on annual leave until 22 Month16. MidCentral DHB stated that as there was no indication on the referral letter as to the declining health of Mr A or of the urgency of the request, the referral letter was left to be reviewed by Dr B when he returned from leave.

91. On 16 Month16 RN E visited Mr A at his home. She recorded that Mr A's weight was 49.5kg. This was down from 51.8kg recorded at the previous visit on 19 Month15. RN E further noted: "[Mr A and his wife] are very fixated on the need to have a scan … [Mrs A] feels that he is losing condition and is generally getting worse." RN E arranged an appointment for Mr A to see Dr D that afternoon.

92. Mr A attended his appointment with Dr D that afternoon and, as Mr A had still not received an appointment for a CT scan, Dr D referred him for an ultrasound scan[28] at Hospital 1, which was scheduled for 26 Month16.

93. On 21 Month16 RN E visited Mr A at his home. She noted that she had discussed Mr A's weight loss with a colleague, who suggested that Mr A "try adding the powdered supplement drink powder to normal milk and foods" in addition to Fortisip, which he was currently having twice a day. RN E recorded that Mr A was scheduled to have an ultrasound scan later that week. RN E noted:

[26] Tiny pinpoint red marks that are an important sign of asphyxia (loss of oxygen).
[27] The triage note is not signed.
[28] A test that uses high frequency sound waves to create an image of organs and structures inside of the body.

> "I feel that he is rather fixated on the idea of having progression of disease. Have suggested that this really may not be the case and that he has just gotten to a stage where his life and wellbeing has now become stable."

Referral for CT scan reviewed

94. On 22 Month16, Dr B returned from leave. The following day, on 23 Month16, Dr B reviewed Dr D's referral letter for Mr A's CT scan and sent a request for a CT at Hospital 1 "to look for recurrent disease". Dr B indicated a priority for the scan as less than two weeks.

95. Dr B stated that he gave the CT scan request "routine priority" because:

> "The requesting letter was for a routine CT scan as offered at my last clinic follow-up after surgery. At no stage was I aware that there were any symptoms or clinical concerns until I was advised of the scan report."

96. On 23 Month16, Mr A emailed Dr D and advised that he had decided against the ultrasound, which was booked for 26 Month16, and would "wait until [Dr B] and his team approved the CT scan". Mr A stated:

> "[Dr B] tells me that even the CT is not fine-grained enough to rule out cancer returning until a tumour shows up that's big enough to be doing real damage. I am content to remain in limbo for the time being, and hope for the best."

97. On 26 Month16 Dr B's request for a CT was logged in the Hospital 1 Medical Imaging booking system, and Mr A was booked for a CT scan on 4 Month17.

98. On 30 Month16 RN E visited Mr A at his home. She noted:

> "[Mrs A] was beside herself with upset, frustration, anger and grief as she is [convinced] that the disease is back. [Mr A] appears to have lost more [weight] since I saw him last week …"

99. RN E noted that Mr A had not attended the ultrasound scan the previous week as he was waiting for a CT scan, and that he was seeing the hospital dietitian later that morning.

Appointment with dietitian

100. Also on 30 Month16, Mr A attended an appointment with a hospital dietitian. By this time Mr A's weight had increased to 50.8kg. The dietitian noted that the primary concerns were "severe constipation" and reflux. The dietitian recommended supplements and arranged follow-up.

CT scan

101. On 4 Month17 Mr A underwent a CT scan at Hospital 2.[29] The scan report noted "mild bronchial dilatation" and queried whether there were any clinical features to suggest

[29] The Hospital 1 scanner was not available at that time.

aspiration.[30] The scan showed oesophageal distension.[31] No obvious metastasis was reported, and it was noted that the density in the left lower lobe of the lungs was likely to be caused by infection, although "comparison with pre-operative imaging and follow-up" was suggested.

102. Dr D received a copy of Mr A's CT scan report. Dr D informed Mr A of the outcome of the scan (that the scan showed thickening of the oesophagus but not the cause) and, on 9 Month17, Dr D wrote to Dr B noting that the CT scan showed "significant hold up in the oesophagus and signs of aspiration in the lungs", and that Mr A had been experiencing reflux cough and difficulty gaining weight. Dr D requested follow-up for Mr A with Dr B. Dr B arranged for Mr A to undergo a gastroscopy at Hospital 1, which was scheduled for 18 Month17.

103. On 10 Month17 RN E contacted Mr A at his home. RN E recorded: "[According to Mr A,] the cancer has not come back but he has got two pockets of distention oesophageal region at the junction and the other in the bowel …" RN E arranged to visit Mr A at his home on 13 Month17.

104. On 13 Month17 RN E visited Mr A at his home. She noted that his weight was 50.3kg and that he was due to see the gastroenterology team at Hospital 1 [on 18 Month17] for a gastroscopy. Mr A told RN E that his toes "looked better".

Hospital 1

105. On 18 Month17 Mr A underwent a gastroscopy at Hospital 1. The findings indicated that Mr A had an "abnormally dilated upper oesophagus with considerable food debris" and that a blockage was causing Mr A's oesophagus and stomach to be bloated. In the gastroscopy report Dr B stated:

> "[Mr A] has malnutrition with significant weight loss … I recommend immediate admission for parenteral nutrition via PICC line[32] after blood tests for general and nutrition assessment. He will also need a contrast study to confirm whether there is a mechanical obstruction at the proximal jejunum,[33] and also an anaesthetic assessment with view to laparoscopy/laparotomy if there is a mechanical obstruction at the proximal jejunum. He can drink small amounts for comfort only."

106. Mrs A told HDC that after performing the gastroscopy, Dr B explained to her and her husband that there was "no sign of cancer, and that's great".

107. Mr A was admitted to Hospital 1 for follow-up treatment regarding the blockage in his oesophagus.

[30] Aspiration occurs when food, saliva, liquids, or vomit is breathed into the lungs or airways leading to the lungs, instead of being swallowed into the oesophagus and stomach.
[31] An enlarging or ballooning effect.
[32] A peripherally inserted central catheter (PICC) is a form of intravenous access that can be used for a prolonged period of time for parenteral (intravenous) nutrition.
[33] The beginning of the second part of the small intestine, situated between the duodenum and the ileum.

108. On 23 Month17 it was recorded that Mr A had an early warning score (EWS)[34] of 1 owing to his heart rate being 110bpm.[35] However, it was noted: "[O]ther [observations] are stable, afebrile.[36] Nil actions taken as high [heart rate] normal for [patient]." Mr A's weight was recorded as 54.8kg and it was noted: "[Patient] states previous weight 51kg."

109. On the morning of 24 Month17 it was recorded in the clinical notes again that Mr A's EWS was 1 owing to his heart rate being 109bpm. Again in the evening it was recorded that Mr A's EWS was 1 as his heart rate was over 100bpm. It was noted: "Other obs stable. Afebrile …"

110. On the morning of 25 Month17 it was recorded in the clinical notes: "EWS — 1 due to [heart rate] — 104bpm. Other [observations] stable, afebrile." Mr A's weight was recorded again as being 54.8kg, and it was noted: "[R]equest daily weigh … monitor input + output. Dietician follow-up Friday." By the evening Mr A's EWS was recorded as zero.

111. On the morning of 26 Month17 it was again recorded with regard to Mr A: "EWS — 1 due to [heart rate variability] — 104bpm. Within [patient's] norms. Nil actions taken …" His weight was recorded as being 54.7kg. By the evening Mr A's EWS was recorded as being "2 due to [respiratory rate] = 16bpm (breaths per minute) + [pulse rate]108bpm. [Patient] had just mobilised 20 mins earlier …"

112. On 27 Month17, a Clinical Nurse Specialist specialising in gastrointestinal cancer care assessed Mr A and noted that he "appeared weak and tired" and was having difficulty swallowing Panadol tablets. The Clinical Nurse Specialist recommended Panadol syrup and noted that Mr A was awaiting a barium swallow. [37]

113. On the same day, Mr A underwent a barium swallow, which showed a blockage in his upper abdomen. A consultant radiologist noted in the radiology report:

> "On correlation with the recent CT scan from [Hospital 2] I think there is excessive soft tissue in the upper abdomen around the distal stomach. The patient tells me he has had recent gastroscopy. This would suggest that this is not a luminal[38] recurrence but appearances are likely to represent extrinsic compression from peritoneal tumour recurrence."

114. Mr A was scheduled for laparoscopic surgery on 4 Month18 in order to attempt to unblock his digestive tract, and to confirm whether his cancer had returned.

[34] A guide to quickly determine the degree of illness of a patient based on blood pressure, heart rate, respiratory rate, temperature and level of consciousness. The patient is given a score between 0 (normal for the patient) and 3 (abnormal).
[35] A normal resting heart rate for adults ranges from 60 to 100 beats per minute (bpm).
[36] Without fever.
[37] A series of radiographs used to examine the gastrointestinal tract for abnormalities. The patient swallows barium, which enhances the visibility of the relevant parts of the gastrointestinal tract by coating the inside wall of the tract and appearing white on the film.
[38] Inside a tubular structure such as an artery or intestine.

Mr A's condition prior to laparoscopy

115. It was noted in Mr A's nursing notes on 29 Month17 that he had an EWS of 3 "due to ongoing tachycardia[39] + [respiration rate]". Again on 30 Month17 it was noted in Mr A's nursing notes that he had an EWS of 3 "due to tachycardia: 114 and [respiration rate] of 16".

116. At 11.26am on 30 Month17, Mr A sent a text message to Mrs A stating that he felt unwell and miserable.

117. Dr C, who was also the anaesthetist for Mr A's Ivor Lewis procedure, told HDC that prior to the laparoscopy, Mr A was noted to have clinical signs of a chest infection, including shortness of breath, and his white blood cell count was above normal.

118. By 11pm on 30 Month17, Mr A's EWS had reduced to 2. His respiratory rate was recorded as 16 and his heart rate was down slightly at 108bpm.

119. On 1 Month18, it is recorded again in Mr A's nursing notes that his EWS was 2 "due to [respiration rate] — 16, [heart rate] — 108". Mr A underwent a preoperative chest X-ray, and sputum[40] swabs and urine samples were taken to determine whether Mr A had an infection.

120. The X-ray showed "obvious changes" as compared to the X-ray taken on 20 Month17, including excess fluid around the lungs. The clinical notes contain a query of metastasis and recommend a repeat CT scan of Mr A's chest. The sputum sample showed *Klebsiella oxytoca*,[41] and Mr A was commenced on Augmentin.[42] Dr B said that Mr A was not clinically septic.

121. On the following day, 2 Month18, the consultant radiologist recorded on the X-ray report:

> "There appears to be either atelectasis[43] or infection behind the heart. The rest of the lungs are clear. Note is made of barium in the lower intrathoracic[44] stomach from the barium swallow of four days ago. This suggests that there is complete obstruction at the level of the thoracic/abdominal stomach."

122. In this respect, Dr C told HDC that by 2 Month18, Mr A's white blood cell count was trending downward and his respiratory rate "remained consistent and stable", indicating that his infection was improving. Dr C told HDC that Mr A's cardiovascular and respiratory observations were stable and "not indicating major concerns in view of the minimally invasive laparoscopic based procedure to be undertaken". Dr C noted that Mr A had underlying acute lung disease, but told HDC that Mr A was "not compromised to such a degree that I considered he was likely to need respiratory support" following the laparoscopic procedure.

[39] An abnormally rapid heart rate.
[40] Saliva and mucus.
[41] A bacterium that often appears in people with impaired immunity, and can cause a number of infections, including septicaemia.
[42] An antibiotic used to treat bacterial infections.
[43] Partial collapse or incomplete inflation of the lung.
[44] Located within the chest.

123. On 3 Month18 Mr A sent a text message to Mrs A stating:

> "[The anaesthetist] says he's all up to date with me, will just meet us in theatre tomorrow am … all systems look good to go. [Initials]."

124. At 10.20pm Mr A's EWS was recorded as between 1 and 2. It was noted that Mr A's vitals were "within [patient's] norms & [patient] asymptomatic".

125. Between 2 and 4 Month18 Mr A was administered 1.2ml of Augmentin every eight hours.

Day of surgery, 4 Month18

126. At 5.30am on 4 Month18 Mr A's EWS was recorded as 2, and again it was noted that his vitals were "within range for patient".

127. On the same day, the laboratory report from swabs taken on 1 Month18 were returned, showing "heavy growth of CANDIDA SPECIES".[45]

Information provided to Mr A pre-surgery

128. Mrs A told HDC that neither she nor Mr A were informed of his condition, including that Mr A had pneumonia[46], she said they were told Mr A had a chest infection.

129. Dr B told HDC that the risks of laparoscopy were definitely outlined in discussion with Mr and Mrs A. Dr B told HDC:

> "I advised [Mr A] that he would not undergo this operation until he had recovered sufficiently from his lung infection to the point where he could readily maintain his blood oxygen levels without supplementary oxygen, that his nutrition state was sufficiently robust to withstand such surgery and that his overall condition was at least satisfactory to the specialist anaesthetist, [Dr C].
>
> …
>
> I advised [Mr A] that he was higher risk than a fit elective patient because of his overall loss of condition compared to, say, several months ago and his recent lung infection. I advised him that although the customary anaesthetic/peri-operative management is to defer surgery under general anaesthetic for at least six weeks after a lung infection to allow full recovery, [Mr A] unfortunately did not have the luxury of this time."

130. Dr B told HDC that prior to Mr A's laparoscopy he advised Mr A that he ought to undergo a laparoscopy for the following two reasons:

> "The first was to settle diagnostic doubt as to whether he had recurrent cancer or not … The second reason was that he continued with unresolved upper intestinal obstruction … Although recurrent cancer was a definite possibility, it would be tragic to assume this was the case … Furthermore, if [Mr A] had localised recurrent/incurable cancer obstructing a localised segment of upper small intestine, a simple intestinal bypass could resolve his

[45] Candida is a fungus that can cause infection.
[46] Bacterial or viral infection of the lungs.

> symptoms to allow discharge from hospital with a much improved quality of life and palliative care at home. …"

131. Dr B stated in his report to the Coroner dated 29 Month18:

> "[T]he aim of this operation was to confirm or refute the diagnosis of recurrent oesophageal cancer and as a therapeutic procedure to manage the blockage, particularly if recurrent cancer diagnosis was made, so that [Mr A] could be managed at home or in the Hospice without IV feeding/fluids."

132. Dr B told HDC that an upper intestinal obstruction could be caused by factors other than recurrent cancer.

133. Dr B advised that although Mr A's condition had improved since his admission to hospital, he did not see it improving significantly in the near future, without surgical intervention. Dr B said that Mr A was "made aware that the timing of the surgery was a best compromise between adequate recovery from his acute illness (lung infection) balanced with his nutrition state and overall clinical condition without the luxury of time to await complete clinical recovery".

134. Dr B said he told Mr A that there is always risk to any surgery, but neither he nor Dr C foresaw a high risk of death, although there was a definitive risk of another lung infection or respiratory difficulties postoperatively. Dr B said that infective and wound healing complications would be the highest risk adverse events, or an anastomotic leak if there was a surgical join made to bypass an obstructed portion of bowel.

135. Dr B told HDC: "I discussed the above on several occasions either in principle or in detail with just myself and him present, or during ward round with my resident medical team and nurse(s), but unfortunately there is no written record in this much detail to prove this."

