Dr C

Dr D

First Public Hospital

Dr E

Second Public Hospital

Dr F

A Report by the

Health and Disability Commissioner

(Case 01HDC09862)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Consumer (deceased)
Ms A	Complainant / Consumer's daughter
Ms B	Consumer's friend
Dr C	Provider / General Surgeon
Dr D	Provider / Radiation Oncologist
Dr E	Provider / Radiation Oncology Registrar
Dr F	Provider / General Practitioner
First Public Hospital	Provider / Public Hospital
Second Public Hospital	Provider / Public Hospital

Complaint

On 6 September 2001 the Commissioner received a complaint from Ms A about the services provided to her mother, Mrs A (deceased), by Dr C, Dr D, a Public Hospital, Dr E, a second Public Hospital and Dr F between August 1999 and April 2001. The complaint was summarised as follows:

Dr C
Dr C, general surgeon, did not provide services with appropriate care and skill to Mrs A between 1999 and 2001. In particular, Dr C did not:

- *diagnose Mrs A with secondary cancer in her lungs during his consultations with her prior to the cancer being detected in January 2001;*
- *communicate appropriately with other health providers caring for Mrs A.*

Dr D
Dr D, radiation oncologist, did not provide services with appropriate care and skill to Mrs A between 1999 and 2001 and did not provide her with adequate information. In particular, Dr D did not:

- *diagnose Mrs A with secondary cancer in her lungs during his consultations with her prior to the cancer being detected in January 2000;*
- *diagnose Mrs A with secondary cancer of the bone during his consultations with her prior to the cancer being detected in March 2000;*
- *communicate appropriately with other health providers caring for Mrs A;*
- *adequately inform Mrs A of the risks and benefits of ceasing her tamoxifen when advising her to do so.*

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

First Public Hospital
Staff at the first Public Hospital did not provide services with appropriate care and skill to Mrs A during her admission in March 2001 and after her transfer to the second Public Hospital. In particular, staff at the first Public Hospital did not:

- *diagnose Mrs A with secondary cancer of the bone as soon as was reasonable;*
- *appropriately treat Mrs A when Dr D was on leave;*
- *adequately assess and treat Mrs A's pain;*
- *correctly read an X-ray in March 2001 which indicated that Mrs A had secondary cancer of the bone;*
- *communicate appropriately with other health providers caring for Mrs A;*
- *ensure Mrs A's blood test results were promptly provided to staff at the second Public Hospital.*

Dr E
Dr E, radiation oncology registrar, did not provide services with appropriate care and skill to Mrs A during her admission to the second Public Hospital in March and April 2001. In particular, she did not:

- *appropriately investigate and treat Mrs A's symptoms, which included an infection, constipation, diarrhoea, swollen abdomen, abdominal pain, low blood pressure and an elevated temperature and pulse rate;*
- *appropriately act upon Mrs A's deteriorating condition;*
- *diagnose that Mrs A had developed peritonitis with a pelvic abscess as a result of a ruptured sigmoid diverticulum from which she later died;*
- *communicate appropriately with other health providers caring for Mrs A.*

Second Public Hospital
Staff at the second Public Hospital did not provide services with appropriate care and skill to Mrs A during her admission to the second Public Hospital in March and April 2001. In particular, they did not:

- *appropriately investigate and treat Mrs A's symptoms, which included an infection, constipation, diarrhoea, swollen abdomen, abdominal pain, low blood pressure and an elevated temperature and pulse rate;*

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

- *appropriately act upon Mrs A's deteriorating condition;*
- *diagnose that Mrs A had developed peritonitis with a pelvic abscess as a result of a ruptured sigmoid diverticulum from which she later died;*

- *communicate appropriately with other health providers caring for Mrs A.*

Dr F
Dr F, general practitioner, did not provide services with appropriate care and skill to Mrs A between 1999 and 2001. In particular, Dr F did not:

- *diagnose Mrs A with secondary cancer in her lungs during his consultations with her prior to the cancer being detected in January 2001;*

- *communicate appropriately with other health providers caring for Mrs A.*

An investigation was commenced on 22 March 2002.

Information reviewed

During my investigation I considered information from Ms A, Ms B, Dr C, Dr D, Dr E, the first Public Hospital and the second Public Hospital. No information was obtained from Dr F, who failed to respond to any requests to participate in this investigation. Mrs A's hospital records were obtained from the first Public Hospital and the second Public Hospital, and her GP records from Ms A.

Independent expert advice was obtained from Dr John Childs, radiation oncologist, Dr Kenneth Menzies, general surgeon, and Dr Trevor FitzJohn, radiologist.

Information gathered during investigation

Background
In November 1998 Mrs A, 48, had a screening mammogram because her sister had just undergone chemotherapy for metastatic breast cancer. The mammogram showed a small lesion in her left breast. Mrs A had a lumpectomy and axillary dissection of her left breast on 24 November 1998 performed by Dr C, general surgeon, of a private clinic in a city. The histology report stated that she had a grade three infiltrating ductal carcinoma which measured 12 by 10 millimetres. There was no evidence of vascular or lymphatic space invasion and the tumour and adjacent foci of the ductal carcinoma-in-situ were clear of the margins. Twenty-four lymph nodes were tested and showed no malignancy.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Dr C referred Mrs A to Dr D, a radiation oncologist at the second Public Hospital, for adjuvant radiotherapy. She underwent adjuvant radiotherapy treatment between 2 February and 11 March 1999. Dr D saw her for follow-up on 9 April 1999. Dr D assessed Mrs A and advised Dr C and her general practitioner (GP), Dr F of a health centre, in a town, by letter that she had recovered well from radiotherapy. Dr D also stated that there was no evidence of a recurrent tumour in her left breast and he recommended that she have adjuvant systemic therapy. His clinical record of 5 January 1999 states: "patient understands the aim of this, possible adverse effects". In his response to my provisional opinion, Dr D advised that it would have been more accurate to record that Mrs A had "been informed of" the possible adverse effects.

Consultation with Dr F on 5 May 1999 – chest X-ray arranged
On 5 May 1999 Mrs A presented to Dr F with pain over her anterior chest around the seventh, eighth and ninth ribs. A chest X-ray was ordered by Dr F and taken on 7 May 1999. It was reported: "no obvious lesions in the left ribs … lung fields clear".

Consultation with Dr C on 13 August 1999
On 13 August 1999 Mrs A presented to her general surgeon, Dr C. She told him that she was very concerned about the pain she was suffering, in particular a pain around her shoulder, which had begun 10 days previously, and a dull ache around her lower left rib cage where she had had fractures some years ago. This pain was intermittent but occasionally with certain movements would become more prominent. Mrs A was concerned about the possibility of a recurrence of her breast cancer or secondary deposits (metastases) and wanted to make sure she did not have either.

Dr C examined Mrs A's shoulder, which was tender. He also examined her ribs for tenderness. He did not examine her lungs (auscultate her chest). He reassured her that there was no sign of any recurrence and that her aches and pain were related to her surgery and recovery from radiotherapy. He did not order any further investigations.

Dr C advised Dr F and Dr D that there was no bony tenderness over any part of Mrs A's spine, scapula or ribs but that she reported a dull ache in the left lower ribs. Dr C considered that the pain came from Mrs A's latissimus dorsi muscle. He also informed Dr F and Dr D that he considered her concern had been exacerbated by the gradual demise of her sister with breast cancer.

Consultation with Dr F on 27 August 1999
On 27 August 1999, Mrs A again presented to Dr F with persistent left-sided chest pain and pain in her upper back, which was noted to be "severe and very tender". Medication was prescribed.

Consultation with Dr D on 15 September 1999
On 15 September 1999 Mrs A presented to Dr D. She reported her persistent chest pain. She also reported back pain, mainly under her left shoulder blade. Mrs A was anxious about the possibility of a recurrence/metastases and told Dr D of her concern. Her sister had died of metastatic breast cancer three weeks earlier and this had significantly affected her

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

outlook. Mrs A advised Dr D that she had fractured some ribs previously and had the same chest pain, and wondered whether the pain might relate to the old injury.

Dr D advised Mrs A that there was no sign of recurrent cancer in her left breast, no lymphadenopathy (lymph node pathology), and her right breast was normal. He confirmed that she was slightly tender over her lateral chest. He suspected that her ongoing chest pain was related to her old rib fractures but suggested that if the pain increased or changed then a bone scan would be appropriate to exclude metastases.

Dr D further noted that Mrs A had intolerable hot flushes from her adjuvant tamoxifen and experienced little benefit from herbal remedies. He recorded that because she was borderline for requiring tamoxifen, this could be stopped if it caused intolerable side effects, or alternative medications could be used. Mrs A was reassured by Dr D's explanation and was discharged from follow-up at his clinic on the understanding that he would be happy to review her on request if the pain increased or changed.

In response to my provisional opinion, Dr D explained that he discussed with Mrs A the pros and cons of stopping tamoxifen and he recalled that she was very pleased that it was going to be stopped. Dr D said that the expected benefit of remaining on tamoxifen was small (approximately 5-10% improvement in disease-free survival after five years) and it would almost certainly not have benefited Mrs A because it turned out that she had rapid progressive hormone refractory metastatic disease, despite the hormone receptors on the primary tumour being positive. At the time (1999) chemotherapy was not indicated and there was no proven alternative hormonal therapy.

Dr D also advised that he usually discharges patients from his care after radiotherapy for breast cancer that is detected in the early stages, provided they have follow-up from a surgeon; he always checks that a surgeon is involved before discharging patients and writes to the surgeon, GP and other providers who are involved, for example a medical oncologist.

Dr D advised Dr F and Dr C that Mrs A was generally doing well but reported ongoing discomfort around the left lateral chest wall. This had been present for one or two years after she had fractured some ribs and was slightly worse than previously but was not otherwise different. Dr D noted that "apparently plain [chest] films have shown no abnormalities". He was unsure when these were taken as the most recent X-ray report he had was dated 7 May 1999.

Consultation with Dr D on 1 October 1999 – bone and ultrasound scan arranged
On 1 October 1999 Mrs A saw Dr D at her request as the pain had increased. Mrs A reported ongoing left lateral chest and back pain. The pain was a mixture of rib and "bone" pain, general aching in her muscles, and some cramping around her ribcage under her left arm, which was increasing in severity and frequency.

Dr D examined Mrs A and noted that she had no hepatomegaly (enlargement of the liver) and was slightly tender in her left lateral chest area and left hip but there was no clinical evidence of degenerative changes. Dr D advised that he had re-requested an ultrasound

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

examination as the initial form appeared lost, and he had also requested a bone scan in view of her persistent bone symptoms. He said that he would review Mrs A in two months' time or earlier if the results of her examinations were abnormal. At this stage Mrs A stopped taking tamoxifen because she was having intolerable side effects from it, and Dr D had advised her of the likely small benefit from continuing on it.

On 11 October 1999 Mrs A had a bone scan and an abdominal ultrasound. The bone scan was negative with no evidence of metastases. The ultrasound indicated that her liver, gallbladder, pancreas and kidneys were normal.

Consultation with Dr F on 27 October 1999
On 27 October 1999, Mrs A presented to Dr F complaining of a congested chest and severe back pain. She was prescribed Voltaren for pain relief.

Consultation with Dr D on 3 December 1999
Dr D next reviewed Mrs A on 3 December 1999. He advised that the bone scan and ultrasound scan of her abdomen were negative for metastases. Mrs A reported that her rib pain persisted but she was reassured by Dr D that it was related to her old rib fractures. Dr D again discharged Mrs A from oncology follow-up but was happy to review her condition on request. Dr D advised that he discharged Mrs A in view of his limited workload capacity. He noted that this is his normal practice where a patient is being followed up by his or her surgeon and GP and there is an absence of significant symptoms.

Dr D advised Dr C and Dr F of Mrs A's condition and noted that her hot flushes and other symptoms had improved slightly since stopping tamoxifen and that he had prescribed Provera to control her menopausal symptoms.

Consultation with Dr C on 14 December 1999
On 14 December 1999 Dr C reviewed Mrs A for her one-year postoperative visit. He advised Dr D and Dr F that she reported being reasonably well although she was still suffering from the pains that were recently investigated. But considering the reassurances given by Dr D and Dr C, she was, according to Dr C, "resigned to accepting the pains as part of some old rib fractures". Dr C stated that there was no sign of any lymphadenopathy or masses in either breast, her liver was not enlarged and there was no bony tenderness. Mrs A told Dr C that she "is vowing that no-one else in her family will ever have to go through such a crisis as [her sister] went through". Her sister died of breast cancer that metastasised to her lungs and had also been under the care of Dr C. He planned to review Mrs A in a further six months.

Consultation with Dr C on 23 June 2000
On 23 June 2000 Dr C reviewed Mrs A for her 18-month postoperative check. She again reported that she was having persistent pain in her chest and back, which Dr C noted was "musculoskeletal type pains in the left chest and back intermittently. It is not typical bony pain." Dr C examined Mrs A's breasts and chest wall. There is no record of him auscultating her chest. Dr C noted that there were no signs of any new lumps in either of her breasts, no lymphadenopathy, no bony tenderness and her liver edge was not palpable.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

He reassured Mrs A that everything was okay and that he would review her in six months' time. Dr C reported his findings to Dr F and Dr D.

Consultation with Dr F on 16 October 2000
About September 2000 Mrs A caught the flu and found it very difficult to shake. On 16 October 2000 Mrs A presented to Dr F for her ongoing pain. Dr F recorded that she was feeling unwell and had "cramp" in the left side of her upper abdomen. Dr F diagnosed a problem with Mrs A's bowel.

Consultation with Dr F's locum on 6 November 2000
On 6 November 2000 Mrs A presented to Dr F's locum with a cough, which she had had for more than two weeks. On examination (auscultation) her chest was wheezy and she was diagnosed as having bronchitis. She was prescribed a Ventolin inhaler and antibiotics (oral Amoxil). Over the next two months Mrs A's cough and wheeze steadily got worse and she became noticeably more tired and breathless to her family.

Consultation with Dr C on 15 December 2000
On 15 December 2000 Mrs A was assessed by Dr C for her two-year postoperative review. He noted that she continued to be well but still suffered a little discomfort in her left shoulder blade, which was relieved by anti-inflammatory drugs. He advised Dr F and Dr D that there was no sign of any clinical recurrence of her cancer in either breast or her axilla (armpit). Also, her lymph nodes were not enlarged, her liver was not palpable and she had no bony tenderness.

