Health New Zealand | Te Whatu Ora
House Officer, Dr B

A Report by the
Deputy Health and Disability Commissioner

(Case 20HDC00866)

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Contents

Executive summary

1. This report relates to the care provided by clinicians associated with Immigration New Zealand to the late Mr A, aged in his twenties, in relation to his semi-urgent cardiac issues between 2016 and 2017, and the care provided to Mr A by Health New Zealand|Te Whatu Ora Southern[1] (Health NZ Southern) at Southland Hospital in 2017. Sadly, Mr A passed away during emergency valvular surgery.

2. This case highlights the potential gaps and/or lack of clarity surrounding the referral pathways, roles, and responsibilities of clinicians and healthcare services regarding non-residents and visa applicants, and the resulting difficulties that can arise for consumers in receiving adequate care in such situations. This requires a collaborative approach between Health NZ and Immigration New Zealand to identify how healthcare services can be provided and managed in a way that responds appropriately to the needs of all consumers within the New Zealand healthcare system.

Findings

3. The Deputy Commissioner was critical that Medical Centre 1 did not have clear systems in place to ensure that staff and Mr A adequately understood and were aware of what tasks were within Medical Centre 1's remit as per Immigration New Zealand guidelines (as opposed to that of a GP). This caused confusion and uncertainty in Mr A seeking care, and in the provision of care to Mr A. The Deputy Commissioner considered that Medical Centre 1 could have taken further action to ensure that Mr A's cardiac issues were actioned in a timely manner.

4. The Deputy Commissioner was critical that Dr D (panel physician and GP at Medical Centre 1) contributed to Mr A's confusion regarding the capacity in which he was receiving healthcare services, and that Dr D did not formally refer Mr A to a treating physician in accordance with Immigration New Zealand guidelines.

5. The Deputy Commissioner was also critical of Dr C (a cardiology specialist) regarding his one-month delay in circulating a clinic letter resulting from his appointment with Mr A, which recommended heart valve replacement surgery within three months of the appointment, delaying the time period in which this care could be provided.

6. The Deputy Commissioner also commented on Immigration New Zealand's existing guidelines regarding the referral process and pathway, and suggested that the roles and responsibilities of its panel physicians and related clinicians could be reviewed and improved to ensure that this information is communicated adequately.

7. The Deputy Commissioner considered that during Mr A's admission to Southland Hospital in 2017, the clinicians involved inappropriately discharged Mr A without further assessment

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

or referral to the Cardiology Department. The Deputy Commissioner considered that ultimately Health NZ Southern held the responsibility for ensuring that Mr A received this care, and found Health NZ Southern in breach of Right 4(1) of the Code.

8. The Deputy Commissioner was critical of the decision by Dr B (a Southland Hospital house officer at the time) to discharge Mr A despite his high-risk features and diagnoses, and that Dr B did not take additional steps to ensure that a follow-up appointment was arranged. However, the Deputy Commissioner considered that there were significant mitigating factors in the care provided by Dr B.

9. The Deputy Commissioner was also critical of Dr E (an Emergency Department (ED) consultant at Southland Hospital at the time) for not undertaking further assessment considering Mr A's symptoms, and for Dr E's inadequate supervision as a consultant in soliciting further information to ensure that decision-making had taken place correctly.

Recommendations

10. The Deputy Commissioner recommended that Medical Centre 1, Dr D, Dr C, Health NZ Southern, Dr E, and Dr B each separately apologise to Mr A's family for the deficiencies outlined in the report.

11. In addition to the above, the Deputy Commissioner recommended that Medical Centre 1 undertake a review of this case and provide evidence to HDC on how Medical Centre 1 will facilitate registration with another practice and clarify with the patient the role of a 'usual treating physician'.

12. The Deputy Commissioner also recommended that Immigration New Zealand discuss further with Health NZ and the Royal New Zealand College of General Practitioners how the management pathway can be improved for those in circumstances such as Mr A's and who are awaiting the outcome of visa applications and provide evidence of such discussion and reflection to HDC.

13. The Deputy Commissioner also recommended that Health NZ Southern provide further education to ED clinicians on the pathways and scoring systems used and provide evidence that valvular emergencies have been included as part of the relevant pathway.

Complaint and investigation

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

15. HDC received a complaint from a community support centre[2] about the care provided to the late Mr A prior to his death at Hospital 2 on 25 Month7[3] during emergency cardiac surgery.

16. The following issues were identified for investigation:

- *Whether Southern District Health Board provided Mr A with an appropriate standard of care in Month7 2017.*
- *Whether Dr B provided Mr A with an appropriate standard of care in Month7 2017.*

17. The parties directly involved in the investigation were:

Mr A's family	Consumer's family
Dr B	House officer
Health New Zealand Southern	District healthcare provider

18. Further information was received from:

Dr C	Cardiologist
Dr D	GP and panel physician
Dr E	ED consultant
Medical Centre 1	
Immigration New Zealand	

19. Also mentioned in this report:

Dr F	GP and panel physician
Dr G	GP
Medical Centre 2	

20. In-house clinical advice was obtained from Dr David Maplesden, and independent clinical advice was obtained from emergency medicine specialist Dr Gary Payinda and cardiologist Dr Russell Anscombe.

[2] Appointed as the proxy executors of Mr A's estate
[3] Relevant months are referred to as Months 1–7 to protect privacy.

Introduction

21. At the outset, I express my sincere condolences to Mr A's family for the devastating events that occurred in 2017.

22. In 2016 Mr A, then aged in his twenties, required a chest X-ray as he was on a tourist visa in Aotearoa New Zealand and wanted to apply for a temporary visa. Mr A's medical history included an aortic valve replacement (AVR)[4] in 2000 when he was 11 years old.

23. For New Zealand visa applications, applicants are assessed for an 'acceptable standard of health criteria'. When a medical examination is required as part of this assessment, the applicant must be seen by a panel physician — a doctor who has been approved by Immigration New Zealand to complete medical examinations and chest X-ray certificates.

24. Mr A was seen by a panel physician at a medical centre to arrange a referral for a chest X-ray for his visa application in March 2016.

25. By 2017, Mr A was living with his fiancée and required a medical assessment for the purpose of applying for a work visa. He was reviewed by panel physicians over Month1 to Month6 for his visa process. He was found to have clinical findings of significant valvular heart disease with clinical evidence of severe aortic stenosis[5] and an enlarged heart, and he was told that he required surgery. However, the clinicians involved did not refer Mr A for further assessment and treatment, and he was told to contact his regular GP instead.

26. Mr A presented to the Emergency Department (ED) at Southland Hospital on 21 Month7, and blood tests showed elevated troponins.[6] Mr A was discharged approximately 4.5 hours later without a cardiology assessment. He returned to the ED with chest pain the next day and was admitted to the ICU for cardiac stabilisation, before being transferred to Hospital 2 two days later.

27. Tragically, he passed away on 25 Month7 during emergency valvular surgery.

28. This report discusses the responsibility of Immigration New Zealand (INZ) panel physicians for patients who require semi-urgent treatment and are awaiting INZ visa decisions; the referral pathway system; and the care Mr A received at the Health NZ Southern Emergency Department.

[4] The aortic valve is one of four valves that control blood flow in the heart. Aortic valve repair or aortic valve replacement can improve blood flow, reduce symptoms of heart valve disease, and prolong life.
[5] The valve between the lower left heart chamber and the body's main artery (aorta) is narrowed and does not open fully. This reduces or blocks blood flow from the heart to the aorta and to the rest of the body.
[6] High levels of troponin are a sign that a heart attack has occurred.

29. This report has two components:

- Part 1 discusses the care provided to Mr A by panel physician clinic and cardiology specialist[7] Dr C, from March 2016 to 14 Month7.
- Part 2 discusses the care Mr A received at Southern District Health Board on 21 Month7.

Part 1: Mr A's care from March 2016 to 14 Month7

Medical centre March 2016

30. In March 2016, Mr A attended Medical Centre 1 as he required a referral for a chest X-ray to apply for a temporary visa.

31. Dr D, a general practitioner (GP) and panel physician at Medical Centre 1, performed a respiratory examination and completed the INZ documentation required for Mr A to undertake a chest X-ray.

Medical centre reviews Month1–Month4

32. Mr A was next seen on 25 Month1, when Dr F, a GP and panel physician at Medical Centre 1, performed Mr A's immigration medical examination (IME) for his application for a work visa (at that time he was on an interim visa, a continuation of his visitor visa).[8] Dr F documented that Mr A had had a heart operation in 2000 for rheumatic fever.

33. On 8 Month2, Mr A attended an appointment with Dr F for follow-up of his immigration results. Dr F informed Mr A that he had mild anaemia, prescribed an iron supplement, and provided a further repeat blood test form.

34. On 20 Month2, INZ notified Medical Centre 1 that Mr A required a cardiologist review because of his cardiac history. The medical centre notified Mr A of the requirement on 21 Month2. It is documented that Mr A telephoned Medical Centre 1 and stated that he did not want a cardiologist referral as he had already had tests with his previous application.

35. On 31 Month4, INZ requested that Medical Centre 1 obtain a cardiologist update on Mr A's rheumatic heart disease. On the same day, Dr D sent a referral to Dr C, a cardiologist, requesting that he review Mr A, as INZ had requested an update on his rheumatic heart disease and his AVR in 2000.

36. In the referral, Dr D noted that an echocardiogram (ECHO) taken in Mr A's home country in 2017 had shown moderate aortic stenosis, mild aortic regurgitation, and mild mitral

[7] INZ advised that 'specialists' in its contexts refers to a specialist to whom a panel physician can refer an applicant when further tests or reports are required, but is not a panel physician in and of themselves.

[8] If applying for a New Zealand visa, a person may need a chest X-ray or medical examination to prove an acceptable standard of health to meet the objectives of INZ's immigration health instructions. These can be performed only by New Zealand panel physicians contracted by INZ.

regurgitation. The referral stated that Mr A had been advised to have monthly penicillin injections, but had missed the last three, and that Dr D was arranging them.

37. Dr D told HDC that he explained to Mr A and his family that the consultation and its associated costs had to be funded by them, as immigration-related matters are not funded.

38. On 6 Month5, Mr A attended Medical Centre 2 and discussed his monthly penicillin injections with a nurse practitioner.[9] The nurse practitioner documented that Mr A was being reviewed by Dr C imminently, that the plan was to await cardiology review, and that Medical Centre 2 nurses would liaise with Medical Centre 1 regarding support and ongoing management in the community.

Cardiology review — 12 Month5

39. On 12 Month5, Mr A attended an appointment with Dr C, who saw him in his capacity as a cardiology specialist[10] to assist in providing an immigration assessment. Dr C told HDC that at the time of events, he also worked as a consultant cardiologist in the public sector, but that his role for INZ was completely separate from his duties as a consultant cardiologist.

40. In his cardiology report,[11] Dr C documented Mr A's cardiac history and noted that Mr A was asymptomatic and playing rugby. Dr C recorded that he had performed a physical examination, electrocardiogram (ECG), and echocardiogram. He concluded that Mr A was presently asymptomatic with NYHA1[12] classification and had clinical findings of significant valvular heart disease with clinical evidence of severe aortic stenosis and an enlarged heart.

41. Dr C recommended a heart valve replacement and noted that the optimal timing of surgery would be within the next three months.

42. Dr C stated that appropriate timeframes for cardiac surgery are controversial and represent a considerable challenge. He said that patients are categorised into wait times of less than 30 days, or less than three months. He told HDC that he decided on the three-month time frame because Mr A had no symptoms, a very high workload and had an absence of any signs of heart failure. Dr C factored in Mr A's age and the previous aortic valve surgery. Dr C stated that at the time he saw Mr A, aortic valve surgery was not required in less than 30 days. Dr C told HDC that the difficulty he faced when assessing Mr A was that there was only one echocardiogram available as a benchmark, and usually he would have several echocardiograms over time to make a judgement of whether left ventricular dysfunction was a new or chronic finding.

43. Dr C did not refer Mr A for surgery. Dr C told HDC that he acted in accordance with the INZ 1216 instruction document (Appendix D). INZ 1216 stipulates that it is not appropriate for

[9] A copy of a consultation note received at Medical Centre 1 on 13 Month5.
[10] This correction was provided by INZ in its response to the provisional opinion, whereas it is understood that Dr C operated under the belief that he was a panel physician at the time.
[11] Addressed to Dr D.
[12] No symptoms and no limitation in ordinary physical activity, eg, shortness of breath when walking, climbing stairs, etc.

the panel physician to give any form of treatment in relation to the applicant, and that they are not permitted to provide treatment to applicants except in emergencies. In addition, a panel physician must not enter into a therapeutic relationship with the applicant, and the panel physician's role is that of an independent examiner who is to provide INZ with an impartial assessment of their findings.

44. Dr C told HDC that when he saw Mr A he did not consider that his clinical circumstance at that time constituted an emergency.

45. Dr C stated that he communicated the following to Mr A and his fiancée:

- Mr A had an important heart abnormality.
- Surgery was definitely required.
- The same funding mechanism previously used by Mr A (the government in his home country) would again be appropriate.

46. Dr C stated that Mr A explained that he would make funding arrangements and that he had a relative working within the health service of the government in his home country who would help with the process of obtaining funding for his repeat surgery. Dr C told HDC that it was his belief that Mr A had intended to pursue obtaining repeat surgery via this mechanism. Dr C said that a copy of his report was emailed to Mr A.

47. Dr C told HDC that at the conclusion of the consultation, he regarded Mr A as discharged back to the care of Dr D.

Circulation of cardiology report

48. INZ 1216 outlines that specialist reports are to be sent directly to the panel physician, in this case Dr D, who is responsible for scanning or attaching electronic reports to eMedical.[13]

49. Dr C's report (dated 12 Month5) was sent on 11 Month6 and acknowledged as having been received by Dr D on 12 Month6.

50. It is documented in Mr A's medical centre records that Dr C's report had been released on 11 Month6 because Dr C's surgery had received full payment only the previous day.

51. Dr C told HDC that he emailed a copy of the report to Dr D with the assumption that Dr D, as Mr A's treating clinician, would refer Mr A for surgery once funding arrangements had been confirmed.