136. The "operation procedure/consent form" for the laparoscopy signed by Mr A states that the benefits and risks were discussed with Mr A, but does not outline what the risks were. The progress notes have no record of risks having been discussed.

137. Dr B told MidCentral DHB in response to their internal review that his assessment of Mr A prior to his laparoscopy was that he was weakened by poor nutrition, pneumonia, and possible recurrence of malignancy. However, Dr B considered that Mr A was able to withstand the impact of laparoscopy. With regard to the risk of placing Mr A under anaesthesia, Dr B stated in his report to the Coroner dated 29 Month18:

> "My anaesthetist, [Dr C], advised me that he had no undue concerns preoperatively or during the operation itself."

138. Dr B stated:

> "I remember [Mr A] chomping at the bit to get on with it. And me saying 'no, let's just wait, because you have a chest infection, and we need to wait on [total parenteral nutrition] and just settle things down'. I don't think that is recorded … And there is probably on 2 occasions, that I had said to him that there was high risk at the moment;

> you are not in a good condition, you got pneumonia. That is not recorded. Unfortunately a lot of what I do is not recorded, a lot of what we all do is not recorded."

139. With regard to conversations between Dr B and Mr A, registrar Dr H told HDC:

> "I witnessed [Dr B] outline the benefits and risks of performing laparoscopic surgery to [Mr A] as part of the informed consent process. Given his condition at presentation and his background of malignancy he was considered a high-risk patient. I also recall a discussion between [Dr B] and [Mr A] and his wife on [the] ward around the principles and potential risks of laparoscopic surgery. After this discussion it was with a collective understanding, ([Mr A], his wife and the medical team), of these benefits and risks, that the decision to go to theatre was made."

Dr C

140. On the morning of 4 Month18, prior to Mr A's surgery, Dr C undertook a preoperative review of Mr A. Dr C told HDC that as he had cared for Mr A during his Ivor Lewis procedure, as well as having had some involvement with him during his current admission, he was aware of Mr A's medical, surgical and anaesthetic history, including that he had not had any difficulties with anaesthesia previously. Dr C told MidCentral DHB that prior to the laparoscopy on 4 Month18, it was identified that Mr A was in poor condition. However, Dr C considered that Mr A "looked well considering, and [he] did not see the need to discuss limitations of care as [he] was not expecting any untoward events". Dr C stated that he did not anticipate that Mr A would fail to wake after the anaesthetic.

141. There is no documentation of Dr C's conversation with Mr A prior to surgery. Dr C told HDC that his note-taking in this respect was "less than optimal", but his recollection is that his conversation would have included the following:

> "My awareness of [Mr A's] medical, surgical and anaesthetic history. My understanding [was] [Mr A] was in a relatively compromised condition with malnutrition and repeated micro-aspiration events.
>
> [Mr A] had persistent tachycardia, was afebrile, had oxygen saturations of 93% but appeared reasonably well. In light of his poor condition, I knew that anaesthesia management had to be guarded but I did not have any specific concerns about [Mr A] undergoing the minimally invasive laparoscopic based procedure to be undertaken.
>
> …
>
> Cardiovascular and respiratory observations were stable and not indicating major concerns … [Mr A] had underlying acute lung disease but was not compromised to such a degree that I considered he was likely to need respiratory support after the laparoscopy.
>
> In accordance with my normal practice, I would therefore have discussed the type of anaesthesia I proposed to use during the procedure and the relevant risks associated with that plan in light of [Mr A's] particular condition.

> I do specifically recall reiterating to [Mr A] that the procedure was being undertaken solely to get him home, with a palliative intent.[47]"

142. Dr C told HDC that he is unable to recall with clarity the exact information he provided to Mr A prior to the laparoscopy procedure. However, Dr C said it is unlikely that he would have considered that the possibility of needing respiratory support after the laparoscopy was a relevant risk to discuss with Mr A at the time of the preoperative discussion. Dr C said: "I knew the anaesthesia management had to be guarded but I did not have any specific concerns about [Mr A] undergoing the minimally invasive laparoscopic based procedure to be undertaken."

143. Dr C stated: "At the time, I felt that the risk of death from the proposed procedure was low and my discussion with [Mr A] would have reflected this view." He further clarified:

> "Given that the surgeon had informed me that [Mr A] had inoperable recurrent oesophageal cancer[48] and this was a palliative procedure in order to be able to feed [Mr A] at home and not remain in hospital. I at the time felt that the proposed procedure (a laparoscopic insertion of feeding jejunostomy) was of low risk of death during the procedure. At the time I felt that the risk of death for a cardiovascular event was small and although there was respiratory compromise present pre-operatively I felt that that could be managed post operatively.
>
> In short I would have discussed the risks of post-operative nausea and vomiting, dental damage the possible need of post operative vasopressors and supplemental oxygen. I do not think that I discussed the risk of perioperative death. Although I assumed with regards to the information given to me by the surgical team the probability of death within the weeks following the operation was high and the intention of the operation was to enable [Mr A] to return home and die with his family."

144. The "Receipt of Information and Anaesthetic Consent" document signed by Mr A mentions information and risks, but nothing specific is noted on the document.

Surgery

145. On the morning of 4 Month18, Mr A underwent his laparoscopic procedure. However, Dr B was unable to complete the procedure to unblock Mr A's digestive tract, and simply took laparoscopic biopsies before terminating the procedure. Dr B recorded in the operation note: "[T]here was no simple, safe surgical manoevure that could restore digestive tract function …" In this respect he told HDC:

> "Because of the distribution of the recurrent cancer, it was impossible to safely perform a simple bypass or endoscopic stent procedure[49] to manage the upper digestive tract blockage so the operation was terminated after the laparoscopic biopsies were taken."

[47] See footnote 49.
[48] There is no evidence that clinicians knew until the laparoscopic procedure on 4 Month18 that the cancer had returned. See paragraph 101 (the discussion around the CT scan of 4 Month17), paragraphs 105–106 (the discussion around the gastroscopy), and paragraphs 130–133.
[49] A medical procedure in which a stent (a hollow device designed to prevent collapse of a tubular organ such as the oesophagus) is inserted.

Delayed waking from anaesthesia

146. Dr C told HDC that shortly before the end of the procedure Mr A was "breathing spontaneously with no assistance from the ventilator". Dr C told MidCentral DHB that at the end of the procedure Mr A's muscle relaxation was fully reversed, his responses were checked, and he was given narcotic reversal (naloxone)[50] in increasing doses. However, Dr C stated that Mr A showed no "neurological signs of waking".

147. Dr C recorded in the anaesthesia record that, following Mr A's procedure, he (Dr C) gave Mr A two doses of anaesthesia reversal (neostigmine)[51] 20 minutes apart at 10.10am and 10.30am, but did not record the dosage each time. Following the termination of the anaesthesia, it took Mr A over an hour to begin breathing spontaneously. Mr A failed to show a neurological response or wake from the anaesthetic.

148. Dr C told HDC:

> "Prior to administering the first dose [of neostigmine] the effect of residual paralysis was checked … This showed four twitches and no fade. This would indicate that there was little or no residual blockade.[52] A single dose of reversal agent would have reversed any effect. The second dose of reversal was given in a situation where the patient was not showing neurological recovery after the termination of the anaesthetic and the cause was not known."

149. Dr C told HDC that the dose of neostigmine given was:

> "2.5mg each time. With the neostigmine 400 mcg of glycopyrrolate[53] was given to offset the cholinergic side effects of the drug."

150. In the period after the procedure ended at about 10.10am, until Mr A arrived in the post-anaesthesia care unit (PACU) at 11.39am, Dr C made no record of Mr A's vital signs to indicate cardiovascular or respiratory function, and neurological function was later summarised as "… not aware … pupils normal … delayed waking …". There is no mention of whether Mr A was breathing spontaneously or being assisted with positive pressure ventilation,[54] or what the inspired oxygen concentration[55] was. Dr C told HDC that he discussed Mr A's condition with the duty anaesthetist, Dr I, in order to seek a second opinion. Finding no reason for the delayed waking from anaesthesia, Dr C said he then had a discussion with the radiology team regarding the possibility of having a CT head scan to check for a neurological cause for the delayed waking. However, he was advised that a CT scan would not be helpful at that point "in the context of no focal neurology[56]". Dr C made a

[50] A reversal agent for narcotics.
[51] A medication that can be used after surgery to help reverse the effects of medicines used to relax the muscles.
[52] "Residual blockade" refers to residual neuromuscular blockade (RNMB), a condition known to be associated with respiratory complications in the postoperative period after muscle relaxant usage.
[53] An anticholinergic drug that can be used before and during surgery to block certain reflexes and to protect against particular side effects of some medicines.
[54] Ventilation in which breaths are augmented by air at a fixed rate and amount of pressure, with tidal volume not being fixed; it is used particularly for patients with acute respiratory syndrome.
[55] The concentration of oxygen in the inspired air, especially that supplied as supplemental oxygen by mask or catheter.
[56] Impairments of the nerves, spinal cord or brain function.

retrospective record at 2pm, which states: "Case discussed with [Dr I] CT not likely to be helpful in the context of no focal neurology."

151. Dr C stated that he also discussed Mr A's condition with an intensive care unit (ICU) specialist, who advised that Mr A was "not the best ICU candidate". Mr A remained on a ventilator while his medical team tried to determine the reasons for his delayed waking. Dr C told HDC that by this time Mr A was breathing spontaneously and that Mr A's monitors and ventilators continually displayed his vitals, which were all considered when determining his overall stability. The readings from Mr A's monitors and ventilators are not documented.

152. Dr C noted in a retrospective record that Mr A was reintubated at approximately 11.30am. He became intolerant of his endotracheal tube,[57] and subsequently Dr C consulted with Dr B. Given Mr A's condition, Dr B confirmed that long-term ventilation and life support measures were not appropriate. Mr A's endotracheal tube was removed and, at 11.39am, he was transferred to the PACU. With regard to his conversation with Dr B, Dr C told HDC:

> "I recall having an in-depth conversation with [Dr B] and the intensive care consultant about the management plan. I believe that we were all in agreement that [Mr A's] prognosis was imminently terminal. What time he had remaining was difficult to predict.
>
> Certainly [Mr A's] prognosis influenced our decisions/discussions concerning offering an escalation of treatment."

153. Dr C did not record the detail of the conversation. However, a PACU RN recorded that after discussions with the anaesthetists and Dr B's surgical team it was decided to discontinue treatment.

Conversations with Mrs A following Mr A's operation

154. Following attempts by Mr A's medical team to ascertain the reason for his delayed waking and subsequent condition, Dr B spoke with Mrs A. In this respect, Dr B recorded in the post-operation note:

> "[Mr A] has had tremendous difficulty coming out of this anaesthetic, only being able to be extubated with difficulty some 90 minutes after the end of the laparoscopy, and this justifies my decision not to proceed with any surgical manoeuvres to relieve his obstruction.
>
> I've had a discussion with [Mrs A] regarding my findings and that [Mr A] will not survive very long after this admission, if he does not succumb during this admission."

155. Dr B told HDC that he discussed the findings and Mr A's condition "fully" with Mrs A. Dr B also told HDC that he cannot recall whether he knew about or advised Mrs A about Dr C's discussion with the ICU or whether Dr C advised Mrs A about this. Dr B stated: "[S]uffice to state that it is never my practice to withhold relevant clinical information."

156. In this respect, Dr H recorded at 12pm:

[57] A catheter that is inserted into the trachea for the primary purpose of establishing and maintaining an airway.

"Discussion between [Dr B] and [Mrs A].

Informed [Mrs A] of [operating theatre] findings and that disease has recurred causing 2 obstructions at level of proximal jejunum and splexi flexure.[58] Therefore, stent bypass and feeding alternatives would have been very difficult.

Also informed [Mrs A] of the difficulty [Mr A] has had waking up from [general anaesthetic]. Currently breathing but severely compromised and unable to respond coherently. High chance of imminent death. Agreement that [Mr A] not for CPR or ventilation. Plan (1) liverpool care pathway[59]."

157. With regard to Dr B's conversation with her, Mrs A told HDC that Dr B spoke to her for "three minute[s]". According to Mrs A, Dr B told her that the anaesthesia had "tipped" her husband over and that following his procedure, it had taken an hour to wake him up. According to Mrs A, Dr B further stated that her husband could not talk and he would not survive. Mrs A told HDC that Dr B did not advise her of the actions taken by Dr C with regard to his discussions with specialists. She understood the information given to her by Dr B to mean that death was "imminent" for her husband and that nothing more could be done for him. In these circumstances, Mrs A believed that Mr A would not want to be put on life support, and she conveyed this to Dr B.

158. Following his conversation with Mrs A, Dr B initiated a Not For Resuscitation order.

159. Dr C told HDC that his focus was on trying to identify a reversible cause for Mr A's condition and, to that end, he discussed the case with the ICU, the duty anaesthetist, a radiologist and Dr B. Dr C stated: "I did not feel it was appropriate to leave the theatre during this time. I understood, at the time, that [Dr B] was attending to meeting with [Mrs A] to discuss the situation with her." At 12.50pm an RN noted:

"[Mrs A] has raised the possibility of taking [Mr A] home — therefore [Mr and Mrs A] seen.

[Mr A] appears imminently terminal. He is aware, agonal (jaw breathing), indications of peripheral shutdown in lower limbs and hand nail beds. Flailing arms. [Mrs A] asked what the arm movement is — I have advised that this appears to be terminal restlessness.[60] I have indicated that we can give him something to settle this but it would lower his [level of consciousness] (pt is very frail). She does not want this. I have advised [Mrs A] that I think time is very short and likely to be in terms of minutes to hours. She was clearly shocked by this prospect …"

[58] A bend in the colon.
[59] The Liverpool Care Pathway was developed to aid members of a multidisciplinary team in matters relating to continuing medical treatment, discontinuation of treatment, and comfort measures during the last days and hours of a patient's life. The Liverpool Care Pathway is organised into sections ensuring that evaluation and care is continuous and consistent.
[60] Terminal restlessness is agitated delirium with cognitive impairment. It tends to occur frequently at the end stage of cancer. The main symptoms are agitation, myoclonic jerks or twitching, irritability and impaired consciousness.

160. Mrs A told HDC that she found it very distressing to see Mr A struggling to breathe and "flailing" his arms. She said that she was not given any warning as to his condition before she saw him. She further stated that she does not recall denying consent to give him medication that would assist in settling him.

161. Mr A was transferred to the PACU, and Dr C handed over Mr A's care to the recovery nurses before meeting with the head of Anaesthesia and an ICU specialist to go over case management and to de-brief. Dr I told HDC that he was available to attend to Mr A during this time, should anaesthesia or medical input have been required.

162. Dr I told HDC that, as the duty anaesthetist on the morning that Mr A had his laparoscopy, he was expected to respond to requests about clinical care from staff and family. However, Dr I stated that during "personal and private" moments:

> "… I would not routinely present myself into the cubicle where patient and family are assembled. But I would still be available for assistance. I have no recollection of being requested for help with [Mr A] …"

163. Mr A did not regain consciousness and, sadly, died at 1.13pm, in the presence of Mrs A.

MidCentral DHB policies

Informed consent policy

"**1. Purpose**
To ensure:

- The proper processes relating to informed consent are followed so that all treatment provided is lawful.
- Consumers have sufficient information about a proposed treatment or procedure, specific to their individual situation, to allow them to evaluate the options without pressure and to agree or not agree to that treatment or procedure being carried out.