Consultation with Dr F's locum on 16 January 2001 – chest X-ray arranged
On 16 January 2001 Mrs A presented again to Dr F's locum. She recorded that Mrs A reported back pain which had become worse over the last three weeks but had been present for 18 months. She found Panadeine and Voltaren unhelpful. Mrs A also had a rattle in her chest with a non-productive cough, which had been present for nine months despite the Ventolin and antibiotic treatment. Dr F's locum recorded that the condition of Mrs A's neck was satisfactory but that her chest was wheezy and she had chest wall pain. Dr F's locum diagnosed her with asthma and musculoskeletal pain and prescribed Flixotide and Voltaren. Dr F's locum referred Mrs A for an X-ray.

The chest X-ray detected that Mrs A had a large solid mass situated posteriorly in the left midzone area. This appeared to be two tumour masses most likely representing secondary deposits. The report also stated that there was no obvious mediastinal (mid-line partition of the chest cavity) abnormality, the right lung and pleural spaces were clear and no bony lesion was seen.

Consultation with Dr D on 22 January 2001 – bone scan, CT scan and biopsy arranged
Dr D advised that on 22 January 2001 he saw Mrs A and noted that her chest pain had become worse over the last few weeks and a chest X-ray showed two large masses in the left lung. She also had pain elsewhere. The clinical notes record: "urgent bone scan CT scan of the chest with a percutaneous biopsy has been requested".

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

It appears from the clinical record that on 25 January 2001 Dr D reviewed Mrs A early at her request. It is noted that "over the last few months she has had an increase in her back pain which is more severe and of a slightly different nature" to what she had experienced before and that it had seriously affected her sleeping. It was now reasonably well controlled with codeine at night and Paradex during the day. The dry cough had settled. Otherwise she was feeling reasonably well with no weight loss, no pain elsewhere, and no chest or abdominal symptoms. The examination showed that there was no evidence of lymphadenopathy and Mrs A's chest was clear apart from a suggestion of a pleural rub in her left posterior lower chest. There were also no masses or palpable tenderness or hepatomegaly in that area.

On about 30 January 2001 Mrs A had a CT-guided percutaneous fine needle aspiration biopsy procedure of her chest at the second Public Hospital. It was recorded prior to the procedure that she had experienced a crampy feeling in her rib cage for the last 12 months and back pain for six months. Mrs A then developed a tick sound when breathing and a dry cough which was thought to have been due to a virus.

A histology report concerning the core biopsy of Mrs A's left lung (obtained through the fine needle aspiration procedure) stated that the sections showed a small amount of poorly differentiated adenocarcinoma in an extensively necrotic background which was consistent with metastatic adenocarcinoma of primary breast origin. This was confirmed by an immunohistochemical report.

On the evening of 30 January 2001, without any precipitating trauma, Mrs A suddenly experienced severe neck pain.

Consultation with Dr D on 2 February 2001
On 2 February 2001 Mrs A had a bone scan and was reviewed by Dr D. Mrs A's daughter advised that her mother told Dr D of her persistent and severe neck pain since 30 January. Dr D cannot recall Mrs A informing him of severe neck pain until their consultation on 5 March 2001.

Dr D reviewed the scans and concluded that the findings were consistent with lung metastases from her primary breast cancer. The CT scan indicated that she had a cluster of very large lesions in her left lung. No mediastinal lesions or lymphadenopathy were detected and the liver, adrenals, spleen and kidneys appeared free of any disease. The bone scan indicated that there was no significant abnormality in Mrs A's skeleton or features that suggested metastatic breast cancer.

Dr D advised that there were no tumours in Mrs A's bones. He told her that the lung metastases were responsible for the back pain. He restarted her on tamoxifen and slow-acting morphine (MST).

Dr D informed Dr C and Dr F's locum of the histology report indicating that Mrs A had metastases in her left lung originating from her breast cancer. Dr D stated that Mrs A was

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

in severe pain despite medication and he had recommenced her on tamoxifen and prescribed Codalax and Maxolon, with morphine elixir for pain.

Consultation with Dr F's locum on 21 February 2001
Mrs A's pain got progressively worse. On 21 February 2001 she was assessed by Dr F's locum after presenting with pain in her shoulders and was advised to continue with her pain relief (morphine sulphate). Mrs A advised that she was receiving treatment from a physiotherapist. Dr F's locum noted that the bone scan (undertaken on 2 February) was negative for metastases.

On 24 February 2001 Mrs A's son obtained a neck brace for her from the Emergency Department at the first Public Hospital.

Radiotherapy consultation on 26 February 2001
On 26 February 2001 Mrs A attended a review meeting for her radiotherapy. She was measured for her radiotherapy treatment. It was recorded that the "collar stays on". By the time she was due to commence her treatment on 5 March 2001 she could no longer lie on her stomach owing to the neck pain. Consequently she had to be remeasured so that she could receive the treatment lying on her back.

Mrs A's friend, Ms B, a retired ambulance officer, saw her on 4 March 2001. Ms B noted that there was a lump on Mrs A's neck as well as one on the top of her skull. Ms A advised that by this time her mother's neck pain had become so severe that she required a collar to stabilise her neck. She had tried physiotherapy and anti-inflammatory painkillers, but they had not helped at all.

Consultation with Dr D on 5 March 2001
On 5 March 2001 Dr D reviewed Mrs A. He recorded that over the last week or two she had experienced severe neck pain which was eased with anti-inflammatory medication and a collar, although physiotherapy had not been helpful. He stated that Mrs A's pain was likely to be caused by a muscular pain or strain, not secondary cancer, because the bone scan on 2 February indicated no evidence of bone metastases. Dr D advised that its sudden onset was more typical of an acute injury and he was falsely reassured by the bone scan. Therefore, he did not conduct a physical examination of Mrs A's neck. He recorded that she agreed with this likely explanation and was happy to manage her pain with analgesia. Dr D also recorded that he examined a one to two centimetre subcutaneous nodule on Mrs A's scalp which was suspicious for metastases. It is not clear whether this was adequately communicated to Mrs A.

In response to my provisional opinion, Dr D explained that the purpose of the meeting on 5 March 2001 was to plan radiotherapy to Mrs A's left chest and was not for a general assessment. The time at planning sessions is fully taken up with important tasks, for example determining appropriate treatment volumes and techniques (which may differ from those previously decided), prescribing doses of radiotherapy, data entry, and obtaining informed consent, as well as with other routine tasks, such as answering phone calls and responding to questions from staff. Dr D recalled that this particular session was extremely hectic and

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

therefore he did not have an opportunity in the scheduled time to properly assess the pain in Mrs A's neck.

Dr D also acknowledged in response to my provisional opinion that, in hindsight, an examination of Mrs A's neck and her arm neurology later that day would have been appropriate. However, he did not think that he would have been able to reliably determine with a clinical examination whether the pain in Mrs A's neck had a benign or malignant cause and, even if he had been suspicious that the cause was malignant, whether radiological investigation was indicated.

In addition, Dr D explained that, although he thought the scalp nodule was probably a metastasis, he did not investigate it further as he knew Mrs A had secondary lung cancer, which had been confirmed by a biopsy. Mrs A was also receiving treatment with tamoxifen. Dr D said that it was often useful not to remove such a lesion because it is easy to assess and indicates the course of the cancer and the effects of treatment.

Dr D said that it was likely Mrs A's bone metastases were progressing rapidly and did not follow the usual pathophysiological process, which takes time to develop and can be detected by a bone scan. The rapid changes in Mrs A's cervical spine detected by the X-rays of 12 and 27 March indicated the rapid progression of her cancer and also that the tamoxifen was not working.

Dr D acknowledged that in hindsight he should have investigated the possibility of bone metastases further, probably with an MRI scan, in view of the persistence and severity of Mrs A's neck pain. He does not believe that an earlier diagnosis would have improved the eventual outcome but it may have saved Mrs A a lot of pain and suffering.

Dr D noted in the clinical records that if her neck pain persisted or became worse "I think that it should be further investigated probably with an MRI scan". Dr D recorded "no letter [to Dr F and Dr C]". In response to my provisional opinion, Dr D advised that he should have sent a copy of his note to Dr F and now he always sends a medical note to a patient's GP.

Mrs A received palliative radiotherapy to her lung masses between 5 March and 9 March 2001. Her neck pain increased after she completed radiation therapy to the chest.

Consultation with Dr F's locum on 12 March 2001
On 12 March 2001 Mrs A telephoned Dr F's locum about her condition. Dr F's locum recorded that she was receiving treatment from a chiropractor for her neck pain with initial improvement. Dr F's locum also recorded that she complained of nausea and vomiting. Dr F's locum referred her for an X-ray of her cervical spine. The X-ray, which was assessed by a private organisation (not the first Public Hospital), indicated that there was no abnormality seen in the cervical spine and alignment was normal.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Admission to the first Public Hospital on 16 March 2001
On 16 March 2001 Mrs A was referred to the first Public Hospital by Dr F's locum. Ms A recalled that any neck movement at all gave her mother unbearable pain and she had to hold her neck in an awkward extended position to minimise her suffering. She could not look down or even straight ahead, which meant she could not walk, wash or feed herself unassisted. Mrs A was keen to have her pain controlled and to return home as soon as possible.

Mrs A was admitted by a locum medical officer. The locum medical officer recorded that she complained of increased cervical neck pain over the last few days despite treatment from a chiropractor and physiotherapist and the use of a soft collar. Mrs A also complained of chest pain. She reported that she had stopped her MST and her pain had increased. Mrs A also reported vomiting, difficulty in holding down her medication, and constipation, although her bowels had moved the day before.

The locum medical officer noted that Mrs A had been diagnosed with metastatic breast cancer in her lungs and had been treated with radiotherapy two weeks ago. He also noted that the bone scan undertaken on 2 February 2001 had not detected any tumour deposits in her cervical spine. The locum medical officer had the impression that Mrs A's neck pain was "?referred from pleura" and she needed pain control. Information was requested from the second Public Hospital.

On 17 March 2001 nursing staff recorded at 6.30am that Mrs A's neck pain was very severe. The next day, nursing staff recorded at 6.30am that Mrs A was much better. The medical officer special scale (MOSS), recorded that same day that Mrs A's pain was not controlled. He discussed this issue with a hospice and recorded that her pain was most likely to be from cerebral metastases.

On 18 March 2001 Mrs A's clinical records from the second Public Hospital were received by fax. This information included Dr D's record of the consultation with her on 5 March 2001 in which he stated that if Mrs A's neck pain persisted or became worse "it should be further investigated probably with an MRI scan".

On 19 March 2001 nursing staff recorded at 6.30am that Mrs A's pain was well within tolerable limits. The locum medical officer reviewed Mrs A on his ward round and recorded that her condition was much improved.

The laboratory reported that Mrs A's WBC was 10.4 x 10^9 per litre (reference range 4.0-11.0), neutrophils 9.8 x 10^9 per litre (reference range 2.0-7.5), lymphocytes 0.49 x 10^9 per litre (reference range 1.0-4.0) and monocytes 0.1 x 10^9 per litre (reference range 0.2-1.0). Her erythrocyte sedimentation rate (ESR) was reported as 89 millimetres per hour (reference range less than 33). The laboratory stated that anaemia and neutrophilia were present.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

On 20 March 2001 nursing staff recorded that Mrs A complained of neck and head pain and hallucinations. She was seen by the social worker at the first Public Hospital, who noted that she wished to go home as soon as possible.

On 21 March 2001 the locum medical officer reviewed Mrs A on his ward round and recorded that she was gradually improving but still had neck pain. A referral was made for physiotherapy to assist with neck movement. The physiotherapist recorded that Mrs A was in considerable neck pain and discomfort. The locum medical officer attempted to contact Dr D (who also provided oncology services to the first Public Hospital) but recorded that he was on leave until 23 March.

On 22 March 2001 nursing staff recorded at 10.15pm that Mrs A complained of neck pain and pain in her abdomen, which was tight and distended. It was also recorded that her family were concerned that she was very constipated. The physiotherapist recorded that she asked the locum medical officer to review Mrs A's X-rays as she was concerned about the odontoid area of her spine in view of her neck symptoms.

On 23 March 2001 nursing staff recorded at 6.00am "?faecal overload" and at 2.00pm Mrs A's abdomen was tender. That day the locum medical officer reviewed Mrs A on his ward round and recorded that she had a worsening hyperextension of "spine/cervical spine" and her pain level was very difficult to assess. The locum medical officer further recorded that he telephoned the second Public Hospital to enquire about an MRI scan of Mrs A's neck, and was awaiting a reply from another radiation oncologist. The locum medical officer recorded that Dr D was on leave until the following Wednesday but had an oncology clinic in another city on Tuesday. The physiotherapist recorded that Mrs A was still very uncomfortable, unable to move her neck, and had an "awful" stomach. The following day nursing staff recorded at 6.30am that Mrs A was incontinent of faeces.

Dr D has no recollection of contact from staff at the first Public Hospital about Mrs A until 27 March. He was on leave for some of the time from 12 March until 16 March. There is no record that her condition was discussed with his colleagues in the Oncology Department at the second Public Hospital, who were covering his practice. Dr D advised me, in response to my provisional opinion, that he encourages other providers to contact him or the oncologist covering his practice directly, rather than leave a message, as this can be misplaced (which he thinks may have happened in this case).

Dr D also explained in response to my provisional opinion that before one of his colleagues went on leave for more than two working days, he or she undertook a formal handover with the oncologist who would cover his or her practice. The handover usually involved inpatients and those outpatients who were receiving treatment, had active problems or were anticipated to have significant problems. Dr D said that at the time he did not consider Mrs A fell into any of the above outpatient categories and therefore he did not specifically discuss her case at the handover.

On 25 March 2001 the nursing staff recorded at 10.00pm that Mrs A complained of pain in the left side of her neck and left arm. The next day nursing staff recorded at 6.45am that

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Mrs A was in considerable neck pain and at 6.15pm that she required regular morphine. The physiotherapist recorded that she advised MOSS that Mrs A should have an MRI in view of her neck symptoms. The physiotherapist considered that Mrs A definitely had a problem with her odontoid peg (part of her second cervical vertebra), despite the previous cervical spine X-ray being reported as clinically normal.