Month5 and Month6

52. Over Month5 and early Month6, Medical Centre 1 made efforts to facilitate Mr A's monthly penicillin injections. Medical Centre 1's senior administrator kept Mr A informed of the

[13] eMedical is an electronic health processing system used by approved panel physicians to send INZ the results of the immigration medication examination.

attempts made to facilitate his penicillin injections and to correct issues he had with his NHI numbers.[14]

53. In early Month6, Medical Centre 1 informed Mr A that due to his current visa, he was not eligible for publicly funded health services.

Follow-up appointment with Dr D — 12 Month6

54. On receipt of Dr C's full report, an appointment was made for Dr D to discuss the report with Mr A.

55. Mr A attended an appointment with Dr D on 12 Month6. Dr D documented that he explained Dr C's letter to Mr A and his fiancée in detail and emphasised the urgency for surgery. Dr D recorded that Mr A and his fiancée had understood the situation.

56. Dr D told HDC that he printed a copy of the specialist letter and gave it to them to take to their regular GP. He said that he told Mr A that currently he was not eligible for publicly funded surgery. Dr D documented:

> 'I also informed them of my role as a panel physician for Immigration medical and that I am not their regular GP and for their regular medical care and for any future referrals they need to see their own GP.'

57. Dr D advised Mr A that he should be having regular penicillin injections, and an injection was administered at the clinic that day.

58. Dr D told HDC that he was aware that Mr A was not eligible for publicly funded health care, but he was not aware of the process for applying for a medical waiver or alternative sources of funding. Dr D stated that he assumed that Mr A's immigration advisor would be taking appropriate steps in this regard. Medical Centre 1's response states that Dr D recommended that Mr A approach his local MP to seek compassionate funding for the surgery.

59. On 16 Month6, Dr D uploaded the full cardiology report to the INZ portal.

60. On 30 Month6, Mr A supplied Medical Centre 1 with a letter from INZ confirming that currently he was not eligible for a permanent visa because of his health issues. Instructions on seeking a medical waiver were provided, including Mr A providing INZ with further comments.

Medical Centre 1: 10–14 Month7

61. On 10 Month7, Mr A presented to Dr G, a GP at Medical Centre 1, for an appointment not related to his visa application. Mr A presented with several symptoms,[15] and Dr G noted that

[14] On 6 Month5 a Medical Centre 2 nurse contacted Medical Centre 1 to note that Mr A had a different name in his passport and also had two NHI numbers. The Medical Centre 1 response notes the considerable efforts made by its staff, via the Ministry of Health, to merge the NHI numbers.
[15] Upper abdominal pain, reduced appetite, nausea, and occasional shortness of breath.

Mr A's observations were within normal range and that he looked well and comfortable. Dr G recorded a working diagnosis of possible gastritis.[16]

62. Dr G told HDC that he reviewed Dr C's cardiology report and wanted to rule out pancreatitis and upper abdominal infections. Dr G provided Mr A with a blood test form and prescribed omeprazole and Acidex and advised Mr A to reduce his alcohol consumption. Dr G documented safety-netting advice to go to ED if his symptoms worsened.

63. Dr F told HDC that on 14 Month7 she received a request from the practice nurse to review Mr A's blood test results taken on 10 Month7. Mr A's blood test results showed mild renal impairment and mild liver damage.

64. Dr F told HDC that she advised the nurse to tell Mr A to increase his fluids and have a repeat blood test in three weeks' time.

65. The practice nurse conveyed the results and advice to Mr A on 14 Month7. The nurse documented that Mr A reported that he was feeling better, and his pain was minimal, but his stomach hurt at times when lying down. The nurse documented that she advised Mr A to go to hospital or to come back to the surgery to see a doctor if it got worse. Dr F told HDC that the nurse said that Mr A was happy with the plan. This was Medical Centre 1's last involvement in Mr A's care.

Further information — whether Mr A was a patient of Medical Centre 1

66. Mr A's representatives state that Mr A thought that he was a patient at Medical Centre 1, and that as he had paid for the GP services, it made him a patient at Medical Centre 1.

Medical Centre 1

67. Dr D told HDC that Mr A was not registered as a patient at Medical Centre 1 and that on several occasions he was encouraged to register with a GP practice.

68. Medical Centre 1 advised that it offers not only family medicine but also occupational medicine and immigration medicals. Medical Centre 1 said that it makes it very clear that it is a third-party provider for immigration medicals, and that regular care needs to be provided by the patient's family GP.

69. Medical Centre 1 stated:

> 'When we undertake medicals for New Zealand Immigration we do so with great consideration to duty of care. If a patient comes and there is an abnormality found, we do our best to follow this up with the patient immediately. We take the time to explain that if an abnormality is found, we will contact them and call them back. We emphasise and continue to discuss that it is of great importance that the patient has their own family doctor and that we will share any required information to continue their ongoing health care with their medical centre. Any case that requires follow up, the patient is

[16] Irritation of the stomach lining.

> contacted and printed reports of the abnormal blood tests and specialist reports are given to them. In the post medical consultation, time is taken to explain the treatment and also what our position as a Panel Physician Clinic is. We also reiterate that they must attend their own Family Doctors for ongoing care and health maintenance.'

70. A scheme[17] for subsidising Mr A's primary care costs listed Medical Centre 1 as Mr A's provider.

Responses to provisional opinion

Medical Centre 1

71. Medical Centre 1 was provided with an opportunity to comment on the relevant sections of the provisional opinion. Medical Centre 1 confirmed that it has now changed ownership. Dr D, Dr F and Dr G no longer work at Medical Centre 1.

72. Medical Centre 1 accepts and agrees with all the findings and recommendations relating to Medical Centre 1. Medical Centre 1 provided HDC with a copy of a formal written apology, for forwarding to Mr A's family, and confirmed that corrective actions will be provided to HDC in the timeline requested. Further information received from Medical Centre 1 has been incorporated into the report where relevant.

Dr D

73. Dr D was provided with an opportunity to comment on the relevant sections of the provisional opinion. Dr D asked the Deputy Commissioner to reconsider her criticisms in light of the information provided. Further information provided by Dr D has been incorporated into the report where relevant.

Dr C

74. Dr C was provided with an opportunity to comment on the relevant sections of the provisional opinion. Dr C sincerely apologised for the criticisms that relate to him, particularly his recommendation regarding the timing of the surgery, and the delay in circulation of his assessment letter. Further information received from Dr C has been incorporated into the report where relevant.

Immigration New Zealand

75. INZ was provided with an opportunity to comment on the relevant sections of the provisional opinion. INZ provided this Office with an explanation of its primary roles and responsibilities as the operational arm of New Zealand's immigration system.

76. INZ also provided the following definitions of panel physicians and specialists in the context of INZ's work:

[17] A scheme for people who are unable to pay, and who without the scheme would not visit their GP/practice nurse or pharmacy.

a) Panel physicians are approved GPs who work for an approved panel clinic and conduct examinations of visa applicants on behalf of INZ. They are constrained in their scope by the INZ Panel Physician handbook.

b) Specialists, on the other hand, are not panel physicians, but practitioners to whom panel physicians can refer an applicant when INZ requires further testing/reporting. Specialists are not constrained in their scope by the INZ Panel Physician handbook.

77. Further information provided by INZ has been incorporated into the report where relevant.

Part 1: Opinion — Introduction

78. To assist my consideration of the care provided by Medical Centre 1 and Dr D, I obtained clinical advice from my in-house GP advisor, Dr David Maplesden. To assist my consideration of the care provided by Dr C, I obtained independent advice from cardiologist Dr Russell Anscombe (Appendix C).

Opinion: Medical Centre 1 — adverse comment

Registered patient

79. Mr A first attended Medical Centre 1 in March 2016, to obtain a referral for a chest X-ray for his visa application. During 2017, he was seen by, or interacted with, Medical Centre 1 staff on multiple occasions in relation to further immigration matters, but also what appear to have been non-immigration-related GP services.

80. Medical Centre 1 told HDC that Mr A was not eligible for publicly funded care and was not a registered patient at Medical Centre 1. This is disputed by Mr A's family.

81. In Aotearoa New Zealand, a patient can be enrolled or registered at a general practice. While enrolment is for funding purposes, registration is for the provision of care irrespective of funding. Therefore, if a patient is eligible for public funding, they can be enrolled at a practice, whereas if they are not eligible for funded care, they cannot be enrolled at a practice but can still ask to be registered with a specific GP and be charged for their care.

82. The instructions in place at the time (INZ 1216 publication 'New Zealand Immigration Panel Member Instructions'), dated July 2015, stipulated:

> 'Panel physicians are not permitted … to provide treatment to applicants except in emergencies. Panel physicians are responsible for … referring applicants requiring treatment, other than emergency treatment, to their usual treating physician. The panel physician should document the referral, the reason for it, and, where applicable

the outcome, in the "General supporting comments" field within the "Examination Grading" section which is in each certificate.'

83. Care was provided to Mr A by Medical Centre 1 outside the scope of INZ 1216 as follows:

- Dr F prescribed Mr A iron supplements in Month1.
- Dr D documented in the cardiology referral letter that 'he was taking steps to facilitate monthly penicillin injections'.
- Mr A attended Medical Centre 1 for non-immigration-related issues (10 Month7).
- Medical Centre 1's senior administrator kept Mr A informed of the attempts made to facilitate his penicillin injections and to resolve his NHI issues.

84. The following is also noted:

- In Month5 it was documented that the Medical Centre 2 nurse would liaise with Medical Centre 1 regarding Mr A's support with ongoing management in the community.
- The scheme set out in paragraph 70 listed Medical Centre 1 as Mr A's provider.

85. My in-house GP advisor, Dr Maplesden, advised that Dr F provided Mr A with treatment that was not urgent in nature. Dr Maplesden stated that while this was good clinical practice, it was outside Dr F's role as an INZ panel physician and could reasonably imply that Dr F was taking on a role as a treating physician. Dr Maplesden advised that in this context, it was understandable that Mr A may have perceived Medical Centre 1 as his 'treating practice'.

86. Dr Maplesden stated that the issue of whether or not Dr D was managing Mr A solely in his role as an INZ panel physician is not clear. Previous non-urgent treatment had been provided by Dr F, and the efforts made by Medical Centre 1 administration staff to clarify Mr A's NHI and facilitate his penicillin injections imply more than a 'casual' therapeutic relationship with the practice. Dr Maplesden advised that whether or not administration of penicillin could be defined as 'emergency treatment' is open to debate.

87. I accept this advice. It is evident to me that Medical Centre 1 was grappling with being limited in the care it could provide Mr A as a panel physician, while trying to meet its duty of care in assisting him in aspects of his general care, outside the scope of panel physicians.

88. However, in my view, assisting Mr A with non-immigration-related matters, however well-intentioned, was contradictory to the information provided to him about the need to register with a separate GP practice, and caused confusion. In my view, it is understandable that Mr A may have believed that Medical Centre 1 was his treating practice.

89. In Month5, Medical Centre 1 was in receipt of the report from the cardiologist indicating severe heart issues and the need for surgery. INZ 1216 stipulated that Medical Centre 1 was responsible for referring this to Mr A's 'usual treating physician'. Dr Maplesden noted that this would involve clearly establishing who that physician was.

90. Medical Centre 1 was aware that Mr A was not registered with another GP practice, and that he did not have a 'usual treating physician' to whom it could refer. I acknowledge that Medical Centre 1 staff members did provide Mr A with a copy of the cardiology report and impressed upon him the urgency of his condition. However, Dr Maplesden advised that it was not adequate management to give him a copy of his cardiology report without some certainty that there would be timely clinical input into his subsequent management. I agree.

91. While Medical Centre 1 staff members may have communicated to Mr A that Medical Centre 1 was not his treating physician and that he needed to register with a GP, as noted above, in my view the Medical Centre 1 staff members' actions caused confusion about Medical Centre 1's role. In view of the confusion this caused, Medical Centre 1 needed to ensure that Mr A's cardiac issues and need for surgery were actioned in a timely manner by taking actions to hand over his care to a separate GP or GP practice. Given the various other less time-critical non-immigration-related care Medical Centre 1 provided Mr A, I consider that it could also have provided further support to him in this despite not being obligated to do so.

92. Although I note that there is no evidence that Mr A lacked capacity or was not capable of undertaking this himself, in my view, given the information that was known about his imminent need for surgery and a GP to facilitate this, Medical Centre 1 could have taken further action to support his registration with another GP by:

- Providing Mr A with a list of general practices in the area and actively following up with him about his registration with another practice.
- Contacting the Primary Health Organisation for the Southern region for guidance and support with this situation (ie, a severe health condition identified in a visa-related assessment but no 'usual treating physician' to hand over to).
- Contacting the Medical Centre 2 nursing team for assistance to support Mr A to register with another general practice, noting its previous involvement and that Medical Centre 2 appears to provide health and other community services.

93. Regardless, Mr A did not register with another GP, and his cardiology report and arrangement of surgery was not actioned, and the requirement of INZ 1216 (to refer to the usual treating physician) was not complied with.

94. I am critical of some of the services that Medical Centre 1 provided to Mr A. Medical Centre 1 did not appear to have clear systems in place to ensure that everyone (GPs, the senior administrator, nursing staff, and Mr A) knew which tasks were within Medical Centre 1's remit under INZ 1216, and which were under the remit of a registered GP practice. I also consider that Medical Centre 1 could have taken further action to ensure that Mr A's cardiac issues and need for surgery could be actioned in a timely manner in the circumstances. However, I acknowledge that there were added complexities regarding Mr A's initial interactions with Medical Centre 1 being related to visa assessments and the restrictions on panel physicians. In this context, I have not found a breach of the Code of Health and Disability Services Consumers' Rights (the Code).

Opinion: Dr D — adverse comment

Care provided to Mr A

95. In 2016 and 2017, Dr D appears to have been involved in Mr A's care both as a panel physician and to assist with non-immigration-related matters.

96. In March 2016, Mr A attended Medical Centre 1 and saw Dr D to obtain a referral for a chest X-ray for his visa application. In Month4, at INZ's request, Dr D sent a referral for cardiology review, which indicated that Dr D was arranging monthly penicillin injections for Mr A.