…

- The informed consent process is properly recorded and documented, and that written consent is obtained from the patient in the circumstances set out in this Policy.

…

3. Roles and responsibilities
Primary responsibility for obtaining informed consent lies with the person responsible for the procedure.

…

5.3 Informed Decision
In order to give a valid legal consent or refusal to treatment, a patient must have access to all the information that is required to enable the patient to make a fully informed choice
…

> Prior to providing treatment, the health professional undertaking the treatment must be satisfied that they have made every endeavour to ensure that the patient or person legally entitled to consent on the patient's behalf fully understands what is being proposed …"

Standards of Service Provision for Upper Gastrointestinal Cancer Patients in New Zealand — Provisional

> "Follow-up promotes recovery and improved quality of life. It is also useful to detect disorders of function, to assess nutritional status, to provide psychosocial support and to audit treatment outcomes (SIGN 2006). The ongoing support of patients with cancer after definitive treatment should ideally take place close to home and family/whanau support, and involve the referring specialist or GP."

Further information obtained during the course of this investigation

Mrs A

Referral for CT scan

164. Mrs A complained to HDC that Dr D's failure to communicate Mr A's urgent need for a CT scan after his consultation on 17 Month13 denied Mr A the opportunity to have specialist treatment and surgical intervention prior to him becoming critically ill in Month17.

165. Mrs A believes that had Mr A had a CT scan earlier, he would have been able to receive the treatment he required to improve his nutrition earlier. Mrs A considers that Mr A's condition was severely compromised by his inability to achieve adequate nutrition.

Absence of palliative care

166. Mrs A complained to HDC that she and her husband were never informed that he was terminally ill. She told HDC that, accordingly, by proceeding to surgery without knowledge that there was a high risk he might not survive it, he was denied the opportunity for palliative care.

Informed consent

167. Mrs A told HDC that she believes that had Mr A been advised that he had pneumonia and sepsis and that there was a high risk of death if he was anaesthetised, he would not have consented to the surgery.

168. Mrs A stated that she accepts that without the surgery Mr A would have died eventually, as he was unable to eat. However, she stated that had he been given the option of palliative care, he could have died "with dignity and in peace …". Mrs A told HDC that, instead, the anaesthesia caused her husband's lungs to collapse, he was unable to speak, and he was deprived of the opportunity to say goodbye to his family.

Dr C's absence after Mr A's surgery

169. Mrs A expressed her disappointment that Dr C was absent following Mr A's surgery, and stated that she felt that he "abandoned" her husband when he needed him.

Dr D

170. Dr D told HDC that he accepted that if Mr A's clinical status had been confirmed earlier it would have allowed for more formal palliative care and given his family more time to adjust to his terminal status.

171. Following these events, Dr D provided Mrs A a written statement in which he said:

> "First, I need to acknowledge your huge loss in [Mr A's] untimely death. I consider that your complaint about my lack of advocacy is understandable … I believe I made assumptions that created a mindset that I didn't recognise, and this mindset led to my lack of clear discussion with you and [Mr A] and lack of appropriate advocacy …"

Referral for a CT scan

172. With regard to his referral letter of 22 Month13, and subsequent referrals to Dr B for a CT scan for Mr A, Dr D stated that he made three mistakes:

> "First, when [Mr A's] condition began to deteriorate I presumed the cancer had recurred. Because I understood that in the event of a cancer recurrence no further cancer treatment was possible, I thought that [Dr B] would have nothing more to offer, and this assumption set the stage for my subsequent lack of advocacy …
>
> Instead I considered that I had to focus on treating [Mr A's] symptoms. So most of my decisions and communications with you and [Mr A] and with [RN E] were about symptoms, because I thought this was the path I need[ed] to take. So I requested the CT scan but I did not communicate with [Dr B].
>
> …
>
> My second mistake was that I was convinced that [Mr A] would receive an appointment for the CT scan, and that we would then make more formal plans for [Mr A's] future care and treatment. I have thought about this a lot, and I can only think that it was because I was convinced this would happen that I did not add information about [Mr A's] symptoms to the CT scan request letter, or write a further full letter, as I so easily could have.
>
> …
>
> My third mistake, which I deeply regret is that I did not discuss clearly with you and [Mr A] my assumption that the cancer had recurred and that we were facing an unbeatable situation.
>
> If we had had this discussion, I consider I would certainly have contacted [Dr B] in private or at the Hospital according to your wishes. It would have been very easy for me to do this, and I deeply regret that my mistake in not having this discussion with you and [Mr A] did not give you this chance."

173. With regard to his failure to follow up his referral for a CT scan, Dr D told HDC:

> "I deeply regret that I did not communicate my thinking clearly to [Mr A and Mrs A] at that time, since I would then have recognised that they needed a specialist review rather

> than just the CT scan we had discussed, and I would have referred [Mr A] directly to [Dr B] for his review. I can absolutely reassure the Commissioner and [Mrs A] that this lack of communication was not due to any paternalistic or indifferent attitude but was an error of judgement in my communication between us about what was happening with [Mr A], and my belief that the expected CT scan would give definitive information that would form the basis of my discussion with [Mr and Mrs A]."

Absence of palliative care

174. In response to Mrs A's concern regarding a lost opportunity regarding palliative care, Dr D told Mrs A:

> "I wish so much that my lack of action earlier had not prevented [Mr A from receiving proper information and support regarding palliative care]. My biggest disappointment in myself as your GP was that I did not facilitate earlier the consultations that would have allowed the move to proper palliative care for [Mr A]."

Changes to practice

175. With regard to changes that he has made since these events, Dr D told Mrs A:

> "I will never again just assume that requests to any other health provider are being actioned, and will always follow up this sort of request. There is provision for this in my computer system and I did not use it because of my mistaken certainty that it would happen in [Mr A's] case."

176. Dr D told HDC that he routinely uses the MedTech[61] Task Manager to ensure any significant referrals receive a response within a "clinically meaningful time". Dr D stated: "Until now I have not used this for letters I send regarding follow up procedures where these have been initiated by the doctor or Clinic to whom I am writing. I will now include these letters as well in my back-up system."

177. Dr D told HDC that he also now ensures that he includes a copy of the relevant clinical notes, or makes a note of relevant clinical symptoms in referral letters, "so that the department receiving the letter is better able to respond".

178. Dr D told HDC that he recognises that he should have communicated with Dr B and Mrs A more clearly. Dr D stated:

> "Until now I had believed communication was one of my strengths, and this failure has been a shock to me. I now repeatedly ask myself whether I have communicated clearly. I will in future check even more with the patient that they have understood what I have communicated about their diagnosis and treatment options to try to avoid misunderstanding or miscommunication."

179. Dr D apologised to Mrs A for the care that he provided to Mr A, stating: "I must extend to you my sincere apology, even though I know you are not obliged to accept this …"

[61] Practice management software that includes reminders and alerts.

Dr B

180. Dr B told HDC that he has created a "generic" information document to be provided to patients either on discharge from hospital after their surgery or at the first clinic visit that occurs within two weeks of discharge. The information covers expected recovery time as well as potential problems that can arise and how to manage these.

181. Dr B has also implemented a post-oesophagectomy treatment plan to be provided to GPs when a patient is referred back into their care.

Dr C

182. Dr C apologised to Mrs A, stating:

> "I would firstly like to express my sincere sympathy to [Mrs A] and her family for the passing of [Mr A] last year and to acknowledge the distress and anxiety that his unexpected passing will have caused them.
>
> …
>
> I cannot find the words to express how sorry I am that [Mr A] did not survive this procedure. The circumstances surrounding [Mr A's] unexpected and tragic death have had an immense impact on me personally and on my practice."

183. With regard to Mrs A's concerns that Dr C was absent following her husband's surgery, Dr C stated that the duty anaesthetist was available for Mrs A and her family, while he attended a de-briefing meeting with a multidisciplinary team. However, he stated that he is "deeply sorry that [Mrs A] feels that I 'abandoned' [Mr A] at this time".

Changes to practice

184. With regard to the information Dr C provided to Mr A prior to him undergoing anaesthesia on 4 Month18, Dr C told HDC that his note-taking was not optimal. He stated that he now always endeavours to make detailed entries in the anaesthesia record, reviews and charts. He also seeks to make a "far more detailed note" of the content of his preoperative discussions with patients.

185. Dr C stated that in light of this case he is now far more aware of "the increased risk of a patient developing post-operative respiratory complications and the consequent risk of death, particularly in a patient in a compromised condition". Dr C said that he now gives greater consideration to the possibility of a patient developing postoperative respiratory complications when planning applicable postoperative care.

186. Dr C stated that now, where an adverse event has occurred, he tries to attend discussions held between the surgeons and the patient or patient's family in the postoperative period. He stated, however, that "to date … this has tended to prove difficult particularly when my attention is focused on attending to the patient (as was the situation in [Mr A's] case)".

Dr I

187. Dr I stated:

"I am truly disappointed that as a clinical team we were unable to ease the family's distress at an absolutely challenging time."

MidCentral DHB

188. On 14 February 2014, MidCentral DHB initiated a review of the care provided to Mr A, including an internal review of its processes for when a referral letter is received. MidCentral DHB found that there was no electronic system to flag that the referral letter had not been followed up (after having been entered into PIMS).

189. As a result of its internal review, MidCentral DHB has implemented the following:

- Developed criteria and a process for follow-up of post-oesophagectomy by the GP.
- Developed a plan for communication between the cancer support nurse, GP and specialist.
- Reviewed the centralised referral process to ensure robust tracking and triaging of referrals.
- Strengthened guidelines for management and communication regarding life-threatening events in the operating theatre. Staff are reminded of requirements.

190. MidCentral DHB is currently in the process of undertaking the following recommendations:

- Investigate the feasibility of direct access to some imaging procedures by GPs.
- Implement "Faster Cancer Treatment" (FCT) and standards for upper gastrointestinal cancer patients in New Zealand.
- Raise awareness of the palliative care services available and the bereavement support options for patients, families and staff.
- Explore the feasibility of early anaesthetic assessment and the criteria.
- Explore options for, and develop a proposal for, a PICC line insertion service.

191. In response to my provisional opinion, Dr B advised that following these events, a document entitled "Oesophagus/Gullet, Stomach, Pancreas Cancer: Follow-up after potentially curative treatment/surgery" was developed and is provided to relevant patients. This document also provides information on how to contact the surgeon.

Response to provisional opinion

192. Mrs A, Dr D (both personally and on behalf of the medical centre) Dr B, Dr C and MidCentral DHB were asked to comment on the relevant sections of my provisional opinion.

193. Dr D, Dr B, Dr C and MidCentral DHB advised that they had no comment to make in regards to the provisional opinion and recommendations made.

194. Mrs A responded and her comments have been incorporated into the information gathered section where relevant.

Opinion: Dr D — Breach

Referral

Initial referral and the option of private health services

195. On 10 Month5, Dr B performed an Ivor Lewis procedure on Mr A. Following his fifth and final cycle of chemotherapy on 30 Month7, Mr A was discharged from the oncology service at Hospital 1.

196. Mr A was followed up by Dr B in his surgical clinic and, following a consultation on 17 Month9, Dr B's registrar, Dr G, wrote to Mr A's GP, Dr D, stating: "[I]f [Mr A] decides he would like a surveillance scan please get back in touch and we can arrange one for him at the six month or 12 month mark."

197. From around Month11 Mr A's condition began to deteriorate. Mr and Mrs A attended a consultation with Dr D on 17 Month13. Mr A brought with him a list of symptoms (including abdominal pain, intestinal gas, full bladder, pain related to food intake and recurrent constipation) and asked Dr D to send to Dr B a referral seeking a CT scan. On 22 Month13 Dr D sent a request for a CT scan to the surgical clinic at Hospital 1.

198. The referral contained no information regarding Mr A's current condition and symptoms. Dr D said that he did not include these because he thought the symptoms were a continuation of those that would have been noted in the last surgical outpatients'review in Month9.

199. The letter was subsequently misplaced at Hospital 1 and no scan was arranged.

200. Mrs A told HDC that at an appointment on 14 Month14 with Dr D, Mr A enquired about a private CT scan and said they would be willing to pay for one. In contrast, Dr D said that had Mr and Mrs A requested a private scan he would have completed the appropriate form and given it to Mr and Mrs A as was his standard practice. There is no reference in the clinical records to a request for a private CT scan. Taking into consideration the information available, including the conflicting accounts parties have in relation to this matter, I am unable to make a finding as to whether Mr A requested a referral for a private scan.

201. My in-house clinical advisor, GP Dr David Maplesden, advised me that the initial referral and the process around provision of that referral (in regard to proactively offering access to private health care) departed from expected standards to a mild to moderate degree. He advised:

> "[T]he physical symptoms [Mr A] was suffering, even if these were felt by [Dr D] to be similar to those he was experiencing at the time of discharge from surgical clinic, should have been listed on the referral form as should have any relevant assessment findings. The absence of such information implied [Mr A] was asymptomatic and requiring 'routine surveillance' rather than having symptoms which might have represented persisting post-operative complications … Even had the initial referral letter not been lost, it is likely the CT scan would not necessarily have been given high priority based on the information contained in the referral form."

202. Dr Maplesden was also critical that Dr D did not offer to arrange for Mr A to access CT scanning or a review by Dr B in the private health sector, despite Mr A having accessed services in the private health sector previously.

203. In my view, Mr A's current symptoms and assessment findings were information required by the triaging clinician. Although I acknowledge that Dr D felt that it would be clear in the circumstances that Mr A would like the scan to be arranged immediately, I am concerned that Dr D did not provide details of the physical symptoms Mr A was suffering, along with any relevant assessment findings, in the initial referral. This was important information that MidCentral DHB required for the purpose of prioritising the referral. While I am unable to make a finding as to whether Mr A requested a referral for a private scan, I am also concerned that Dr D did not proactively offer Mr A the option of private CT scanning, or review by Dr B in private.

Follow-up of, and resending of, initial referral

204. On 27 Month14 Mr A reported new symptoms to Dr D — that he was waking up with a "sharp burn" at the base of his throat and was experiencing fatigue and shortness of breath on exertion.

205. On 9 Month15, Mr A attended a further appointment with Dr D and asked about the referral for a CT scan, as he had not heard back about it. On 10 Month15 Dr D wrote to Mr A and told Mr A that he wanted to see him again if his symptoms progressed, and queried whether he had heard from the surgical clinic regarding a CT scan appointment. Dr D did not receive a response from Mr A to this letter.

206. On 24 Month15 Mr A emailed Dr D noting that as it was now ten months since his Ivor Lewis procedure, the six-month scan was overdue. Dr D sent his original referral letter of 22 Month13 to Hospital 1 and again did not include any further information to that in his original request.

207. Dr D said he believed that he needed only to remind the surgical clinic team that a CT scan had been promised and the appointment was outstanding, and that he would have included information about Mr A's symptoms had that not been the case.

208. The copy sent on 24 Month15 was received by MidCentral DHB on 26 Month15. However, as Dr B was on annual leave and there was no indication in the referral as to Mr A's declining health or urgency, the referral letter was left to be reviewed by Dr B when he returned in Month16. Mr A underwent a CT scan at Hospital 2 on 4 Month17.

