HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Inappropriate endometrial ablation contributing to delayed diagnosis of cancer

Executive summary

1. This report is the opinion of Ms Rose Wall, Deputy Health and Disability Commissioner. It relates to care provided by Dr A, obstetrician and gynaecologist, to Mrs B, both as a private specialist at a private specialist hospital and as a public specialist at Health New Zealand | Te Whatu Ora (Health NZ).

2. In 2016, Dr A performed an endometrial ablation (a procedure that destroys the endometrium, also called the uterine lining) on Mrs B (aged 60 at the time) to treat heavy menstrual bleeding. Mrs B saw Dr A again in 2020 for suprapubic (lower abdominal) pain and brown vaginal discharge and was discharged from his care in April 2021 once he was satisfied that there was no 'major pathology' causing her symptoms. In early 2023, Mrs B was diagnosed with grade 1 endometrial cancer and scheduled for a hysterectomy, which Dr A performed on 30 March 2023 in his public capacity at Health NZ. During the surgery, it was identified that the cancer had spread, and Mrs B was informed of this by a registrar the following day, without a support person present. In May 2023, the cancer was upgraded to stage IVB endometrial cancer.

3. I obtained expert advice from Dr John Short, obstetrician and gynaecologist, who identified that Dr A's decision to perform an endometrial ablation on Mrs B was a severe departure from the accepted standard of practice and advised that this led directly to the difficulties and delays in diagnosing the endometrial cancer. Dr Short also identified a moderate departure regarding communication with Mrs B and her family about the spread of cancer in March 2023 and some mild departures regarding care provided between June 2020 and April 2021.

4. Under the Code of Health and Disability Services Consumers' Rights (the Code), Dr A had a responsibility to ensure that services were provided with reasonable care and skill. I consider Dr A's decision to treat Mrs B with an endometrial ablation on 2 September 2016 was not appropriate, and, as such, I consider that Dr A did not provide services to Mrs B with reasonable care and skill and therefore breached Right 4(1) of the Code. I have also made adverse comment about the care Dr A provided to Mrs B between June 2020 and April 2021 and about Dr A's communication with Mrs B and her family.

Recommendations

5. My provisional opinion included a proposed recommendation that Dr A provide a written apology to Mrs B for the breach of the Code identified in this report. Dr A proactively provided this apology with his response to my provisional opinion, and it has been forwarded to Mrs B.

6. I recommend the following:

a) Dr A audits his consumer records (with both the private specialist hospital and public hospital) since 2016 to identify: a) whether any other endometrial ablations were performed on postmenopausal women and b) whether they are at a higher risk of endometrial cancer (particularly if there was any evidence of a proliferative endometrium), the detection of which may be complicated by the ablation. The summary of findings, with any corrective actions, is to be provided to the Health and Disability Commissioner (HDC) within three months of the date of this report.

b) Dr A uses an anonymised version of this case for wider education of his peers. The case study presentation should detail the actions or decisions taken, the results of these actions or decisions, and the appropriate course that should have been taken to arrive at a more desirable outcome. Evidence confirming the content of the presentation (eg, conference abstract or presentation material) and delivery (eg, a record of communication to peers or attendance records) is to be provided to HDC within six months of this report.

Background

7. On 1 June 2016, Mrs B saw Dr A in his capacity as a private specialist at the private specialist hospital for abnormal uterine bleeding. Dr A completed an endometrial biopsy, which showed 'weak proliferative endometrium', meaning the uterine lining was somewhat thickened because of exposure to oestrogen. A clinic letter from Dr A in August 2016 states that Mrs B was keen to undergo a hysterectomy but that her high body mass index (BMI) would make a hysterectomy challenging, so he suggested a diagnostic hysteroscopy and an endometrial ablation as a less invasive option to rule out any abnormal endometrial pathology and control the bleeding. Dr A performed the hysteroscopy and ablation on 2 September 2016. The histology from this hysteroscopy showed 'disordered proliferative endometrium', meaning the endometrium had grown unevenly or become too thick because of prolonged 'unopposed' exposure to oestrogen.

8. Mrs B returned to Dr A in June 2020 after a referral from her general practitioner (GP) for suprapubic pain and brown vaginal discharge. Magnetic resonance imaging (MRI) showed an enlarged uterus due to adenomyosis (a condition where endometrial tissue grows into the muscular walls of the uterus) and mild endometrial thickening with an irregular margin against the myometrium (the thick muscular middle layer of the uterine wall). In October 2020, Dr A referred Mrs B to the public hospital for a further diagnostic hysteroscopy, which was done on 4 March 2021. Dr A was the consultant for this procedure. The histology results from the endometrial sample were 'nondiagnostic', meaning there was not enough endometrium to sample. The clinic letter to Mrs B from the public hospital stated that this was reassuring and no further endometrial sampling or tests were required.