97. Dr D then received the cardiology report with recommendations for surgery in Month6. At the follow-up appointment on 12 Month6, Dr D administered penicillin to Mr A. Dr D documented:

> 'I also informed them of my role as a panel physician for Immigration medical and that I am not their regular GP and for their regular medical care and for any future referrals they need to see their own GP.'

98. Medical Centre 1 told HDC that Mr A was not a registered patient at Medical Centre 1. However, Mr A's family disagrees and states that as he paid for services, he was a patient. In Aotearoa New Zealand, if a patient is eligible for public funding, they can be enrolled at a practice. If a patient is not eligible for funded care (like Mr A), they cannot be enrolled at a practice but can still ask to be registered with a specific GP and be charged for their care.

99. The instructions in place at the time (INZ 1216 publication 'New Zealand Immigration Panel Member Instructions'), dated July 2015, stipulated:

> 'Panel physicians are not permitted … to provide treatment to applicants except in emergencies. Panel physicians are responsible for … referring applicants requiring treatment, other than emergency treatment, to their usual treating physician. The panel physician should document the referral, the reason for it, and, where applicable the outcome, in the "General supporting comments" field within the "Examination Grading" section which is in each certificate.'

100. Dr Maplesden noted that it is not clear whether Dr D was managing Mr A solely in his role as an INZ panel physician. Dr Maplesden noted that Dr D provided a penicillin injection, and that whether the administration of penicillin can be considered an 'emergency treatment' is open to debate.

101. I acknowledge that Dr D explained the cardiology letter recommendations and explained to Mr A that he needed to register with a GP practice for treatment not related to his immigration assessments, and that Dr D documented this at the time. I also acknowledge

that it is unclear whether administration of penicillin is an emergency treatment. However, I consider that this contributed to Mr A's confusion about who was his treating physician.

102. Mr A's family asserts that as he was paying for a service, this meant that he was a registered patient. However, paying for a service does not automatically make someone a registered patient. Notwithstanding this, I consider that Dr D blurred the lines between his responsibility as an INZ panel physician and as a treating physician (as he administered penicillin and was trying to facilitate monthly penicillin injections for Mr A). While I am not critical of Dr D for administering penicillin, I consider that his actions contributed to the confusion around whether Mr A was registered with Medical Centre 1.

Management of cardiology report

103. On 12 Month5, Dr C diagnosed Mr A with significant valvular heart disease and recommended heart valve replacement surgery with the optimal timing of that surgery within three months. On 12 Month6 Dr D met with Mr A. Dr D told HDC that he:

- Gave Mr A a copy of the specialist letter to give to his regular GP; and
- Told Mr A that immigration-related matters are not publicly funded and that he would have to fund a cardiologist consult and associated costs.

104. Dr D did not refer Mr A to his treating physician and documented:

> 'I … informed them of my role as a panel physician for Immigration medical and that I am not their regular GP and for their regular medical care and for any future referrals they need to see their own GP.'

105. Dr Maplesden advised that it was not adequate management to give Mr A a copy of his cardiology report without some certainty that there would be timely clinical input into his subsequent management. However, Dr Maplesden advised that this was a mild departure from accepted standards, noting that:

- The absence of an established or well-known pathway or clarity of responsibilities for accessing funding for patients such as Mr A, including whether to refer before a funding decision is available or await the funding decision prior to referral.
- Dr D was conscientious in ensuring that Mr A was receiving his penicillin prophylaxis.
- Mr A was asymptomatic and there were still two months available in the recommended operation time frame.
- Mr A was given clear instructions regarding the need for surgery and the need to find a regular GP, and he was provided with a copy of the cardiology report.

106. Dr Maplesden stated that Mr A's clinical situation was not (at this stage) an emergency, and the cardiologist report had been requested by INZ and was to be reviewed by an INZ medical assessor (separate from the panel physician), who would be responsible for advising an immigration officer regarding medical suitability for the relevant visa and/or medical waiver.

107. Dr Maplesden advised that if it is accepted that Dr D was managing Mr A in his role as a panel physician, he had a responsibility (per the previously cited INZ 1216) to formally refer Mr A to his usual treating physician (which would involve clearly establishing who that physician was) given the nature of the issue at stake — that being a time-critical requirement for cardiac valvular surgery.

108. Dr D had an obligation under INZ 1216 to formally refer Mr A to his usual treating physician and did not do so. Dr D was aware that Mr A did not have a treating physician. Given this, as well as the time-sensitive nature of the operation Mr A required, and in the context of the confusion created as to whether Mr A was registered with Medical Centre 1, in my view, Dr D could have taken further steps to ensure that there was timely clinical input into Mr A's subsequent management. This could have included:

- Supporting his registration with another medical centre, either by:
  a) Providing Mr A with a list of general practices in the area and actively following up with him about his registration with another practice.
  b) Contacting the Primary Health Organisation for the Southern region for guidance and support with this situation (ie, a severe health condition identified in a visa-related assessment but no 'usual treating physician' to hand over to).
- Delegating these tasks to other Medical Centre 1 staff members to assist.

109. However, I acknowledge that there is no established pathway or clarity of responsibilities for accessing funding for patients such as Mr A, and that this put Dr D in a difficult position. However, in my view, given that Dr D was aware that Mr A had no one to refer him for the operation he required, further action could have been taken.

110. Furthermore, I do not consider the fact that Mr A was asymptomatic to be a mitigating factor. Mr A required an operation, and this was recommended to occur within three months and, by the time Dr D received the information that Mr A required this operation, one month had already passed. Therefore, there were two months left for Mr A to obtain funding and have the operation within the optimal recommended timing.

111. While I acknowledge that Dr D was not obligated to facilitate Mr A's registration with another GP, in light of Dr D's assistance with facilitating Mr A's monthly penicillin injections, I consider that Dr D could also have supported Mr A in this respect.

Conclusion

112. For the reasons outlined above, I am critical that Dr D:

- Contributed to Mr A's confusion regarding the difference between an INZ panel physician and a treating physician by administering penicillin.
- Did not formally refer Mr A to his treating physician in accordance with INZ 1216 or take further steps to ensure that Mr A had a treating physician, in the circumstances as outlined above.

113. However, I acknowledge that there were added complexities around the restrictions on panel physicians. In this context, I have not found a breach of the Code.

Opinion: Dr C — adverse comment

Three-month time frame

114. On 12 Month5, Dr C undertook an assessment of Mr A. Dr C concluded that Mr A was presently asymptomatic but had clinical findings of significant valvular heart disease, with clinical evidence of severe aortic stenosis and an enlarged heart. Dr C recommended replacement of the heart valve and advised that the optimal timing of surgery would be within three months.

115. My cardiology advisor, Dr Russell Anscombe, advised that in light of Mr A's clinical findings:

> '[E]ven in the absence of symptoms [the clinical findings] would indicate a risk of subsequent deterioration. Using the "Cardiology National prioritisation webservice" as a guide (previously the Cardiac CPS service), the recommended maximum wait time would be 30 days.'

116. Dr Anscombe was unsure whether Dr C utilised this tool when deciding on the minimum wait time.

117. Dr Anscombe advised that there was a minor deviation from best clinical practice as a shorter maximum wait time for surgery than three months should have been recommended. He took into account Mr A's complete absence of symptoms and high physical capacity described by Mr A as mitigating factors.

118. I accept this advice. In response to the provisional opinion, Dr C confirmed that he reflected on the importance of the consistent use of the National Prioritisation Webservice.

Delay in circulation of letter

119. Dr C's letter for the appointment on 12 Month5, which recommended replacement of Mr A's heart valve within three months, was not sent to Dr D until 11 Month6.

120. I am disappointed that there was a month's delay in sending the letter to Dr D. This delay meant that Dr D and INZ had only two months to organise the surgery.

121. I note that the reason for the delay recorded by the Medical Centre 1 receptionist was that payment had not been made. In response to the provisional opinion, Dr C confirmed that although he had not anticipated the delay, he accepts responsibility for the delay, and he has made changes to his processes to consider ways in which the process can be improved to ensure that time-critical information is shared when payment is outstanding.

Guidance from Immigration New Zealand — other comment

122. In my opinion, a key factor that influenced the management of Mr A's care outlined above was his visa status in New Zealand and related processes and guidelines.

123. It is evident that there were complicating factors relating to the INZ 1216 document that required panel physicians not to become involved in patient care except for emergencies, but in a case such as Mr A's, this resulted in a gap in who should be responsible for a time-sensitive condition where there is not a regular treating clinician.

124. Dr Maplesden also noted that in a case such as Mr A's, the absence of clear guidance regarding clinical responsibilities and of a clearly defined referral pathway affects the decision whether to refer before or after a funding decision is available.

125. I am concerned that there is a gap in the system for patients like Mr A, with no clear pathways or lines of responsibility, which compromises patient safety. In my view, INZ should have a clear pathway for such consumers to register with a GP and should ensure that all clinicians involved are clear on their specific roles and responsibilities.

126. I wrote to INZ, highlighting these concerns. In its response to the provisional opinion, INZ informed HDC of its roles and responsibilities, outlining that in the financial year ending June 2024 over 3 million visa holders arrived in New Zealand, and that 'in most cases' INZ is not aware of whether a visa holder intends to remain in New Zealand long term. INZ also raised the fact that it is unable to 'force' private clinics to enrol patients, particularly considering the current shortages in the general practice field.

127. INZ also stated that there is 'already clear guidance in the [Panel Physician's Handbook]', and there is ongoing training and education sessions by the Chief Medical Officer, and 'established' channels of contact between the hospital and immigration contact centres.

128. I acknowledge the existing guidance and information available to clinicians, and the limitations to overseeing the health care of visa holders who arrive in New Zealand. However, I consider that it would be beneficial to review the existing guidance and information in light of the issues highlighted in this case. For example, I note that the cardiologist involved considered that he was a panel physician, whilst INZ advised that he was not, and, rather, was a 'specialist'. INZ noted that the cardiologist may have erroneously believed he was constrained in providing care to Mr A. I note that the INZ 1216 at the time of events outlines that 'as it is inappropriate for the panel physician to act as a patient advocate, INZ also relies upon any referred specialist assessment as being independent, objective, and providing an opinion that might be reasonably obtained from any equivalent medical specialist'. I consider that this wording lends itself to the implication that although panel physicians and specialists provide different services, specialists should hold themselves to a similar independent and objective position regarding the patient's care as

that of a panel physician, and therefore, the confusion in this case was understandable. I consider that INZ has a responsibility to ensure that this information is successfully communicated and conveyed to clinicians involved.

129. With respect to the requirement that panel physicians not become involved in patient care except for emergencies, while I have considered that in this case Medical Centre 1 could have taken further action, given that the actions of its staff blurred the lines of responsibility such that Mr A could have considered Medical Centre 1 to be his usual treating practice, this is not to say that panel physicians should be responsible for arranging registration with a separate general practice for all patients seen as part of visa processes. I acknowledge that such a suggestion would be onerous, and not appropriate, as there are sound reasons behind maintaining the independence of panel physicians.

130. I also acknowledge that it is not feasible for INZ to oversee this for all visa holders who enter New Zealand. However, in my view, consideration could be given as to whether the relevant processes could be reviewed and amended as appropriate by INZ, to provide for the particular circumstances as arose for Mr A. That is, to ensure that there is a person responsible for management, where there is a time-sensitive and serious condition, which was known to the panel physician, specialist, INZ Health Assessment Team, INZ Medical Assessor, and Immigration Officer. Any such review of process should be undertaken with patient safety, workload of general practices, and patient health literacy and financial barriers in mind.

131. With respect to the accessibility of relevant INZ information to healthcare providers, in INZ's response to the provisional opinion it advised that INZ does not determine or confirm funding for health care or treatment, and that Health NZ can 'easily ascertain and verify' immigration status to decide funding of medical care, and that there is a 'well-established process' under the relevant Memorandum of Understanding.[18] Given the evidence received from the providers as outlined in this report, I also consider that this highlights the need to work with Health NZ to review existing guidance regarding the process, and to further consider accessibility of this information by other healthcare providers, such as primary care services.

Part 2: Care provided at Southland Hospital on 21 Month7

Southland Hospital — 21 Month7

132. On 21 Month7, Mr A attended the ED at Southland Hospital via ambulance. At 11.05am he was seen by a nurse, who documented that Mr A was pale on arrival and 'known to have another valve replacement' and calculated his Early Warning Score[19] as two.

[18] Information Matching Agreement signed between Ministry of Health and Department of Labour in July 2011.
[19] The Early Warning Score system is used by hospitals in New Zealand to trigger review by doctors and/or nurses when a patient's health is deteriorating. Patients are given a score between 0 and 10 based on their vital signs, with higher scores triggering reviews more frequently and from more experienced staff.

133. Dr B, ED house officer,[20] recorded Mr A's seven-day history of chest pain, rheumatic fever at age 11, and AVR in 2000, and that Mr A had been seen by Dr C in Month5 while arranging Mr A's immigration work visa.

134. Dr B ordered blood tests and a chest X-ray and performed an ECG. The ECG noted no changes, but the blood test results showed that two troponin levels were elevated at 40.[21] Dr B treated Mr A with fluids but did not discuss Mr A with the Cardiology Department.

135. Dr B documented:

> 'D[iscussed]/W[ith] patient/family re[garding] status of repeat surgery as recommended by cardiology to be within 3 months of Sept[ember]. P[atien]t is waiting for medical funding to be approved as he is not a resident — supposed to hear in next week or so, but have contacted them to attempt to expedite this due to increasing symptoms.'

136. With respect to the clinical note indicating contact with INZ, Health NZ told HDC that Dr B cannot recall whether she contacted Immigration or whether the note was referring to the family contacting Immigration, but she believes it unlikely that she contacted the Immigration Service herself. Health NZ stated that this note makes it clear that Dr B believed that Mr A's immigration status was being followed up actively.

137. Mr A was placed on the Southland DHB Accelerated Chest Pain (ACP) Pathway — a treatment pathway that aims to identify low-risk patients with chest pain who are not having a heart attack, enabling efficient and safe discharge home. The ACP Pathway does not apply to patients with high-risk features.