209. Referrals involve a two-way process of communication. The referring clinician must ensure that the referral contains adequate information and is sent to the appropriate recipient. The recipient should act on the referral in a timely manner and advise the referring clinician and the patient of the outcome. As I have stated previously, doctors who refer patients to a specialist need to take reasonable steps to follow up the referral, especially if the patient's need for specialist assessment has become more urgent following the referral.[62]

[62] Anthony Hill, "Referrals trip up GPs and DHBs", *NZ Doctor*, 10 October 2012.

210. Mr A had a new onset of reflux, and ongoing weight loss and abdominal pain. Dr Maplesden advised that Dr D should have reconsidered the scan as being for investigation of symptoms, rather than surveillance, and been more proactive in ensuring that the investigation was undertaken in a timely manner. Dr Maplesden noted that Dr D could have checked with Hospital 1 whether the referral had been received and asked whether the investigation had been scheduled, or contacted Dr B directly. Dr Maplesden advised that "this oversight was a mild to moderate departure from expected standards", but that "[m]itigating factors were the relatively reassuring reports from the [cancer support nurse] and her involvement with [Mr A's] oversight".

211. Approximately a month had passed since Dr D sent the initial referral, but there had been no correspondence from MidCentral DHB. Meanwhile, Mr A had developed further symptoms. Although I acknowledge that Dr D was receiving reports from RN E, I consider that Dr D had sufficient information before him to indicate that further action was necessary to ensure that investigation was undertaken in a timely manner, such as following up on the referral with Hospital 1. I am concerned that this did not occur.

212. Dr Maplesden also advised:

> "[T]his was a missed opportunity for [Dr D] to review the priority of, and clinical indications for, [Mr A's] CT at the time he re-sent his original referral … This was another opportunity to discuss private referral, or for him to contact [Dr B] directly, when there appeared to be undue delay in the original referral being actioned and particularly noting [Mr A's] ongoing and progressive symptoms and anxiety regarding the possibility of cancer recurrence. [Dr D's] management of [Mr A] on this occasion represents a moderate departure from expected practice."

213. I consider that when Dr D decided to send the second referral, he should have provided additional information regarding Mr A's condition, discussed the possibility of a private referral with Mr A, and contacted Hospital 1 or Dr B directly regarding the delay with the referral. I am critical that none of these steps were taken.

214. As Dr Maplesden noted:

> "Even if terminal recurrence of cancer was a suspected diagnosis, confirmation of [Mr A's] clinical status several weeks earlier than it was eventually done would have allowed consideration of more specific palliative therapy, and more adjustment time for [Mr A] and his family, even if his overall prognosis remained grim."

Conclusion

215. Dr D did not provide sufficient information about the physical symptoms Mr A was suffering or any relevant assessment findings in the initial referral on 22 Month1, and did not proactively offer Mr A the option of private CT scanning, or review by Dr B in private at that stage.

216. When Mr A's symptoms worsened, and nothing had been heard about the original referral, Dr D resent the same referral on 24 Month15. He did not provide updated information about Mr

A's symptoms in this referral, discuss the possibility of private referral, or contact Hospital 1 or Dr B about the delay.

217. Accordingly, I consider that Dr D failed to provide services to Mr A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

Information provided

218. As already stated, on 27 Month14 Mr A reported new symptoms to Dr D — that he was waking up with a sharp burn at the base of his throat, and experiencing fatigue and shortness of breath on exertion.

219. Dr D thought the symptoms could be attributed to the re-emergence of cancer. However, he did not tell Mr A that. Dr D has acknowledged that he did not discuss with Mr A his assumption that the cancer had returned and that Mr A's condition was terminal. Dr D accepted that if Mr A's clinical status had been confirmed earlier it would have allowed for more formal palliative care and given his family more time to adjust to his terminal status.

220. In my view, Dr D should have discussed with Mr A his symptoms, his likely prognosis, and the options available to him. I am critical that this did not occur.

Opinion: Medical centre — No breach

221. In addition to any direct liability for a breach of the Code, under section 72(2) of the Health and Disability Commissioner Act 1994 (the Act), employing authorities are vicariously liable for any breaches of the Code by an employee. Under section 72(5) of the Act, an employer is liable for acts and omissions by an employee unless the employer proves that it took such steps as were reasonably practicable to prevent acts or omissions leading to an employee's breach of the Code.

222. During the period under investigation, Dr D was an employee of the medical centre. Dr D had access to MedTech Task Manager to ensure that significant referrals were responded to suitably. In my view, Dr D's failures in this case were Dr D's alone. Accordingly, I do not find the medical centre directly liable, or vicariously liable, for Dr D's breach of the Code.

Opinion: Dr B — Adverse comment

Management before Ivor Lewis procedure

223. Mr A presented to his GP, Dr D, and reported two months of upper abdominal discomfort and difficulty swallowing. Dr B performed an upper gastrointestinal endoscopy on 1 Month1, which disclosed probable oesophageal cancer. Dr B organised blood tests and a CT scan and,

following receipt of the results, organised for Mr A's case to be discussed at the next multidisciplinary forum due to be held whilst Dr B was away.

224. A diagnostic laparoscopy was later scheduled for 22 Month1, and another endoscopy and biopsy were performed, following which cancer was diagnosed.

225. My expert advisor, general surgeon Dr Patrick Alley, noted that Dr B's absence did not impede the decision of the multidisciplinary team on 14 Month1, and advised that he did not find cause for concern about the delay between the endoscopy on 1 Month1 and the diagnostic laparoscopy on 22 Month1.

226. Mr A was scheduled for an Ivor Lewis procedure on 3 Month5 and, accordingly, he presented to Hospital 1 that day, and was prepared for surgery and taken to theatre. However, Dr B was not available to perform the surgery as he was away, so Mr A's surgery was rescheduled for 10 Month5. Dr B explained that he had made an error in scheduling the procedure for this day. I am critical of this error, which meant that Mr A was taken to theatre for surgery before it was realised that Dr B could not attend.

227. On 10 Month5 Dr B performed an Ivor Lewis resection, following which the histology showed carcinoma of the oesophagus with 28 of the lymph nodes containing metastatic tumour. Dr Alley advised that "this is a serious negative prognostic indicator of both the aggression of the disease and its likely extension beyond the surgical zone of excision".

Management after Ivor Lewis procedure

228. On 17 Month9, Mr and Mrs A attended a follow-up appointment with Dr B and his registrar, Dr G, after Mr A had completed chemotherapy treatment.

229. Dr B told Mr A that routine clinical or imaging follow-up after an Ivor Lewis procedure was not his usual practice and that there was almost never any second chance at cure if the oesophageal cancer returned.

230. Following the consultation, Dr G wrote to Dr D stating that Hospital 1 did not follow up patients with serial imaging, but that if Mr A wanted a surveillance scan, Dr D was to contact them in order to arrange one in six or 12 months' time.

231. Dr Alley advised that he considered that accurate and safe surgery had been performed on 10 Month5, but noted that if surgeons are going to opt for a "non intervention" follow-up, then the guidelines have to be very clearly enunciated. Dr Alley stated:

> "Access to the surgeon in the event of the patient experiencing problems has to be guaranteed and that has to be the starting point for instituting investigations and in my view to put the onus for arranging the scans on the patient is neither fair nor reasonable."

232. Dr Alley advised that, in this case, the follow-up arrangements were "not precise" and should have been dictated by symptoms rather than arbitrary arrangement of a CT scan.

233. I note Dr Alley's advice, and suggest that more precise arrangements for follow-up would have been appropriate.

Information provided prior to laparoscopy

234. Mr A had a CT scan at Hospital 2 on 4 Month17, which showed oesophageal distention, but no obvious cancer. Dr D wrote to Dr B advising him of the outcome of the CT scan, and noting that Mr A had been experiencing reflux and weight loss. Dr D requested that Dr B follow up, so Dr B arranged for Mr A to undergo a gastroscopy at Hospital 1 on 18 Month17. The findings of the gastroscopy indicated that Mr A had an abnormally dilated upper oesophagus with considerable food debris, and that the blockage was causing Mr A's oesophagus and stomach to be bloated.

235. Mr A was admitted to Hospital 1 for follow-up treatment regarding the blockage in his oesophagus, and later underwent a barium swallow, which showed a blockage in his upper abdomen. Mr A was scheduled for laparoscopic surgery on 4 Month18 in order to attempt to unblock his digestive tract, and to confirm whether his cancer had returned.

236. Mrs A was concerned that neither she nor her husband were adequately informed about Mr A's condition prior to the surgery. Mrs A said that if Mr A had been aware of this, and of the related risks involved with the surgery, he would not have consented to undergoing the procedure.

237. In contrast, Dr B told HDC that he advised Mr A that he would not undergo the operation until he had recovered sufficiently from his lung infection to the point that he could readily maintain his blood oxygen levels without supplementary oxygen, that his nutritional state was sufficiently robust to withstand such surgery, and that his overall condition was satisfactory to the anaesthetist.

238. Dr B said he told Mr A that he was a higher risk than a fit elective patient, and that although the customary anaesthetic/perioperative management would be to defer surgery for at least six weeks after a lung infection, Mr A did not have the luxury of time. Dr B said that he told Mr A that he was not in a good condition and had pneumonia. Dr B said he discussed the information about risks with Mr A on several occasions, but he made no written record of the conversations. Neither the progress notes nor the "operation procedure/consent form" include any detail of specific risks of the procedure or discussions about these.

239. However, in support of Dr B's account, registrar Dr H said that he was present when Dr B outlined the benefits and risks of performing laparoscopic surgery to Mr A. Dr H said that given Mr A's presentation and background of malignancy he was considered a high risk patient. Dr H told HDC that after this discussion "it was with a collective understanding, ([Mr A], his wife and the medical team), of these benefits and risks, that the decision to go to theatre was made".

240. Given the evidence available, I accept that Dr B discussed with Mr A the risks and benefits of the surgery. However, in all the circumstances, including the lack of documentation in this regard, it is unclear the extent to which specific risks were discussed. I am critical that Dr B did not record anything about his discussions with Mr A.

241. Dr Alley advised that neither the CT scan nor the endoscopy disclosed the true reasons for Mr A's symptoms. Dr Alley stated that it was quite reasonable to proceed to a laparoscopy,

because of the possibility that there was a correctable and benign reason for Mr A's symptoms.

242. Dr Alley further advised that "although [Mr A] was frail and suffering an, as yet, undiagnosed burden of cancer, there were no significant issues raised in his pre-operative workup that would have precluded surgery". Accordingly, I consider that it was not unreasonable for the procedure to proceed on 4 Month18.

Events following laparoscopy

243. Following termination of the laparoscopic procedure, Mr A was breathing spontaneously. However, once the anaesthetic was reversed, Mr A showed no neurological signs of waking.

244. Anaesthetist Dr C discussed Mr A's condition with an ICU specialist. Dr C stated that the ICU specialist advised that Mr A was "not the best ICU candidate". Dr C also recalls having an "in-depth conversation" with Dr B and the ICU specialist about the management plan, and told HDC that he believed everyone was "in agreement that [Mr A's] prognosis was imminently terminal".

245. Dr B told HDC that after the laparoscopy he discussed the findings and Mr A's condition "fully" with Mrs A. Dr B cannot recall whether he knew about or advised Mrs A about Dr C's discussion with the ICU specialist or whether Dr C advised Mrs A about this, but said: "[S]uffice to state that it is never my practice to withhold relevant clinical information." Dr H recorded at 12pm that there had been a discussion between Dr B and Mrs A during which Dr B informed Mrs A of the operative findings and also Mr A's failure to wake up from the general anaesthetic. Dr H recorded that Dr B said that Mr A was currently breathing but severely compromised and unable to respond coherently, and that there was a high chance of imminent death. It was agreed that Mr A was not for cardiopulmonary resuscitation or ventilation.

246. Mrs A told HDC that Dr B spoke to her for three minutes. She said that Dr B told her that the anaesthesia had "tipped" Mr A over and that following his procedure, it had taken an hour to wake him up. Mrs A also told HDC that Dr B stated that Mr A could not talk and he would not survive. She said that Dr B did not advise her of Dr C's discussions with specialists.

247. Mrs A understood the information given to her by Dr B to mean that Mr A's death was "imminent", and that nothing more could be done for him. Mrs A believed that, in these circumstances, Mr A would not want to be put on life support, and she conveyed this to Dr B. At 12.50pm An RN noted: "[Mrs A] has raised the possibility of taking [Mr A] home — therefore [Mr and Mrs A] seen." The RN recorded that she told Mrs A that she thought time was very short and likely to be in terms of minutes to hours. An RN also noted that there had been a discussion with the anaesthetists and Dr B's surgical team regarding Mr A's ongoing treatment.

248. Taking into account the information available, I consider it more likely than not that Dr C and Dr B had a conversation regarding Mr A's prognosis, and that Dr B discussed the prognosis with Mrs A. However, I am unable to determine the nature or timing of the information Dr C passed on to Dr B regarding his discussion with the ICU specialist or the extent of the information provided to Mrs A about that discussion.

Conclusion

249. Although I consider that, overall, the treatment Dr B provided to Mr A was satisfactory, I am critical of the scheduling error by Dr B on 3 Month5, and of the imprecise nature of the follow-up arrangements after Mr A's Ivor Lewis procedure.

250. I am also critical that Dr B did not document the discussion with Mr A regarding the risks and benefits of the laparoscopic surgery.

Opinion: Dr C — Breach

Record-keeping

251. On the morning of 4 Month18 prior to Mr A's scheduled laparoscopy, anaesthetist Dr C undertook a preoperative review of Mr A. Dr C had cared for Mr A previously during his Ivor Lewis procedure (on 10 Month5) and was aware of Mr A's medical, surgical and anaesthetic history, including that previously he had had no difficulties with anaesthesia.

252. I am concerned at the standard of Dr C's record-keeping in this case.

253. The failure to maintain adequate records is poor practice, affects continuity of care, and puts patients at real risk of harm.[63] The Medical Council of New Zealand statement "The maintenance and retention of patient records" (August 2008) emphasises the importance of record-keeping, and requires doctors to keep clear and accurate patient records that report: relevant clinical findings; decisions made; information given to patients; and any drugs or other treatment prescribed.

254. In particular, I am concerned that Dr C failed to document:

a) his conversation with Mr A prior to his laparoscopic procedure on 4 Month18, or any of the information provided to Mr A prior to the procedure regarding specific risks related to going under anaesthesia (such as on the consent form). I note that in this respect Dr C accepted that his note-taking was "less than optimal";

b) Mr A's respiratory issues in the preoperative anaesthetic review record;

c) the dosages of neostigmine that were administered (twice) during the procedure;

d) Mr A's vital signs (to indicate cardiovascular or respiratory or neurological function) in the period after the procedure ended at about 10.10am until 11.39am;

e) whether Mr A was breathing spontaneously or being assisted with positive pressure ventilation; and

f) the inspired oxygen calculation.

255. Similarly, Dr C said that he discussed Mr A's condition with the duty anaesthetist, Dr I, in order to seek a second opinion, and then had a discussion with the radiology team regarding

[63] See Opinion 13HDC00482, 18 March 2015.

the possibility of having a CT head scan to check for a neurological cause for the delayed waking. Dr C stated that he also discussed Mr A's condition with an ICU specialist, who advised that Mr A was "not the best ICU candidate". However, there are no records of these conversations other than a retrospective record that states: "Case discussed with [Dr I] CT not likely to be helpful in the context of no focal neurology."