On 27 March 2001 MOSS reviewed Mrs A's condition and recorded that she had experienced severe neck and head pain for the previous two weeks. This pain was different from the dragging pain in her back for which she had received radiotherapy. Mrs A reported that she had not injured her neck but it clicked and the pain had initially affected her right side, then the left side. She considered that her pain might be better at present. Mrs A also reported that she had a frozen shoulder, which had been sore for several weeks, needed support while walking and could not get up from lying down. She also complained of pain below her left ear lobe when flexing her neck forward. MOSS recorded that Mrs A's neck pain "? came on after vomiting" and that she also had constipation and diarrhoea.

MOSS requested an X-ray and recorded that Mrs A's condition had been discussed with Dr D. He considered that she needed to be admitted to the oncology ward at the second Public Hospital in a few days' time for a review and an MRI. The X-ray report of Mrs A's cervical spine stated:

> "… There is a loss of cortex of the anterior margin of C2 inferiorly, consistent with metastatic bone disease. The cortical line was faintly visible on the previous film, appearances suggest relatively rapid progression of disease here. Further evaluation of this area with an urgent CT scan is recommended ... "

On 28 March 2001 nursing staff recorded at 6.30am that Mrs A was incontinent of faeces. MOSS contacted Dr D again in view of the X-ray of 27 March. He advised her to transfer Mrs A to the second Public Hospital immediately for further investigation, "? CT/MRI". MOSS wrote a transfer letter to Dr D informing him that Mrs A's main problem was severe neck pain, and enclosed a copy of the X-ray report of 27 March. MOSS also said that over the last 12-24 hours Mrs A had had tachycardia and decreased blood pressure and oxygen saturation. She had also had a low grade temperature but was now afebrile although "quite hot/sweaty". MOSS advised Dr D that she had requested a blood test and asked the laboratory to forward the results to him. MOSS asked for copies of all tests from 28 March to be forwarded directly to the second Public Hospital and also to Dr D. She also advised the second Public Hospital in her transfer letter which laboratory the blood had gone to for their follow-up if necessary. She said that she had not treated Mrs A with antibiotics as she appeared clinically well.

The laboratory reported that Mrs A's haemoglobin was 114 grams per litre (reference range 120-155), WBC 21.2, neutrophils 19.9, lymphocytes 0.4 and ESR 84. The report stated "marked neutrophilia" and "Neutrophil toxic changes present. ? Infection. Elevated ESR persists". The laboratory also reported that Mrs A's C-reactive protein (CRP) was 416mg per litre (reference range less than 5). It recommended an urgent clinical review unless the cause was known.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

The nursing referral from the first Public Hospital, dated 28 March 2001, said that Mrs A had constipation (++) and noted: "patient very upset re bowel function no happy medium either constipated or diarrhoea".

Transfer to the second Public Hospital on 28 March 2001

Dr E

On 28 March 2001 Mrs A was transferred by ambulance to the second Public Hospital where she was assessed by Dr E, who was a medical registrar responsible for inpatient oncology radiation patients. Her friend, Ms B, and her sister-in-law were with Mrs A during her assessment by Dr E. Ms B advised that Dr E asked whether Mrs A's stomach was always that size, to which she responded that Mrs A had never had a stomach that big. She thought that Mrs A looked as if she was heavily pregnant.

Dr E recorded that Mrs A was afebrile, her pulse was 88 beats per minute and regular, and her blood pressure was 120/60mmHg. Mrs A's chest was clear with occasional bibasal creptations, and her abdomen was tympanic (distended) and tender in deep palpitation with palpable faeces. Dr E also recorded that her bowel sounds were present and she had power in all her limbs.

Dr E's impression was that Mrs A had metastatic breast cancer and that she could be on too much morphine and was constipated. Dr E planned to obtain a copy of the blood results (requested by the first Public Hospital) by fax and request an MRI. She also planned to treat Mrs A's constipation. Her pain was controlled with increasing analgesia (morphine). Dr E discussed her management plan with Dr D and they decided not to request a bone scan in view of the previous one in February.

Mrs A had an MRI scan on 29 March 2001, which indicated that she had an enhancing mass surrounding her C2 vertebral body which was most likely metastatic breast cancer. Mrs A had not opened her bowels since admission. During the evening shift of 29 March she was given laxatives by a nurse and had a loose bowel motion. Overnight the nursing notes record that Mrs A was incontinent with liquid diarrhoea (twice).

On 30 March 2001 Dr E reviewed Mrs A on her ward round. The notes record that she was still in pain, afebrile and her observations were stable. Staff were instructed to give her laxatives as required. The nursing staff recorded that Mrs A's temperature was 37.4C° and that she was much more comfortable. She had had "no further diarrhoea".

The laboratory reported that Mrs A's WBC was 19.60 and stated that the neutrophil result (18.03) indicated that sepsis or inflammation could be present. The laboratory reported a mid-stream urine test as indicating an inflammatory response but no antibacterial activity. A culture indicated that there were multiple bacterial species present with probable contamination. The laboratory report states: "the NEUTROPHILS show a shift to immaturity, as seen in reactive process eg. Post operative, sepsis or inflammation".

On 31 March 2001 Mrs A was reviewed by an orthopaedic surgeon. He recommended that she undergo a cervical spine fusion, which was to be arranged for the following week. At

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

9.30pm the nursing staff recorded that Mrs A's temperature was 37.5°C, her neck pain was well controlled but she complained of a "gripey" stomach. The nursing notes record that Mrs A's bowels had not opened and laxatives were given.

Mrs A became extremely unwell over the weekend. She was seen and assessed by the medical officers on duty in the hospital over the weekend, who communicated with the oncologist on call.

House officer
On 1 April 2001 the house officer was called at 11.30am to assess Mrs A as her temperature had increased to 38.9°C. She reported that her neck pain was controlled and that she had some abdominal pain but felt all right. The house officer recorded that Mrs A had no chest pain or cough, her temperature was 38°C, pulse 150, her chest was resonant and clear, her abdomen was firm and she had active bowel sounds. The house officer further recorded "fever (?) cause, anxiety +++ and constipation" and requested a full blood count, blood cultures, chest, left shoulder and abdominal X-rays, mid-stream urine and sputum and stool specimens.

The house officer reviewed the chest X-ray and recorded that Mrs A had a large opacity in her midzone area which might be due to an infection or metastases. He noted (mistakenly) that the opacity had not been reported on previous X-rays. The chest X-ray was later reported (6 August) as indicating no change in Mrs A's chest and no significant abnormality in her left shoulder. The second Public Hospital explained that the X-ray showing the metastases was performed outside the second Public Hospital and the house officer was possibly referring to the previous X-ray performed in the second Public Hospital in 1999, which did not refer to metastases. The house officer also recorded that the abdominal X-ray indicated lots of faeces in her descending colon. The abdominal X-ray was later reported (also on 6 August) as indicating normal distribution of bowel gas and content in her abdomen. The house officer prescribed Augmentin 500mg three times a day and a fleet enema.

The laboratory reported that Mrs A's WBC was 22.00 and her neutrophils 21.56. The laboratory stated that the neutrophil result indicated toxic changes as seen in bacterial sepsis. A clean catch urine specimen test and a mid-stream urine test were reported as indicating an inflammatory response but no antibacterial activity. A culture indicated the presence of *L Proteus mirabilis* as the predominant strain.

The nursing staff recorded at 10.00pm that Mrs A's temperature was 37.2°C, her pulse was 128, her pain was well controlled and she had been given a fleet enema with moderate result.

Night house officer
On 2 April 2001, at midnight, the nursing staff requested the night house officer to attend as soon as possible because Mrs A had laboured breathing and tachycardia. The night house officer recorded that her pulse was 150, blood pressure 89/60, respiratory rate 40 breaths per minute and that her oxygen saturation levels were 85% on air and 96% on oxygen. An

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

ECG indicated sinus tachycardia, with no acute changes. Mrs A's heart was of normal size and her chest was resonant. The night house officer recorded that he would discuss with the medical registrar the possibility of a pulmonary embolus.

Medical registrar
The medical registrar reviewed Mrs A's condition and recorded that she reported intermittent shortness of breath during the day and now felt terrible and very short of breath. She reported no pain or cough. The registrar recorded that Mrs A appeared pale and unwell, her respiratory rate was 40 breaths per minute, pulse 150 and blood pressure 86/60. Mrs A's oxygen saturation levels were 85% on air increasing to 90% with nasal prongs. Her temperature was 36°C. The registrar also recorded that she had bronchial sounds in the anterior of her chest but it was clear posteriorly and she had sinus tachycardia. The registrar's impression was that Mrs A had a pulmonary embolus, a pneumonic process and infiltrating cancer. The registrar discussed Mrs A's condition with the on-call consultant radiation oncologist, who instructed that she was not to be resuscitated and that heparin be administered.

The night house officer reviewed Mrs A's condition and noted that she still had laboured breathing, her pulse rate was 150, blood pressure 90/70 and that her oxygen saturation level was 97% on oxygen. The night house officer reviewed her again at about 6am and recorded that she had been unconscious for the last hour and was not responding to verbal sounds or painful stimuli. Mrs A's pulse was 150, blood pressure 120/70 and she had "rattly" breathing. A chest examination revealed that she had transmitted sounds from her upper airway. The times at which these two reviews were conducted are not recorded. Mrs A died on the morning of 2 April 2001.

Death certificate
Dr E pronounced Mrs A dead at 8.30am. Dr E recorded that her impression was that Mrs A had "[d]isseminated breast cancer and acute chest infection with probable PE ? as cause of death". A post-mortem was arranged. Dr E completed Mrs A's death certificate and recorded her causes of death as: "acute chest infection, PE" (direct cause); disseminated breast cancer" (antecedent cause); and "tachycardia" (underlying condition). The death certification is dated 2 April 2001.

Post-mortem
On 3 April 2001 a post-mortem was conducted. The post-mortem report dated 14 June 2001 stated that Mrs A's peritoneal cavity contained over two litres of pus, with an abscess measuring 80 x 70 x 40 millimetres in the left lower abdominal wall. The abscess was connected to a perforated diverticulum in the sigmoid colon. Inflammatory exudate (material discharged from blood vessels) of an infectious nature were seen on all serosal (smooth transparent membrane lining the abdomen) surfaces.

A swab taken from the abscess cavity indicated heavy growth of *Escherichia coli*, *Streptococcus anginosis*, mixed anaerobes (micro-organisms that live and grow with little or no molecular oxygen) and *Bacteroides fragilis*. The pathologist's provisional diagnoses

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

were peritonitis with a pelvic abscess as a result of a ruptured sigmoid diverticulum, and metastatic breast cancer in Mrs A's left lung, both kidneys, spleen and mediastinum.

Referral to medical oncologist
In response to my provisional opinion, Dr D advised that it was not necessary to obtain the opinion of a medical oncologist to assist him with Mrs A's treatment. Dr D said that he would have made a referral if Mrs A had received successful surgery on her cervical spine because she might have required palliative chemotherapy in view of the ineffectiveness of her hormonal therapy.

Follow-up actions
The second Public Hospital submitted that its staff provided services to Mrs A with reasonable care and skill; however, there were aspects of Mrs A's care that could have been done better, and processes are in progress to address these. Following this complaint, the second Public Hospital advised that the following actions are being undertaken:

(i) Review of Health Record Management. This has already commenced with the organisation's move towards achieving Quality Health Standards requirements for Accreditation. This includes:

- Filing of health records
- Recording alert notifications
- Manual faxing of patient information
- Checking record documentation
- Requirements for documentation of clinical activities
- Quality of documentation, including legibility and identification of the recorder.

(ii) A review and update of how a patient's plan of care is recorded and co-ordinated. The action currently being progressed is the further development of clinical pathways, or a co-ordinated plan of care document, which will provide an overall summary to all health providers involved in managing the patient at any given time.

(iii) A project is currently underway that is reviewing, updating and implementing a policy for diagnostic services. This includes the timeliness of results, the documentation of results, and the availability of information in an appropriate manner.

(iv) Investigation of the frequency of consultant review of all inpatients within the Oncology and Haematology setting. This will include telephone consultations and how they are documented and actioned.

Responses to provisional opinion

- Dr D advised that he will review his practice in light of my report and apologise to Ms A.

- The second Public Hospital advised that it accepted my provisional opinion.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Independent advice to Commissioner

Independent expert advice was obtained from Dr John Childs, radiation oncologist, Dr Kenneth Menzies, general surgeon, and Dr Trevor FitzJohn, radiologist. My independent advisors provided detailed reports on the quality of services provided to Mrs A, which are attached as Appendix I to this report.

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

1) Every consumer has the right to have services provided with reasonable care and skill.

…

5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

RIGHT 6
Right to be Fully Informed

1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –
   a) An explanation of his or her condition; and
   b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; …

Opinion: No breach – Dr C

Dr C performed a lumpectomy and left axillary dissection on Mrs A's left breast in November 1998. He referred her to Dr D for radiotherapy to the left breast. Dr C saw Mrs A following radiotherapy on 13 August 1999, and again in December 1999, June 2000, and December 2000 for postoperative checks. Mrs A reported chest pain to Dr C on these occasions. He reassured her that there was no evidence of secondary cancer and that her pain was probably related to radiotherapy and her previous injury.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Ms A complained that Dr C did not provide services with appropriate care and skill by not diagnosing her mother with secondary cancer in her lungs or communicating appropriately with health providers caring for her.

In response to the complaint Dr C advised that Mrs A reported that her chest pain was intermittent and remained unchanged or slightly better. It was not the "gnawing" pains of secondary bone cancer but was musculoskeletal. Also, a chest X-ray in May 1999 and bone scan and abdominal scans in October 1999 indicated no sign of secondaries. He commented that most patients with advanced chest secondaries rarely have pain and the most likely clinical symptom was breathlessness. If Mrs A had been breathless he would have auscultated her chest and requested an X-ray. An MRI or CT scan was not clinically indicated and not recommended as a routine investigation in managing breast cancer.

In my opinion Dr C provided Mrs A with services with reasonable care and skill. Accordingly, Dr C did not breach Right 4(1) or 4(5) of the Code for the reasons set out below.

I accept the advice of my expert surgical advisor, Dr Menzies, that Dr C provided Mrs A with services of an appropriate standard. In particular, I accept his advice that it was reasonable for Dr C to rely on a chest X-ray taken in May 1999 (which was clear) at his consultation with Mrs A in August 1999 and conclude that her chest pain related to radiotherapy. Further, at the consultation in December 1999, it was reasonable for Dr C to attribute her chest pain to previous rib fractures because the bone and ultrasound scans undertaken in October 1999 were clear for metatastic disease. It was also reasonable for Dr C to conclude at the consultation in June 2000 that, because Mrs A's chest pain was intermittent and he could not detect any other abnormalities on physical examination, it was unlikely to be caused by secondary cancer. Finally, it was reasonable for Dr C not to auscultate Mrs A's chest at these consultations because it is not routine and was not indicated in her case. Secondary lung cancer cannot be detected by physical examination and she did not present with breathlessness.