138. Mr A's pain settled and no changes to the ECG were noted. Following the ACP Pathway, Dr B discussed Mr A with Dr E, an ED consultant, and discharged him home at 4.05pm for follow-up with the GP or Cardiology. She also documented that following the discussion, 'no referral [was] to be made'.

139. Health NZ stated that the medical staff involved thought that Mr A was under active management from the Cardiology team. Health NZ told HDC that with hindsight, it is clear that at this presentation a cardiologist opinion should have been sought, and Mr A could have been referred to the Cardiology Department at Hospital 2 (even if it was thought to be the second referral).

140. Health NZ agreed that it appeared that Mr A was placed on the ACP Pathway without appropriate consideration of valve dysfunction as an alternative diagnosis. Health NZ also highlighted that it was documented that there was a discussion with Mr A's family about repeat surgery, so there does appear to have been some consideration of his valvular disease.

[20] In Month7 Dr B was a house officer and had been working in the ED at Southland Hospital for a short time.
[21] High levels of troponin are a sign that a heart attack has occurred.

141. Dr B told HDC that during her time at Southland Hospital she was working in the ED as part of a short intern placement under close supervision of a consultant ED physician each shift, and she had no ability to diagnose and put in place management plans without discussion with the consultant.

142. Dr B told HDC that now, as a doctor with five more years of experience than she had at the time of events, she acknowledges that despite Mr A's history of failing valve replacement, she did not consider the surgical cardiac emergencies associated with acutely worsening valvular regurgitation or aortic dissection, and she incorrectly placed Mr A on an ACP Pathway. Dr B acknowledged that she overlooked other features and that she lacked the knowledge and experience to make a different decision at that time. Dr B accepted that Mr A should not have been discharged and should have been referred to the inpatient Cardiology Service.

Subsequent events

143. Mr A returned to ED the next day, on 22 Month7, with continued and increasing chest pain. The ED immediately referred Mr A to the Critical Care Unit, and he was admitted with a plan to transfer to the Cardiology Department in the morning.

144. At 9am on 23 Month7, a doctor at Southland Hospital spoke to a cardiologist at Hospital 2. An urgent ECHO was arranged, and the plan was for Mr A to be transferred to Hospital 2.

145. On 24 Month7, Mr A was transferred to Hospital 2. However, he deteriorated further while attempts were being made to stabilise his condition prior to valve surgery. He underwent emergency valvular surgery on 25 Month7 after suffering a cardiac arrest. Sadly, Mr A died during the surgery.

Health NZ adverse event report findings

146. Health NZ emphasised in its response to the provisional opinion that it does not stand by the adverse event review and would like to formally apologise for the report. Health NZ does not agree that it is a fair estimation of causal relationships between the factors at play, including the root cause of the incident, and the report would not be Health NZ's conclusions today.

147. Health NZ's adverse event report (2018) identified that the root cause of these events was INZ's failure to meet to confirm the funding in a timely fashion.[22] The adverse event report concluded that the contributory findings were:

a) Communication difficulties between ED and the patient and family.

b) Several assumptions being made that were impossible to verify regarding funding and onward referral of the patient.

[22] In its response to HDC, INZ refuted this statement, stating that '[n]o evidence has been provided to INZ that INZ officials would not meet with Health NZ on this case'.

c) A lack of appreciation of the significance of the cardiological symptoms and the persistently elevated troponin.

148. The report findings stated the following:

- There appears to have been an assumption that Mr A was being actively managed by either Cardiology or Cardiac Surgery.
- Information regarding Mr A's immigration status was unclear and could not be verified easily.
- There seems to have been some confusion as to the role of the cardiologist involved in the immigration medical assessment.
- There was some confusion (by staff) regarding provision of treatment in an acute situation when the person is not eligible for free or subsidised health services in New Zealand.

149. The report noted that when Mr A presented to the ED it was not clear to staff whether there was a definitive plan regarding Dr C's recommendations or Mr A's INZ status for funding.

Further information

Health NZ Southern

150. Health NZ expressed its apologies for the outcome for Mr A and extended its condolences to the family.

Dr B

151. Dr B stated that her intention at the time was to provide Mr A with the best possible care, and now that she has more experience, there are things she wishes she had done that may have changed the outcome. Dr B extended her sincere apologies and condolences to Mr A's family.

Responses to provisional opinion

Complainant — community support centre

152. The community support centre was provided with an opportunity to comment on the 'information gathered' section of the provisional opinion, and it confirmed that it had no further comments to make regarding that section of the provisional report.

Health NZ Southern

153. Health NZ Southern was provided with an opportunity to comment on the provisional opinion. It confirmed that it had no specific comments or concerns and that it accepted the recommendations relating to Health NZ Southern. Further information provided by Health NZ Southern has been incorporated into the report where relevant.

154. Health NZ Southern confirmed that although Dr E no longer works for Health NZ (nor practises in New Zealand), Dr E was provided with an opportunity to comment on the provisional opinion. Dr E chose not to provide further comment on the provisional report

but stated that she would like to apologise to Mr A's family 'for any oversight or shortcomings that contributed to the death of Mr A'.

Dr B

155. Dr B was provided with an opportunity to comment on the provisional opinion. Dr B had no further comments and accepted my provisional findings, recommendations, and proposed follow-up actions.

Part 2: Opinion — Introduction

156. During Mr A's presentation to the ED on 21 Month7 he had elevated troponins. He was managed on the ACP Pathway without cardiology assessment, and he was discharged approximately 4.5 hours later. Mr A re-presented to the ED the next day and was transferred to Hospital 2 for further management. Sadly, he passed away on 25 Month7 during emergency valvular surgery.

157. To assist my consideration of the care provided while Mr A was at Southland Hospital ED, I obtained independent advice from an emergency medicine specialist, Dr Gary Payinda (see Appendix B).

Opinion: Health New Zealand Southern — breach

Discharge from ED on 21 Month7 — breach

158. As a healthcare provider, Health NZ was required to provide Mr A services with reasonable care and skill.

159. On 21 Month7 Mr A attended the ED with signs of clinical instability. Dr B ordered blood tests and a chest X-ray, performed an ECG, and treated Mr A with fluids. Mr A was placed on, and managed according to, the ACP Pathway. Dr B did not discuss Mr A with a cardiologist or refer Mr A to the Cardiology Department. Mr A's pain settled and no changes to the ECG were noted. Dr B discussed Mr A with Dr E, an ED consultant, and Mr A was discharged home for follow-up with the GP or Cardiology, with no referral made.

160. Dr Payinda advised that given the high-risk features Mr A was experiencing, the diagnoses of an acute valve-related emergency and/or worsening heart failure should have been considered and investigated, but documentation does not show that it was. Dr Payinda advised that the ACP Pathway was followed inappropriately, and ultimately Mr A was discharged home without specialist cardiologist input.

161. Dr Payinda advised that the standard of care would have been not to discharge the patient, and to refer Mr A to the Cardiology team during his ED visit and, if a cardiologist was not available, a good alternative course of action would have been to request input from the medical team.

162. Dr Payinda advised that the care provided was inadequate, and he considers that it represents a severe departure from accepted practice.

163. Health NZ agreed that it appears that Mr A was placed on the ACP Pathway without appropriate consideration of valve dysfunction as an alternative diagnosis. Health NZ also highlighted that there was a documented discussion with Mr A's family about repeat surgery, so some consideration of his valvular disease does seem to have been given. Health NZ stated that for Mr A, the exclusion of an ischaemic cause of the chest pain appeared to reassure medical staff that the cause of pain was not sinister, without extensive additional investigations having been completed. Health NZ told HDC that with hindsight, it accepts that Mr A could have been referred to the Cardiology Service in Hospital 2, or to the Medical Service at Southland Hospital as appropriate.

164. I accept Dr Payinda's advice. In my view, Mr A should have received further assessment to consider his symptoms, he should not have been placed on the ACP Pathway, and he should not have been discharged from Southland Hospital ED.

165. Regarding who was responsible for the discharge, it is noted that at the time of events Dr B was a house officer who had been working in the ED at Southland Hospital for a short time. Dr B was the most junior member of the medical staff involved in Mr A's care. Dr B told HDC that during her time at Southland Hospital ED she was working under close supervision of a consultant ED physician each shift, and she had no ability to diagnose and put in place management plans without discussion with the consultant.

166. Where an ED house officer has discharged a patient after seeking appropriate input from a consultant, that consultant has overall responsibility for the decision. My independent clinical advisor, Dr Payinda, also advised that if the senior clinician has concerns about the plan, they must ask sufficient questions to be satisfied that the right decision is being made.

167. Due to the passage of time, I cannot identify whether Mr A was discharged because Dr B did not provide adequate information to Dr E or because Dr E did not make sufficient enquiries or likely a combination of the two.

168. Notwithstanding this, it is clear that Mr A was discharged inappropriately that day. While individuals played a role in the event, in the circumstances I consider that the overall responsibility to provide an appropriate level of care sat with Health NZ. Accordingly, I find that Health NZ failed to provide Mr A services with reasonable care and skill and breached Right 4(1) of the Code.

Visa and funding status impact on care — other comment

169. Health NZ's adverse event report identified that the root cause of the incident was that 'Immigration NZ failed to meet to confirm funding in a timely fashion'. However, I have not received evidence to suggest that care was withheld or delayed during Mr A's presentations to Southland Hospital as a result of his lack of funding.

170. Health NZ's adverse event report also found that there was 'some confusion' regarding providing treatment in an acute situation to a patient who is not eligible for free or subsidised health services in New Zealand. It is not clear whether this is in relation to Mr A's presentation to the ED or a more general comment made following the review process.

171. While I consider that Mr A was discharged inappropriately, it does not appear that this confusion was a contributory factor in his discharge on 21 Month7, as his management and discharge appear to have been based on the ACP Pathway rather than his eligibility.

172. Health NZ also identified the difficulty in accessing or obtaining information from INZ about immigration status and funding. I consider it appropriate that Health NZ made relevant recommendations to establish a clear pathway and obtain clarity on process from INZ and will follow up on these. I have made a recommendation to support a better understanding of providing treatment in these circumstances.

Opinion: Dr B — adverse comment

Decision to discharge — 21 Month7

173. On 21 Month7 Mr A attended ED with chest pain. Dr B ordered blood tests and a chest X-ray and performed an ECG. Mr A was placed on, and managed according to, the ACP Pathway. Dr B treated Mr A with fluids but did not discuss Mr A with a cardiologist or refer Mr A to the Cardiology Department. Mr A's pain settled and no changes to the ECG were noted. Dr B discussed Mr A with ED consultant Dr E, and he was discharged home for follow-up with a GP or Cardiology.

174. Dr Payinda advised that the standard of care would have been not to discharge Mr A, and to refer him to the Cardiology team during his ED visit and, if a cardiologist was not available, to obtain input from the medical team.

175. Dr Payinda advised that given the high-risk features Mr A was experiencing, the diagnoses of an acute valve-related emergency and/or worsening heart failure should have been considered and investigated, but documentation does not show that this occurred. Dr Payinda advised that the ACP Pathway was followed inappropriately, and ultimately Mr A was discharged home without specialist cardiologist input.

176. Dr Payinda advised that the care provided was inadequate and represented a severe departure from accepted practice.

177. Health NZ agreed that it appears that Mr A was placed on the ACP Pathway without appropriate consideration of valve dysfunction as an alternative diagnosis. Health NZ also highlighted that there was a documented discussion with Mr A's family about repeat surgery, so some consideration of his valvular disease does seem to have been given. Health NZ stated that for Mr A, the exclusion of an ischaemic cause of the chest pain appeared to reassure medical staff that the cause of pain was not sinister, without having completed extensive additional investigations. Health NZ told HDC that with hindsight, it accepts that

Mr A could have been referred to the Cardiology Service in Hospital 2, or to the Medical Service at Southland Hospital as appropriate.

178. I accept Dr Payinda's advice. In my view, Mr A should have received further assessment to consider his symptoms, he should not have been placed on the ACP Pathway, and he should not have been discharged from Southland Hospital ED.

Follow-up care

179. Dr B discharged Mr A with advice to follow up with his GP or with Cardiology. Dr B documented that she discussed with Mr A and his family the status of the repeat surgery as to be within three months of Month5. Dr B recorded: '[P]atient is waiting for medical funding to be approved as he is not a resident — supposed to hear in next week or so but have contacted them to expedite this due to increasing symptoms.' After the discussion with Dr E, Dr B documented: 'No referral to be made.'

180. Dr Payinda stated that an immigration medical assessment is for the immigration service to decide an administrative question and not intended to replace personalised medical care.

181. Dr Payinda advised that as Mr A would have been expected at that point to have a heart surgery date scheduled in approximately one month's time, there should have been appointments (cardiology and preoperative anaesthetics) evident either online or from discussions with Mr A and/or his family. Dr Payinda stated that the absence of these appointments should have been a red flag for Dr B that there was a lack of proper and timely follow-up. Dr Payinda advised that in the setting of a need for a time-pressured valve replacement, this oversight is concerning. Dr Payinda stated that Dr B did not take additional steps to verify the existence of an outpatient appointment.

182. Dr Payinda advised that the follow-up arrangements and referrals put in place following Mr A's discharge on 21 Month7 were inadequate and represented a moderate departure from accepted practice.

183. Health NZ stated that it is unfair to criticise Dr B unduly for not checking the presence of an outpatient appointment before discharging Mr A, as it was her clear understanding that follow-up was to occur, and it is unusual for all pieces of information supplied by patients to require verification.

184. Dr Payinda advised that even if an appointment for Mr A had existed, given that Mr A's symptoms had worsened significantly over the preceding weeks, Dr B and Dr E could have made a second referral to outpatient Cardiology, to help expedite Mr A's care. Dr Payinda stated that a second referral would have made Cardiology aware of Mr A's worsening symptoms so that his appointment could be escalated. Dr Payinda advised that not making a referral was not best practice.

185. I accept Dr Payinda's advice. In my view, a further referral to Cardiology should have been made. While I acknowledge the factors around checking the presence of an outpatient

appointment, I consider this to have been a missed opportunity for further enquiry, and I encourage Dr B to reflect on this issue.