9. On 10 March 2021, Mrs B's GP referred her back to Dr A for follow-up and clarification around a prescription for pessaries. Mrs B saw Dr A at the private specialist hospital on 24 April 2021, where they discussed the hysteroscopy results and, again, whether a hysterectomy might be possible. Dr A again recommended a conservative approach because

he felt reassured by Mrs B's lack of bleeding and the results of the MRI scan and the hysteroscopy and was conscious that Mrs B was a high-risk surgical candidate because of the presence of several risk factors, including a high BMI, hypertension, and previous surgery for a suburethral sling (approximately 20 years earlier). In a clinic letter after this appointment, Dr A also noted that he was 'quite comfortable' that he was not missing any major pathology. Dr A formed a working diagnosis of adenomyosis, bowel issues, or a complication from her suburethral sling. Dr A stated that he was also conscious that a hysterectomy would not guarantee that Mrs B's pain would improve. Mrs B continued to have brown discharge and severe pain, which required regular tramadol. Dr A prescribed gabapentin in addition for pain control, but this was ineffective, and no further follow-up was arranged.

10. Mrs B continued to seek help from her GP and underwent a colonoscopy with normal results in February 2022. In September 2022, a urologist reviewed her to investigate whether her suburethral sling could be causing the ongoing pain. The urologist ordered an abdominal MRI, which was performed on 4 January 2023 and showed a distended endometrium. Gynaecology review was recommended, so Mrs B's GP referred her back to Dr A on 11 January 2023, noting the results of the MRI and that Mrs B was experiencing worsening pelvic pain and light bleeding (which had started the month prior).

11. At an appointment with Dr A at the private specialist hospital in early February 2023, a cervical smear test was completed, the results of which showed abnormal cells. Dr A recommended a hysterectomy because of a suspicion of endometrial cancer. The oncology department recommended another hysteroscopy and a colposcopy for diagnostic purposes before undertaking the hysterectomy. These were done on 24 February 2023. The findings of the hysteroscopy were consistent with grade 1 endometrial cancer.

12. Mrs B underwent a hysterectomy on 30 March 2023, performed by Dr A, assisted by Dr C, a registrar. During the hysterectomy, multiple small growths were seen outside the uterus, including on the fallopian tubes, ovaries, and parts of the bladder and bowel. The day after the hysterectomy, Dr C informed Mrs B that the cancer appeared to have spread. Mrs B did not have a support person present with her at that time and was, understandably, very upset.

13. In May 2023, it was confirmed that Mrs B had stage IVB endometrial cancer. Mrs B is concerned that the diagnosis of cancer was delayed.

14. An Accident Compensation Corporation (ACC) treatment injury claim was accepted in February 2024 for 'failure to diagnose and treat postmenopausal symptoms, resulting in a missed diagnosis of endometrial cancer, progressing to stage 4 cancer.' The 'date of injury' determined by ACC was 2 September 2016 – the date of the endometrial ablation. ACC concluded:

> 'On the balance of probabilities, had [Mrs B] been appropriately treated with progesterone and ongoing monitoring opposed to endometrial ablation in [2016], it is unlikely [she] would now have a diagnosis of stage IVB endometrial cancer.'

Provider responses

15. Health NZ and Dr A have been provided opportunities to respond to the concerns raised. Relevant information from these responses is summarised below.

Health NZ

16. Health NZ stated that the usual process after a non-diagnostic histology result would be for a further management plan to be made by the treating clinician, who would consider the individual patient's clinical situation and risk factors.

17. Health NZ completed an adverse event review (AER) of the care provided to Mrs B at the public hospital. The AER identified inadequate sampling at the original 2021 hysteroscopy, with no formal follow-up arranged, as a care delivery problem. This finding appears to have been made in the context of postmenopausal bleeding being a symptom at that time.[1] The AER also noted that this was a complex case because Mrs B's prior ablation affected the accuracy of the hysteroscopy and because of the presence of additional risk factors (including prediabetes and a high BMI) but that these complicating factors were not recognised by the clinician overseeing her care (Dr A).

Dr A

18. Dr A told HDC that, when Mrs B presented to the private specialist hospital in 2020, he was concerned about a serious condition causing her symptoms and undertook the necessary investigations: he attempted an endometrial biopsy, arranged an MRI scan, and referred Mrs B to the public hospital for hysteroscopy and further management. After the hysteroscopy, Dr A felt reassured by the results and considered other possible causes for the pain. He stated that, without a proper diagnosis, and in the context of medical comorbidities and a high risk of surgical complications, he did not consider doing a hysterectomy. Dr A also noted that Mrs B's symptoms were not classical for endometrial cancer in that she initially had lower abdominal pain with no bleeding and that it was also unusual because it was present only at night and settled with analgesia.