256. In my view, Dr C's record-keeping was inadequate in a number of areas. Accordingly, I consider that he breached Right 4(2) of the Code for failing to keep clear and accurate patient records in accordance with his professional obligations.

Information provided to Mr A

257. Dr C told MidCentral DHB that prior to the laparoscopy Mr A was in poor condition but he (Dr C) considered that he "looked well considering, and [he] did not see the need to discuss limitations of care as [he] was not expecting any untoward events". Dr C stated that he did not anticipate that Mr A would fail to wake after the anaesthetic.

258. Dr C's recollection is that his conversation would have included the type of anaesthesia he proposed to use during the procedure, and the relevant risks associated with that plan in light of Mr A's condition.

259. Dr C is unable to recall the exact information he provided to Mr A prior to the laparoscopy procedure. He said it is unlikely that he would have considered that the possibility of needing respiratory support after the laparoscopy was a risk that he should discuss with Mr A. Dr C said: "I knew the anaesthesia management had to be guarded but I did not have any specific concerns about [Mr A] undergoing the minimally invasive laparoscopic based procedure to be undertaken."

260. Dr C stated: "At the time, I felt that the risk of death from the proposed procedure was low and my discussion with [Mr A] would have reflected this view." Dr C further advised that he would have discussed the risks of postoperative nausea and vomiting, dental damage, and the possible need for postoperative vasopressors and supplemental oxygen, but did not think that he discussed the risk of perioperative death.

261. The "Receipt of Information and Anaesthetic Consent" document signed by Mr A mentions information and risks, but nothing specific is noted on the document.

262. Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including an explanation of the risks and benefits of each option.

263. Taking into consideration the information available, I am unable to make a finding as to the specific matters Dr C discussed with Mr A because of Dr C's limited recall and poor record-keeping (discussed above). However, I am concerned that Dr C indicated that he did not think that he discussed the risk of perioperative death, and remind Dr C of the importance of providing consumers with material information from which they are able to balance the risks and benefits of going under anaesthesia.

Neostigmine administration

264. Dr C documented in the anaesthesia record that, following Mr A's procedure, he gave Mr A two doses of anaesthesia reversal (neostigmine) 20 minutes apart at 10.10am and 10.30am (the dosage was not recorded). I note that this decision was arrived at as a result of discussions with colleagues. Dr C told HDC:

> "Prior to administering the first dose [of neostigmine] the effect of residual paralysis was checked … This showed four twitches and no fade. This would indicate that there was little or no residual blockade. A single dose of reversal agent would have reversed any effect. The second dose of reversal was given in a situation where the patient was not showing neurological recovery after the termination of the anaesthetic and the cause was not known."

265. I note that Dr C told HDC that the dose of neostigmine given was:

> "2.5mg each time. With the neostigmine 400 mcg of glycopyrrolate was given to offset the cholinergic side effects of the drug."

266. Mr expert advisor, anaesthetist Dr Malcolm Futter, noted that neostigmine may cause deterioration in neuromuscular function. Dr Futter considered that a single dose of reversal agent would have reversed any effect, and the second dose of reversal was given in a situation where Mr A was not showing neurological recovery after the termination of the anaesthetic and the cause was not known. However, I accept that Dr C's decision to give a second dose of neostigmine was arrived at as a result of discussion with peers.

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267. On 22 Month13 Dr D sent a request for a CT scan to the surgical outpatient clinic at Hospital 1. On 25 Month13 a note was made in the PIMS that the letter dated 22 Month13 had been received and registered on the PIMS with the comment that the consultant was to view it. However, the referral was not actioned, and MidCentral DHB has not been able to locate the original letter. MidCentral DHB had no electronic system to flag that the referral letter had not been followed up after having been entered into the PIMS.

268. On 24 Month15 Dr D sent his referral letter of 22 Month13 for the second time, and it was received by MidCentral DHB on 26 Month15. This copy of the referral letter was placed in the triage folder for the surgical clinic to triage. The triage consultant noted, "[S]how [Dr B]," but, at that time, Dr B was on annual leave so the referral letter was left to be reviewed by Dr B when he returned from leave. As the referral suggested that it was for routine follow-up and did not include Mr A's current symptoms, I do not think it was unreasonable to wait until Dr B returned before actioning the referral.

269. On 22 Month16, Dr B returned from leave and reviewed the referral letter. He sent a request for a CT scan to look for recurrent disease to Hospital 1. Dr B indicated a priority for the scan as less than two weeks.

270. On 26 Month16 Dr B's request for a CT scan was logged in the Hospital 1 medical booking system, and Mr A was booked for a CT scan on 4 Month17.

271. In my view, MidCentral DHB's process for management of referrals was inadequate, as Mr A's initial referral was not tracked sufficiently in order to ensure that triage occurred. As I have stated previously:[64]

> "DHBs also owe patients a duty of care in handling referrals from GPs within the district and from other DHBs. A specific aspect of the duty of care is the duty to cooperate with other providers to ensure continuity of care under Right 4(5) of the Code. A DHB must have robust systems for managing referrals so that the referred patients do not fall through the cracks in the system."

272. The receiving clinician or DHB should take appropriate and timely steps in managing referrals. In this case, MidCentral DHB did not have a robust system in place for this and, as a result, Dr D's initial referral was not actioned. Accordingly, I find that MidCentral DHB failed to ensure the quality and continuity of services provided to Mr A and breached Right 4(5) of the Code.

Recommendations

273. I recommend that Dr D organise an independent GP peer to conduct a random audit of 10 referrals to specialist secondary services that Dr D has instigated within the last 12 months, to check that appropriately documented requests have been performed and appropriate reminders have been put in place to follow up such referrals. Dr D is to provide a copy of the audit to HDC within three months of the date of this report.

274. I recommend that Dr D attend training on communication and report to HDC, within three months of the date of this report, with evidence of attendance and a report on the content of the training.

275. I recommend that, within three months of the date of this report, MidCentral DHB review the effectiveness of the following measures it implemented as a result of its internal review:

a) The criteria and process for follow-up of oesophagectomy.

b) The plan for communication between cancer support nurses, GPs and specialists.

c) The centralised referral process with regard to tracking and triaging of referrals.

d) The guidelines for management of communication regarding life-threatening events in the operating theatre.

[64] Anthony Hill, "Referrals trip up GPs and DHBs", *NZ Doctor*, 10 October 2012.

276. I recommend that MidCentral DHB report to HDC on the implementation of the remaining recommendations from the internal review within three months of the date of this report.

277. I recommend that Dr C undergo further training on record-keeping within six months of the date of this report, and report to HDC with evidence of the content of the training and attendance.

278. I recommend that Dr B, within three months of the date of this report:

a) Review the effectiveness and appropriateness of his approach taken to follow-up.

b) Review the effectiveness of the written information provided to patients on discharge from hospital.

c) Report to HDC on the implementation of his post-oesophagectomy treatment plan which he intends to provide to GPs when a patient is referred back into their care.

279. I recommend that Dr D, Dr C and MidCentral DHB each provide a written apology to Mrs A for their breaches of the Code, within three weeks of the date of this report. The apologies are to be sent to HDC for forwarding.

Follow-up actions

280. A copy of this report will be sent to the Coroner.

281. A copy of this report with details identifying the parties removed, except MidCentral DHB and the experts who advised on this case, will be sent to the Medical Council of New Zealand, and the Council will be advised of the names of Dr C and Dr D.

282. A copy of this report with details identifying the parties removed, except MidCentral DHB and the experts who advised on this case, will be sent to the Royal New Zealand College of General Practitioners, and it will be advised of Dr D's name.

283. A copy of this report with details identifying the parties removed, except MidCentral DHB and the experts who advised on this case, will be sent to the Australian and New Zealand College of Anaesthetists, and they will be advised of Dr C's name.

284. A copy of this report with details identifying the parties removed, except MidCentral DHB and the experts who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: In-house clinical advice to the Commissioner

The following expert advice was obtained from Dr David Maplesden, in-house clinical advisor:

"1. Thank you for the request that I provide clinical advice in relation to the complaint from [Mrs A] about the care provided to her late husband, [Mr A], by [Dr D]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. […] I have reviewed the information on file: complaint documentation from [Mrs A]; response from [Dr D]; GP notes ([the medical centre]); MidCentral DHB (MCDHB) response including internal and external reviews into the care provided to [Mr A] by MCDHB; [Hospital 1] clinical notes; some Coronial documentation. At this point I have not been asked to comment on DHB management of [Mr A], although the DHB reports identify some issues with communication at the primary:secondary interface relevant to the current complaint in addition to possible clinical issues.

2. Brief clinical synopsis from available documentation:

(i) [Mr A] was diagnosed with oesophageal cancer in [Month1] based on gastroscopy and biopsy performed in private by surgeon [Dr B] on 1 [Month1]. PET scan was then performed and staging laparoscopy undertaken (22 [Month1], [Hospital 3] — [Dr B]). Following discussion at the MCDHB surgical conference [Mr A] underwent pre-op chemotherapy ([Hospital 1]) and then an oesophagectomy on 10 [Month5] ([Dr B] — [Hospital 1]). Histology showed T4N3Mx classification with 13 removed lymph nodes positive for tumour. [Mr A] had two cycles of chemotherapy post-operatively ([Hospital 1]). He was followed up in [Hospital 1] outpatient clinics (surgical and medical oncology). On 18 [Month8] [Mr A] was discharged from medical oncology follow-up having tolerated chemotherapy poorly and declining a third cycle. Clinic notes include *Due to his positive lymph node post-op condition, there is a higher risk of relapse of his cancer. He is aware of the risk and will have a further discussion in the future with [Dr B]*.

(ii) In [Month8] [Mr A's] feeding tube (PEJ) was removed. On 17 [Month9] he was reviewed in [Hospital 1] surgical outpatient clinic by [Dr B] and a surgical registrar. The clinic note concludes *We had a pragmatic discussion in the presence of his wife about ongoing surveillance for his cancer. As you know, there are no further treatment options if there is recurrence. We usually do not follow people up with serial imaging in [Hospital 1]. However, if [Mr A] decides that he would like a surveillance scan, please get back in touch and we can arrange one for him at the 6 month or 12 month mark.*

(iii) GP notes show Mr and [Mrs A] tended to communicate with [Dr D] by e-mail, including discussion of symptoms, progress and requests for appointments and repeat prescriptions. GP review had been undertaken on 4 [Month9] when [Mr A] was noted to be slowly improving following his surgery and chemotherapy. Repeat prescriptions for [Mr A's] regular medications were supplied on 5 [Month10], and 1 [Month13]. In an e-mail from [Mrs A] to [Dr D] dated 27 [Month11] [Mrs A] notes her husband is still experiencing post-prandial upper abdominal pain but *he looks very good … he is gaining*

weight very slowly considering that he cannot eat much at any given time … perhaps you could give [Mr A] *a call to reassure him …* [Dr D] replied by e-mail that he had tried to phone but could not make contact. He advised a trial of an antispasmodic (mebeverine) *to see if your food is triggering a reactive spasm around your surgery site.*

(iv) Next GP contact recorded was an e-mail from [Mr A] to [Dr D] dated 1 [Month13] in which [Mr A] related *I am doing pretty well, recuperating from a hectic but wonderful three weeks with family …* repeat of regular medications was requested and there was no reference to ongoing GI symptoms. [Mr A] concluded *I read that half the people diagnosed with adenocarcinoma are dead within a year after diagnosis. Mine was [a year ago], so today we are quietly celebrating getting on the better side of the statistics.*

(v) Despite the optimistic e-mail, [Mr A] then presented to [Dr D] on 17 [Month13] with an extensive list of symptoms and questions. These included reference to abdominal pain, *intestinal gas (& full bladder) quite painful, recurrent constipation cycles … persistent gut aches … all over! Any expansion or contraction = pain … no food = no pain … Are these normal post-Ivor-Lewis symptoms? At what point should we request a CT or PET? …* These symptoms were recounted in [Dr D's] clinical notes. No examination findings are documented other than height (180cm) and weight (56kg). GP notes include *Worried advised no Rx if recurs. I suggested solitary peripheral met might be excised but lung or central or multiple liver mets not amenable to Rx → request scan → disc situation w dietitian …* Flu vaccine was administered and as an initial investigation plain abdominal X-ray was ordered (undertaken 28 [Month13] — Clinical details on request form were *Post-Ivor Lewis oesophagectomy, abdo discomfort, variable BMs. Faecal loading?* Report concluded *Changes consistent with constipation*). [Dr D] notified [Mr A] of the X-ray result, and prescribed laxatives, in a note dated 28 [Month13], requesting [Mr A] to contact him if the constipation did not improve.

(vi) Clinical notes show that on 22 [Month13] [Dr D] referred [Mr A] to [the PHO] Cancer Support Nurse (CSN) for review, enclosing a copy of the symptom and query list [Mr A] had presented. Acknowledgement of the referral was dated 23 [Month13]. On 22 [Month13] [Dr D] also sent a referral letter to the surgical outpatient clinic at [Hospital 1] listing 'Current problem' as *adenocarcinoma distal oesophagus, Ivor Lewis oesophagectomy [Month5], 13/28 nodes involved so post-op adjuvant chemo. I enclose a copy of the last clinic letter of 17 [Month9] indicating that routine follow-ups don't influence outcome but offering a surveillance scan if requested. [Mr A] is keen to take up this offer of a 6 month scan, given that his chemo finished 30 [Month7]*. There is no reference in this referral to [Mr A's] current symptoms of abdominal pain, particularly pain related to food intake.

(vii) In his response, [Dr D] states he sent the request directly to surgical outpatients with a copy of the last outpatient letter because the CT request was not 'standard', [Dr B] had been managing [Mr A] latterly in the public system, and if [Dr B] was not available, the request would be actioned by one of his colleagues. He did not list [Mr A's] ongoing symptoms because they appeared to be a continuation of symptoms noted at the last surgical outpatient review in [Month9] and *most likely represented ongoing post-surgical symptoms* that [Mr A] was having difficulty adjusting to, together with concerns ([Mr A's]) that the symptoms could be masking a cancer recurrence. *My initial request for the*

CT scan was therefore for surveillance as offered by the Surgical Clinic … I felt the message would thus be clear that [Mr A] would like the scan arranged immediately given that we were then close to the 6-month point.

(viii) [Mr A] next presented on 14 [Month14] noting his constipation, though improved somewhat, was still problematic … *At times bowel spasm, can feel wind trapped, can last hours … nerve pains around lateral RUQ …* Stronger laxatives were prescribed with nortryptiline for neuralgia and a repeat of mebeverine. On 24 [Month14] [Dr D] documented a call from the CSN noting an improvement in [Mr A's] pain and bowel symptoms but new reflux symptoms. A prescription for omeprazole was requested and supplied.

(ix) On 27 [Month14] [Mrs A] contacted [Dr D] by e-mail requesting an urgent appointment for her husband because of worsening 'acid reflux' symptoms, 'lung ache' and tiredness. [Mr A] was reviewed by [Dr D] the same day with no cardio-respiratory abnormalities noted and management plan of blood tests, increase dose of omeprazole and raise head of bed. Bloods were unremarkable other than the non-specific finding of moderately raised CRP (34mg/L — normal <5). In an e-mail from [Mrs A] to [Dr D] dated 2 [Month15], [Mrs A] expressed relief at the blood test results (notified by mail on 27 [Month14]) and noted her husband's reflux had improved somewhat with the strategies undertaken.