Conclusion

186. In my opinion, Mr A should not have been discharged from the ED on 21 Month7. I am critical of Dr B's role in the care provided. At the time of events, Dr B was a house officer and had been working in the ED at Southland Hospital for a short time. Dr B was the most junior member of the medical staff involved in Mr A's care, and I consider that her lack of experience is a significant mitigating factor. She was also working under the supervision of a consultant, who ultimately was responsible for Mr A's treatment. Dr B discussed Mr A's care with her supervisor, and both agreed to discharge him home. As such, the decisions made were not entirely her own.

187. Dr B has reflected on the events and acknowledged that she lacked the knowledge and experience to make a different decision at that time. Dr B stated that she accepts that Mr A should not have been discharged and should have been referred to the inpatient Cardiology service.

188. Accordingly, although I am critical of the care Dr B provided to Mr A, I do not consider that she breached the Code.

Opinion: Dr E — adverse comment

189. On 21 Month7 Mr A attended ED with chest pain. Dr B ordered blood tests and a chest X-ray and performed an ECG. Mr A was placed on, and managed according to, the ACP Pathway. Dr B treated Mr A with fluids but did not discuss Mr A with a cardiologist or refer Mr A to the Cardiology Department. Mr A's pain settled and no changes to the ECG were noted.

190. Dr E was the ED consultant supervising Dr B in her care of Mr A that day.

191. Before discharging Mr A, Dr B discussed his presentation with Dr E. Dr E agreed that Mr A could be discharged and did not appear to question Dr B's management of Mr A. After her discussion with Dr E, Dr B documented: '[N]o referral to be made.' Mr A was discharged with advice to follow up with his GP or with Cardiology.

192. My independent clinical advisor, Dr Payinda, advised that the standard of care would have been not to discharge Mr A, and to refer him to the Cardiology team during his ED visit and, if a cardiologist was not available, to obtain input from the medical team.

193. Dr Payinda advised that given the high-risk features Mr A was experiencing, the diagnoses of an acute valve-related emergency and/or worsening heart failure should have been considered and investigated, but documentation does not show that this occurred. Dr Payinda advised that the ACP Pathway was followed inappropriately, and ultimately Mr A was discharged home without specialist cardiologist input.

194. Dr Payinda advised that the care provided was inadequate and represented a severe departure from accepted practice.

195. Health NZ agreed that it appears that Mr A was placed on the ACP Pathway without appropriate consideration of valve dysfunction as an alternative diagnosis. Health NZ also highlighted that there was a documented discussion with Mr A's family about repeat surgery, so some consideration of his valvular disease does seem to have been given. Health NZ stated that for Mr A, the exclusion of an ischaemic cause of the chest pain appeared to reassure medical staff that the cause of pain was not sinister, without having completed extensive additional investigations. Health NZ told HDC that with hindsight, it accepts that Mr A could have been referred to the Cardiology Service at Hospital 2, or to the Medical Service at Southland Hospital as appropriate.

196. I accept Dr Payinda's advice. In my view, Mr A should have received further assessment to consider his symptoms, should not have been placed on the ACP Pathway, and should not have been discharged from Southland Hospital ED.

197. Dr Payinda also advised that the follow-up arrangements and referrals put in place following Mr A's discharge on 21 Month7 were inadequate and represented a moderate departure from accepted practice.

198. Dr Payinda advised that even if an appointment for Mr A had already existed, given that Mr A's symptoms had worsened significantly over the preceding weeks, Dr B and Dr E could have made a 'second' referral to outpatient Cardiology to help expedite Mr A's care. Dr Payinda stated that a 'second' referral would have been fully warranted, given that Mr A's symptoms had worsened significantly over the preceding weeks, and a 'second' referral would have alerted Cardiology of Mr A's worsening symptoms so that an appointment could be pushed forward. Dr Payinda advised that not making the referral was not best practice.

199. I accept Dr Payinda's advice. In my view, a further referral to Cardiology should have been made.

200. As this Office has highlighted previously:[23]

- It is the supervising consultant's role to review the care provided by all ED house officers.
- The consultant has a supervisory role over the ED and the emergency medicine house officers working within it, and, if a patient is discharged, the ED senior clinician must agree with the discharge plan.
- If the senior clinician has concerns about the plan, they must ask sufficient questions to be satisfied that the right decision is being made.

[23] See Opinion 19HDC02396.

201. Dr B told HDC that during her time at Southland Hospital ED, she worked each shift under close supervision of a consultant ED physician and had no ability to diagnose and put in place management plans without discussion with the consultant.

202. Owing to the passage of time, I cannot identify whether Mr A was discharged because Dr B did not provide adequate information to Dr E, or because Dr E did not make sufficient enquiries, or whether it was a combination of the two.

203. Notwithstanding that, because Mr A was discharged inappropriately, I consider that there was inadequate consultant supervision on 21 Month7. While it was Dr B's responsibility to relay all the relevant information to Dr E, Dr E should have solicited further information. I remind Dr E of the importance of eliciting pertinent information from junior doctors to allow for better SMO decision-making.

204. I am critical of Dr E for her role as supervising consultant in the discharge of Mr A, and for the lack of follow-up arrangements put in place on 21 Month7. However, in the circumstances, I have not found a breach of the Code.

Changes made

205. Health NZ's adverse event report made the following recommendations, and Health NZ provided HDC with an update on progress with respect to each of these:

a) All patients attending the ED who are awaiting a time-dependent clinical intervention, and the presentation is related to that intervention, will be discussed with the relevant service.

   — Health NZ stated that this is now the agreement with the ED, although at the time of the incident, usually this would have been reasonably expected to occur when deemed necessary or appropriate.

b) Further discussion with INZ is to be undertaken to ensure that a clear management pathway for patients presenting acutely is made available, ideally by the provision of a database accessible to appropriate healthcare institutes.

c) INZ needs to clearly define the roles and responsibilities of medical staff providing assessments. The awareness of these roles and responsibilities needs to be widely communicated and be easily available for reference.

   — In relation to these two recommendations, Health NZ said that discussion with INZ occurred with the then Medical Director and the Chief Medical Officer of Immigration, and discussions were left with INZ to investigate whether it could review its processes in this regard. Health NZ said that the decisions of INZ affect a patient's visa status, and this in turn affects their eligibility for funded health care,

but there is a clear pathway for patients who require acute medical attention, to which all medical staff adhere.

— Health NZ also said that INZ has made it clear that any patient, regardless of residence status, who presents to a hospital acutely unwell must be treated as is appropriate for their condition in order for the treating doctor to discharge their duty of care, and resident status should not influence any medical treatment under any circumstances.

d) Education opportunities be made available to all staff regarding the eligibility direction and guidance for providing care in both acute and elective situations.

— Health NZ said that non-resident funding is managed by the General Manager of Operations, who is always available to provide ongoing training and guidance regarding any staff member who is directly involved with these processes.

206. Health NZ also told HDC:

a) Education is an integral part of Southland Hospital ED, and education on the ACP Pathway is part of wider education on the topic provided to the ED team.

b) Several registrars and consultants have undergone training on point-of-care ultrasound, and this is encouraged at Health NZ Southern.

c) Southland Hospital ED now provides written discharge advice for patients with acute chest pain.

d) Further education was provided to registrars in June 2024 as set out in my recommendations to Health NZ Southern.

207. Dr B told HDC that she has reflected on the events surrounding Mr A's death, and learnings from it. Dr B stated that she has had exposure to patients suffering from the consequences of rheumatic heart disease and has learnt much more about the condition and its management.

208. Dr C told HDC that he has reflected on the findings of the provisional opinion and considered the importance of the Cardiology National Prioritisation webservice and has made changes to his practice in light of this reflection. Dr C also told HDC that he has made process changes in his office to ensure that time-critical information is shared with the referring doctor promptly.

Recommendations

209. I recommend that Medical Centre 1:

a) Provide a written apology to Mr A's family for the criticisms identified in this report. The apology is to be sent to HDC, for forwarding to Mr A's family, within three weeks of the date of this report.

b) Undertake a review of this case to emphasise the 'non-treating' role of INZ-contracted panel physicians and determine how best to advocate for patients such as Mr A in the future. In particular, provide evidence to HDC on how Medical Centre 1 will facilitate registration with another practice and clarify with the patient the role of the 'usual treating physician'. This information is to be provided to HDC within three months of the date of this report.

210. I recommend that Immigration New Zealand, in conjunction with Health NZ and the Royal New Zealand College of General Practitioners, further consider improvements to the pathway for management of patients in circumstances such as Mr A's, including improving accessibility and suitability of information to support patients in New Zealand awaiting the outcome of visa or funding applications. As part of this:

a) Review related guidance and training that clarifies roles and responsibilities of panel physicians, specialists, medical assessors, and the clinician responsible for the patient, to ensure that these roles and responsibilities are communicated effectively to all parties, and so that providers can cooperate effectively with one another and have access to relevant information. This may include improvements or addendums to the handbook, and improvements to how the handbook can be accessed by medical staff.

b) Reflect on how relevant INZ information can be made more accessible to other healthcare providers (such as the ED of a public hospital) should a person present acutely during their time in New Zealand, including reiterating Health NZ's role in this process.

211. Evidence that this has been completed is to be sent to HDC within eight months of the date of this report.

212. I recommend that Health NZ Southern:

a) Provide a written apology to Mr A's family for the breach of the Code identified in this report. The apology is to be sent to HDC, for forwarding to Mr A's family, within three weeks of the date of this report.

b) Provide further education to ED clinicians on the utility and limitations of the Accelerated Chest Pain Pathway and Emergency Department Assessment of Chest Pain Scoring (EDACS) system, including training on understanding the limitations of EDACS scoring in light of ischaemic ECG changes and positive troponins that is essential to its safe use. Evidence that this has been completed is to be sent to HDC within three months of the date of this report.

c) Within three weeks of the date of this report, provide evidence that valvular emergencies has been included on the Acute Chest Pain Pathway.

213. I recommend that Dr E provide a written apology to Mr A's family for the criticisms identified in this report. The apology is to be sent to HDC, for forwarding to Mr A's family, within three weeks of the date of this report.

214. I recommend that Dr B provide a written apology to Mr A's family for the criticisms identified in this report. The apology is to be sent to HDC, for forwarding to Mr A's family, within three weeks of the date of this report.

215. I recommend that Dr D provide a written apology to Mr A's family for the criticisms identified in this report. The apology is to be sent to HDC, for forwarding to Mr A's family, within three weeks of the date of this report.

216. I recommend that Dr C provide a written apology to Mr A's family for the criticisms identified in this report. The apology is to be sent to HDC, for forwarding to Mr A's family, within three weeks of the date of this report.

Follow-up actions

217. A copy of this report with details identifying the parties removed, except Health NZ Southern and Southland Hospital, and the advisors on this case, will be sent to Immigration New Zealand and the Royal New Zealand College of General Practitioners and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to Commissioner

FROM : David Maplesden

CONSUMER : [Mr A] (dec)

PROVIDER : [Dr D]

DATE : 28 October 2020

(1) Thank you for the request that I provide clinical advice in relation to the complaint … about the care provided to [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 agree to follow the Commissioner's Guidelines for Independent Advisors. I have reviewed the following information: complaint from … on behalf of the family of the late [Mr A]; response from [Medical Centre 1] including individual responses from GPs [Dr D], [Dr F] and [Dr G]; clinical notes [Medical Centre 1]; response and clinical notes from cardiologist [Dr C]; response and clinical notes Southern DHB (Southland Hospital (SH) and [Hospital 2]). The complaint relates to timeliness of referral for surgical management of [Mr A's] aortic valve disease. Sadly, [Mr A] died while undergoing emergency valve replacement surgery at [Hospital 2] on 24 [Month7] [when he was in his twenties]. A timeline and comments on management are presented below.

(2) 2006 — [Mr A] was transferred [to NZ] for aortic valve replacement (AVR) surgery (aortic valve disease secondary to rheumatic fever) [In New Zealand] with surgery paid for by [the government of his home country]. He returned [home] following this.

(3) … March 2016 — [Mr A] attends [Medical Centre 1] to request a form for a chest X-ray required by INZ as part of visa requirements. [Dr D] completed a respiratory examination and the INZ documentation required for [Mr A] to undertake the chest X-ray.

(4) 25 Month1 — [Mr A] attends [Medical Centre 1] for an immigration medical examination (IME). These can be performed only by NZ Panel Physicians contracted by Immigration New Zealand (INZ). The IME was performed by [Dr F]. Blood tests were performed as part of the requested medical assessment. Responsibilities of Panel Physicians are outlined in the INZ1216 publication 'New Zealand Immigration Panel Member Instructions'[24]. This includes: *Panel Physicians are not permitted … to provide treatment to applicants except in emergencies.* Panel Physicians are responsible for … *referring applicants requiring treatment, other than emergency treatment, to their usual treating physician. The Panel Physician should document the referral, the reason for it, and, where applicable the*

[24] https://www.immigration.govt.nz/documents/industry/inz1216.pdf (Most recent version Feb 2019). Accessed 28 October 2020.

outcome, in the 'General supporting comments' field within the 'Examination Grading' section which is in each certificate.

(5) 8 [Month2] — [Dr F] reviewed blood tests results with [Mr A]. Mild anaemia was present (Hb 126 g/L) and [Dr F] undertook a focused functional enquiry to exclude any obvious 'red flags', advised dietary measures and prescribed an iron supplement. A form was provided for repeat blood test in six weeks but this was not carried out by [Mr A].

Comment: [Dr F] provided [Mr A] with treatment that was not urgent in nature. While this was good clinical practice, it was outside [Dr F's] role as an INZ Panel Physician and could reasonably imply [Dr F] was taking on a role as treating physician. In this context, it seems understandable [Mr A] might have perceived [Medical Centre 1] to be his 'treating practice'.

(6) 20 [Month2] — INZ electronic software gives an automatic indication that [Mr A] required cardiologist review because of the cardiac history provided. [Mr A] notified of this situation on 21 [Month2] but declined cardiologist referral at this stage. IME documentation apparently then submitted without cardiology report.