19. Dr A acknowledged that he could have offered Mrs B a follow-up appointment to be seen at the clinic after a few months and that, if her symptoms persisted at that point and no other causes of pelvic pain were found, she may have been offered a hysterectomy but that serious consideration would have been given to the risks this would pose. Dr A noted that, when he discharged Mrs B in April 2021, he had advised her to contact his practice if she had any ongoing symptoms.

20. Dr A also stated that it is his usual practice to see postoperative patients immediately or the day after their surgery. Dr A said that he had a full-day theatre list on the day of Mrs B's hysterectomy, which meant he was unable to see her on the same day, and he intended to go and speak with her the following day. Dr A had been assisted during the hysterectomy by Dr C (a fourth-year registrar), and on the morning of 31 March, Dr C completed an early ward round (because she had a gynaecological clinic that day), which involved checking on all patients they had operated on the previous day. It was during that ward round that Dr C

[1] Note that, based on clinical records and on advice from Dr Short, this does not appear to have been the case. This is discussed further in the opinion section of this report.

informed Mrs B of the apparent spread of cancer. Dr A acknowledges that it was inappropriate to deliver this news to Mrs B without any support and without Dr A or a more senior doctor present. Dr A advised that, when delivering bad news, his usual practice is to ensure that the patient is comfortable and has a support person present, and he regrets not ensuring Dr C was aware of his usual process and that Dr A was intending to deliver the news himself.

Expert advice

21. To assist in my investigation, I obtained independent advice from Dr John Short, an obstetrician and gynaecologist (**Appendix A**). I note that Dr Short was also the expert advisor to ACC on the care Dr A provided to Mrs B.

22. Dr Short identified that the ablation in 2016 was not indicated and that the decision to perform an endometrial ablation at that time was 'utterly inappropriate and led directly to the difficulties and delays in diagnosing Mrs B's endometrial cancer.' Dr Short advised that performing this ablation was a severe departure from accepted practice and 'the single most significant aspect of this case.'

23. Dr Short also identified that Mrs B being given unexpected, bad news without a support person present and (perhaps more significantly) Dr A not providing adequate supervision of a junior doctor was a moderate departure from accepted practice.

24. Dr Short noted that Dr A does not appear to have considered the impact of Mrs B's prior ablation when addressing her later gynaecological issues and that this was a mild departure from accepted practice. He also noted that it would have been good practice for Dr A to have arranged a six-month follow-up appointment after the 2021 hysteroscopy, considering Mrs B's ongoing symptoms, although Dr Short clarified that this would be the 'counsel of perfection.'

25. Dr Short further clarified that the primary red flag or symptom for endometrial cancer in postmenopausal women is bleeding (red blood) and that brown discharge and pain are less reliable indicators for endometrial cancer and are not commonly associated with it.

Opinion: Dr A – breach

26. My role is to determine whether Dr A delivered services to Mrs B to an appropriate standard, including whether services were provided with reasonable care and skill (Right 4(1) of the Code). To do this, I have considered all the information gathered, including from Mrs B and her family, Dr A, Health NZ, ACC, and my independent expert advisor, Dr Short. I set out below how I have formed my opinion that Dr A breached Right 4(1) of the Code and why I propose to make adverse comment regarding the care he provided to Mrs B between June 2020 and April 2021, and his communication with Mrs B and her family.

2016 ablation – breach

27. In June 2016, the histology from an endometrial biopsy showed that Mrs B had a 'weak proliferative endometrium'. Dr Short advised that proliferative endometrium is not a normal finding in postmenopausal women (which Mrs B was) and was indicative of ongoing stimulation with oestrogen, which created a risk of progression to more serious changes

(ie, pre-cancerous or cancerous cellular changes) if not treated appropriately with progesterone therapy and monitored with repeat biopsy. Dr A did not treat this with progesterone therapy. After Mrs B experienced further abnormal uterine bleeding over the next few months, Dr A decided to perform a diagnostic hysteroscopy and endometrial ablation on Mrs B on 2 September 2016, with the intention of ruling out any abnormal endometrial pathology and controlling the bleeding. The histology from this hysteroscopy showed disordered proliferative endometrium, which does not appear to have been considered or discussed at a postoperative appointment on 21 September 2016, and no further follow-up appears to have occurred until Mrs B re-presented in June 2020.

28. Dr Short advised that the decision to perform an ablation on 2 September 2016 was 'utterly inappropriate' as it is not indicated for treatment of postmenopausal women and was not indicated in this case. Dr Short considers this to have been a severe departure from accepted practice and that ablating the uterus may have masked abnormalities and potentially impeded future identification of abnormalities.