(x) On 5 [Month15] [Mr A] was seen by [Dr D's] colleague [Dr F] following referral by the CSN because of dusky toes. [Dr F] assessed circulation as satisfactory and ordered repeat blood tests which were unremarkable, including CRP having reduced to 8.1 mg/L. On 10 [Month15] [Dr D] wrote to [Mr A] informing him of the results and noting he wanted to see him again *if your symptoms progress …* He added Gaviscon to [Mr A's] regime and asked *Have you heard from the Surgical Clinic yet?* [Dr D] states he received no response to this query at the time. On 16 [Month15] a visiting community pharmacist e-mailed [Dr D] with some suggestions regarding [Mr A's] medication regime. On 19 [Month15] [Dr D] was contacted by the CSN who noted [Mr A] had had significant relief of his reflux symptoms with Gaviscon, and moderate relief of his abdominal pain with nortryptiline and paracetamol. However, he was *concerned about his weight* which at that stage was recorded as 51.8kg although, according to the external report, the CSN had documented a weight of 48.6kg on 24 [Month14].

(xi) On 24 [Month15] [Dr D] e-mailed [Mr A] with advice regarding pain management, use of Vitamin D for the toe symptoms, notification a dietitian referral had been made (by the CSN), and the advice *I'll re-send the letter to the Surgical Clinic requesting the 6 month CT scan.* A copy of the information sent originally on 22 [Month13] was sent to surgical outpatient clinic at [Hospital 1]. In his response, [Dr D] states *The reason for re-sending the letter was my belief that I simply needed to remind the Surgical Clinic team that a CT scan had been promised and the appointment was outstanding and needed to be authorised … had I believed that the CT scan was not imminent or that my [Month15] letter would not be a sufficient reminder to expedite this, I would have included information about [Mr A's] recent symptoms …* The results of the MCDHB internal investigation confirm the original referral letter was received but lost prior to specialist triage. The report states the second referral letter was received and sent to [Dr B] for

review. It was known [Dr B] was on leave until mid-[Month16] but the information contained in the referral gave the impression the request was for 'routine' surveillance and it was felt it could reasonably wait for [Dr B] to return from leave. [Dr B] reviewed [Dr D's] note on 22 [Month16] and made a referral for [Mr A's] CT scan *to look for recurrent disease* with a requested category 3 urgency (≤ 2 weeks). [The investigation was scheduled to be undertaken at Hospital 2].

(xii) On 16 [Month16] the CSN reported to [Dr D] that [Mr A] had lost further weight (now 49.5kg) and had ongoing abdominal symptoms. [Dr D] reviewed [Mr A] later that day and noted *further weight loss — 48.5kg, pains across upper abdomen, can usually attribute to having just eaten … OE scaphoid abd, tender firm mass LUQ→ bloods, uss. Doesn't want to do these [until 26 Month16] …* On 23 [Month16] [Mr A] notified [Dr D] that he would wait for [Dr B] to organise a CT scan as he didn't feel the ultrasound would provide reassurance regarding cancer recurrence. However, he noted he was *feeling better lately* and had ongoing contact with the CSN. On 30 [Month16] [Dr D] has recorded contact from the CSN stating she *has organised CT scan [Hospital 2] ?next week as [Hospital 1] wait was longer …*

(xiii) CT scan was undertaken at [Hospital 2] on 4 [Month17] with the recorded indication being *Follow-up after Ivor Lewis oesophagectomy for adenocarcinoma distal oesophagus [Month8]. To look for recurrent disease.* Marked distension of the neo-oesophagus was noted together with left lower lung abnormalities which were thought to be inflammatory/infective rather than metastatic. However the oesophageal distension was suspicious for recurrent disease. Gastroscopy by [Dr D] on 18 [Month17] showed evidence of upper GO obstruction and [Mr A] was hospitalised for further investigation and nutritional support. Investigations included gastrograffin swallow, sigmoidoscopy and barium swallow leading to exploratory laparoscopy on 4 [Month18]. Laparoscopy showed evidence of peritoneal carcinomatosis and locally recurrent cancer (inoperable). [Mr A] had persistent respiratory difficulties following the anaesthetic and sadly died shortly after extubation on 4 [Month18]. [Mrs A] has complaints regarding aspects of her husband's secondary care management which are not the subject of this report.

3. [Mrs A] is concerned that her husband's providers assumed he would not survive long after his oesophageal cancer diagnosis and treatment and this adversely affected the provision of timely and appropriate medical care. With respect to the care offered by [Dr D], she is concerned that he: did not recognise [Mr A's] persisting abdominal symptoms as being possibly obstructive in nature; did not refer to [Mr A's] abdominal symptoms in his CT referral letter; did not contact [Dr B], who had provided the bulk of [Mr A's] surgical care in the private and public sector, of [Mr A's] progressive symptoms; did not advocate on behalf of [Mr A] to ensure he received timely investigation of his symptoms, particularly regarding delays in the CT request being actioned. Because of these deficiencies, [Mrs A] believes her husband was denied the chance of symptomatic (palliative or curative) treatment which might have extended his life, and the family had little time to adjust to his terminal diagnosis.

4. In his response [Dr D] acknowledged there were deficiencies in his communication with [Mr and Mrs A]. He has outlined factors contributing to the miscommunication and expressed regret at the sequence of events. He has made changes to his processes since

the complaint with more comprehensive use of the 'Task Manager' function of his PMS to track all written referrals (as opposed to new referrals) and a commitment to include relevant clinical notes in referrals for follow-up care.

5. You have asked specific questions which are recorded and answered below:

(i) *Do you believe that it was appropriate for [Dr D] to 'consult' with [Mr A] (and [Mrs A] about [Mr A's] condition) via email (24 [Month11] and {Month13]).* Looking at these 'virtual' consultations in the context of an established pattern of e-mail contact on clinical issues and the face to face contact that occurred over the period in question, I think these consultations were reasonably undertaken from a clinical perspective and did not adversely affect [Mr A's] overall clinical management. With the increasing use of 'patient portals' allowing patients access to their own results and clinical records and very secure e-mail communication, such virtual consultations are becoming more common although such contact will not always be clinically appropriate.

(ii) *Please can you advise if the initial referral requesting the CT scan was of an appropriate standard.*

I believe the standard of the initial referral, and the process around provision of this referral, departed from expected standards to a mild to moderate degree. This relates to two issues: [Mr A] was evidently not offered access to private CT scanning or review by [Dr B] in private despite him having accessed the private health sector during the earlier phase of his illness; more importantly, the physical symptoms [Mr A] was suffering, even if these were felt by [Dr D] to be similar to those he was experiencing at the time of discharge from surgical clinic, should have been listed on the referral form as should have any relevant assessment findings. The absence of such information implied [Mr A] was asymptomatic and requiring 'routine surveillance' rather than having symptoms which might have represented persisting post-operative complications such as sub-acute obstruction, or cancer recurrence. Even had the initial referral letter not been lost, it is likely the CT scan would not necessarily have been given high priority based on the information contained in the referral form.

(iii) *Please comment on the adequacy of the actions taken by [Dr D] in regards to following up with [Dr B]/MidCentral DHB on his initial referral.*

In light of [Mr A's] persistent symptoms, particularly abdominal pain only partly responsive to therapy, new onset reflux symptoms and ongoing weight loss, I believe [Dr D] should have reconsidered the scan as being for investigation of symptoms rather than 'surveillance', and been more proactive in ensuring the investigation was undertaken in a timely manner. This might have involved either personally, or via his nurse, checking with [Hospital 1] that the referral had been received and when the investigation was scheduled, or by contacting [Dr B] directly. Certainly by 27 [Month14], when [Mr A's] pain was persisting (although somewhat improved) and his reflux symptoms were worsening, such an action was indicated. This oversight was a mild to moderate departure from expected standards. Mitigating factors were the relatively reassuring reports from the CSN and her involvement with [Mr A's] oversight (although she should perhaps have communicated more specifically with [Dr D] regarding [Mr A's] progressive weight loss).

(iv) *In [Month15], when there was a change in [Mr A's] symptoms, should [Dr D] have undertaken additional steps to expedite the existing CT referral or completed a new referral in light of the new symptoms?*

This issue is largely addressed in my comments above. There was a missed opportunity for [Dr D] to review the priority of, and clinical indications for, [Mr A's] CT at the time he re-sent his original referral on 24 [Month15]. This was another opportunity to discuss private referral, or for him to contact [Dr B] directly, when there appeared to be undue delay in the original referral being actioned and particularly noting [Mr A's] ongoing and progressive symptoms and anxiety regarding the possibility of cancer recurrence. [Dr D's] management of [Mr A] on this occasion represents a moderate departure from expected practice. Even if terminal recurrence of cancer was the suspected diagnosis, confirmation of [Mr A's] clinical status several weeks earlier than it was eventually done would have allowed consideration of more specific palliative therapy, and more adjustment time for [Mr A] and his family, even if his overall prognosis remained grim.

(v) *Did [Dr D] provide sufficient follow up and advocacy for [Mr A] as his GP?*

I feel [Dr D] provided adequate clinical follow-up and support for [Mr A] with respect to symptom control and assessment, monitoring with blood tests and referral for abdominal X-ray and CSN support. However, as discussed above I think there were deficiencies in his CT referral and follow-up process and in his communication with [Mr and Mrs A] regarding any rationale for not actively expediting the investigation. His response clearly outlines his thinking at the time, and the remedial actions he has since undertaken appear appropriate to the situation.

(vi) *Any other comments you may wish to make about the care provided by [Dr D].*

I have no further comments other than those recorded above. However, I note there were deficiencies in the DHB processes regarding referral handling which did contribute to the delays [Mr A] experienced, and if care of a patient is 'handed over' to primary care with an acknowledgement that CT surveillance would be a reasonable consideration (as occurred in this case), it seems a reasonable expectation that the primary care provider might be able to refer directly for the CT surveillance on the recommendation of the specialist rather than having to refer back to the specialist clinic. However, the current situation whereby primary care providers have virtually no direct access to CT scanning (other than specific pathways such as suspected renal colic) is not unique to MCDHB."

Appendix B: Independent general surgeon advice to the Commissioner

The following expert advice was obtained from Dr Patrick Alley.

"My name is Patrick Geoffrey Alley. I am a vocationally registered General Surgeon employed by Waitemata District Health Board. Additionally I am the Director of Clinical Training for that DHB.

I graduated M.B.Ch.B from the University of Otago in 1967. I gained Fellowship of the Royal Australasian College of Surgeons by examination in 1973. After postgraduate work in England I was appointed as Full Time Surgeon at Green Lane Hospital in 1977. In 1978 I joined the University Department of Surgery in 1978 as Senior Lecturer in Surgery. I was appointed as Full Time Surgeon at North Shore Hospital when it opened in 1984. My present principal role in that DHB is as Director of Clinical Training. I am a clinical director for the Ormiston Surgical and Endoscopy Hospital in South Auckland.

I am a Clinical Associate Professor of Surgery at the University of Auckland, have chaired the Auckland branch of the Doctors Health Advisory Service for many years and have formal qualification in Ethics. I declare no conflict of interest in this case.

Clinical Narrative
[Mr A] (hereafter referred to as 'the patient') presented to his general practitioner [in] 2012. He stated that he had had two months of upper abdominal discomfort and some difficulty swallowing. His general practitioner referred him for an upper GI endoscopy which was done on the 1st of [Month1]. The surgeon involved was [Dr B] a vocationally registered general surgeon (hereafter referred to as 'the surgeon'). This investigation disclosed a thickening and reddened area at the lower end of the oesophagus and the conclusion was this was a probable oesophageal cancer. Biopsies at this endoscopy were suspicious for cancer but not diagnostic. He was referred to the multi-disciplinary team meeting of medical and radiation oncologists, surgeons and radiologists. His case was discussed on the 14th of [Month1]. Several things happened as a sequel to this meeting. A PET scan was arranged to determine any distant spread (none was apparent) and preoperative chemo-radiotherapy with a view to surgery after three cycles of ECX was arranged. ECX is named after the initials of the drugs used: epirubicin cisplatin capecitabine (Xeloda).

Finally a diagnostic laparoscopy was scheduled for 22 [Month1]. Another endoscopy and biopsy was done at this stage as well. These biopsies irrefutably diagnosed cancer. The laparoscopy confirmed a bulky area at the lower end of the oesophagus but no evidence of spread within the abdominal cavity. He then completed three cycles of chemotherapy as a prelude to his surgery with a further three cycles being planned for him after his surgery.

He underwent an Ivor-Lewis resection on the 10th of [Month5], a procedure whereby the abdomen and right chest is opened either sequentially or simultaneously to remove the

upper stomach and lower oesophagus. This procedure went well. However the histology of the excised gastro oesophageal section showed adenocarcinoma of the oesophagus with significantly 28 of the lymph nodes containing metastatic tumour. This is a seriously negative prognostic indicator of both the aggression of the disease and its likely extension beyond the surgical zone of excision.

Three post-operative cycles of chemo therapy were scheduled but in the event the patient only received two of these. The side effects from this particular regime are potentially difficult — nausea, fatigue and anorexia are quite common. Omission of his final cycle of chemotherapy was fully discussed and agreed to by his treating oncology team.

He was seen at intervals in the general surgical outpatients department until his post-surgical status was stable. On 17 [Month9] the surgeon discussed the situation with the patient and his family and indicated that further routine follow up was not indicated because it was unlikely any constructive surgical approach could be made to manage any recurrent disease. In his opinion it was better to manage the symptoms as they arose as routine investigations may either not find any recurrent disease or will show recurrent but asymptomatic disease not amenable to surgery.

On 22 [Month13] the patient's GP wrote to the surgeon requesting a scan be done on the patient as he had developed some symptoms. This letter was either not seen or not acted on so there was a delay in getting it done. The scan was eventually done on 4 [Month17]. It showed no obvious malignancy although there was some thickening at the upper end of the gastric remnant.

The surgeon was eventually told the results by letter from the general practitioner. Because of the obstructive upper GI symptoms he was brought in for endoscopy. This was done on 18 [Month17] but no obvious recurrence was found.

On 4 [Month18] he underwent a laparoscopy to further elucidate whether the obstruction was due to recurrent tumour or some unrelated mechanical problem such as an adhesion from that previous surgery. A major generalised recurrence of his cancer was found in his abdomen and no remedial surgery could be offered. Sadly he was unable to be resuscitated from the anaesthetic and/or the procedure and he died in postoperative recovery area of the theatre suite. The case was referred to the coroner but I am unaware if it has been investigated yet.

You have asked that the following questions about this case be answered. I will do that and also append some additional comment for your consideration.

The appropriateness of scheduling [Mr A] for a staging laparoscopy on 22 [Month1].

Given that the first endoscopy was on the 1st of [Month1] and the diagnostic laparoscopy was not done until 21 days later, this is an obvious question. Contemporary management of most major cancers and particularly oesophageal cancer is defined by a multidisciplinary team of, principally, oncologists, surgeons, pathologists and

radiologists. The timing of adjuvant radiotherapy and chemotherapy is important as these modalities have a profound effect on the patient's ability to withstand major surgery. The first availability for this was the 14th of [Month1]. It is accepted that the surgeon was on leave at that time but this did not impede the decision from the multidisciplinary committee and I find no cause for concern about the delay from the 1st of [Month1] until the end of [Month1].