(7) 31 [Month4] — [Mr A] apparently received a request from INZ for him to be referred for a cardiologist review in relation to his history of rheumatic fever. He attended [Dr D] at [Medical Centre 1] with the request. Referral was made to cardiologist [Dr C] for the requested review. Referral letter includes: *NZ Immigration service has advised the following: Please provide a Cardiologist update on rheumatic heart disease affecting mitral & aortic valves with AVR {tissue} in 2006. ECHO in 2017 (In [home country]) showing moderate AS & mild AR also mild MR. He has been advised monthly Penicillin injections, unfortunately he missed the last 3 injections and I am taking steps that he gets it for us.*

(8) 6 [Month5]: [Mr A] attended [Medical Centre 2] and saw [a nurse practitioner] to discuss monthly penicillin injections (copy of consult note received at [Medical Centre 1] 13 [Month5]). The consultation includes [Mr A's] vital signs (normal) and hearts sounds consistent with known valve disease. Imminent review by [Dr C] noted. Plan is to *await Cardiology review and [Medical Centre 2] nurses will liaise with [Medical Centre 1] regarding support with ongoing management in the community.* The same day a [Medical Centre 2] nurse contacts [Medical Centre 1] to note [Mr A] has a different name in his passport and also has two NHI numbers. The [Medical Centre 1] response notes the considerable efforts made by their staff via Ministry of Health to try and merge the NHI numbers. Over this period ([Month5] and early [Month6]) there were also considerable efforts made to facilitate [Mr A's] monthly penicillin injections at minimal cost to him, including calls to the PHO. The practice manager kept [Mr A] informed of the attempts being made to facilitate his injections and NHIs and confirmed with him in early [Month6] that he was not currently eligible for publicly funded health services.

Comment: It appears [Medical Centre 1] staff were conscientious in trying to facilitate [Mr A's] penicillin injections and coordination of his NHI. It is understandable [Mr A] might therefore have perceived [Medical Centre 1] to be his primary care provider and I note [PHO]

subsidizing [Mr A's] primary care costs received dated 10 [Month7] list [Medical Centre 1] as [Mr A's] provider.

(9) 12 [Month5]: [Mr A] reviewed by cardiologist [Dr C] who notes the assessment is being undertaken at the request of the NZ Immigration Service. [Mr A's] cardiac history is noted together with the fact he should be having monthly penicillin injections. He is currently asymptomatic and playing [sport]. However, echocardiogram shows severe disease of the replaced aortic valve and replacement of that valve is recommended with the statement *optimal timing of surgery should be within the next three months given the degree of left ventricular systolic impairment.* There is no indication a referral has been made for surgery. [Dr C] notes a copy of the report was provided to [Mr A] via his fiancée's e-mail address, and he explained to [Mr A] the need for surgery and the same funding mechanism that was previously accessed by [Mr A] ([government in his home country]) would again be appropriate. [Dr C] gained the impression from [Mr A] he would make funding arrangements. [Dr C] cites the INZ 1216 regulations regarding his responsibility in undertaking the examination … [Dr C] states a copy of the report was sent electronically to [Dr D] with the assumption [Dr D], as [Mr A's] treating clinician, would refer [Mr A] for surgery once funding arrangements had been confirmed.

Comment: There is some confusion over precisely when [Dr C's] report was received at [Medical Centre 1]. The practice manager response states a report was received on 12 [Month5] which noted [Mr A] required surgery, and there is an inbox entry on that date which would correspond. However, there is a later comment in the practice manager response that the manager contacted [Dr C's] rooms on 11 [Month6] *as the full report including echo and ecg reports still has not been received. I called and discussed this with the secretary. They confirmed receiving payment in full the day before and send through the full reports. Until payment in full was received [Dr C's] administration was not willing to release the medical reports.* On receipt of the full report an appointment was made to discuss the report with [Mr A]. I have viewed only a single report dated 12 [Month5] and which appears complete. There might be some concern that relevant clinical information was withheld from the referring GP for a month until the patient had paid their account, particularly given the limited time frame recommended for surgical intervention. This probably requires clarification from [Dr C's] staff with copies of the two reports provided (if this was the case). I suspect the 'second report' contained actual ECG images and the detailed echocardiography report but this needs to be confirmed.

(10) 12 [Month6] — [Mr A] is seen by [Dr D] to discuss the cardiologist report. Notes include *explained the urgency of his valvular surgery* and that [Mr A's] fiancée was in attendance and understood the situation. [Dr D] explained [Mr A] was not currently eligible for publicly funded surgery and notes: *I also informed them of my role as a panel physician for Immigration medical and that I am not their regular GP and for their regular medical care and for any future referrals they need to see their own GP. I printed a copy of the specialist letter which I gave to them to take to their regular GP.* However, [Dr D] advised [Mr A] he should be having regular penicillin injections and an injection was administered at the clinic that day. [Dr D] states [Mr A] was not registered as a patient at [Medical Centre 1] and was

encouraged to register with a practice on several occasions. [Dr D] was aware [Mr A] was not eligible for publicly funded health care but was not aware of the process for applying for a medical waiver or alternative sources of funding, and assumed [Mr A's] immigration advisor would be taking appropriate steps in this regard. The practice manager response states [Dr D] did recommend [Mr A] approach his local MP to try and seek compassionate funding for the surgery. The full cardiology report was uploaded to the INZ portal by [Dr D] on 16 [Month6]. On 30 [Month6] [Mr A] supplied [Medical Centre 1] with a letter from INZ confirming he was currently not eligible for a permanent visa because of his health issues but instructions were provided on seeking a medical waiver including the consumer providing INZ with further comments (Appendices provided with the letter not on file).

Comments:

(i) If the report received by [Dr D] on 12 [Month5] is identical to that on file, I would be mildly critical (given the optimum time frame for surgery recommended in the report), that he was not seen until 11 [Month6] to discuss the content of the report. The issue regarding the reports requires clarification as discussed above. It appears the receipt of the additional details I assume were provided on 11 [Month6] (ECG images and full echocardiography report) were required by INZ and the delay in providing them may have impacted on the timing of the INZ Medical assessor review of [Mr A's] case.

(ii) The issue of whether or not [Dr D] was managing [Mr A] solely in his role as an INZ Panel Physician is not clear. Non-urgent treatment had previously been provided by [Dr F] and the efforts made by [Medical Centre 1] administration to staff to clarify [Mr A's] NHI and facilitate his penicillin injections imply more than a 'casual' therapeutic relationship with the practice. Whether or not administration of penicillin could be defined as 'emergency treatment' is open to debate. If it is accepted [Dr D] was managing [Mr A] in his role as a Panel Physican, I believe he had a responsibility (per the previously cited INZ1216) to formally refer [Mr A] to his usual treating physician (which would involve clearly establishing who that physician was) given the nature of the issue at stake — that being time critical requirement for cardiac valvular surgery. I do not believe it was adequate management to give [Mr A] a copy of his cardiology report without some certainty there would be timely clinical input into his subsequent management. This is a mild criticism noting: the absence of an established or well-known pathway or clarity of responsibilities for accessing funding for patients such as [Mr A]; [Dr D] was conscientious in ensuring [Mr A] was receiving his penicillin prophylaxis; [Mr A] was asymptomatic and there were still two months available in the recommended operation time frame; [Mr A] was given clear instructions regarding the need for surgery and the need to find a regular GP, and he was provided with a copy of the cardiology report.

(iii) The absence of clear guidance regarding clinical responsibilities in a case such as [Mr A's] is an important point. His clinical situation was not (at this stage) an emergency, and the cardiologist report had been requested by INZ and would be reviewed by an INZ medical assessor (separate to Panel Physician) who is responsible for advising an immigration officer regarding medical suitability for the relevant visa and/or medical waiver. Section A4.70 of

the NZI Operational Manual[25] states: *Any decision to grant a medical waiver must be made by an immigration officer with Schedule 1–3 delegations (see A15.5) … When determining whether a medical waiver should be granted, an immigration officer must consider the circumstances of the applicant to decide whether they are compelling enough to justify allowing entry to, and/or a stay in New Zealand.* The letter from INZ supplied by [Mr A] to [Medical Centre 1] on 30 [Month6] did not suggest a further report was required at that stage from a medical practitioner.

(iv) The absence of a clearly defined referral pathway also impacts on the decision whether to refer before a funding decision is available or await the funding decision prior to referral. The issue of private referral was raised in the complaint and I would expect this to have been given as an option when [Mr A's] situation was discussed with his 'usual treating physician'. However, the estimated $50–70,000 cost for AVR would be outside the means of many individuals (although this should not be assumed on an individual basis) which is why the alternative funding pathways (including foreign government funding and medical waiver) exist.

(v) The complaint notes [Mr A] was granted a medical waiver which sadly was received a few days after his death. It is unclear who applied for the waiver or what criteria were applied in granting the waiver. However, it must be observed that had [Mr A] not had his unexpected and rapid deterioration in late [Month7], it is quite feasible on being granted the waiver, his surgery could have been organised within the three-month time frame recommended by [Dr C] although this assumes [Mr A] had found a 'usual treating physician' to facilitate cardiac surgical referral. It may be a major contributing issue to [Mr A's] untimely death was not so much the failure to organise surgery within the recommended three-month time frame (with access to funding being the limiting factor), but more the fact his condition deteriorated acutely and somewhat sooner than predicted. Whether he was provided with appropriate treatment once the acute deterioration was noted is outside the scope of this report.

(13) 10 [Month7] — [Mr A] presented to [Medical Centre 1] with a several day history of epigastric pain and reduced appetite. He was seen by [Dr G] who noted [Mr A] was a poor historian. However, [Dr G] accessed the previous cardiology report. Clinical notes are of a very reasonable standard and the documented history and physical assessment is consistent with the working diagnosis of possible gastritis. There is no reference to history or assessment findings suggestive of acute cardiac decompensation. Treatment provided was appropriate for the diagnosis and safety netting advice (go to ED if symptoms worsen) is documented. Blood test form was provided. Results showed mild renal impairment and mild hepatic dysfunction. These were discussed with [Dr F] and conveyed to [Mr A] by the practice nurse on 14 [Month6]. The nurse has documented checking [Mr A's] current status (improved somewhat), advice to improve his fluid intake and recheck bloods in three weeks (form generated) and safety-netting advice reiterated. I believe [Mr A's] management on these occasions was consistent with accepted practice.

[25] https://www.immigration.govt.nz/opsmanual/#44864.htm Accessed 28 October 2020

(14) 21 [Month7] — [Mr A] attended Southland Hospital ED with chest pain and was discharged following an assessment. He returned to ED on 22 [Month7] and was admitted to ICU for cardiac stabilisation prior to being transferred to [Hospital 2] on 24 [Month7]. He deteriorated further while attempts were being made to stabilise his condition prior to valve surgery and he underwent emergency valvular surgery on 24 [Month7] after suffering a cardiac arrest. Sadly [Mr A] died during surgery.

(15) Recommendations

(i) It would be desirable to have a clear pathway for managing patients such as [Mr A] and this might require input from INZ, DHBs and RNZCGP.

(ii) [Medical Centre 1] undertake a review of this case to emphasise the 'non-treating' role of INZ-contracted Panel Physicians and determine how best to advocate for patients such as [Mr A] in the future, in particular facilitating registration with an appropriate practice if they are unable to register the patient themselves, and clarifying with the patient the role of the 'usual treating physician'.

(iii) I believe it is appropriate to seek external advice from a cardiologist:

- Was the recommendation made by [Dr C] following his review of [Mr A] on 12 [Month5] (recommend AVR within three months) clinically appropriate? Was there any indication for more urgent intervention (including medication)? Would you expect [Dr C], in the clinical context described, to have referred [Mr A] to a cardiac surgeon?
- Please comment on [Mr A's] management from the time of his admission to Southland Hospital on 22 [Month7] to his cardiac arrest in [Hospital 2] on 24 [Month7], in particular whether there should have been earlier consideration for transfer to [Hospital 2] or for cardiac surgery. (I understand separate advice is being sought regarding [Mr A's] management on 21 [Month7]).

Appendix B: Independent clinical advice to Commissioner

The following independent advice was obtained from Dr Gary Payinda, Emergency Medicine Specialist, dated 25 January 2021:

'Thank you for asking me to provide expert advice to the Health and Disability Commissioner regarding care provided by Southern District Health Board to [Mr A] in [Month7].

Please extend my condolences to the family of young [Mr A] on their loss. I do not have a personal or professional conflict in this case and have reviewed a copy of HDC's Guidelines for Independent Advisors as well as the following documents:

1. Letter of complaint dated 20 May 2020
2. Southern District Health Board's response dated 15 September 2020
3. Clinical records from Southern District Health Board covering the period from 2017 to 2018.

What follows is a case summary provided by the Health and Disability Commissioner. My amendments are included in square brackets:

"[Mr A] had a history of rheumatic fever and underwent an aortic valve replacement in 2006. He was referred to a cardiologist, [Dr C], by his general practitioner (GP) [for an immigration examination], who in [Month5] identified that a valve replacement was needed [optimally] within three months.

[Mr A] was not eligible for funding of his surgery in New Zealand. On 21 [Month7], [Mr A] presented to the Southland Hospital Emergency Department (ED) with a 7 day history of chest pain, and it was known that he had severe aortic stenosis secondary to degeneration of original tissue aortic valve replacement. The letter from [Dr C] was sighted.

[Mr A] advised the clinicians that he was waiting for Immigration New Zealand regarding funding for surgery. Two of [Mr A's] troponin levels were checked and were elevated at 40. Repeat troponin testing showed no change, and a Chest Pain score of 8 was recorded. [Mr A] was discharged home for follow-up with his GP/cardiology. [Mr A] returned to Southland ED the next day on 22 [Month7] with chest pain. An ECG found dynamic changes and [Mr A] was admitted to the Critical Care Unit (CCU). He was transferred to the Intensive Care Unit at [Hospital 2] on 24 [Month7] and sadly passed away on 25 [Month7] during surgery." I have typed in bold the issues upon which I was asked to advise.

1**. The adequacy of the care provided to [Mr A] when he presented to Southland Hospital ED on 21 [Month7];**

a. What is the standard of care/accepted practice?

b. If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?

c. How would it be viewed by your peers?

d. Recommendations for improvement that may help to prevent a similar occurrence in future.