29. I take careful note of Dr Short's advice that endometrial ablation in this case was neither indicated nor an appropriate course of treatment. My expert's remarks in this respect are concerning, and I am therefore extremely critical that Dr A did not recognise the significance of Mrs B's proliferative endometrium and the increased risk for pre-cancerous and cancerous changes (particularly given her other risk factors for endometrial cancer, including high BMI and pre-diabetes) and did not treat this appropriately. I consider that, by performing an endometrial ablation on 2 September 2016 and not recognising the significance of proliferative endometrium (present in both the August and September 2016 histology results) or treating this appropriately, Dr A did not provide Mrs B with services with reasonable care and skill, and, as such, breached Right 4(1) of the Code.

Care provided from June 2020 to April 2021 – adverse comment

30. Health NZ's AER identified inadequate sampling at the original 2021 hysteroscopy with no formal follow-up arranged as a care delivery problem. However, I note that this appears to have been determined in the context of postmenopausal bleeding occurring at that time (a red flag for endometrial cancer). The information available to me suggests that Mrs B was experiencing a brown-ish discharge rather than red blood (until early 2023, when bleeding re-occurred). Dr Short provided clarification on what constitutes postmenopausal bleeding and advised that brown-ish discharge would not be considered postmenopausal bleeding.

31. Dr Short initially advised that lack of follow-up after the 2021 hysteroscopy was a mild departure from the accepted standard of care but later clarified that this was a 'counsel of perfection' rather than a criticism.

32. Further, Health NZ's AER and Dr Short both identified that Dr A does not appear to have considered the impact of Mrs B's prior ablation on the accuracy of the hysteroscopy or ease of diagnosing endometrial cancer in this case. Dr Short advised that it was a mild departure from the accepted standard of care to not consider the impact of the previous ablation in decision-making, acknowledging the benefit of hindsight.

33. I accept Dr Short's advice that there was a mild departure regarding a lack of consideration of the impact of the prior ablation during this period of care. I consider that it would have been best practice for Dr A to have arranged further follow-up in light of Mrs B's ongoing symptoms, risk factors for endometrial cancer, and the complexity created by the prior ablation.

Communication – adverse comment

34. On 31 March, Dr C (Dr A's registrar) informed Mrs B that, during surgery, they had seen multiple small growths outside the uterus, suggestive of a spread of cancer. Mrs B did not have a support person present at the time and was very upset by this news. Dr A told HDC that his usual practice is to see postoperative patients either immediately or on the day after their surgery, but a full-day theatre list meant he was unable to see Mrs B on the day of her surgery, and he intended to go and speak with her the following day. Dr A acknowledges that it was inappropriate for Mrs B to be told this news without having any support and without Dr A or a more senior doctor present, and he regrets not ensuring Dr C was aware of his usual process (to ensure the patient is comfortable and has a support person present) and that he was intending to deliver the news himself.

35. Dr Short noted that the findings at surgery were unexpected and suggested a stage of cancer considerably more advanced than previously thought, and that in these circumstances, Dr A should have made himself available for the ward round and been proactive in taking responsibility to disclose these findings to Mrs B and her family. Further, Dr Short advised that it was inappropriate to put a junior doctor in this situation of informing Mrs B. Dr Short advised that Mrs B being given unexpected, bad news without a support person present, and (perhaps more significantly) Dr A not providing adequate supervision of a junior doctor was a moderate departure from the accepted standard of care.

36. I accept Dr Short's advice that this was a moderate departure from the accepted standard of care, and I am critical that Dr A was not more proactive in ensuring that the unexpectedly bad news was communicated to Mrs B with a support person present. I am also critical that he did not provide adequate supervision of Dr C in regard to this. Therefore, while Dr A has offered an explanation for his absence and not being available to speak to Mrs B himself, at the very least Dr A should have communicated and coordinated with Dr C better to ensure the news was delivered appropriately.

Follow-up actions

37. A copy of this report will be sent to the Medical Council of New Zealand, and it will be asked to consider whether further action on its part, including a competency review, is called for in the circumstances.

38. A copy of this report with details identifying the parties removed, except my independent expert advisor, will be sent to the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and the New Zealand College of Sexual and Reproductive

Health (NZCSRH) and placed on the HDC website, www.hdc.org.nz, for educational purposes.

Rose Wall
Deputy Health and Disability Commissioner

Appendix A: Independent clinical advice to the Commissioner

The following independent advice was obtained from obstetrician and gynaecologist Dr John Short:

'Independent clinical advice to Health and Disability Commissioner

Complaint:	**[Mrs B] / Health New Zealand | Te Whatu Ora – […] and [private specialist hospital]**
Our ref:	**C23HDC01950**
Independent advisor:	**Dr John Short**

I have been asked to provide clinical advice to HDC on case number C23HDC01950. I have read and agree to follow HDC's Guidelines for Independent Advisors.

I am not aware of any personal or professional conflicts of interest with any of the parties involved in this complaint.