The appropriateness of the care provided by [Dr B] following [Mr A's] Ivor Lewis procedure in [Month5], including but not limited to his advice regarding arranging a CT scan for [Mr A] in 6 or 12 months.

I find this a challenging question to answer because, not unreasonably, the precise detail of what was said between the surgeon and the patient is not recorded. The inference is as stated in the clinical narrative. That is that regular follow up for such a cancer known to have nodal metastatic disease is not indicated because the recurrence may be difficult to detect, if detected it may not be amenable to treatment and finally investigations may disclose asymptomatic recurrence which is not treatable. In fact the surgeon's contention proved to be correct in that the recurrence was not detectable on either a CT scan or endoscopy and it took a laparoscopy to finally prove that he had a major recurrence.

It seems, however, from the letter of 17 [Month9], that the decision about a follow up CT scan was rather left to the patient to decide and he (the patient) reasonably sought help later to get the scan done.

The nub of the issue is the nature of the clinician–patient relationship in this particular case. A reasonable expectation of patients would be the performance of accurate and safe surgery. In the case of the patient's major surgery on 10 [Month5] this has clearly been fulfilled. However if surgeons are going to opt for a 'non-intervention' follow up then the guidelines have to be very clearly enunciated. Access to the surgeon in the event of the patient experiencing problems has to be guaranteed and that has to be the starting point for instituting investigations and in my view to put the onus for arranging scans on the patient is neither fair nor reasonable. I suspect that the patient may have interpreted the surgeon's remarks about follow up as a statement about futility which may have implied the feeling that there was nothing more that could be done. Were that the case, then patients would reasonably not be keen to 'bother the doctor'.

In defence of the surgeon however it is clear that the patient had access to good primary care and reporting of those symptoms led to the arranging of the CT scan. That did lead to another issue which I next comment on.

The appropriateness of [Dr B's] actions on 22 [Month16], with regard to [Dr D's] referral for a CT scan.

I am uncertain as to what exactly happened here. My understanding is that the patient's GP wrote to the surgeon asking that a scan be done. There then occurred an 'unexpected administrative delay' which meant that the scan was not done until 4 [Month17]. This

probably made no material difference to the patient's outcome but it would be concerning if there was a correctable deficiency in the process of arranging such scans. The real issue is that it could well have made a difference to a patient in a different circumstance when such a scan could be a critical determinant of effective treatment or not. Therefore an elaboration of what constituted the 'unexpected administrative delay' is necessary before defining whether there was any departure from standard practice.

Information provided to [Mr A] prior to his laparoscopy procedure on 4 [Month18] with regard to:

a) The laparoscopy procedure and associated risks.
b) His current condition and associated risks related to undergoing the laparoscopy procedure.

Ironically the surgeon's view of follow-up proved to be the case. Both the CT scan and the endoscopy failed to disclose the true reason for the patient's symptoms and because of this uncertainty and the possibility that there was a correctable and benign reason for those symptoms it was quite reasonable to proceed to a laparoscopy. How that was introduced to the patient and his family I do not know. However the patient's wife is unequivocal about their position saying that had they known what the outcome would be they would never have agreed to laparoscopy. The surgeon and anaesthetist both indicated and their view is supported by objective tests (chest X-ray and laboratory work) that he was a suitable candidate for this relatively low risk procedure. Overall one has to rely on the patient's family for an account of what happened here. As is commonly the case the nature of such conversations is not recorded in the case notes. I do not know what explanation the surgeon gave as to the cause of the patient's death apart from ensuring that proper referral was made to the coroner. I would have expected that the surgeon would have given an estimation of risk. But given that although he was frail and suffering an, as yet, undiagnosed burden of cancer there were no significant issues raised in his pre-operative work up that would have precluded surgery. His demise after the laparoscopy was a devastating and unexpected event.

Information that [Dr B] provided to [Mrs A] following his laparoscopy procedure.

The patient's demise was, understandably, extremely distressing for his family. How the medical staff responded to this distress is central to the question asked. It is clear that the patient's family were unimpressed by the explanations given by medical staff. Whether the stress of the event on the surgeon contributed to poor communication remains uncertain. I would have expected that the surgeon would demonstrate considerable sympathy and support for the family and that he would guarantee his ready availability to respond to the family's concerns. I note that the surgeon did not discuss the outcome of his discussions with the anaesthetist about the patient's likely survival. Neither did he inform the family that the anaesthetist had discussed the patient with the intensive care staff and they had offered a bed if necessary. It would have been at best reassuring for the patient's family to know that such discussions had taken place. The fact that they were not party to the discussions is difficult to justify.

SUMMARY AND RECOMMENDATIONS

1. The patient suffered a particularly aggressive type of oesophageal malignancy.
2. At operation (after appropriate adjuvant chemotherapy) the disease was found to be outside the boundaries of the surgery.
3. This meant it was only a matter of time before spread and a premature death ensued.
4. The arrangements for follow up and scanning were somewhat imprecise.
5. Despite the poor outcome the second laparoscopy was justified.
6. Communication between the surgeon and the patient's family was perceived to be poor by the family.

While the adjuvant treatment of the patient and the performance of the surgical procedures were appropriate, my estimation is that communication with the patient and his family was imperfect.

- Follow-up arrangements were not precise. That should have been dictated by symptoms rather than an arbitrary arrangement of a CT scan.
- Risk estimation for the second laparoscopy seemed not to have occurred.
- Communication and information provision after the second laparoscopy was not gauged positively by the family and they were not party to significant discussions between the anaesthetist and the intensive care unit.

These represent moderate departures from the norm of good practice.

Yours sincerely

P.G. Alley FRACS

Surgeon and Director of Clinical Training

Waitemata DHB."

Appendix C: Independent anaesthetist advice to the Commissioner

The following expert advice was obtained from Dr Malcolm Futter:

"Thank you for seeking advice on the care provided to [Mr A] by [Dr C] on 4th [Month18] at [Hospital 1].

I have read the HDC Guidelines for Independent Advisors and endeavoured to follow them in compliance with the instructions which were included with your letter. The advice provided is based on thirty years experience gained as a specialist anaesthetist and an interest in the pharmacology of drugs used in anaesthesia.

The comments below are based upon a review of information provided by your office (which included a covering letter, summary of the complaint, copies of hospital notes and statements by anaesthesia staff at [Hospital 1]).

My advice regarding the specific matters which you wish me to address follows the order/numbering used in your covering letter.

[Please include in your advice, your opinion in regard to the following matters:

1) Information provided by [Dr C] to [Mr A] prior to his laparoscopy procedure on 4 [Month18] with regard to:
    a. The laparoscopy procedure and associated risks.
    b. His current condition and associated risks related to undergoing the laparoscopy procedure.

2) The appropriateness of the care provided by [Dr C] to [Mr A] during his laparoscopic procedure on 4 [Month18].

3) [Dr C's] actions following [Mr A's] laparoscopy procedure on 4 [Month18] with regard to:
    a. [Dr C's] post operative management plan for [Mr A]/discussions with other medical staff.
    b. [Mrs A's] allegations that [Dr C] took 'personal time' following [Mr A's] procedure.]

1) There is no contemporaneous documentation regarding information provided by [Dr C] to [Mr A] prior to his laparoscopy procedure on 4th [Month18]. The preoperative assessment makes no mention of respiratory issues and [Mr A's] overall perioperative risk was categorized as being ASA3. Whilst part of the standard format of the 'receipt of information and consent document' signed by [Mr A] makes mention of information and risks nothing specific has been noted on this document.

    At the time of induction no note was made of cricoid pressure [a technique using endotracheal intubation to reduce the risk of regurgitation] being applied, bag mask ventilation was used and an 'army medic' performed the intubation which suggests

[Dr C] thought the risk of ongoing aspiration was low.

In a later 'discussion' document (not dated and including the anaesthetic technician involved in [Mr A's] care) [Dr C] acknowledged that [Mr A] had been in 'poor condition with an oxygen saturation of 93% on air and that the ongoing aspiration and malnutrition were risk factors'. However because [Mr A] 'looked well considering ...' and the laparoscopy was expected to have a 'low impact' [Dr C] thought there was no 'need to discuss limitations of care as *(he)* was not expecting any untoward events' and 'post operative ICU care was not felt to be necessary'.

a) An anesthetist would not normally provide much information regarding laparoscopy, this being the responsibility of the surgeon. There might be mention of possible intraoperative respiratory and cardiovascular effects of the procedure and any postoperative consequences. It is not possible to comment on the amount of information [Dr C] might have provided.

b) As noted already, there is no documentation of information given to [Mr A] regarding his specific problems and the consequent risks of laparoscopy. However subsequent comments by [Dr C] in the 'discussion' document suggest he probably did not present [Mr A] with a risk of perioperative death sufficient to deter him from agreeing to anaesthesia and laparoscopy.

2) Some discrepancies exist between the anaesthesia record (the only contemporaneous record of the care provided by [Dr C] during the laparoscopy), a post mortem note by [Dr C] in the patient chart (14.00h 4th [Month18]) and subsequent comments in the discussion document:

— As noted above, cricoid pressure and avoidance of bag mask ventilation as part of a 'classic' rapid sequence induction (RSI) do not appear to have been used. Accepting there is some debate concerning the efficacy of RSI in patients at risk of aspiration I would have expected at least a modified RSI to be used and the 'proceduralist/intubator' to be more practiced if [Dr C] thought 'ongoing aspiration' was a risk factor. That being said the choice of muscle relaxant (rocuronium) and dosage (1 mg.kg) suggest rapid intubating conditions were being sought.
— Given the likely potentiating effect of [Mr A's] malnutrition/wasting on the duration of a relatively large dose of muscle relaxant (rocuronium) it would not be surprising if full reversal of relaxation was difficult. [Dr C] was clearly uncertain about the effect of the first dose of reversal agent (neostigmine) given at 10.10h since a further dose was given at 10.30h. It is not clear what doses were used but if it was 2.5mg of neostigmine on each occasion this of itself may have caused problems with complete reversal. In the discussion document [Dr C] simply says the muscle relaxation was 'fully reversed and response checked' with no mention of difficulty or how the check was made.
— Oxygen saturations for a significant part of the laparoscopy were about 94% which, although adequate, did require the inspired oxygen fraction to be 0.66–0.72 and the application of 5cm of positive end expiratory pressure (PEEP). The

subsequent comment about 'no difficulty oxygenating' is correct regarding the intraoperative period but does not address the likelihood of a problem with oxygenation postoperatively.

— After the recording of an elevated end tidal carbon dioxide partial pressure (59mm.Hg) at about 10.05h there is no further reference to carbon dioxide despite the potential for hypercapnia to cause somnolence.

Other aspects of [Dr C's] care during the laparoscopy were quite appropriate. The use of the agent to maintain blood pressure (metaraminol) was quite reasonable. Naloxone appears to have been used to determine if [Mr A's] unresponsiveness was due to a residual sedative effect of the fentanyl/remifentanil rather than because the naloxone was needed to reverse opiate respiratory depression.

3)

a) [Dr C's] initial postoperative management appears to have been in the operating room since the procedure ended at or about 10.10h but [Mr A] is not recorded as arriving in the Post Anaesthesia Care Unit until 11.39h. Throughout most of that time there were no recordings of [Mr A's] vital signs to indicate cardiovascular or respiratory function and neurological function was later summarized as '… not aware … pupils normal … delayed waking …' and tolerance of the endotracheal tube. There is no mention of whether he was breathing spontaneously or being assisted with positive pressure ventilation nor of the inspired oxygen concentration however in the subsequent discussion document it is stated that [Mr A] was 'not hypoxic during this period'.

[Dr C] describes attempts to determine the reason for [Mr A's] unresponsive state — a radiologist was spoken to about the possibility of a CT scan and the duty anaesthetist 'attended to review [Mr A] and provide a second opinion', although in a letter to the HDC the duty anaesthetist of 4th [Month18] says he 'did not have any clinical input into his *([Mr A's])* care on that day'.

In a subsequent chart note and the discussion document [Dr C] states that during this time there were also discussions with the ICU specialist and with the surgical specialist, [Dr B] — the latter appears to be confirmed by a chart note made by the surgical registrar ([Dr H]) at 12.00h. The discussion document also suggests [Dr C] 'needed time to talk with [Mrs A] around treatment from here on'.

It was at about this time that a consensus appears to have been arrived at whereby [Mr A] would be extubated, transferred to PACU and provided with palliative care only, despite the availability of an ICU bed. The PACU observations of respiratory function (labored breathing at 24 bpm and an oxygen saturation of 80% despite high concentrations of inspired oxygen) indicated a likely deterioration of [Mr A's] state. [Dr H's] chart note and the 'Not for Cardiopulmonary Resuscitation Order' suggest the surgical team arranged that [Mr A] be placed on a palliative care pathway.

b) Having been involved in a transfer of care to PACU staff and the palliative care team it would not be inappropriate for [Dr C] and others involved in [Mr A's] care to

reflect and discuss with colleagues what had happened ('debrief'). This is an early part of the audit process and allows staff to begin to come to terms with unexpected and upsetting events. It is unusual for this process to be referred to as 'personal time' although [Mrs A] may be aware of something else [Dr C] was doing.

If there is any further advice or assistance I can provide please let me know.

Yours sincerely

Dr Malcolm Futter."

Dr Futter provided the following additional advice via email on 6 November 2014:

"1. I am unable to say categorically what information was provided although [Mrs A] subsequently suggests intra or early postoperative death was not mentioned and [Dr C's] notes and comments do not suggest he considered there was a high risk of death.

2. [Dr C] should have informed [Mr A] that he was at increased risk of post operative respiratory complications and that these compounded by his other problems increased the risk of perioperative death. However, in order for [Mr A] to balance the respective risks of anaesthesia/surgery and continuing 'conservative' management [Dr C] would have needed to note that the risk of immediate perioperative death was still relatively small — far smaller than the high likelihood that without an intervention [Mr A] would neither be able to effectively eat or drink nor would there be any certainty concerning the extent of any recurrent disease (it is presumed the surgeon would also have made these points in his pre-operative discussion).

3. The pre operative discussion would ideally have been between not only [Mr A] and [Dr C] but would have had the surgeon present and possibly others able to provide information on the options available to [Mr A] (eg. intensivists and palliative care physicians). In practice, in the context of acute and semi acute surgery, such multi disciplinary/family meetings do not often occur.

4. My professional experience has been that despite being faced with an 'immediate' anaesthetic risk most patients will still elect to undergo anaesthesia and surgery when there is a far greater risk of death should surgery/anaesthesia be declined. The difference between knowing and not knowing the risks in such circumstances, whilst it may prepare patients and their families for the outcome, does not often result in a different decision."

Dr Futter provided the following additional advice on 22 January 2015:

"Thank you for seeking comment on the response from [Dr C]/MidCentral Health dated 18th December 2014.

[Dr C's] response clarifies some issues and allows me to expand on my previous comments.

1) Pre-operative information given to [Mr A]:

It is now clear that [Dr C] considered [Mr A] to have a very low risk of major perioperative complications. This was based on [Dr C] having previously anaesthetized [Mr A] without problems for a major surgical procedure and on [Mr A's] relatively 'stable', albeit suboptimal, cardiorespiratory status when he presented for laparoscopy. Given that not all anaesthetists mention perioperative death or serious adverse outcome, unless the probability of these events is relatively high and/or their likelihood may well cause the patient to decline the proposed surgery, it explains why [Mrs A] was not forewarned of adverse early post-operative events.