Dr C followed up Mrs A at regular intervals and reported his assessment and management plan to Dr D and her GP. I am satisfied that Dr C reviewed Mrs A at appropriate intervals and communicated appropriately with other health providers caring for her.

I agree with my expert surgical advisor that, in hindsight, it would have been useful for Dr C to have requested a chest X-ray or an MRI in June or December 2000, especially since Mrs A was understandably anxious about secondary lung cancer in light of her sister's situation, had persistent chest pain, and a chest X-ray had not been taken since May 1999. An earlier chest X-ray would have probably resulted in the earlier detection of her lung metastases.

However, in forming an opinion on whether Mrs A received care of an appropriate standard, I need to be wary of "hindsight bias". The avoidance of hindsight bias requires in this case that the subsequent diagnosis of lung metastases in January 2001 and death of Mrs A does not influence my assessment of whether the care provided was of an appropriate standard having regard to her presentation and the information available at the time.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

At the time Dr C concluded that Mrs A's pain was not related to secondary cancer but attributable to other causes. Accordingly, he did not consider a further chest X-ray was indicated. I accept my expert advice that Dr C provided services with reasonable care and skill, having regard to Mrs A's presentation and the information available at the time. I am also satisfied that he communicated effectively with other health providers. In my opinion Dr C did not breach Right 4(1) or Right 4(5) of the Code.

Opinion: Breach – Dr D

Ms A complained that Dr D did not provide services with appropriate care and skill and did not provide her mother with adequate information. In particular, that Dr D did not diagnose Mrs A with secondary cancer in her lungs or of the bone, did not communicate appropriately with other health providers caring for Mrs A or adequately inform her of the risks and benefits of ceasing tamoxifen.

I accept the advice of my expert radiation oncology advisor, Dr Childs, that overall Dr D provided Mrs A with services of a reasonable standard of care apart from some minor omissions. However, in my opinion Dr D breached Right 4(1) in failing to examine Mrs A's neck, and Right 4(5) in not communicating appropriately with her GP.

Diagnosis of secondary lung cancer
In my opinion Dr D did not breach Right 4(1) of the Code in relation to the diagnosis of Mrs A's secondary lung cancer.

Mrs A was referred to Dr D, radiation oncologist, following her surgery in November 1998 for radiotherapy to her left breast. She underwent radiotherapy treatment. Dr D saw her for follow-up on 9 April 1999 and stated that there was no evidence of a recurrent tumour in her left breast. Dr D discharged Mrs A from his care in September 1999. At this consultation, Dr D noted that she had chest pains and suggested that if they persisted a bone scan would be appropriate to exclude metastases (a chest X-ray had been taken in May 1999).

As the pain persisted, Mrs A saw Dr D in October 1999 and a bone and ultrasound scan were arranged. Dr D saw Mrs A for follow-up in December as planned, and advised her that the scans were clear. Mrs A was again discharged from Dr D's care unless problems arose. On 16 January 2001 a chest X-ray detected that Mrs A had a large solid mass situated posteriorly in the left midzone area.

Ms A complained that Dr D did not diagnose Mrs A with secondary cancer in her lungs. In response Dr D advised that he adequately investigated Mrs A's chest pain with a bone scan (the most sensitive examination available for the detection of bone metastases) and an ultrasound scan. Furthermore, the X-ray taken in May 1999 showed no lung or left rib pathology. He advised that a chest CT scan is not indicated without other obvious signs of

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

chest pathology. He did not seriously consider malignancy because Mrs A had experienced chest pain for some time, which had not altered substantially, and it is extremely rare for lung metastases to cause significant chest pain. Dr D said that he believed that Mrs A's chest pain was due to her previous rib fractures. He advised that he did not auscultate Mrs A's chest in September 1999 because this examination does not reliably diagnose or exclude lung metastases.

I accept my expert advice that it was reasonable for Dr D to conclude at his consultation with Mrs A on 15 September 1999 that her chest pain was due to previous rib fractures, because the nature of her pain had not changed for over a year and therefore did not suggest a new problem. In these circumstances, it was reasonable for Dr D to rely on the X-ray of 7 May 1999. I also accept my expert advice that Mrs A's recent axillary surgery could have provided a reasonable explanation for her pain and that it is very unusual for intrapulmonary metastases to cause chest pain. Lung metastases are not usually detectable on auscultation unless they are very advanced. Therefore, it was reasonable that Dr D did not auscultate Mrs A's chest at the consultation on 15 September 1999. It was also reasonable that Dr D concluded at the consultation on 3 December (not 1 October, as stated by Dr Childs) that the pain was unlikely to be metastases because of the fracture history and the normal results of the bone scan and ultrasound scan of her liver.

I agree with my expert advisor that in retrospect it would have been appropriate for Dr D to have requested a chest X-ray in December 1999. Again, I consider that this would have been prudent because Mrs A was understandably anxious about lung metastases in light of her sister's situation, she had persistent chest pain, and a chest X-ray had not been taken since May 1999.

However, as noted above, in forming an opinion on whether Mrs A received care of an appropriate standard, I need to be wary of "hindsight bias". The avoidance of hindsight bias requires in this case that the subsequent diagnosis of lung metastases and death of Mrs A does not influence my assessment of whether the care provided was of an appropriate standard having regard to her presentation and the information available at the time. At the time Dr D concluded that her pain was not related to metastases but attributable to her rib fracture and managed her accordingly. While Mrs A did in fact have metastatic breast carcinoma, which was identified by a chest X-ray in January 2001, in my opinion Dr D's care of Mrs A in this regard was reasonable in light of the information at the time.

Accordingly, Dr D did not breach Right 4(1) in relation to the diagnosis of Mrs A's secondary lung cancer.

Diagnosis of secondary bone cancer

In my opinion Dr D did breach Right 4(1) of the Code in relation to the diagnosis of Mrs A's secondary bone cancer.

In January 2000, Mrs A saw Dr D at her request following an abnormal chest X-ray which indicated secondary lung cancer. Dr D arranged further investigations, including a bone scan, CT scan and biopsy. He reviewed Mrs A again on 25 January 2001. At this

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

consultation it is documented that her back pain was more severe and of a different nature to her previous pain. On 2 February, Dr D saw Mrs A again and reported persistent and severe pain. Dr D concluded that the findings were consistent with lung metastases from her primary breast cancer.

I have received conflicting information about when Mrs A initially reported severe neck pain to Dr D. It is my view that Mrs A probably informed Dr D of her neck pain in February; however, that does not materially affect my view of the events. What is clear is that Mrs A reported severe neck pain to Dr D by 5 March 2001 (at the latest). I note Dr Childs' advice that the date at which neck pain was reported does not materially affect his advice. However, if Dr D had been alert to the issue at the consultation on 2 February, it may have hastened earlier investigation with a CT or MRI scan, which would have confirmed bone metastases.

On 5 March Dr D further reviewed Mrs A, who again reported severe neck pain. He concluded that Mrs A's pain was likely to be caused by a muscular pain or strain. Therefore, he did not conduct a physical examination of Mrs A's neck. Dr D also recorded that he examined a one to two centimetre subcutaneous nodule on Mrs A's scalp which was suspicious for metastases. Dr D advised that if her neck pain persisted or became worse it should be further investigated, probably with an MRI scan. On 27 March an X-ray arranged by Dr F's locum revealed metastatic bone disease.

Ms A complained that Dr D did not diagnose her mother with secondary bone cancer. Dr D advised that at the radiotherapy planning session on 5 March 2001 he thought Mrs A's neck pain was not due to secondary cancer because her bone scan on 2 February 2001 was clear and its sudden onset was more typical of an acute injury. Dr D commented, in response to my provisional opinion, that the radiotherapy planning session on 5 March 2001 was "extremely hectic" and that he thought he would not be able to reliably determine with a clinical examination whether the neck pain had a benign or malignant cause, or (even if he was suspicious that the cause was malignant) whether radiological investigation was indicated. Therefore, he did not conduct a physical examination of Mrs A's neck.

Dr D also advised that he did not further investigate or alter treatment of the nodule on Mrs A's scalp because she had been on tamoxifen only for a short time and there was no evidence that it had become worse. I also note Dr D's statement in response to my provisional opinion that, although he thought the scalp nodule was probably a metastasis, he did not investigate it further because he thought it could be a secondary from Mrs A's lung cancer, which had been confirmed by biopsy. In his view it is often useful not to remove such a lesion because it is easy to assess and indicates the course of the cancer and the effects of treatment.

I accept my expert advice that Dr D appropriately arranged an urgent CT of Mrs A's chest, a biopsy and a bone scan when he saw her on 22 January 2001 with an abnormal chest X-ray. As a result of these investigations he appropriately concluded that her chest pain was due to the large metastases in her posterior chest and treated her appropriately.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

I also accept my expert advice that at the radiotherapy planning session on 5 March 2001 (or soon thereafter if time did not permit this) Dr D should have examined Mrs A's neck and undertaken a neurological examination of her arms in view of her severe neck pain. This should have taken place even though the lesion that was later detected in her neck by MRI scan may not have been palpable at that stage and the bone scan was clear. In this respect I note Dr D's comments in response to my provisional opinion that in hindsight it was "clearly appropriate" that he examine Mrs A's neck and her arm neurology and "appropriate" that this occur later on the day of the radiotherapy planning session. Dr D also acknowledged in hindsight that he should have investigated Mrs A's neck pain, "probably" with an MRI scan, in view of its persistence and severity.

Accordingly, in my opinion Dr D breached Right 4(1) of the Code by not examining Mrs A's neck by 5 March 2001.

Communication with other health providers
In my opinion Dr D breached Right 4(5) of the Code in relation to his communication with other health providers.

On 5 March 2001 Dr D saw Mrs A and recorded that if her neck pain persisted or became worse "I think that it should be further investigated probably with an MRI scan". Dr D recorded "no letter [to Dr F and Dr C]". Her neck pain did become worse and on 12 March 2001 Mrs A telephoned Dr F's locum about her condition. Dr F's locum referred her for an X-ray of her cervical spine, which indicated that there was no abnormality seen in the cervical spine and alignment was normal.

On 16 March 2001 Mrs A was admitted to the first Public Hospital with severe neck pain. Attempts were made to contact Dr D, who was on leave. On 23 March, the first Public Hospital telephoned the second Public Hospital and was awaiting a reply from another radiation oncologist. On 27 March, the first Public Hospital contacted Dr D and discussed Mrs A's condition. It was agreed that she would have an MRI scan at the second Public Hospital in a few days' time. On 27 March an X-ray revealed metastatic bone disease, which was then discussed with Dr D. It was agreed that Mrs A would be urgently transferred to the second Public Hospital. Mrs A was transferred on 28 March, and on 29 March an MRI scan was performed. The MRI scan revealed a mass around her C2 vetebral body.

Ms A raised concerns about Dr D's communication with other health providers caring for her mother. Dr D advised in response that letters are almost always sent to other involved health professionals, such as the patient's GP, and other specialists (occasionally notes are made in the medical record but no copy sent to the others if it is felt not to be necessary); sometimes, it can be up to two weeks before those letters are received (due to delays in typing because of the workload and lack of secretarial staff), but a phone call will be made if it is felt important that information is quickly passed on. It is also his practice to encourage patients to seek earlier review if things do not go as expected.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Dr D also noted that when he goes on leave it is his usual practice to undertake a formal handover to colleagues who may be involved in care of his patients in his absence. This is done for all the inpatients and outpatients directly under his care (although he indicated in his response to my provisional opinion that he did not specifically discuss Mrs A's situation, which is addressed below).

Mrs A was entitled to expect co-operation between the providers involved in her care, to ensure that she received quality and continuity of care. Dr D needed to accurately note and convey to Mrs A's GP relevant information in relation to her care. It is essential for a patient's GP to be informed of the conclusions of a specialist's examination and management plan.

I was encouraged to note that Dr D routinely reported his consultations with Mrs A to Dr C and her GP. However, unfortunately he did not report his consultation with Mrs A of 5 March 2001; in particular, that an MRI scan was warranted if Mrs A's neck pain persisted or became worse. I acknowledge that this was a minor omission in the context of otherwise good communication with other health providers. However, this was important information, which may have expedited her MRI scan, the diagnosis of bone metastases, and possibly her overall management.

Dr D commented in response to my provisional opinion that he should have sent Mrs A's GP a copy of his record of the consultation on 5 March 2001. I am reassured that his current practice is to keep GPs informed in this way. Dr D advised me that he did not specifically discuss Mrs A's case with the colleague covering his practice, prior to going on leave in March 2001. This is disappointing, in light of Mrs A's severe neck pain and Dr D's record at the consultation on 5 March that an MRI scan might be required. It was reasonably foreseeable that his colleague might be required to arrange the scan while Dr D was on leave.

In my opinion Dr D did not co-ordinate effectively with Mrs A's GP when he failed to inform her of the conclusions of Mrs A's attendance and her management plan on 5 March 2001. Although I do not believe that this affected the ultimate outcome, Dr D was nevertheless in breach of Right 4(5) of the Code.

Communication with Mrs A

In my opinion Dr D did not breach Right 6(1)(b) of the Code in relation to his communication with Mrs A about the risks of stopping tamoxifen in late 1999.

Dr D recommended that Mrs A have adjuvant systemic therapy (tamoxifen). His clinical record of 5 January 1999 states that "patient understands the aim of this, possible adverse affects". Mrs A started tamoxifen on 23 April 1999. In September and October 1999 she reported that she was suffering intolerable side effects. Dr D informed her that she could stop her tamoxifen because of the side effects and the likely small benefit. In about October 1999 Mrs A stopped taking tamoxifen.

Ms A raised concerns about Dr D's communication with her mother about the risks associated with her discontinuing tamoxifen. Dr D advised in response that he

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

recommended that Mrs A discontinue tamoxifen because of its intolerable side effects and the likely small benefit she would gain from the medication. I acknowledge that Dr D advised in response to my provisional opinion that he would have discussed with Mrs A the pros and cons of stopping or remaining on tamoxifen. He recalled that she was very pleased to stop taking tamoxifen and, in view of the nature of her illness, it would almost certainly not have been beneficial.