I am aware that my report should use simple and clear language and explain complex or technical medical terms.

Qualifications, training and experience relevant to the area of expertise involved:	MBBS 1995 Newcastle upon Tyne, MRCOG 2000, FRANZCOG 2007 I am an Obstetrician and Gynaecologist, vocationally registered in New Zealand since 2007.
Documents provided by HDC:	1. Letter of complaint dated 25 July 2023 2. Further concerns from the complainant dated 1 February 2024 3. Dr [A]'s response and enclosures dated 8 October 2023 4. Clinical records from [private specialist hospital] covering the period 4 October 2020 to 15 February 2023 5. Health New Zealand's response and enclosures dated 24 January 2024 6. Clinical records from Health New Zealand covering the period 2017–2023 7. Copy of your advice to ACC dated 19 December 2023.
Referral instructions from HDC:	Dr John Short Please review the enclosed documentation that relate to the care provided to [Mrs B] by **Health New Zealand | Te Whatu Ora (Health NZ) and** advise: 1. Whether it was reasonable that Health NZ did not arrange a further hysteroscopy or further assessment following the non-diagnostic result of March 2021.

	2. Whether it was reasonable that Health NZ did not arrange a postoperative follow-up after the March 2021 hysteroscopy. 3. Whether it was reasonable to advise Mrs [B] of the spread of cancer the day after the hysterectomy and without a support person present. 4. Whether Mrs [B] could have avoided the need for two surgeries (rather than one) had the para-aortic node been identified at the point of the CT scan and initial Multi-Disciplinary Meeting. 5. Any other matters that you consider warrant comment relating to the care provided by Health NZ. Please also review the enclosed documentation that relate to the care provided to [Mrs B] by **[private specialist hospital] / Dr [A]** and advise: 1. Whether it was reasonable that Dr [A] did not arrange a further hysteroscopy or further assessment following the non-diagnostic result in March 2021. 2. Whether it was reasonable that Dr [A] did not advise Health NZ that Mrs [B] had returned to him in April 2021 with continuing issues post-surgery. 3. Whether it was reasonable that Dr [A] discharged Mrs [B] in April 2021 without further follow-up. 4. Whether Dr [A] adequately considered Mrs [B]'s risk factors for endometrial cancer (obesity and a thickened endometrium) before discharging her. 5. Whether the standard of communications with Mrs [B] and her family was reasonable. In particular, Dr [A]'s discussions of 30 March, 31 March and 20 April 2023.[2] 6. Any other matters that you consider warrant comment. **Further question:** 1. We would also like your comment on an aspect of the advice you provided to ACC. In your report for ACC, you comment on the appropriateness of the endometrial ablation performed on Mrs [B] in [2016]. Please see point 4 of your report to ACC.

[2] Pages 3 and 4 of the family timeline document and page 120 of Health NZ […] records as examples.

	Could you please advise us if the concern you raised is significant and warrants further consideration from this Office and whether in your view this procedure was clinically indicated.

Factual summary of clinical care provided complaint:
[This section of the advice template has been removed as it was not completed. HDC informed Dr Short that in the context of time constraints, it would not be required.]

QUESTIONS REGARDING HEALTH NEW ZEALAND

Question 1: Health NZ: Whether it was reasonable that Health NZ did not arrange a further hysteroscopy or further assessment following the non-diagnostic result of March 2021.	
List any sources of information reviewed other than the documents provided by HDC:	
Advisor's opinion:	The findings at hysteroscopy were normal. Therefore, further investigation was not required on this basis. Mrs [B] presented with symptoms not typical of endometrial cancer. Her symptoms were suprapubic pain and brown discharge. The key symptom of endometrial cancer, upon which all guidance is based, is postmenopausal bleeding. It is quite clear from documentation prior to the hysteroscopy that this symptom was not reported. In fact, the operation note (March 2021) clearly states 'no bleeding' under the heading of 'indication'. The ultrasound scan (May 2020) states "intermittent low abdominal pain" as the indication and does not mention bleeding. Dr [A]'s letter of June 2020 clearly states, "[Mrs B] does not have any vaginal bleeding" (paragraph 2, line 5). Therefore, further hysteroscopy was not indicated on the basis of persistent symptoms. The ultrasound and MRI findings indicated a hysteroscopy was required to exclude endometrial pathology. However, these findings are overruled by the hysteroscopy findings, as hysteroscopy has greater specificity and positive predictive value for endometrial pathology. The term 'non-diagnostic' is misleading and used inappropriately in my opinion. The term implies

	inconclusive findings when, in fact, an atrophic endometrial cavity with no endometrium in the sample is a normal finding in a postmenopausal woman. Therefore, it is my opinion that it was reasonable that Health NZ did not arrange a further hysteroscopy at that time.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	Women with persistent postmenopausal bleeding despite normal/reassuring investigations should have repeat assessment investigations after an interval of 6 months. However, this standard does not apply in Mrs [B]'s case as she did not have bleeding. There is no specific standard of care for further investigation of suprapubic pain and brown discharge following a normal hysteroscopy.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	No departure
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	Peers without knowledge of the final outcome would agree.
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	