2) Perioperative care:

a) [Dr C] considered there was some (presumably slight) risk of regurgitation and aspiration since [Mr A] was intubated 'sitting up' (the Trendelenburg position [Dr C] refers to is actually the opposite of this — it is a supine, head down, position).

b) It is still not clear to me why a second dose of neostigmine was given, particularly when an objective measure of neuromuscular function had confirmed complete reversal of the relaxant's effects. Neostigmine given to a patient who has little or no residual non depolarizing neuromuscular block may cause a deterioration in neuromuscular function.

c) [Dr C] suggests that although not recorded, in the period when [Mr A] remained intubated and spontaneously breathing capnometry continued and that this ruled out hypercapnia as contributing to his delayed awakening.

3) Withdrawal of 'supportive' care:

It appears that the decision to remove [Mr A's] endotracheal tube was based on the belief that despite uncertainty about the cause or likely duration of his relatively unresponsive post-operative state it had been agreed that no further 'artificial life support' would be given.

If you wish me to make any further comment please let me know.

Yours sincerely,

Dr Malcolm Futter."

Dr Futter provided the following additional advice on 20 February 2015:

> "Unfortunately [Dr C's] response has not clarified this particular issue (see 1. below) which is one of three aspects of [Mr A's] care about which I still have doubts:
>
> 1. In a previous reply [Dr C] stated 'the extent of reversal achieved was checked using a peripheral nerve stimulator with an accelerometer (the NMT [Neuromuscular Transmission] module on the GE anaesthetic machines). The response was four twitches with no fade after the first dose'. This type of assessment/monitoring of recovery after use of neuromuscular blocking drugs provides an objective measure upon which to base management and the results described mean there is no residual paralysis and that further neostigmine is not required. Despite appearing to accept this in his latest response [Dr C] still states 'Residual neuromuscular block was still a possible cause of [Mr A] not waking …'.
>
> In fact a second dose of neostigmine in such circumstances may cause a reduction in muscle strength and despite what [Dr C] stated in his earlier reply ('the second dose of reversal … was administered nearly 21/2 hours post the initial dose') the anaesthesia record shows the times of administration of the two doses as 10.10 and 10.30h. [Dr C] has not said if the nerve stimulator/accelerometer measurement was repeated after the second dose of neostigmine.
>
> 2. Despite the questions I have about possible residual neuromuscular block (and its effect on [Mr A's] breathing and airway), if recognised as a potential issue it could have been managed by supporting breathing at least until there was no question of residual paralysis. The last documented measure of the adequacy [Mr A's] breathing/ventilation was a slightly raised expired carbon dioxide of ?59 mm.Hg at about the time the first dose of neostigmine was given. [Dr C] has subsequently stated that 'hypercapnia was excluded as a cause of delayed neurological recovery' but not explained how or when.
>
> 3. Perhaps the major aspect of the care that remains unclear to me is the extent to which any of the clinical teams involved were aware of the precariousness of [Mr A's] post operative condition and the likely speed of his decline once extubated — as far as I can gather [Mrs A] was not expecting him to die within a few hours.
>
> It might be helpful to ask the following questions:
>
> 1. Was the adequacy of [Mr A's] post operative breathing assessed in sufficient detail as to determine the 'stability' of his overall condition eg. were there serial measures of respiratory rate, inspired oxygen concentration, oxygen saturation and end tidal carbon dioxide levels?
>
> 2. If a gradual decline in adequacy of breathing and oxygenation was noted over that relatively short period was that information, combined with the effect of removing a 'secure' airway (ie the endotracheal tube) known to each of the responsible clinicians (anaesthetist, intensivist and surgeon) and the implications of it presented to [Mrs A]?

> Given the passage of time and apparent lack of contemporaneous documentation of some of these issues it may be difficult to obtain clear answers. Similarly it will probably not be possible to discover the extent to which [Mr A's] terrible prognosis (death within a few days due to a combination of gastrointestinal obstruction and probable respiratory failure) contributed to the decision by medical staff to withdraw support within a couple of hours of surgery.
>
> Kind regards,
>
> Malcolm Futter."

Dr Futter provided the following additional advice on 21 April 2015:

> "I have read [Dr C's] response and my comments are as follows:
>
> With regard to the monitoring of [Mr A's] immediate post operative vital signs and their stability — [Dr C's] recall (observations were not documented at the time) is that they were stable. Although it was believed [Mr A] was 'imminently terminal' there appears to have been a 'consensus' that he should be extubated.
>
> [Dr C] appears not to have spoken to [Mrs A] around the time of extubation and is thus unable to state what her expectations were.
>
> [Dr C's] decision to give a second dose of neostigmine, although in my opinion debatable on the basis of information given, was arrived at as a result of discussion with peers.
>
> In the absence of any other contemporaneous, documented, information I can offer no further advice."

Appendix D: In-house nursing advice to the Commissioner

The following expert advice was obtained from RN Dawn Carey, in-house nursing advisor:

"1. Thank you for the request that I provide clinical advice in relation to the complaint from [Mrs A] about the care provided to her late husband, [Mr A]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors. […] My advice is limited to the care provided by [RN E] in her capacity as Cancer Support Nurse (CSN).

2. I have been asked to provide advice regarding the following matters:

   i. [RN E's] role as a cancer support nurse
   ii. Whether [RN E] acted appropriately when questioned by [Mr and Mrs A] about the cost of a private scan
   iii. Whether [RN E] acted appropriately in communicating with [Mr A's] GP, [Dr D]

I have reviewed the following documentation: letter from Nationwide Advocacy Service to [the PHO] including [Mrs A's] complaint about the care provided by [RN E]; response from [the PHO] including a statement from [RN E], CSN position description, CSN consultation notes for [Mr A]; [Mr A's] GP notes; Mid Central DHB clinical notes; Community Cancer Support Nurses' Service pamphlet.

3. [Mrs A's] complaint details and [Mr A's] clinical diagnosis and treatments are comprehensively covered in the Investigator's memorandum to me. For the purposes of brevity I have not repeated this information in my advice.

4. Review of clinical records focussing on scope of clinical advice
   i. On 22 [Month13], [Mr A] was referred for community cancer nurse support by his GP, [Dr D]. The referral to [RN E] was accompanied by a copy of [Mr A's] discharge summary from the surgical clinic (dated 17 [Month9]) and a copy of questions that [Mr A] had discussed at his last GP consultation. The GP referral letter informed [RN E] that [Mr A] had been referred for a CT scan at the patient's request.
   ii. [RN E's] typed consultation notes dated 24 [Month14] report having the first face to face meeting with [Mr and Mrs A] on 7 [Month14]. [Mr A] is described as ... *a very slight gent 48.6kg ... Constipation has always been an ongoing problem ... has expressed never had reflux* ... Notes report advising [Mr A] to increase his oral laxative medication; supplying general information about diet and the Ivor Lewis procedure; and that [RN E] ... *would be in contact with GP regarding analgesia, laxatives* ... and that she had referred [Mr A] to the hospital dietetic department. ... *Have expressed that he is doing and has done really well to get this far he is aware that the majority of patients do not do well* ... A separate entry reports receiving a phone call from [Mrs A] on the morning of 24 [Month14] asking for contact. Due to sickness, [RN E] had not been in touch with [Mr A] since 7 [Month14]. Consultation notes detail [Mr A] reporting ... *he had been getting some acid reflux these past few days* ... that the nortriptyline and further

laxatives which were commenced on 14 [Month14] had *... improved his pain by 50% and his bowel actions are now daily which is so much better for him as he has more energy. Have stated I have done another ref to the dietitians ...* Medtech GP notes report receiving an update from [RN E] and omeprazole being prescribed in response to the reported reflux symptoms. The MCDHB clinical file has a copy of the 24 [Month14] referral from [RN E] requesting dietitian input.

iii. [RN E] reports next visiting [Mr and Mrs A] on 5 [Month15]. *... he explained that he was still getting this post nasal drip which was causing him to get reflux late at night, ... commenced on Losec 40mg nocte ... had improved things but its still there ... he is also getting moderate amount of pain post the last meal ... talked about analgesia ... suggested he try Gaviscon ... noted that his toes are dusky purple ... have been in contact with [Dr D] practice and requested an appointment today ...* [Mr A's] feet were reviewed the same day by [Dr F], a colleague of [Dr D]. Notes on 8 [Month15] report [RN E] contacting the GP practice for an update following Dr F's examination of [Mr A].

iv. Telephone contact from [Mr A] is reported on 15 [Month15] requesting a visit that week. *He said that he feels that he is still decreasing in his wt ... sleep very disrupted this last week, still getting reflux ... was given some Gaviscon doesn't really like it ... tending to use Mylanta ... had constipation for three days ... aware that he needs to increase medications ... have arranged to see ...* An email to [Dr D] from a Community Pharmacist is on file … *[RN E] (Cancer Nurse) asked me about a patient ... with bad reflux.* The email offers some suggestions regarding [Mr A's] medications. Also on file is a response (dated 17 [Month15]) confirming that [RN E's] referral requesting dietitian service input was being triaged. Notes from the home consultation on 19 [Month15] report *... [Mr A] stated that he has now tried the Gaviscon tablets and has had two really great nights sleep ... concerned about his weight (today 51.8kg) ... [Mr A] has not lost weight, he feels that he has concerns about his lack of muscle ... he is still trying to have at least two ensure supplement drinks a day. He is still managing 6 small meals a day too ... also states that the Nortriptyline has decreased his over all pain ... he is getting increased pain in the later part of the day ... I have asked [Dr D] to review ...* Medtech GP notes confirm [RN E] contacting and updating [Dr D].

v. On 16 [Month16] consultation notes report [Mr and Mrs A] as being *very fixated by need to have a scan ...* [Mr A] *... still getting reflux ... feels he has reduced energy levels and is tending to get a lot of gastric wind ... have arranged for them to see [Dr D] this afternoon ... weight today was 49.5kg which is a loss fro 50.6kg= 1.1 kg in two weeks ...* Medtech GP notes confirm [RN E] contacting and updating [Dr D] *... pt requesting scan to rule out disease progression.* Same day GP consultation reports a plan for *... bloods, uss. Doesn't want these until [26 Month16] ...*

vi. [RN E] visited [Mr A] on 21 [Month16] and reports that *... he appears less anxious about his appearance... I feel he is rather fixated on the idea of having progression of disease, have suggested that this really may not be the case ...* At [RN E's] next visit on 30 [Month16], she reports [Mrs A] as *... beside herself with upset, frustration, anger and grief as she is convinced that the disease is back, [Mr A] appears to have lost more wt since I last saw him ... cheek bones*

have sunk in more … troubled more with constipation and wind … as well as indigestion/reflux … did not attend ultrasound test earlier this week, said he was not up to doing this, they have arranged to have a CT scan done … Due to a delay in getting a CT scan appointment at [Hospital 1], arrangements were for [Mr A] to have the CT scan at [Hospital 2] instead. Medtech GP notes report [RN E's] update *Pt concerned Ca has returned so has organised CT scan [Hospital 2] ? next week …* [RN E] reports contacting [Mr A] via telephone the same afternoon to advise that the blood test results that were back and were within normal limits. [Mr A] reported feeling better with less pain following the passing of constipated stool and that he was expecting [Hospital 2] to contact him on Monday with an appointment date for his CT.

vii. [Mr A] contacted [RN E] on 10 [Month17] following receipt of his CT scan results … *he stated that he had a mixed bag of news. Stated the cancer has not come back but he has two pockets of distension oesophageal region at the junction and the other in the bowel … No real value from the dietitian …* Three days later, [RN E] visited Mr and [Mrs A] at their home. *Wt 50.3kg today. Appeared happier in spirits but low because of wt, talk about the* [CT] *results … explained that as yet I had not seen these … talked again what they can do with food to increase the cal in the meal … have talked about all this before. Still fixated on his bowels and still not using the laxative on a regular basis, talked through this again …*

viii. [RN E] did not see [Mr A] again. On 18 [Month17] [Mr A] was admitted to [Hospital 1] where he underwent investigations and intravenous nutritional support. On 4 [Month18], [Mr A] underwent a restaging laparoscopy. This revealed cancer recurrence and widespread metastasis. Following extubation, [Mr A] had persistent respiratory difficulties and died shortly afterwards.

5. Clinical advice

i. [RN E's] role as a cancer support nurse

As a RN the nursing care that [RN E] provided to [Mr A] was subject to the RN standards relevant at the time[1]. The Community Cancer Support Nurses' Service (CCSNS) pamphlet identifies [RN E] and her colleagues as *nurses who have completed cancer competency training.* As such, I do not consider [RN E] to be a specialist in gastrointestinal cancers but more 'generalist' as indicated by her broader title — cancer support. I would expect [RN E] to be able to recognise changes pertinent to a client's cancer related health status. The ability to evaluate such signs and symptoms would depend on the depth of the cancer competency training and the knowledge/experience that [RN E] would have acquired from working with her client group. The main focus of the CSN service is specified as *to assist the client and their family … facilitate interaction with secondary services and coordinate care.* I consider this to mean that the CSN would participate in effective and timely communication across the healthcare team including hospital and specialist services. In my opinion, this expectation is also reflected in the submitted position description. While there is some evidence of secondary service interactions — [RN E] referring [Mr A] to the dietitian and her

[1] Nursing Council of New Zealand (NCNZ), *Code of conduct for nurses* (Wellington: NCNZ, 2012).

support in getting a CT scan appointment at [Hospital 2] — the main focus of [RN E's] communications were with [Mr A's] primary health providers — [Dr D], community pharmacist.

Based on the contemporaneous CSN notes there were fluctuations in [Mr A's] weight — 48.6kg 7 [Month14], 51.8kg 19 [Month15], 50.6kg ~ 2 [Month16], 49.5kg 16 [Month16], 50.3kg 13 [Month17]. On admission to [Hospital 1] on 18 [Month17], [Mr A's] weight is recorded as 50kg. In my experience, it is pretty typical for patients to struggle with their weight after undergoing an Ivor Lewis procedure. Symptoms such as reflux are also common. Such symptoms are not always indicative of cancer recurrence. In my opinion, the evaluation of such symptoms requires secondary health service involvement. I note that the completed MCDHB internal review resulted in recommendations around the communication flow between the hospital Gastrointestinal Clinical Nurse Specialists and the community Cancer Support Nurse Service. I agree that this is appropriate and necessary.

ii. Whether [RN E] acted appropriately when questioned by [Mr and Mrs A] about the cost of a private scan

There is no reference to [RN E] being asked about a private scan in the consultation notes or in her submitted statement to the HDC. I would not expect [RN E] to have up-to-date knowledge of the cost of a private CT scan. However, it does seem reasonable that a health professional at ease with navigating the health system would be aware of the general process of how community clients access a CT scan and be able to advise accordingly if asked. I note that [RN E] communicated [Mr A's] wish to have a scan to rule out disease progression on 16 [Month16] and that [Mr A] attended a GP appointment the same day.

iii. Whether [RN E] acted appropriately in communicating with [Mr A's] GP, [Dr D]

Yes, based on the contemporaneous consultation notes. There is evidence of [RN E] communicating with [Dr D] regularly and keeping him informed. In my opinion [RN E] acted appropriately in her communications with [Dr D].

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