On balance, I am satisfied that Dr D provided Mrs A with sufficient information about the risks and benefits of stopping tamoxifen. It is important to bear in mind that at the time Mrs A was advised to stop the medication she was suffering from intolerable side effects, the likely benefits were considered small, there was no evidence of metastases, and her prognosis was good.

Although I agree with my expert that there were some issues around communication with Mrs A and her family (see "other comments" section below), in my opinion Dr D did not breach Right 6(1)(b) of the Code in relation to information about the risks and benefits of stopping tamoxifen. I am pleased to note that Dr D and the second Public Hospital Oncology and Haematology Clinical Practice Group have identified this as an area for improvement and intend to review patient information on tamoxifen.

Opinion: No breach – First Public Hospital

On 16 March 2001 Mrs A was admitted to the first Public Hospital with severe neck pain. During her admission, Mrs A's pain was not always well controlled. The first Public Hospital consulted the hospice for advice. Mrs A reported pain in her neck and abdomen, which was tight and distended, and had constipation and diarrhoea during her admission. On 18 March 2001 the first Public Hospital received Mrs A's clinical records from the second Public Hospital, which noted that if her neck pain persisted or became worse "it should be further investigated probably with an MRI scan". However, the first Public Hospital was unable to provide this service. On 21 March 2001 the locum medical officer attempted to contact Dr D and was advised that he was on leave. On 23 March the locum medical officer again contacted the second Public Hospital about the MRI scan and was awaiting a reply from another radiation oncologist, as Dr D was on leave. On 27 March an X-ray was obtained and revealed secondary cancer of the bone. It was agreed that Mrs A should be referred to the second Public Hospital for review and an MRI scan.

Mrs A's daughter complained that staff at the first Public Hospital did not provide services with appropriate care and skill. In particular, that staff at the first Public Hospital did not: diagnose her mother with secondary cancer of the bone as soon as was reasonable; appropriately treat her when Dr D was on leave; adequately assess and treat her pain; correctly read an X-ray in March 2001, which indicated that she had secondary cancer of the bone; communicate appropriately with other health providers caring for her; or ensure that her blood test results were promptly provided to staff at the second Public Hospital.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

In response to the complaint, the first Public Hospital stated that it did provide services to Mrs A with reasonable care and skill. The recent bone scan and X-ray were clear for metastatic bone cancer. The first Public Hospital advised that careful management of analgesia was required to avoid Mrs A experiencing hallucinations as reported in her nursing notes on 20 March. Advice from the hospice was obtained. Mrs A was focused on returning home with a view to carrying out some work from home. A heavily medicated state would not have allowed her to achieve this objective. A compromise was found with her prescribed regular medication and additional analgesia if required, to balance the fine line of breakthrough pain.

In my opinion the first Public Hospital did not breach Right 4(1) or 4(5) of the Code in relation to the care of Mrs A for the following reasons.

I accept the advice of Dr Childs that overall the first Public Hospital provided Mrs A with services of an appropriate standard. My expert noted that staff at the first Public Hospital should have considered an earlier specialist referral when Mrs A's symptoms were problematic despite their initial appropriate symptomatic measures. However, the time frame for referral back was reasonable considering that the bone scan had not shown metastases and the initial cervical spine X-ray was not abnormal.

Upon admission to the first Public Hospital, information in relation to Mrs A was promptly requested and received from the second Public Hospital by fax. This included Dr D's note of 5 March that an MRI scan should be considered if the pain persisted. It appears that staff at the first Public Hospital initially had some difficulty contacting Dr D or a colleague covering his practice to seek advice or arrange a scan. This was an unfortunate lapse in communication. However, there was subsequently effective liaison with Dr D. A further X-ray was obtained on 27 March, in response to the physiotherapist's concerns, and finally revealed metastatic bone cancer. I note that at this point, Mrs A's transfer to the second Public Hospital and her MRI scan were arranged promptly.

The X-ray of Mrs A's cervical spine was reported by a radiological practice (which is contracted to provide services to the first Public Hospital) as indicating no abnormality. However, an X-ray report of 27 March 2001 detected bone metastases and stated that "the cortical line was faintly visible on the previous film …". I obtained independent expert radiological advice from Dr Trevor FitzJohn about whether the X-ray of 27 March 2001 raised an issue about the accuracy of the X-ray on 12 March 2001. A copy of his advice is attached in Appendix I. I accept Dr FitzJohn's advice that there is no evidence that the second report contradicted the first. I am satisfied that staff at the first Public Hospital correctly read the X-ray of 12 March 2001.

I am also satisfied that the first Public Hospital took all reasonable steps to ensure that the blood test results were promptly provided to the second Public Hospital. MOSS asked for copies of all tests from 28 March to be forwarded directly to the second Public Hospital and also to Dr D. She had also advised the second Public Hospital in her transfer letter which laboratory the blood had gone to, for their follow-up if necessary.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Taking into account all of the circumstances at the time, while aspects of the care provided by staff at the first Public Hospital were not ideal, I am satisfied that they provided services to Mrs A with reasonable care and skill and did not breach Right 4(1) or 4(5) of the Code.

Opinion: No breach – Dr E

In my opinion Dr E did not breach Right 4(1) of the Code.

On 28 March 2001 Mrs A was transferred by ambulance to the second Public Hospital where she was assessed by Dr E, who was a medical registrar responsible for inpatient oncology radiation patients. Dr E noted that Mrs A's abdomen was tympanic (distended) and tender in deep palpitation with palpable faeces. Dr E also recorded that bowel sounds were present and Mrs A had power in all her limbs. Dr E's impression was that Mrs A had metastatic breast cancer and that she could be on too much morphine and was constipated. Dr E discussed Mrs A's condition and management plan with Dr D and they decided not to request a bone scan in view of the previous one in February.

Ms A complained that Dr E did not provide services with appropriate care and skill to her mother. In particular, she did not appropriately investigate and treat Mrs A's symptoms, which included an infection, constipation, diarrhoea, a swollen abdomen, abdominal pain, low blood pressure and an elevated temperature and pulse rate; appropriately act upon her deteriorating condition; diagnose that she had developed peritonitis with a pelvic abscess as a result of a ruptured sigmoid diverticulum, from which she later died; or communicate appropriately with other health providers.

Dr E advised that there was no evidence that Mrs A had intra-abdominal pathology on admission to the second Public Hospital even though blood tests (requested by the first Public Hospital) indicated that she had a raised WBC and neutrophils. Dr E considered that this was caused by Mrs A's high doses of steroids or bone marrow infiltration because she did not have a fever and her physical examination did not detect any infection site. Additionally, her WBC remained stable until 30 March 2001. Dr E also advised that Mrs A's symptoms until 30 March 2001 (after which Dr E was off duty) were mainly neck pain and constipation. There was no indication of any infection because she did not have a fever or abdominal pain and her blood pressure, temperature and pulse rate remained satisfactory.

I accept the advice of Dr Childs that Dr E provided Mrs A with services of an appropriate standard. In particular, I accept his advice that Dr E's abdominal findings were consistent with constipation caused by high doses of morphine. Furthermore, there were no clinical signs that Mrs A had a pelvic abscess or peritonitis. Therefore, it was reasonable that Dr E did not alert medical and nursing staff, who would be caring for her during the weekend, to monitor her condition for an infection. However, it is likely that Mrs A's symptoms of peritonitis (typically rigidity, extreme and rebound tenderness and absence of bowel sounds)

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

were masked by steroids and high doses of morphine. In these situations, it is critical that providers have a high index of suspicion.

In my opinion Dr E did not breach Right 4(1) of the Code.

Opinion: No breach – Second Public Hospital

Mrs A was transferred to the second Public Hospital on 28 March and cared for by its staff until her death on 2 April 2001. Mrs A's daughter complained that it did not provide her mother with a reasonable standard of care. In particular, that staff did not appropriately investigate and treat Mrs A's symptoms, which included an infection, constipation, diarrhoea, a swollen abdomen, abdominal pain, low blood pressure and an elevated temperature and pulse rate; appropriately act upon her deteriorating condition; diagnose that she had developed peritonitis with a pelvic abscess as a result of a ruptured sigmoid diverticulum, from which she later died; or communicate appropriately with other health providers.

The second Public Hospital stated that its staff provided services to Mrs A with reasonable care and skill; however, there were aspects of Mrs A's care that could have been done better, and processes are in progress to address these.

I accept the advice of Dr Childs that staff at the second Public Hospital provided Mrs A with services of an appropriate standard. In my opinion the second Public Hospital did not breach Right 4(1) or 4(5) of the Code for the reasons set out below.

House officer
I accept my expert advice that Mrs A had no signs of an intra-abdominal infection when the house officer assessed her on 1 April. I note that the house officer conducted an abdominal examination, ordered relevant investigations for fever, and requested an abdominal X-ray (which was satisfactory). I also note that the house officer recorded that Mrs A's bowel sounds were active. I accept that it was reasonable that the house officer did not discuss his findings with a senior doctor.

I note with concern that the house officer at the second Public Hospital considered that the lung pathology indicated by the chest X-ray he requested was new. This is disappointing in view of the CT scan (reported on 25 January 2001) which detected cancer in Mrs A's left lung and the supplementary immunohistochemical report dated 12 February 2001, which confirmed this as metastases from breast cancer. These investigations were requested by Dr D and were (or should have been) in Mrs A's medical file. I also note that Dr E recorded on admission that Mrs A had lung metastases.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Medical registrar
Following assessment the medical registrar came to the same conclusion as the house officer, except that the suspicion of a pulmonary embolus was raised as another possibility for Mrs A's deterioration. Pulmonary embolism is a common event with advanced malignancy and it was reasonable to consider it as a possibility. I accept my expert advice that there was no reason for the registrar to have suspected intra-abdominal infection and therefore no indication for abdominal examination or further investigations.

Night house officer
I accept my expert advice that the impression of the night house officer who assessed Mrs A on 2 April 2001 – that her deterioration might be caused by respiratory problems from her aggressive terminal malignancy – was reasonable. The night house officer appropriately consulted with the medical registrar about Mrs A's condition. It was reasonable for the medical registrar to consider that Mrs A's deterioration might be caused by a pulmonary embolism, as this is common with advanced malignancy and there was no clinical evidence of intra-abdominal pathology.

Communication
On 16 March 2001 Mrs A was admitted to the first Public Hospital with severe neck pain. By 18 March the first Public Hospital received Mrs A's clinical records from the second Public Hospital, which included Dr D's advice about an MRI scan. It appears that staff at the first Public Hospital initially had some difficulty contacting Dr D or a colleague covering his practice to seek advice or arrange a scan. On 21 March the first Public Hospital attempted to contact Dr D, and was advised that he was on leave. On 23 March, the first Public Hospital telephoned the second Public Hospital and was awaiting a reply from another radiation oncologist. The second Public Hospital has no record of these telephone contacts. This is of concern. However, I note that on 27 March, staff at the first Public Hospital had no difficulty contacting Dr D, and the providers co-operated effectively to ensure that Mrs A received continuity of care.

Taking into account all of the circumstances at the time, while aspects of the care provided by staff at the second Public Hospital were not ideal, in my opinion the second Public Hospital did not breach Right 4(1) or 4(5) of the Code. I commend the second Public Hospital on the steps it has taken in response to this case, particularly in relation to communication and health record management.

Opinion: No vicarious liability – Second Public Hospital

Employers are vicariously liable under section 72(2) of the Health and Disability Commissioner Act 1994 for ensuring that employees comply with the Code of Health and Disability Services Consumers' Rights. However, under section 72(5) an employing authority has a defence if it shows that it took such steps as were reasonably practicable to prevent an employee from breaching the Code. In my opinion, in two respects Dr D

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

breached Right 4(1) and 4(5) of the Code. However, the second Public Hospital is not vicariously liable for the isolated breaches by Dr D in this case.

Opinion: No further action – Dr F

Mrs A's daughter complained that Dr F did not provide services with appropriate care and skill to her mother. In particular, that Dr F did not diagnose Mrs A with secondary cancer in her lungs during his consultations or communicate appropriately with other health providers caring for her. Dr F did not respond to my letter informing him of my intention to investigate this complaint or provide his medical records (which I obtained from Ms A). It is disappointing that Dr F did not participate in my investigation.

I have decided to take no further action in relation to Dr F's involvement in this case for the following reasons. I have recently been advised that Dr F no longer practises medicine. Further, it is clear that Mrs A's secondary lung cancer was difficult to detect. Although Mrs A presented to Dr F with back pain or upper abdominal pain on 27 August 1999, 27 October 1999 and 16 October 2000, it is likely that he was reassured by the opinions of Dr C and Dr D that Mrs A did not have metastatic lung cancer.

Other comments

Medical certificate of causes of death
The medical certificate of causes of death (completed by Dr E) stated that Mrs A died from an acute chest infection, pulmonary embolism, disseminated breast cancer and tachycardia. Ms A complained that the death certificate did not accurately record the causes of death in view of the post-mortem findings. In response to this complaint the second Public Hospital advised that its usual practice is to complete a certificate at the time of death. However, the certificate is kept until an autopsy has been undertaken because it may need amendment. The second Public Hospital regrets that this did not happen in this case.

Communication
In response to my provisional opinion, Ms A commented:

> "The failure by the doctors to properly communicate the seriousness of Mum's condition in the days before she died meant that we were denied the chance to say good-bye properly – to tell her how much we loved her and how much we would miss her. …
>
> I am inclined to think that the breakdown in communication was more a failure of the system than of the individual doctors involved. I realise that doctors must distance

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

> themselves from the emotional concerns of their patients and families to keep themselves sane. It must be unbelievably hard to deal with terminally ill patients and their families. I know I could not do it. But, I wonder whether systems could be put in place to prevent these problems from recurring. When Mum and I asked Dr D for a prognosis, perhaps a note could have been put on the file and other providers (ie GP) advised. The advice regarding prognosis could have then been regularly reassessed (monthly?) and updated as required. If a patient and family request a prognosis, it is reasonable to assume that they want to be told when time is running out."

I urge the providers involved in Mrs A's care in the second Public Hospital to reflect on the above comments.

Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand.
- A copy of this report, with details identifying the parties removed, will be sent to the Royal Australian and New Zealand College of Radiologists, the Royal Australasian College of Surgeons, and the Chief Medical Advisors of all District Health Boards, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix I: Independent advice to Commissioner

Radiation Oncology Advice from Dr John Childs

The following expert advice was obtained from Dr John Childs, radiation oncologist:

"**Introduction**

This report is in response to a request from the Health and Disability Commissioner to provide an opinion on the care given to Mrs [A]. Copies of all clinical documents provided by the Commissioner have been reviewed and my opinion is structured on the questions provided in the terms of reference. An appendix table is attached (Attachment A) that summarises a schedule of the key events and occurrences that were considered in this response. Other related events were reviewed however the table contains those most relevant to the opinion required.