Question 2 Health NZ: Whether it was reasonable that Health NZ did not arrange a postoperative follow-up after the March 2021 hysteroscopy.	
List any sources of information reviewed other than the documents provided by HDC:	
Advisor's opinion:	See above.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	See above. Within the public system, due to the limited resources, it would be accepted practice to not arrange follow-up after a normal hysteroscopy. In most cases, the patient would be informed of findings and results and discharged back to the care of the GP.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	No departure
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	My peers would agree with [this] opinion.
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	

Question 3: Health NZ: Whether it was reasonable to advise Mrs [B] of the spread of cancer the day after the hysterectomy and without a support person present.	
List any sources of information reviewed other than the documents provided by HDC:	

Advisor's opinion:	This is difficult to answer. This scenario is certainly far from ideal. However, giving bad news is never easy and there is never a good time. The information was divulged on a ward round by Dr [C], a registrar, who appears to have been working without senior supervision. In fact, it is not clear if Dr [A] saw Mrs [B] in hospital at any point postoperatively. The circumstances under which the information was divulged are also not clear; for example, if Mrs [B] asked if 'everything looked ok' or if Dr [C] volunteered the information. Regardless, the duty of open disclosure may have influenced Dr [C]'s decision to be less circumspect with the information. The findings at surgery were unexpected and suggested a stage of cancer considerably more advanced than previously thought and discussed. In these circumstances, it was inappropriate of Dr [A] to put a junior doctor in this situation. He should have made himself available for the ward round and been proactive in taking responsibility for disclosing the findings to Mrs [B] and her family. He and his team should also have had the foresight to realise the gravity of this information and the effect that it may have had on Mrs [B] and her family and planned accordingly.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	To my knowledge, there are no formal standards to guide us in this situation. However, it would generally be considered good practice for a specialist to see their patients on day 1 postop and to take responsibility for sharing bad news with them and their families. Given the circumstances of such a significant difference in the findings, it would certainly be most appropriate to ensure a support person was present before divulging this information. I am sure my peers would agree on all counts.

Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	Moderate departure, on the basis of unexpected, bad news being given without a support person present and (perhaps most significantly) Dr [A] not providing adequate supervision of a junior doctor.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	See above
Please outline any factors that may limit your assessment of the events.	See above
Recommendations for improvement that may help to prevent a similar occurrence in future.	Introducing a culture and system whereby specialists see their patients on day 1 postoperatively and take responsibility for divulging unexpected, bad news themselves.

Question 4 Health NZ: Whether Mrs [B] could have avoided the need for two surgeries (rather than one) had the para-aortic node been identified at the point of the CT scan and initial MDM.	
List any sources of information reviewed other than the documents provided by HDC:	
Advisor's opinion:	Mrs [B would certainly have avoided a second surgery if the para-aortic node had been identified on the initial reporting of the CT scan and initial MDM.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	Assuming this relates to the fact that the reporting radiologist did not identify the node, this is outside my scope of practice, and advice from a radiologist would be required.

Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	This is outside my scope of practice, and advice from a radiologist would be required.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	This is outside my scope of practice, and advice from a radiologist would be required.
Please outline any factors that may limit your assessment of the events.	I am not a radiologist.
Recommendations for improvement that may help to prevent a similar occurrence in future.	

Question 5: Any other matters that you consider warrant comment relating to the care provided by Health NZ.	
List any sources of information reviewed other than the documents provided by HDC:	
Advisor's opinion:	There are multiple instances of poor communication from Health NZ. This includes comments by the registrar about a hysterectomy during the March 2021 admission, the use of ambiguous and misleading terms such as 'non-representative' and 'non-diagnostic' in correspondence from the medical staff to Mrs [B], and the scenario described in question 3.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	

Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	

QUESTIONS REGARDING DR [A]

Question 1 Dr [A]: Whether it was reasonable that Dr [A] did not arrange a further hysteroscopy or further assessment following the non-diagnostic result in March 2021.	
List any sources of information reviewed other than the documents provided by HDC:	
Advisor's opinion:	It was reasonable. See above.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	See above

Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	No departure.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	See above
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	

Question 2 Dr [A]: Whether it was reasonable that Dr [A] did not advise Health NZ that Mrs [B] had returned to him in April 2021 with continuing issues post-surgery.	
List any sources of information reviewed other than the documents provided by HDC:	
Advisor's opinion:	This was reasonable.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	I am not aware of any standards or guidelines on this matter, nor any expectations that such information should be shared.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	No departure