The care provided was inadequate, a severe departure from accepted practice, and would be viewed as such by my peers.

When [Mr A] presented to Southland Hospital ED on 21 [Month7] he showed signs of clinical instability. He had multiple vital sign abnormalities, was pale, with persistent tachypnea (increased respiratory rate), and low blood pressure on arrival which continued during care and which had not improved by discharge ("SBP 90s" was noted, meaning systolic blood pressure in the 90s, which would be atypically low for a healthy young male). He also had a kidney injury, with a rising creatinine and egfr, two measures of kidney function.

His symptoms were also concerning for an emergency condition, with loss of exercise tolerance (he used to play [sport] during 2017 but was now short of breath on exertion, raising the possibility of, among other things, heart failure), chest pain and shortness of breath that was worsening and at times severe, chest pain radiating to his back (which can be concerning for aortic disease), and nausea and vomiting. In [Dr B's] words, he looked "pale" and "miserable".

Because he had an aortic valve replacement (AVR), an emergency medicine specialist would consider him to be at higher than normal risk for aortic valve emergencies including valve failure with stenosis (the valve opening getting too small) or regurgitation (blood flow reversal due to a leaking valve), clotting, and/or infection. Aortic valve replacements also increase the risk of damage to the aorta, including dissection (tearing), and damage to the chambers of the heart and its ability to pump, which can eventually cause heart failure. AVR patients can also be at increased risk of heart attacks and arrhythmias (rhythm irregularities).

The standard of care for a patient presenting as [Mr A] would be for referral to an inpatient cardiology team during his ED visit, due to the complexity of his condition as detailed above and the concerning features of his history. It is very difficult to assess cardiac function, extent of valvular disease, and aortic disease quickly and effectively in the emergency department, even with troponin testing, ecg, and chest x-ray. Acute workup may involve an echocardiogram, CT scan, or other specialised testing.

What appears to have occurred is that rather than consider the "surgical" cardiac emergencies of acutely worsening valvular regurgitation or aortic dissection, the patient was incorrectly placed on a ACS (acute coronary syndrome) pathway, whose usual aim is to identify low-risk patients with chest pain who are not having a heart attack, enabling early, efficient, and safe discharge home.

In this case, the Southland DHB Accelerated Chest Pain Pathway appears to have been misapplied. The patient was not low-risk by history, signs, or symptoms, had concerning changes on ECG, and positive troponins. The ACP pathway does not apply to patients with suspected causes of chest pain other than cardiac ischaemia; the pathway pro forma itself reminds clinicians to consider alternative diagnoses such as aortic dissection, pulmonary embolism, pericarditis, as well as other non-ischaemic causes of chest pain. If one of these conditions is suspected, patients must exit the pathway.

Given the high-risk features detailed above, the diagnoses of an acute (ie, new, or worsening) valve-related emergency and/or worsening heart failure should have been considered and investigated, but documentation does not show that it was. The accelerated chest pain pathway was inappropriately followed, and the patient was ultimately discharged home without specialist cardiologist input.

Confirmation bias is a common risk for practitioners of emergency medicine. It involves fixating on one diagnostic pathway (for example: chest pain/heart attack/ACS) rather than considering a more broad differential diagnosis (could this be a valvular or aortic emergency or something else?) even when additional information (renal injury, hypotension, ongoing chest pain and vomiting, or historical features such a history of a degenerated AVR) doesn't necessarily support the initial diagnosis.

There are no "medical decision-making" notes documented in the emergency department notes of 22 [Month7] addressing perhaps the most pertinent clinical question: whether the patient's decline in function was the result of his known aortic valve degeneration having worsened to the point where an emergency condition was present.

Even if "chest pain" due to cardiac ischaemia (heart muscle dysfunction due to low oxygen delivery) was the primary issue to be investigated, simply "ruling out" a heart attack would have been insufficient. The troponin level (a blood test indicator of heart attack, among other things) was abnormally elevated, but not rising on repeat testing, suggesting [Mr A] was not having a new heart attack. But with symptoms of exertional chest pain, chest pain at rest, and shortness of breath that was severe and worsening over weeks, the possibility of decompensated heart failure with kidney injury, and/or unstable angina should have been considered and specialist medical input sought.

For these reasons, the standard of care would have been to not discharge the patient, but to instead seek cardiologist input in the first instance. If no cardiologist was available, then referral to the medical team input could serve as a surrogate.

Recommendations for the future to prevent a recurrence:

1. In-service education for ED clinicians on the utility and limitations of the SDHB Accelerated Chest Pain Pathway and EDACS scoring system. Understanding when the ACP pathway should not be applied is essential to its safe use. Understanding the limitations of EDACS scoring in light of ischaemic ECG changes and positive

troponins is essential to its safe use. Teaching, revision, and audit of performance are the ways SDHB can ensure its ED cardiac pathways are being used appropriately.

2. Consider a "Medical Decision Making" section of the online discharge note. Having to explicitly document one's reasoning creates a "pause point" to reconsider the diagnosis and the justification for a discharge. It also helps GPs and later clinicians provide better continuity of care if they understand the reasoning behind a discharge.
3. Encourage emergency medicine consultants to demonstrate proficiency at critical care point of care ultrasound (POCUS). Ultrasound allows emergency medicine clinicians to rapidly identify significant valvular emergencies, but does require training and skills maintenance.[2] [3] Basic echocardiography skills are not yet the standard of care for Australasian emergency departments, but the momentum is shifting towards it.
4. Include "valvular emergencies" on the list of alternative diagnoses to consider on the Accelerated Chest Pain Pathway.

2. The adequacy of follow-up arrangements put in place following [Mr A's] discharge on 21 [Month7]. Please also comment on the adequacy of referrals made;

a. What is the standard of care/accepted practice?

b. If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?

c. How would it be viewed by your peers?

d. Recommendations for improvement that may help to prevent a similar occurrence in future.

The follow-up arrangements and referrals put in place following [Mr A's] discharge on 21 [Month7] were inadequate. They comprise a moderate departure from accepted practice and would be viewed by my peers as such.

[Mr A] was discharged home by [Dr B] (supervised by [Dr E]). [Dr B] documented "safe to be discharged, DPH followup next week. Well advised." [Dr B] also documented that she had discussed the case with the consultant [Dr E], "happy for d/c [discharge] home and f/u [followup] with GP/Cardiology, no referral made". And "D/W [discussed with] patient/family re [regarding] status of repeat surgery as recommended by cardiology to be within 3 months of [Month5]. Patient is waiting for medical funding to be approved as he is not a resident — supposed to hear in next week or so but have contacted them to expedite this due to increasing symptoms." [It was later clarified by SDHB that "they" likely referred to the patient's family.]

The Southland DHB later documented, "With hindsight however, we accept that confirmation [Mr A] could have been referred for a (presumably) second time to the

Cardiology Service in [Hospital 2], or to the Medical Service at Southland Hospital as appropriate."

There exists a shared responsibility between patient and doctor to ensure followup is adequately planned and actually occurs. [Dr B] believed the family had arranged followup regarding a repeat valve replacement. This had not occurred. It appears that several parties (doctor, patient, and/or family) may have been unclear about the purpose of an immigration medical assessment. It is an assessment made by a cardiologist (in this case [Dr C]) for use by the immigration service in deciding an administrative question. It is not intended to replace personalised medical care. The critically important information it contained however, needed to be actioned. Hence it was shared by the cardiologist with GP [Dr D]. [Mr A] required GP-coordinated medical care, and a GP referral to a cardiologist (and likely further to a cardiothoracic surgeon). Whether this process failed or was delayed is not within the scope of my review.

What is apparent is that [Dr B] believed an outpatient process was well underway when it was not. This is not a "severe" departure from the standard of care because [Dr B] had made a good faith attempt to inquire about followup plans, and believed [Mr A] had both GP and cardiology followup.

It is a moderate departure from standard of care, because [Dr B] could have, but did not, take additional steps to verify that an outpatient appointment existed. With an "optimal" heart surgery date only a month or so away, there should have been evidence of an appointment available either online, or evident upon discussion with the patient and his family. Indeed, if a cardiac surgery was supposed to be occurring within a month, there would likely already have been cardiology and pre-operative anaesthetics appointments performed by the time of the ED visit.

There were none, and that should have been a red flag for [Dr B] that proper and timely followup did not exist. In the setting of a need for a time-pressured valve replacement, this oversight is concerning.

Even if an appointment for [Mr A] did already exist, [Dr B] and [Dr E] could have made a "second" referral to outpatient cardiology, to help expedite the care. A "second" referral would have been fully warranted, given that the patient's symptoms had worsened significantly over the preceding weeks. A "second" referral would provide a chance for cardiology to become aware of [Mr A's] worsening symptoms and push the appointment forward. It was stated in the medical note that after discussion with [Dr E], "no referral to be made". This was not best practice.

Recommendations:

1. As has already been stated by Southland DHB, there is an admission that proper outpatient followup was not adequately organised. They say they now have a plan in place to ensure that all ED patients awaiting time-critical outpatient interventions will have their case discussed with the relevant teams, to ensure that others do not

slip through the cracks. This is excellent, as long as it occurs reliably. SDHB should perform audits to identify the extent to which it is complying with this safety plan.

2. SDHB should review its IT systems to ensure that ED clinicians have the ability to readily access information on outpatient appointments.
3. SDHB ED should review its discharge advice to ensure it informs patients of what signs and symptoms to look out for, what to do, and who to turn to, if a problem is found after discharge, as well as detailing what is the followup plan. This advice should be printed and provided to patients or carers, and not just provided verbally, whenever practical.[4]

3. Whether adequate follow-up occurred in relation to [Mr A's] application for funding for surgery;

a. What is the standard of care/accepted practice?

b. If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?

c. How would it be viewed by your peers?

d. Recommendations for improvement that may help to prevent a similar occurrence in future.

I must clarify that as an emergency medicine specialist, my answer relates solely to ED staff responsibilities, and not to GP or outpatient specialty team responsibilities.

In relation to [Mr A's] application for funding for surgery, the ED staff provided adequate follow-up.

There is no expectation that emergency department staff provide follow-up or management services for applications for funding for health services. The management of issues regarding funding of an outpatient elective surgery is the responsibility of the patient and the clinicians and administrators involved in that patient's care. In this case: the patient's GP, the cardiologist to whom they would have been referred, and any relevant DHB or immigration service administrators.

It would be inappropriate for emergency department staff to involve themselves in the approval process of outpatient elective surgical procedures, given that ED care is, by definition, episodic, emergent, and not recurring or ongoing.

As SDHB intimated in their reply, the ED staff do not have to concern themselves with issues of "ability to pay" as a criterion for medical care in the setting of an emergency condition.

Emergency treatment can be given to any patient independent of their ability to pay or immigration status. Emergency medicine training stresses providing care to patients without prejudice.

In the course of our work as emergency doctors we treat people who have committed grave crimes, or caused great injury to others, and pride ourselves on doing the right thing for them as patients, with professionalism. This professionalism extends to providing emergency stabilisation and treatment of patients without regard to their ability to pay. In many cases where patients are not legally entitled to subsidised care, emergency clinicians may not even be aware of the intricacies of their billing arrangements. The DHB handles the financial aspects of the visit separate to the clinicians' management of the time-critical emergency.

My opinion is that the ED staff involved have made a poor decision in discharging [Mr A], but I do not think it is due to economic issues. In New Zealand EDs, unlike some other countries, there is no financial incentive to withhold emergency care from patients due to an inability to pay. We have the luxury of making emergent care decisions without regard to the patient's financial situation.

If the emergency medicine doctors involved had believed [Mr A] required immediate heart surgery that night, I believe there would have been no cost issues that influenced those doctors' decisions.

If it was recognised as a surgical emergency, the referral to cardiology, and then to cardiothoracic surgery would have been made promptly. Any decisions about money would be left to administrators to deal with after the fact. That is a luxury that emergency doctors have that is not shared with their colleagues in private hospitals, or in the elective (non-emergency) surgery setting, who must settle billing issues prior to care.

4. Any other matters in this case that you consider warrant comment.

I have respect for the strong patient advocacy of the [community support centre]. I have not been asked to speak to issues of "anchored bias or racism" reflecting "an appalling level of clinical neglect", but I can say that in this case, it seems confirmation bias (described above) is enough to explain most of what occurred in the ED the night of that first visit by [Mr A].

The patient presented with chest pain and was incorrectly placed on a chest pain pathway despite his history of a failing valve replacement. Other features of concern were missed or overlooked, and he was discharged in the mistaken belief that adequate outpatient followup with GP and cardiology had already been arranged. Confirmation bias may explain why new or conflicting information was discounted and the diagnosis of "chest pain" was not reconsidered.

Secondly, contrary to the … assertions, it appears that the ED staff did not refuse to read [Dr C's] report. In fact, on that first ED visit of 21 [Month7] at 1246, the treating ED doctor typed a summary of [Dr C's] report into [Mr A's] online SDHB clinical record.

Lastly, I note that [Dr C's] cardiologist update for the immigration service states that the "optimal timing of this surgery should be within the next three months". I note the use

of the term "optimal", rather than saying that repair was "mandatory" within the next three months.

Of course, the patient's symptoms and condition later worsened, meaning this recommendation was no longer strictly applicable. A repeat cardiology assessment was needed, and unfortunately did not occur in the outpatient setting via GP, nor in the hospital setting on his first visit of 21 [Month7], ultimately culminating in a tragic outcome for [Mr A].

My condolences go out to [Mr A's] family over the loss of their loved one. I hope my report can help shed light on what happened, as well as on what needs to happen in the future to prevent such occurrences.

If there are any questions or further clarification needed, please do not hesitate to contact me.

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HDC Expert Advisor

25/01/2021

1 Scott, Errors in clinical reasoning: causes and remedial strategies, BMJ 2009;338:b1860

2 https //a cem.org.a u/getmedia/000b84ee-378f-4b65-a9a7-c1 74651c2542/Feb_16_P21_Use_of Focussed_US_in_EM.aspx

3 DOI: 10.1111/1742-6723.12033 and https://doi.org/10.1002/ajum.12130

4 https://acem.org.au/getmedia/9ba6f4fa-8d89-43aa-baal-e3bb912735ed/P55_v02_Component_of EM_Consultation_Jul-14.aspx. See page 6.'