The Care provided by Dr [D]

1. Diagnosis and management of chest problems

Did Dr [D] properly investigate, monitor and treat the symptoms Mrs [A] presented with on 15 September, 1st October and 3rd December 1999 in view of the information that was available to him.

Did Dr [D] properly examine Mrs [A], particularly her chest in view of her presenting condition?

Dr [D's] statements that:

He did not seriously consider lung metastases as it is extremely rare for these to cause significant chest pain and that Mrs [A's] chest pain was more likely to have a benign cause.

He considered Mrs [A's] rib pain, which had been present for some time was due to a previous injury.

What other action (including further investigations if any should Dr [D] have taken at the above consultations? In your response please include comment on whether it was reasonable for Dr [D] to rely on an X-ray taken in May 1999 at the consultation on 15 September 1999 and subsequent consultations.

At the consultation on the 15th September Dr [D] assessed that Mrs [A] had left chest wall pain for at least one year. Because her pain had not changed in nature to suggest a new problem he reasonably assumed that it was likely to be due to benign changes related to an old rib injury. Therefore it was reasonable for him to consider that the

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

findings of a previous chest x-ray 4 months earlier were still relevant to the ongoing symptoms. He appropriately recommended that if there was any change in the nature of the pain that further investigation would be indicated.

The conclusion that the chest pain was more likely due to benign causes was valid and although previous injury was an explanation the more recent axillary surgery could have also been a reasonable explanation for her discomfort. It is very unusual for intrapulmonary metastases to cause chest pain, the circumstances in which pain may occur is when the lung tumour is involving the pleura, invading into the chest wall, invading into a rib, or invading into the brachial plexus. The subsequent chest x-ray that showed metastases was over one year later and it is unlikely that these would have been visible on a further chest x-ray at the time of Dr [D's] consultation or that they were the explanation for the long-standing history of chest pain.

Dr [D] undertook a relevant examination and auscultation of the chest at that consultation would not have contributed to making an earlier diagnosis of the lung metastases because lung metastases usually do not produce abnormal findings on auscultation unless they are very advanced causing effusions, atelectasis or pulmonary oedema. Although chest auscultation would be a thorough examination, it was not inappropriate practice to omit this in the clinical circumstances.

At the consultation on 1/10/99 Dr [D] noted that the pain was continuing and requested a bone scan and ultrasound scan of the liver. The bone scan and ultrasound scan were normal and on that basis together with the history Dr [D] reasonably concluded that the pain was unlikely to be due to metastases. In retrospect it may have been appropriate to have undertaken a further chest x-ray however it is likely that a chest x-ray at this time would not have shown the lung metastases. The omission of another chest x-ray I would deem a minor variation from good practice. It is noted that it was over 12 months later before Mrs [A] represented because of further symptoms and an abnormal chest x-ray. It is likely that the pulmonary metastases were not the cause of the earlier chest pain for which Dr [D] undertook investigations and the lung metastases probably developed over a much shorter time frame prior to her re-referral to Dr [D].

Was it appropriate on 3rd December 1999 for Dr [D] to discharge Mrs [A] from follow-up in view of her persisting chest pain?

Because Dr [D] had not found an obvious explanation for the chest pain, and in particular had excluded bone metastases as a cause for the pain, discharge from the clinic was appropriate. He had clearly indicated to the GP that re-referral should occur if there were further concerns and the Surgical Specialist was also continuing to see Mrs [A] for follow-up.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

What actions if any should Dr [D] have undertaken in view of Dr [C's] letters of 12 June and 15 December 2000?

Dr [C's] letter to Dr [D] indicated that while Mrs [A] was complaining of intermittent pains in her left chest and back he stated she was otherwise well and that the pain did not appear to be typical for bone pain. There were no features from Dr [C's] description of the pain that would indicate pulmonary (lung problems) as the cause. On the basis of the information contained in the letter there was no reason for Dr [D] to have taken any action. There were no features on the assessment by Dr [C] that Mrs [A's] symptoms could be due to recurrence (metastases) of the breast cancer.

Dr [C's] letter to the GP on 15/12/2000 indicates that Mrs [A] was complaining of no new problems and that ongoing discomfort in her left shoulder blade was being relieved by anti-inflammatory analgesics. There was no detail in this letter to indicate that Dr [D] needed to take further action.

Should Dr [D] have given more consideration to or detected Mrs [A's] secondary lung cancer prior to or in December 1999? If so at what point?

Lung metastases as a cause for chest pain is very uncommon and given the information available to Dr [D] he had no reason to suspect that the cause for Mrs [A's] chest pain was either bone metastases (which he reasonably excluded with a bone scan) or lung metastases (which he had no reason to suspect). It is likely that had a chest x-ray been requested the end of 1999 this probably would not have shown the abnormalities that were detected one year later.

2. Diagnosis and management of neck problems

Did Dr [D] properly investigate, monitor and treat the symptoms Mrs [A] presented with on 22 and 25 January, 2 February and 5th March 2001 in view of the information (including that from Dr [C]) that was available to him?

Dr [D] at the consultation on 22/1/01 noted that Mrs [A] had worsening pain over several weeks and from his brief note (although this was not explicit as to the exact sites of pain) it appears that he was aware of pain at other sites and I assume (particularly in light of the statement by [Ms A]) this may have included that he was also aware of the neck pain. He appropriately arranged a series of urgent investigations, a CT scan of the chest, a biopsy to confirm the diagnosis of metastases and a bone scan. These investigations were all appropriate and expedited within a short period of time. Dr [D] reviewed Mrs [A] again on 25/1/01 (presumably to complete further assessment and check on her interim progress). At this consultation it is documented that the back pain was more severe and of a different nature (character) to her previous pain. He appropriately concluded that:

1. Mrs [A] now had metastases and needed to consider further palliative treatment options.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

2. The new left chest pain was due to a large metastasis in her posterior chest – this was a reasonable conclusion given that the CT report suggested that the tumour was probably encroaching onto the diaphragm and therefore causing pain through involvement of the diaphragmatic pleura.

3. Palliative radiotherapy to the chest was a reasonable option for treatment.

In your above advice please comment on:

Dr [D's] statements that he considered the right anterior scalp lump which he examined on 5th March 2001 was suspicious for metastases but further treatment or investigation was not warranted because Mrs [A] had been on tamoxifen for a short time and there was no sign the lump was becoming worse.

At his consultation on 5/3/01 Dr [D] explicitly documents a history of severe neck pain and on examination noted a subcutaneous nodule. He concluded that the nodule was a metastasis however considered the neck pain was possibly not due to bone metastasis in view of the recent bone scan which had shown no evidence of changes in the cervical spine. However even with a high suspicion of bone metastases the appropriate initial management was to adjust the oral analgesia and continue to await a response to Tamoxifen that had only recently been re commenced. Dr [D] advised that Mrs [A] should have further investigation with an MRI if the pain persisted or became worse. Because useful clinical responses to Tamoxifen may take several months to become apparent it was premature to assess whether Mrs A was responding and it was appropriate to observe without further additional treatment.

Should Dr [D] have examined Mrs [A's] neck on 5th March 2001?

In the presence of severe neck pain it is good practice to examine the neck and to undertake a neurologic examination of the arms. The lesion that was subsequently seen on MRI scanning would not have been palpable on neck examination and the palpation of a lump by a non-medical observer was probably the posterior spinous process that is normally palpable in most patients.

Should Dr [D] have referred Mrs [A] to an oncologist? If so at what point?

Dr [D] is an oncologist who specialises in the use of radiation treatment compared to a medical oncologist who specialises in the use of chemotherapy. The term oncologist is generic applying to both specialties. Dr [D] was appropriately trained and experienced to continue managing Mrs [A] and there was no indication for referral to a medical oncologist.

What other action if any should have Dr [D] taken at the above consultations?

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Should Dr [D] have given more consideration to or detected Mrs [A's] bone cancer prior to her admission to [the first Public Hospital] on 16th March 2001? If so at what point?

It is unusual for a bone scan to be negative with bone metastases from breast cancer however in a small proportion of patients, particularly when there is aggressive rapidly progressive disease the scan can be negative. It was appropriate that a cervical spine x-ray was arranged very shortly after on 12/3/01. Mrs [A's] metastases were rapidly progressive as indicated by the change in the appearance of the cervical spine x-rays. The initial x-ray on 12/3/01 was reported as normal (although in retrospect there may have been some subtle abnormalities) compared to x-rays on 27/3/01 when there were definite changes of bone destruction. Mrs [A] was admitted to [the first Public Hospital] on 16/3/01 because of neck pain transferred to [the second Public Hospital] 28/3/01 for an MRI scan and further management.

Please give your advice on the basis that the Commissioner accepts that Dr [D] first knew of Mrs [A's] neck pain on 26th February or 5th March 2001. However, although Dr [D] did not record this the complainant contends that Dr [D] was informed of Mrs [A's] neck pain on 2nd February 2001. Please indicate whether this earlier date would alter your advice.

The earlier date does not materially alter my advice although had Dr [D] had a higher level of attention at the consultation this may have hastened earlier investigation with a CT or MRI scan. A period of further observation was reasonable clinical practice because she was on analgesics and only recently commenced tamoxifen.

Dr [E]

Did Dr [E] properly investigate, monitor and treat Mrs [A's] symptoms from 5th March 2001 until the end of her duty on 30th March 2001. In your response include comments on the following:

Should Dr [E] have given more consideration to or detected that Mrs [A] had an infection of her abdominal area? If so at what point? In your advice please advise whether Dr [E's] statement was reasonable that she noted the raised white cell count and neutrophils in the blood results for 28th March 2001 sent by [the first Public Hospital] but interpreted them as secondary to Mrs [A's] high dose steroids or to possible bone marrow infiltration in the absence of fever or examination features suggesting infectious foci.

What further actions including investigations if any should Dr [E] have undertaken in view of Mrs [A's] symptoms including those associated with her bowel function and distended abdomen?

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Was the medication prescribed or authorised by Dr [E] appropriate?

Dr [E] assessed Mrs [A] on the admission to [the second Public Hospital]. She provided a detailed clinical note. Her assessment from the clinical examination was appropriate. The abdominal findings were consistent with constipation and there were no features that would have raised a suspicion for a more serious intraabdominal problem such as a pelvic abscess or peritonitis. The investigations and treatment she ordered were appropriate and consistent with her clinical assessment. There were no features on clinical assessment that would have alerted her or any other clinician to the possibility of an occult intraabdominal infection. In the absence of a fever her interpretation of the blood results (neutrophil leucocytosis) as being consistent with the effect of corticosteroids or response to bone marrow infiltration by malignancy was reasonable.

A senior Public Hospital staff member comments that the findings on clinical examination were not atypical of narcotic related constipation and would not have alerted Dr [E] to the possibility of other intraabdominal pathology.

Constipation and abdominal distension are commonly encountered in patients on high dose morphine and therefore the assessment that this was the likely problem was reasonable. It is likely that clinical signs of other intra abdominal pathology would be masked by narcotic analgesia and high dose steroids if indeed intra abdominal infection was present at the time of admission. The initial management prescribed by Dr [E] was therefore appropriate.

Did Dr [E] take appropriate action on the basis of the blood tests of 30th March 2001 and Mrs [A's] other symptoms before her shift ended? In your advice please also include comment on whether the weekend summary should have alerted other staff to the possibility that Mrs [A] had an infection.

By the 30th March there were still no overt clinical features that would have raised a suspicion for infection therefore it was reasonable for Dr [E] and other staff not to have raised a concern about infection prior to the weekend.

Dr [D's] statement that analgesics and steroids are likely to have masked the typical signs and symptoms of her peritonitis.

It is highly likely that the narcotic analgesia and steroids would have masked the clinical signs and symptoms of peritonitis and may have also masked the symptoms of the antecedent pelvic abscess.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Staff at [the second Public Hospital]

Did staff at [the second Public Hospital] (other than Dr [E]) properly investigate, monitor and treat Mrs [A's] symptoms during her admission to the second Public Hospital? If not what should they have done and at what point?

The monitoring by staff at [the second Public Hospital] was appropriate and the action taken to call for an assessment by on call medical staff was appropriately requested once she was found to have a fever.

1. The House Officer

Were the actions of the House Officer who assessed Mrs [A] twice on 1st April appropriate? If not, what should the House Officer have done?

The actions of the on call house officer on 1/4/03 were appropriate given the clinical findings. An abdominal examination was conducted and although the term 'firm' to describe abdominal examination was imprecise, I interpret this to mean that Mrs [A's] abdomen was probably distended with no obvious guarding, rebound or tenderness. The relevant investigations were ordered for her fever and it is particularly noted that a plain abdominal film was ordered. This can be useful to assess possibilities of bowel obstruction, ileus or perforation of a viscous. A chest x-ray was interpreted to show a new opacity and therefore in the circumstances it was reasonable to have a high suspicion for a diagnosis of pulmonary infection. Broad-spectrum antibiotics appropriate to the suspected clinical diagnosis of a chest infection were commenced.

I believe that the house officer did not find signs to raise a suspicion of intra abdominal infection and that those signs were not present. The initial actions taken by the house officer were appropriate and recognised as standard practice in a patient who is immune suppressed as a consequence of treatment with steroids and widespread malignancy. There appears to have been no reason for the house surgeon to discuss the findings with a more senior clinician and it is unlikely that a senior clinician would have come to a different conclusion.

2. Night House Officer

Were the actions of the night house officer who assessed Mrs [A] on 2nd April 2001 appropriate? If not, what should the night house officer have done?

The actions and assessment made by the on call house officer on 2 April 2001 were appropriate. The clinical findings were predominantly of respiratory problems and there continued to be no symptoms or features that would have alerted this clinician to making further consideration for intra abdominal infection as an underlying cause for Mrs [A's] deterioration. Given the clinical finding it was reasonable for the house officer to conclude that the problems were due to complications from rapidly progressive widespread terminal malignancy. In this situation it was reasonable to be

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

circumspect about further extensive investigations, particularly as they were unlikely to change continuing management. It appears there were no obvious features that would have alerted the house officer to the possibility of intra abdominal sepsis. The house officer appropriately requested review by the on call registrar.