How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	They would agree.
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	

Question 3 Dr [A]: Whether it was reasonable that Dr [A] discharged Mrs [B] in April 2021 without further follow-up.	
List any sources of information reviewed other than the documents provided by HDC:	
Advisor's opinion:	Mrs [B] arranged to see Dr [A] to seek clarification regarding the hysteroscopy findings, which he duly provided. As stated above, I don't think further follow-up or investigation was required from an endometrial cancer perspective. However, it might be considered good practice to keep her under review from the point of view of her pain symptoms, or make onward referrals to suitable specialists, especially as there was no diagnosis and significant medications were required (tramadol and gabapentin). I must emphasise though that this would probably not have accelerated the diagnosis of endometrial cancer.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	There is no specific standard of care, and decisions would be at a clinician's discretion.

Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	Mild departure
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	I suspect a majority, but definitely not all, of my peers would agree.
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	

Question 4 Dr [A]: Whether Dr [A] adequately considered Mrs [B]'s risk factors for endometrial cancer (obesity and a thickened endometrium) before discharging her	
List any sources of information reviewed other than the documents provided by HDC:	
Advisor's opinion:	Yes, I believe Dr [A] did adequately consider the risk factors for endometrial cancer before discharging her. One factor he definitely did not consider was the effect the previous ablation procedure may have had on the ease of diagnosing endometrial cancer, nor the abnormal histology at that time (see below). However, I have the advantage of hindsight when making this connection, so it is hard to be completely objective in assessing the significance. Also, in his defence, the presenting symptom of pain, without any bleeding, is not typical or classical of endometrial cancer. Also, ultrasound assessment of endometrial thickness is less accurate for diagnosing endometrial cancer than a hysteroscopy (which was normal in this case). The

	reassuring hysteroscopy and histology, together with the lack of reported bleeding, would certainly have outweighed any concern about risk factors.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	Mild departure, for not considering the impact of the previous ablation procedure in his decision-making.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	This would be mixed because the symptoms were atypical and the investigations were reassuring.
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	

Question 5 Dr [A] Whether the standard of communications with Mrs [B] and her family was reasonable. In particular, Dr [A]'s discussions of 30 March, 31 March and 20 April 2023.	
List any sources of information reviewed other than the documents provided by HDC:	
Advisor's opinion:	The discussions on these dates relate to undocumented telephone conversations, so it is difficult to comment. The family's recollections are described in the complaint. However, there is no contemporaneous record from Dr [A].

	As stated earlier, he should have taken greater personal responsibility in disclosing the surgical findings to Mrs [B] and her family. By engaging in a conversation with her son-in-law on 30 March, he should have been honest when asked about suspicious areas outside the uterus. He should also have taken responsibility for talking to Mrs [B] himself, rather than this being done by the registrar. He appears to have corrected this in conversation on 31 March. However, this was only after the family approached him. He certainly should have been more proactive in his communication and disclosures. Re 20/4, it is worth noting that Dr [A] was apparently not present at either MDM. Overall, I think he was in a very difficult position at this point. Given the situation of the unexpected spread at the time of surgery and the missed lymph node, I imagine that Dr [A] found this to be an especially difficult situation and could be forgiven for missing some details. Regarding discussions about the hysteroscopy in 2021, he appears (in the family's account) to have been open and honest. The 'non-diagnostic' result mentioned was disclosed in his letter to Mrs [B] in March 2021. As stated earlier, the term 'non-diagnostic' is unhelpful and misleading as it implies an incomplete or inadequate assessment. In fact, the findings were as one would expect in a postmenopausal woman, particularly one without bleeding.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	No specific standards. It would be considered best practice to talk to Mrs [B] himself, with her family present. This could have been arranged very easily.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	See earlier comments. Re 30 and 31 March – Moderate departure for not taking personal responsibility and not being proactive is discussing the unexpectedly bad findings with Mrs [B] and her family himself. Regarding 20 April – no departure.

How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	My peers would disapprove of Dr [A]'s conduct.
Please outline any factors that may limit your assessment of the events.	Lack of documentation. Also, my lack of knowledge of Dr [A]'s duty of disclosure to a patient's family prior to disclosing maters to the patient herself (relevant to 30 March).
Recommendations for improvement that may help to prevent a similar occurrence in future.	See earlier comments.