Appendix C: Independent clinical advice to Commissioner

The following independent advice was obtained from Dr Russell Anscombe, dated 9 December 2022:

'**[Dr C]**

The appropriateness of [Dr C's] recommendation that [Mr A] required an aortic valve replacement within 3 months made on 12 [Month1]:

[Dr C's] report is a thorough, high-quality assessment of [Mr A]. His documentation of the history, examination findings and key investigation findings are clearly communicated in the report and his conclusions are well reasoned. [Dr C] indicated that [Mr A] had severe degeneration of a bioprosthetic aortic valve replacement with severe aortic stenosis and severe aortic regurgitation. Based on [Mr A's] clinical condition and the findings from the available investigations (predominantly the echocardiogram) [Dr C] felt that surgery was required within 3 months. Assessing appropriate timeframes for any form of cardiac surgery is controversial and represents a considerable challenge.

I have attempted to explore the various issues relevant to this case below.

What would the recommended wait time be if an objective scoring tool was used?

The finding of severe LV dilatation plus a reduced left ventricular ejection fraction (LVEF<40%), even in the absence of symptoms would indicate a risk of subsequent deterioration. Using the "Cardiology National prioritisation webservice" as a guide (previously the Cardiac CPS service), the recommended maximum wait time would be 30 days.

It is not clear if [Dr C] used this prioritisation tool to guide his recommendation, but it is used widely in New Zealand to assist with decision making and would have been available in 2017. This tool is a guide, and the bands patients are placed in are predominantly based on expert opinion. The prioritisation tool is used to rank access to the scarce Cardiothoracic surgery resource. It also indicates which patients are at potential risk of negative outcomes if they exceed maximum recommended wait times. This tool has been validated. A retrospective analysis of cases (both CABG and Valve cases) the Major Adverse Cardiac Event (MACE) rate was increased in patients whose wait for surgery exceeded the recommended wait time. Since the introduction of this tool there has been an 80% reduction in deaths on the Cardiothoracic surgical waiting list. Whilst it is not perfect, it is a consistently applied objective tool for prioritisation of patients. The tool is used consistently for this purpose in New Zealand. The tool assesses 3 key factors to determine priority:

Grading of Symptoms

Disease severity

Degree of Cardiac Dysfunction

Using this tool the recommendation would be a 30 day maximum wait time for Surgery.

What are the major determinants of prognosis in severe aortic stenosis or regurgitation?

The evidence available in the literature is that the most important prognostic indicator for severe aortic regurgitation and/or severe aortic stenosis is symptoms. [Dr C] clearly states that [Mr A] was not only asymptomatic but was continuing to participate in high intensity physical activity (he had been playing [sport]).

[Dr C] does not indicate whether he used a prioritisation score to assist decision making here. Use of the tool would have indicated a shorter recommended wait for surgery (<30 days as opposed to <90 days). Timeframe assessment is an imperfect science and the complete absence of symptoms and [Mr A's] high physical capacity at time of assessment are likely to be the key factors in [Dr C's] recommendations. 3 months is still relatively long, however, given the patient's asymptomatic status at the time of assessment could be justified.

a. What is the standard of care/accepted practice?

According to the Cardiac CPS a maximum wait time for surgery would be 30 days, however there is a degree of flexibility here based on patient specific factors.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate or severe) do you consider this to be?

In my opinion this is a minor deviation from best clinical practice. The mitigating factors being the absence of symptoms and high physical capacity.

c. How would it be viewed by your peers?

Most of my peers probably would have recommended a slightly shorter maximum wait time for surgery than 3 months, however it is very likely that they would consider the complete absence of symptoms and high physical capacity described by the patient to justify waiting longer than 30 days.

d. Recommendation for improvement that may help prevent a similar occurrence in the future.

Consistent use of "National Prioritisation Webservice" when adequate data available to use it.

Whether you would have expected an alternative action or intervention on 12 [Month5]?

This question specifically relates to [Dr C's] role in [Mr A's] care. [Dr C] states that he saw [Mr A] in his role as a Medical examiner (Panel Physician) for the NZ immigration Service. As such he is an independent examiner who provides Immigration NZ with an impartial clinical assessment. In this role he must not enter into a therapeutic relationship with the applicant and additionally must not provide treatment unless in

an emergency. The duties involve referring applicants requiring treatment to their usual treating physician. He clearly outlines in his letter that [Mr A] has a significant problem with the aortic valve requiring surgery. A recommended timeframe for surgery within 3 months indicates that the intervention is not required immediately nor as an emergency. Even if a shorter timeframe was more appropriate (such as, less than 30 days), this still would not constitute an emergency. [Dr C's] report was appropriately forwarded to the Doctor responsible for [Mr A's] ongoing care ([Dr D]). [Dr D] would then be responsible for referrals for specialist review and subsequent work-up towards definitive management. Further action on [Dr C's] behalf therefore was not required. In my opinion there is no departure from the standard of care and most of my peers would agree with this.

The reasonableness of not referring [Mr A] to a cardiac surgeon on 12 [Month5]

This question is covered in question 2. While it is possible that direct referral to a Cardiothoracic surgeon would have facilitated earlier treatment with the potential for a different outcome, this approach would have been a contrary to the recommendations outlined in the Immigration service policy guidelines. Again, there has been no departure from accepted practice and most peers would agree with this.

Southland Hospital

Please comment on [Mr A's] management from the time of his admission to Southland Hospital on 22 [Month7] to his cardiac arrest in [Hospital 2] on 24 [Month7]. In particular, please comment on whether you would have expected earlier consideration for transfer to [Hospital 2] for cardiac surgery. If so, outline at which point you would have expected consideration for transfer to have taken place.

I have reviewed the clinical record pertaining to [Mr A's] admission to Southland Hospital from 22 [Month7] to 24 [Month7].

He was initially seen by the emergency team in the evening and subsequently referred to the medical team later that night. The medical consultant personally reviewed the patient in the early hours of the 23rd and again at about 0900 hours on the 23rd. The reviews were well documented and the management plans clear and appropriate.

Based on the assessments by both the Emergency and General medical teams it was felt that [Mr A's] symptoms were due to progression of severe mixed aortic valve disease. The diagnosis of demand ischaemia (first mentioned by the emergency department) seemed the most appropriate explanation for his presentation. This seems a vastly more likely explanation than alternative causes for chest pain and elevated troponin levels such as coronary ischaemia. The management plan outlined was appropriate and this comprised supportive management focusing on close monitoring in CCU, aggressive symptom control while planning for urgent transfer to [Hospital 2] for definitive management. Whilst his symptoms were difficult to control, they did respond partially to prescribed pain relief and anti-emetics. Importantly the patient was

closely monitored, and it was clear he remained clinically stable with stable blood pressures and oxygen saturations.

[Southland Hospital] sought advice appropriately from the [Hospital 2] on-call Cardiologist on the morning of 23 [Month7]. They discussed management and planned for an urgent transfer to [Hospital 2] on the 24th of [Month7]. [The cardiologist] suggested commencing a low dose GTN infusion to help relieve ongoing chest discomfort. This resulted in further relief of symptoms. A repeat echocardiogram was quickly performed on the morning of 23 [Month7]. This demonstrated a marked deterioration in LV function (LVEF ~20%) plus the development of significant pulmonary hypertension. These findings indicated that there had been progression in the severity of [Mr A's] cardiac condition, and were negative prognostic indicators. They did not, however, necessarily indicate a requirement for more urgent transfer. Rather, the echo findings supported the previous decision-making, and helped explain the patient's clinical presentation.

There is good documentation in the clinical record that [Mr A] was closely monitored throughout the 23rd of [Month7] until his transfer to [Hospital 2] the following day. Throughout his time in Southland Hospital his observations (HR, BP and O2 saturations) remained stable. There was no indication of increasing instability and therefore no need to request earlier transfer to [Hospital 2]. There are no clues to indicate the precipitous decline that occurred after arrival in [Hospital 2] and certainly no indication that earlier transfer would have resulted in a different outcome.

The care provided by Southland Hospital was appropriate and advice was sought from [Hospital 2] in a timely fashion. Likewise the timeframe for transfer was appropriate and relatively rapid. I have no recommendations that I believe would prevent a similar occurrence in the future.'

Appendix D: Relevant standards

New Zealand Immigration Panel Member Instructions INZ 1216 July 2015

The Panel Physician

The role of the Panel Physician is to provide a comprehensive assessment of the applicant's current state of health and record this accurately on the INZ medical certificates.

This includes:

- personally undertaking the IME, including confirming the identity of the person being examined and to whom the information on the medical certificates relate
- applying the appropriate medical, ethical and professional standards during the examination and in completing the certificate
- ensuring that a parent or guardian is present when taking the history and examining children under 18 years of age
- capturing the required information accurately and comprehensively on the certificate
- commenting on anything identified during the examination that appears to contradict information provided by the applicant
- referring the applicant for standard (compulsory) blood tests, and any other tests that may be appropriate given clinical or risk factors present
- ensuring that pre- and post-test counselling is carried out in accordance with local protocols and standards. For example, include advice on vaccination for close contacts of those testing positive to hepatitis B antigen
- referring the applicant for the required chest x-ray
- referring applicants requiring treatment, other than emergency treatment, to their usual treating physician. The Panel Physician should document the referral, the reason for it, and, where applicable the outcome, in the 'General supporting comments' field within the 'Examination Grading' section which is in each certificate
- recording on the medical certificate the name of any interpreter and/or chaperone present during the examination, and relationship (if any) to the applicant being examined
- reviewing all the information on the certificate (including results from blood tests and chest x-ray) and provide an impartial assessment of the applicant's current state of health and any significant conditions that may have an impact on their future health
- remaining accountable for any part(s) of the examination/completion of the medical certificate, that is delegated to a staff member within the practice
- advising INZ of changes to their clinic's contact details, operating hours, working arrangements, clinic closures and their leave arrangements.

INZ expects Panel Physicians completing an IME to have the necessary medical expertise and experience to fulfil the above responsibilities. Panel Physicians are not:

- responsible for providing opinions on immigration decisions
- authorised to provide oversight of examinations conducted by non-Panel Members
- permitted to provide treatment to applicants except in emergencies
- authorised to make an assessment of the admissibility or inadmissibility of the applicant or the applicant's family members to New Zealand. This is the function of the immigration officer
- permitted to make any statement to the applicant which might be construed as implying a favourable or unfavourable immigration assessment outcome
- permitted to undertake an IME where the applicant is a relative of the panel member, or where the panel member has a personal or financial interest in the immigration application, in such cases the examination shall be declined
- permitted to receive or accept service or incentive fees or gratuities of any kind from third parties, including migration agents or referral agencies. If panel members accept service of fees from any third parties for these services, INZ may cancel the physician's panel membership.

A4.70 Determination of whether a medical waiver should be granted (residence and temporary entry)

1. Any decision to grant a medical waiver must be made by an immigration officer with Schedule 1–3 delegations (see A15.5).
2. When determining whether a medical waiver should be granted, an immigration officer must consider the circumstances of the applicant to decide whether they are compelling enough to justify allowing entry to, and/or a stay in New Zealand.
3. Factors that officers may take into account in making their decision include, but are not limited to, the following:

    1. the objectives of Health instructions (see A4.1) and the objectives of the category or instructions under which the application has been made;
    2. the degree to which the applicant would impose significant costs and/or demands on New Zealand's health or education services;
    3. whether the applicant has immediate family lawfully and permanently resident in New Zealand and the circumstances and duration of that residence;
    4. whether the applicant's potential contribution to New Zealand will be significant;
    5. the length of intended stay (including whether a person proposes to enter New Zealand permanently or temporarily).

4. An applicant who is the partner or dependent child of a New Zealand citizen or residence class visa holder, who would otherwise meet the criteria for residence under Partnership (see F2.5(a)) or Dependent Child (see F5.1(a)) instructions, will be granted a medical waiver unless the limitations on the grant of medical waivers to such persons set out at A4.60(a) and A4.60(b) apply.
5. An applicant who has been recognised as having refugee or protection status (except those invited to apply under the Community Organisation Refugee Sponsorship category) will be granted a medical waiver, unless the limitation on the grant of medical waivers to such persons set out at A4.60(a) applies.
6. An immigration officer should consider any advice provided by an Immigration New Zealand medical assessor on medical matters pertaining to the grant of a waiver, such as the prognosis of the applicant.
7. An immigration officer must record decisions to approve or decline a medical waiver, and the full reasons for such a decision.

Medical Council of New Zealand

Conducting medical assessments for third parties

Key principles about your role as an assessing doctor

4 If a third party asks you to conduct a medical assessment of a patient, you are not in a treating relationship. This means that the relationship between the patient and you as the assessing doctor is different from when a patient seeks care and treatment from you.

5 As an assessing doctor, your role is to conduct a medical assessment and provide an impartial medical opinion to the third party who has employed or contracted you. Your role does not include providing any form of treatment to the patient, and it is important that the patient understands this.

6 Your opinion may influence the third party's decisions about the patient. For example, the third party may decline cover or compensation. Because of the possible implications for a patient, you must ensure that your professional opinion and recommendations are accurate, objective, and based on evidence.

…

How you can facilitate an effective medical assessment

12 In a medical assessment for a third party, the stakes may be high for the patient. This could lead to differing expectations, misunderstandings, and confusion about the assessing doctor's responsibility to the patient.

13 If a third party asks the patient to attend a medical assessment:

Check that the patient understands the purpose of the medical assessment and your role as the assessing doctor

a) You must ensure the patient understands the purpose of the medical assessment and your role as the assessing doctor. Although the third party will usually contact the patient beforehand, you should confirm that this communication took place, and provide further explanation to the patient, if needed. This should include explaining the differences between your role as an assessor, and the role of the patient's own doctor as their treatment provider.

…

Check that the patient understands that you will be reporting back to the third party who engaged you

e) Explain to the patient, your obligation to report back to the third party about the medical assessment you conducted. Specifically, you must ensure the patient understands that your report will be the property of the third party, and that it is the third party who makes the final decision about the patient. As such, you should ask the patient to direct any subsequent concerns or requests for information to the third party.