3. Medical Registrar

Were the actions of the medical registrar who assessed Mrs [A] on 2nd April 2001 appropriate? If not, what should the medical registrar have done? In your advice please include comments on:

Should the medical registrar have examined Mrs [A's] abdomen or conducted or requested any further examinations?

Was the impression of the medical registrar as to the cause of Mrs [A's] symptoms reasonable?

Should the medical registrar have given more consideration to or detected that Mrs [A] had an infection in her abdominal area?

The medical registrar following assessment came to the same conclusion as the house officer excepting that the suspicion for a pulmonary embolus was raised as another possibility for Mrs [A's] deterioration. Pulmonary embolism is a common event with advanced malignancy therefore it was reasonable to consider this possibility in this setting. There was no reason for the registrar to have suspected intra abdominal infection and therefore no indication for abdominal examination or further investigations.

On Call Oncologist

Were the actions of the on call oncologist who was contacted by the medical registrar appropriate? If not, what should have the on call oncologist done?

There was no further action the on call oncologist should have taken based on the finding of both the house officer and registrar.

The standard of care provided

Overall Dr [D] and the other providers gave a reasonable standard of care apart from some minor omissions by Dr [D], that were unlikely to have influenced the treatment provided and would not have altered the final outcome. Overall a good standard of care was provided and apart from some minor issues there appears to have been no departure from reasonable practice.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Aspects of care requiring additional comment

Based on the details in the documentation provided there are no issues that warrant further investigation however there are several areas that should be noted for quality of care improvement:

1. Improve documentation of clinical assessments particularly the accuracy and completeness of clinical accounts.

2. Clearer documentation and reflection on decisions about the extent of investigations required when patients or family raise concerns about whether symptoms might be due to recurrent cancer.

3. Consideration of timelier specialist referral when patient symptoms are problematic despite initial appropriate symptomatic measures. While under care at [the first Public Hospital] consideration of earlier referral for further investigation (MRI or CT scan) might have been considered because the patient's pain although improved was continuing to be a significant problem. However notwithstanding this observation for improvement the care provided was otherwise appropriate. Although there was a delay to confirming the diagnosis the palliative care provided in the interim was appropriate and while earlier surgery or radiotherapy may have ultimately provided greater relief of her neck symptoms these treatments would not have altered the overall outcome.

4. Improvement of communication with the patient and family: the family clearly had considerable concerns about their mother however it is difficult to assess to what extent they raised their concern with medical staff and whether medical staff understood or elicited these issues in their interactions with the patient or family. There was an issue of whether there was clear communication between Dr [D] and the family. With a high standard of practice it would be considered appropriate to fully discuss with the patient and family the concern for the possibility of spread of cancer and options for further investigation. From the clinical records it is not possible to assess how much the family understood about their mother's diagnosis and care in particular:

    a. The dilemma faced by medical staff in confirming the clinical diagnosis given the nature of symptoms and the negative bone scan.

    b. The understanding that metastatic breast cancer is incurable and that the objective of investigation and treatment was to provide the most appropriate means of symptom relief (palliation) but will not usually prolong survival.

    c. Support for the family to come to terms with the very rapid sequence of events due to the extremely aggressive nature of Mrs [A's] cancer.

5. Provision of opportunities for bereavement counselling and discussion of events following a sudden and tragic loss. It is understandable that [Ms A] had

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

considerable difficulty in coming to terms with events and the opportunity to discuss her concerns directly with staff involved following her mother's death may have been helpful.

Conclusions

Mrs [A] was diagnosed with a small good prognosis breast cancer for which it was anticipated there was a reasonable probability of a good long-term outcome. Therefore the development of aggressive widespread metastases was a surprise both to the clinicians and family.

All the staff involved with Mrs [A's] care provided a reasonable standard of care and I could find no clear evidence that there was a departure from reasonable standards.

1. Communication with Mrs [A] and her family

Mrs [A] initially had an early stage carcinoma of the breast with good prognostic factors but unfortunately developed aggressive widespread metastases in the lungs and bones. Her history and clinical findings did not give a clear indication of metastases and it is doubtful whether her earlier symptoms were due to metastatic disease. An earlier diagnosis of her metastatic disease would not have altered her overall survival and it is not certain that this would have resulted in better palliative care. It appears from Mrs [A's] daughter's perspective that there were points at which Mrs [A] and the family may have desired more discussion with clinicians around the concern for the possibility of metastases and the options for further investigations. In any event some of those investigations (particularly the bone scan) did not support the suspected possibility of metastases. I believe there were probably some issues around communication of these difficult issues with the family by Dr [D] and it is not obvious how much Dr [D] acknowledged or understood Mrs [A's] or the family concerns. In the context of providing reassurance when the symptoms were not indicative of definite cancer recurrence is always difficult. Although this issue is raised as one for reflection by the clinicians involved it would not be seen as a variation from reasonable practice.

2. Diagnosis of the Lung Metastases

Mrs [A's] chest pain was atypical and clearly remained unchanged in character or severity for a long period of time. It is very unusual for lung metastases to cause chest pain unless they are involving the pleura or invading the chest wall. It appears unlikely that metastases were the cause of the chest pain when first assessed by Dr [D] and with the rapid progression of her disease more likely that these developed over a much shorter period of time prior to her re referral to Dr [D]. While the diagnostic delay created by the difficulties in establishing her diagnosis meant earlier use of radiotherapy, alternative hormonal therapy or chemotherapy was not possible it is not clear that earlier intervention would have made a significant difference because of the

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

widespread rapid progression of metastases at other sites. Other appropriate symptomatic measures were being provided.

3. Diagnosis of metastases to the cervical spine

Although earlier referral back to oncology from [the first Public Hospital] for further investigation may have been desirable to confirm the diagnosis of metastases to the cervical spine appropriate interim management was provided. The time frame for referral back was reasonable considering that the bone scan had not shown metastases and the initial cervical spine x-ray was not unequivocally abnormal.

4. Diagnosis of Mrs [A's] abdominal problems

Steroids and analgesic drugs are likely to have masked the overt clinical signs of intra abdominal infection. It is uncertain when perforation may have occurred however there were no features in the history that would have raised a suspicion for this diagnosis. Once features of infection were detected initial appropriate actions were taken however her very rapid decline with widespread metastatic cancer meant that surgical intervention was unlikely to be an option. Although shortly prior to Mrs [A's] death there was evidence of infection there were no obvious signs of an acute or serious intra abdominal problem that might warrant further investigation.

There is no evidence that an earlier diagnosis of metastatic breast cancer changes the overall long term outcome or survival. For patients with cancer the balance between overly aggressive investigation that raises anxiety and may not always confirm the suspected diagnosis versus more limited investigations to exclude clinically obvious causes is always difficult. The extent to which investigations should be arranged when care is palliative is a fine balance. When early metastases are a cause for significant symptoms earlier detection may lead to more timely use of palliative treatment options and in some instances this will improve quality of life. In Mrs [A's] care although an earlier diagnosis of metastatic disease may have led to earlier use of other palliative measures this would not have altered the overall outcome. It is doubtful that earlier investigations would have enabled a firm clinical conclusion particularly because the disease was progressing very rapidly.

The course of events has clearly been an enormous shock to Mrs [A's] family particularly her sudden death due to an undiagnosed ruptured pelvic abscess and the request for an explanation of events is very reasonable. I trust this report will be of some assistance to help the family understand the course of events related to their mother's care."

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Attachment A

Complaint Regarding Care Provided to Mrs [A] by Dr [D], Dr [E] and staff at [the second Public Hospital]

Primary Diagnosis: Carcinoma Left Breast (Grade 3 infiltrating duct carcinoma T1N0M0 Oestrogen and progesterone receptor positive)

Secondary Diagnosis: Lung metastases from Carcinoma Breast

Secondary Diagnosis: Bone metastases to cervical vertebral bodies

Secondary Diagnosis: Peritonitis secondary to ruptured diverticular abscess

Schedule of events as documented in medical records

Date	Event	Details	Outcome	Comment
24/11/98	Surgery for Breast Cancer	Wide local excision of tumour from left breast with left axillary dissection	12mm invasive ductal carcinoma grade 3 ER PR positive no metastases to axillary lymph nodes	Small good prognosis breast cancer

5/1/99	Consultation with Dr [D]	Assessment for adjuvant post operative treatment	Offered Post operative radiotherapy to the breast Discussion with medical oncologist regarding adjuvant systemic treatment	Appropriate discussion and recommendation about adjuvant therapy
	Post operative radiotherapy to left breast			
9/4/99	Consultation with Dr [D]	Assessment post radiotherapy Minor post radiotherapy skin reaction No other problems noted	Adjuvant Tamoxifen offered Not eligible for adjuvant Hormone trial	
5/1/99	Chest X-ray	Normal		
7/5/99	Xray chest and left ribs	Normal chest x ray No obvious lesions in the ribs	Bone scan recommended	Subsequent bone scan showed no abnormality
15/9/99	Follow-up Clinic Dr [D]	Discomfort left lateral chest wall present for 1 – 2 years since rib fractures – pattern of pain unchanged. Severe hot flushes on Tamoxifen Exam chest wall – slight	Bone scan recommended if pain continues or change in severity Stop Tamoxifen if hot flushes remain a problem Discharged from oncology	History indicated no clear indication for further investigations on this assessment – no reason to suspect a significant change. Appropriate to recommend further investigation if change of symptoms

		tenderness no other abnormalities Noted that previous CXR showed no abnormality	follow-up with re referral if further concerns	Uncertain whether further chest x-ray would have demonstrated any abnormality Aetiology of pain was not clear but given the long-standing unchanged character benign causes though more likely such as from previous injury or related to radiation. Auscultation of chest would not have detected any abnormality
1/10/99	Follow-up Clinic Dr [D]	Continued pain left lateral chest Left hip pain Examination: tender left chest wall and hip	Bone scan requested Ultrasound Liver Discontinued Tamoxifen	Appropriate investigations requested on basis of recorded clinical problems
3/12/99	Consultation Dr [D]	On provera Chest pain persists Hip pain settled Bone and liver scan normal	Discharged from oncology Provera dose reduced	3/12/99

3/12/99	Follow-up Dr [D] ([first Public Hospital])	Improvement of hot flushes Chest pain (ribs) persists Hip pain settled Bone scan normal Ultrasound scan normal	Provera reduced to 5 mg Discharged from clinic with re referral as required	Earlier CXR may have been indicated although clinical features did not explicitly indicate a need for this – probably would not have shown lung changes at this stage
16/1/01	Chest X-ray	7cm mass left mid zone 4.5cm mass No bone lesions		
22/1/01	Follow-up Dr [D] ([first Public Hospital])	Continued chest pain worse over "last few weeks" Also notes that there was pain "elsewhere" CXR Lung masses Other sites of pain (not specified) No record of examination however this was not necessarily indicated in view of the plan to proceed with urgent investigations.	Bone scan CT scan chest CT guided lung biopsy	Appropriate investigations requested

25/1/01	CT Chest	Tumour masses left lower lobe 7 other lesions throughout both lungs up to 5mm Tumour extending to diaphragm		
25/1/01	Follow-up Dr [D] (consultation)	Increased back pain (presumably referring to posterior chest) Pleural rub left posterior chest	Awaiting investigations Options for palliative treatment under consideration	
30/1/01	Lung Biopsy	Metastatic Adenocarcinoma weakly ER positive PR negative		
2/2/01	Bone scan	No abnormalities seen		
22/2/01	Follow-up Dr [D] (consultation)	Severe pain FNA shows poorly differentiated carcinoma consistent with metastases from previous breast cancer Bone scan normal Large mass posterior left chest considered cause for her increasing pain	Arrangement for palliative radiotherapy to chest Recommenced on Tamoxifen Commenced on Morphine MST and morphine elixir	Appropriate treatment recommended and arranged

5/3/01	Commenced palliative radiotherapy	20Gy in 5 fractions to left posterior chest		
5/3/01	Follow-up Dr [D] ([first Public Hospital])	Severe neck pain 1-2 weeks Bone scan normal Nodule right anterior scalp (confirmed on examination) Due to commence palliative radiotherapy to her chest	If pain persists further investigation recommended	
12/3/01	X-ray cervical spine	No abnormality reported		
16/3/01	Admitted to [the first Public Hospital] ([locum medical officer])	Not coping at home Neck and chest pain Problems with nausea Constipated Abdomen not distended	Dr [D] Contacted Recommenced on Morphine oral and sc infusion	
17/3/01	Nursing notes	Continued problems with neck pain	Increase dose subcutaneous morphine infusion	
18/3/01	Medical Officer Special Scale (Ward Round)	Pain not well controlled	Discussion with [MOSS] Hospice	

			Commenced dexamethasone 4mg daily	
19/3/01	Full Blood Count ([first Public Hospital])	Hb 105 (L) WBC 10.4 (H) SN 9.8 (H) Neutrophils show Toxic changes		
27/3/01	X-rays cervical spine ([first Public Hospital])	Loss cortex anterior margin C2 suspicious for metastasis	Comparison with previous cervical spine x-ray suggested rapid progression	
28/3/01	Full blood Count ([first Public Hospital])	Moderate anaemia Neutrophil leucocytosis Neutrophil toxic changes Hb 114 WBC 21.2 (H) SN 19.9 (H) Neutrophils show Toxic changes		Left Shifted White Count consistent with stressed marrow: 1. Infection 2. Steroids 3. Malignant Infiltration of bone marrow
28/3/01	Referral from [the first Public Hospital]	Severe neck pain request for transfer to [the second Public Hospital] for further	Transfer to [the second Public Hospital]	

		investigation 24 hours prior noted to have low grade fever 37.5 but afebrile at time of transfer.		
28/3/01	Admission [the second Public Hospital] Registrar Assessment Dr [E]	Severe neck pain Constipation Examination: Afebrile Distended tympanic abdomen Tenderness deep palpation Bowel sounds present PR declined by patient Assessment: Need for improved pain relief Constipation	MRI requested Commenced on subcutaneous morphine infusion pump Orthopaedic referral Coloxyl and senna for constipation	Actions were appropriate in the context of the clinical history and examination findings