Question 6 Dr [A]: Any other matters that you consider warrant comment.	
List any sources of information reviewed other than the documents provided by HDC:	
Advisor's opinion:	
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	

Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	

FURTHER QUESTION

Question 1: We would also like your comment on an aspect of the advice you provided to ACC. In your report for ACC, you comment on the appropriateness of the endometrial ablation performed on Mrs [B] in [2016]. Please see point 4 of your report to ACC. Could you please advise us if the concern you raised is significant and warrants further consideration from this Office and whether in your view this procedure was clinically indicated.	
List any sources of information reviewed other than the documents provided by HDC:	
Advisor's opinion:	This is the single most significant aspect of this case. The decision to perform endometrial ablation at that time was utterly inappropriate and led directly to the difficulties and delays in diagnosing Mrs [B]'s endometrial cancer.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	Endometrial ablation is not indicated for treatment of postmenopausal women. Proliferative endometrium is not a normal finding in postmenopausal women. It indicates ongoing stimulation with oestrogen, and there is a risk of progression to more serious (ie, cancerous or pre-cancerous) changes if not treated appropriately, with progesterone therapy, and monitored with repeat biopsy.

Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	Severe departure
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	My peers would agree
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	The above information is well known amongst practitioners. This amounts to an individual clinician's error of judgement and is not a systems or culture issue.

By signing this report, I agree to HDC correcting any formatting, spelling, or grammar issues on the proviso that the substance of the report and any quoted material remains unchanged.

Name: Dr John Short
Date of Advice: 12 August 2024'

'

Email clarification regarding advice from Dr Short:

'**From:** John Short
Sent: Monday, September 23, 2024, 12:27 PM
To: […]
Subject: RE: Summary of call: 23HDC01950

CAUTION: This email originated from outside of the organization. Do not click links or open attachments unless you recognize the sender and know the content is safe.

That pretty much sums it up. […]
Thanks for your patience
John'

From: […]
Sent: Monday, 23 September 2024 11:31 am
To: John Short
Subject: RE: Summary of call: 23HDC01950

Kia ora John,
Just a very brief follow up on this one to ensure my notes from our call are correct. If you could review and let me know, I can then progress the investigation.

Regards
[…]

From: […]
Sent: Thursday, September 12, 2024, 6:00 PM
To: John Short
Subject: Summary of call: 23HDC01950

Kia ora John,
Thanks kindly for taking my call just now to discuss this complaint. Below, I have provided a summary of our discussion and the information you provided. Please review and make amendments as needed to ensure it is correct.

Clarification of brown discharge
You advised that:

- the primary red flag/symptom for endometrial cancer (in postmenopausal women) is bleeding (red blood).
- Brown discharge and pain are less reliable indicators for endometrial cancer and are not commonly associated with it.
- Brown discharge would not necessarily warrant further investigation, particularly in the period immediately after a hysteroscopy procedure (as it could be related to the procedure).

- If there were concerns, a 6-month follow-up would be suggested. However, if the clinician was satisfied/confident that the preceding investigations had been thorough enough, then a 6-month follow-up may not necessarily have been warranted.

Hysteroscopy results 'non-diagnostic'
You reiterated your view that the term 'non-diagnostic' is inappropriate and may cause confusion. You advised that:

- There was 'insufficient endometrium for analysis';
- This result is to be expected/indicates 'normal' for a postmenopausal woman as it is expected that the uterus has atrophied. If there has been growth (rather than atrophy), this could be a marker for potential abnormalities.
- This 'normal' finding, along with Dr [A]'s visual inspection of the uterus during the procedure, which did not identify any abnormalities, was likely reassuring.
- As Dr [A] was confident with diagnostic testing/results conducted to this point, further follow-up/assessment was not clinically indicated.

Ablation
You reiterated your view that Mrs [B]'s previous ablation procedure was not warranted. You advised that:

- A 'proliferative endometrium' in a postmenopausal woman is abnormal
- This indicates that cells are behaving in a way they should not be (ie, growing when they should be atrophying)
- Ablating the uterus may have masked abnormalities and potentially impeded future identification of abnormalities.

Overall, you are of the view that, in this case, all of the relevant steps (including diagnostic testing) were taken, and Dr [A] has acted in a manner that most other clinicians would. You had some slight criticism that he did not offer a 6-month follow-up after the hysteroscopy.

Your main criticism is that uterine ablation to treat postmenopausal bleeding and a proliferative endometrium is a severe departure from standard practice.

If you could please confirm via email if this is correct or make corrections as needed, it would be appreciated.
Thanks again for your time today, really appreciate it.

Ngā mihi nui,

[…]
Senior Investigator | Kaitūhura Matua
Office of the Health and Disability Commissioner | Te Toihau Hauora, Hauātanga
Freephone: 0800 11 22 33
Website: hdc.org.nz '

Further advice following Dr [A]'s response to notification:

'**From:** John Short
Sent: Sunday, 19 October 2025 9:24 pm
To: […]
Subject: Re: CONFIDENTIAL: Further EA request – [B] 23HDC01950

Hello […]

I have looked at the documents provided and my original advice. My opinion is unchanged. I can also confirm that the clinical documents provided were also included in the documents reviewed to formulate advice for ACC and HDC.

Thanks

John'