28/3/01	Temperature Chart	28/3 (2045hrs) – T 36 30/3(1800hrs) – T 37.5 31/3 (1600hrs) – 37 1/4 (1015) – 39 2/4 (0800) – 40.3		First noted to be Febrile 30/3 (1800)
29/3/01	Nursing note	Needed assistance to toilet Appears confused at times		
29/3/01	MRI Scan	Mass surrounding C2 vertebral body consistent with metastasis Possible nerve root compression		
30/3/01	Liver Function Tests Electrolytes	ALP 132 (H) Albumin 25 (L) Corrected Calcium 2.71		
30/3/01	MSU	Low grade pyuria		
30/3/01	Full Blood Count	Hb 91 (L) WBC 19.6 (H)		Consistent with reactive process: In context of her clinical problems this may be caused by inflammation, infection, steroids, and malignant infiltration of

		Segmented neutrophils 18.03 (H) Neutrophils show shift to immaturity		marrow.
30/3/01	Ward Round Dr [E]	Neck Pain Significant Problem Afebrile	Commenced on Mexilitine for pain	
30/3/01	Ward Round	Pain continued problem Afebrile	Commenced on mexilitine for pain	
30/3/01	Nursing note	2 episodes diarrhoea Patient disoriented		
30/3/01	Nursing note	More comfortable Still confused		
30/3/01	Full Blood Count	Moderate Anaemia Neutrophil leucocytosis with shift to immaturity		
31/3/01	Nursing note (2215)	T 37.5 Pain well controlled		

		Episode “Gripey” stomach pain		
1/4/01	Chest X-ray X-ray left Shoulder	CXR: No change Left Shoulder: No abnormality		
1/4/01	Blood Culture	No growth		
1/4/01	Full blood count	Hb 95 WBC 22 (H) SN 21.56 (H) Neutrophils show Toxic changes		Consistent with reactive process but most likely bacterial sepsis
1/4/01	MSU	Low grade pyuria Mixed Bacterial Growth predominant organism Proteus Mirabilis		
1/4/01	On call house Surgeon Assessment	Patient noted to be febrile T 38.9 Pain controlled Some abdominal pain Chest clear Abdomen “firm” active bowel	Full blood count Blood cultures Stool specimens CXR and abdominal X Ray	

		sounds Assess: ? cause of fever Constipation		
1/4/01	On call house Surgeon Assessment	CXR – new opacity left mid zone – ? infection Abdominal X-ray – Faeces descending colon	Commenced on Augmentin Enema	
1/4/01	Full Blood Count	Moderate anaemia Hb 95 g/l Neutrophil Leucocytosis WBC 22.0 Neutrophil toxic changes		
2/4/01	On call house officer assessment	Patient dyspnoeic with tachycardia but afebrile	Discussed with on call registrar	
2/4/01	Assessment by on call registrar	Patient unwell with increased respiratory rate, tachycardia and hypotensive. Possibility of pulmonary embolus suspected.	On call oncologist notified. Commenced on IV fluids and given one dose of heparin (anticoagulant)	Documented clinical features were those of deteriorating respiratory problem in setting of advanced metastatic cancer. Clinical impression from the hospital record is that the staff considered she was

				deteriorating from her advanced cancer (and related complications) and was dying from terminal cancer. Medical decision was moving to providing symptomatic care for deterioration attributed to complications from advanced cancer. I can find no record of discussion with the family and whether they understood that the medical view was to provide symptomatic cares about her deteriorating condition. However the family were notified of Mrs [A's] deterioration and the family were contacted and in attendance.
2/4/01	Nursing note	Deterioration of patient's condition noted Unconscious and not responding to physical or verbal stimuli Family contacted and in attendance		
2/4/01	Seen by registrar	Certified death	Discussion with family	

			Autopsy requested	

General Surgery Advice from Dr Kenneth Menzies

The following expert advice was obtained from Dr Kenneth Menzies, general surgeon:

> "This complaint to the Health & Disability Commissioner was from [Ms A] regarding the care to her Mother, Mrs [A], during her terminal illness. Mrs A died on 2 April 2001. The letter of complaint from [Ms A] was sent to the Health & Disability Commissioner on 5 September 2001. The complaint involves three doctors – Dr [E], Dr [D], [Dr C], and also [the second Public Hospital] and [the first Public Hospital]. I have been asked to provide medical/professional expert advice in relation to the complaint concerning the care provided by Dr [C]. In this report I will not comment on matters relating to the other two doctors or to the two health institutions.
>
> This report is based on the following supporting information:
>
> - The letter of complaint from [Ms A] to the Health & Disability Commissioner, dated 5 September 2001.
> - The letter from [the Commissioner] to Dr [C], dated 22 March 2002.
> - The letter from Dr [C] to [the Commissioner], dated 3 April 2002.
> - The letter from Dr [D] (Radiation Oncologist) to [the Commissioner], dictated on 29 March 2002.
> - The report from […] Chief Executive Officer of [the second Public Hospital] to [the Commissioner], dated 13 May 2002.
> - Copies of the clinical notes of the Oncology Clinical Practice Group.
> - Report from [the first Public Hospital] to [the Commissioner], dated 17 April 2002.
> - Letter from Dr [E] to [the Commissioner], which is undated, but which was received at the Office of the Health & Disability Commissioner on 11 April 2002.
> - Other incidental correspondence.
>
> Ms [A's] complaint in regard to Dr [C] is summarised as follows:
>
> *Dr [C], General Surgeon, did not provide services with appropriate care and skill to Mrs [A] between 1999 and 2001. In particular, he did not:*
>
> - *Diagnose Mrs [A] with secondary cancer in her lungs during his consultations with her prior to the cancer being detected in January 2001.*
> - *Communicate appropriately with other health providers caring for Mrs [A].*

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Mrs [A] was referred to Dr [C] by her General Practitioner, Dr [F] on 19 November 1998. Dr [C] had performed a mastectomy for cancer on Mrs [A's] Sister […] earlier in the year 1998. Mrs [A] had decided to have a screening mammogram which showed a lesion in her left breast. Fine needle aspiration cytology of the lesion had confirmed a high-grade carcinoma. It was at this stage that she was seen for the first time by Dr [C]. After taking a history and examining her, he discussed with her the management of the cancer of her left breast. Mrs [A] was keen to have conservative surgery and arrangements were made for operation the following week.

Operation was performed on Mrs [A] in [a private hospital], [in a city], by Mr [C] on 24 November 1998.

The operation involved hook wire localisation and wide excision of the left breast lesion followed by left axillary dissection with frozen section of the margins. Post-operatively Dr [C] referred Mrs [A] to Dr [D] (Radiation Oncologist) for radiotherapy to the left breast.

There is no complaint or controversy with regard to Dr [C's] management of Mrs [A] up to this point. Dr [C] saw Mrs [A] following completion of her radiotherapy on 13 August 1999 and again on three subsequent occasions – 16 December 1999, 23 June 2000, and 15 December 2000.

At the consultation on 13 August 1999, Mrs [A] complained of pain in the left shoulder region and in the lower left rib cage. Dr [C] examined the left breast, the axilla and the chest wall. He noted tenderness over the belly of the latissimus dorsi and pectoralis muscle and he concluded that the left shoulder pain was due to the effects of the radiotherapy which she had recently concluded. He could detect no bony tenderness over the spine, scapula or ribs, though there was a dull ache in the left lower ribs and he concluded that the pain in this region was the result of previous fractures. These conclusions seem quite reasonable. He also mentions that Mrs [A] had a high level of anxiety at that stage resulting from the gradual demise of her Sister with breast cancer.

I believe it was reasonable for Dr [C] to rely on a chest x-ray taken in May 1999. It is very unlikely that any changes would occur during the three months from May until August of 1999.

Dr [C] conducted inspection and careful palpation of Mrs [A's] chest wall. [Ms A] complains that he did not perform auscultation of her chest. This is not a component of the examination which a surgeon would routinely undertake during follow-up of breast cancer patients. As Dr [C] indicates in his letter (3 April 2002) auscultation of the chest would not elicit the presence of lung secondaries. The only significant finding which could be detected on auscultation would be the presence of a large pleural effusion. If a patient presented with shortness of breath, then it would indeed be appropriate to undertake auscultation of the chest. However, Mrs [A] did not

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

complain of shortness of breath at any of her consultations with Dr [C] and there was no evidence of pleural effusion noted by the pathologist in his post-mortem report.

When Dr [C] saw Mrs [A] on 14 December 1999, he notes that 'she remains reasonably well although still suffering from the pains'. She had been seen in the interval between 13 August and 14 December 1999 by Dr [D] on at least two occasions.

She had had a bone scan and an ultrasound scan of the abdomen performed on 11 October 1999 and both investigations were clear for metastatic disease. Dr [D] states that when he saw her on 3 December 1999 her symptoms were improving though she continued to have rib pain. One would have anticipated if there were secondary deposits in the ribs that this would have become evident on her bone scan. The assumption that her rib pain was due to her old injuries therefore seems quite reasonable.

When Dr [C] saw Mrs [A] on 23 June 2000, he noted that 'her only complaint is that she does get musculoskeletal type pains in the left chest and back intermittently. It is not typical bony pain.' He could not detect any abnormality on physical examination of her breasts or her chest wall or on palpation of the liver at that stage. Dr [C] concluded that as the pain was intermittent it was unlikely to be due to secondaries. His decision not to investigate further at that stage was, in my opinion, reasonable.

I have been asked to comment on the following:

Should Dr [C] have reviewed Mrs [A's] condition more regularly? If so, at what point?

I wish to quote from 'Guidelines for the Surgical Management of Breast Cancer'. This was published in September 1997 by the Section of Breast Surgery in New Zealand of the Royal Australasian College of Surgeons. Paragraph 5.3 entitled 'Follow-up' states:

> *'General Principle*
>
> *After treatment for breast cancer, there should be a follow-up programme developed for each woman which takes into account the nature of her disease and treatment and her individual needs'.*

Guideline 3 states:

> *'Follow-up visits should be planned for each woman and should include a clinical assessment and mammography.*
>
> *There is no general agreement about the required frequency or duration of follow-up visits and only limited data to support any particular regimen'.*

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Women who have both surgery and radiotherapy for breast cancer are usually followed up by both their surgeon and the radiation oncologist. Follow-up by the general practitioner is also usually part of the follow-up programme. This is in fact what occurred post-operatively in the case of Mrs [A]. Mrs [A] was seen at six monthly intervals by Dr [C] and this seems appropriate.

I was asked to comment on the following:

'Should Dr [C] have given more consideration to or detected Mrs [A's] secondary lung cancer? If so, at what point?'

Secondary lung cancer is often quite silent, in other words it does not tend to cause any symptoms. The presence of secondary lung cancer cannot be determined by physical examination. It can usually be diagnosed by a chest x-ray, though in some cases a CT of the chest is required to diagnose the presence of lung secondaries. Mrs [A] had a chest x-ray performed in January of 2001. This showed two large masses in her left lung. A CT scan done shortly afterwards confirmed the presence of the two large secondaries and it also showed numerous other small lung metastases.

With the value of hindsight it is likely that if Mrs [A] had had a chest x-ray and/or a CT of the chest performed in the Year 2000, her metastatic disease may have been diagnosed earlier. One cannot conclude that the chest pains that she complained of during the Year 2000 were in fact due to the lung secondaries. As I have mentioned, lung secondaries are usually silent.

If I could quote further from the guidelines for the surgical management of breast cancer. Guideline No. 5 on Page 53 states:

> *'Routine investigations other than mammography are rarely helpful and should only be used to evaluate symptoms.*
>
> *There is no evidence of an improved outcome resulting from routine use of investigations and only mammography is indicated on a regular basis.*
>
> *Routine investigations such as bone and liver scanning, chest x-rays and blood tests do not lead to improved outcomes'.*

It is always easy to be wise in hindsight. It may have been useful for Dr [C] to have ordered a chest x-ray when he saw Mrs [A] either on 23 June 2000 or on 18 December 2000.

However, the fact that he did not, I would not regard as being negligent. The clinical course of Mrs [A's] disease indicates that she had an aggressive breast cancer. Even though her axillary lymph nodes were negative it is evident in retrospect that metastases had already occurred prior to the operation which was performed on 24 November 1998. At the post-mortem, which was performed following her death on 2 April 2001, there was evidence of metastatic disease in both the left and right kidneys, the left and right adrenal glands, the spleen and mediastinum, as well as the left and

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

right lungs. It is unlikely that Mrs [A's] survival would have been improved by earlier detection of her lung secondaries.

The letter sent to Dr [C] by the Health & Disability Commissioner on 22 March 2002 states that Dr [C] did not communicate appropriately with other health providers caring for Mrs [A]. There is no evidence to support this contention. Dr [C] referred Mrs [A] to Dr [D] shortly after the operation in November 1998. He provided Dr [D] with a copy of the operation report and the pathology report and following each of the follow-up visits by Mrs [A], Dr [C] wrote to the patient's GP with a copy to Dr [D]. In my opinion, he did communicate appropriately with other health providers caring for Mrs [A].

CONCLUSION:

Unfortunately, Mrs [A] had a very aggressive breast cancer. Even though the breast tumour was only discovered by screening mammography and even though the pathology at the time of her operation seemed favourable, in retrospect it is evident that malignant cells from the breast cancer had already metastasised widely prior to the diagnosis being made. Metastatic disease may be quite silent and not clinically apparent. Irrespective of the treatment which she had her ultimate outlook and survival was predetermined by the biological behaviour of her cancer.

In my opinion, Dr [C], General Surgeon, provided services with reasonable care and skill to Mrs [A]."

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Radiology Advice from Dr Trevor FitzJohn

The following expert advice was obtained from Dr Trevor FitzJohn, radiologist:

> "Thank you for asking me to comment on the enclosed reports of 27 March 2001 and 12 March 2001 regarding Mrs [A]. I have no personal or professional conflicts with either of the radiologists mentioned in the reports. I therefore can offer you some advice, specifically:
>
> > '*I would be grateful if you could consider these and advise the Commissioner whether the report of 27 March 2001 raises an issue about the accuracy of the report of 12 March 2001.*'
>
> The two reports are from the same radiological practice […] of which [the radiologist who reported the X-ray of 12 March 2001] is the senior partner, and presumably [the radiologist who reported the X-ray of 27 March 2001] is a locum or associate.
>
> The initial report [of 12 March] appears well presented and succinct. It is divided into clinical symptoms, which are those details alerted to the radiologist by the referring clinician, and a report which states that there is no abnormality present.
>
> The second report by [of 27 March] is a little fuller in detail; perhaps more clinical details were supplied to him or this is his style. Some of us are verbose, others succinct, both acceptable. He notes in the clinical details that the plain films from two weeks ago were normal. I suspect that here he is referring to the information supplied to him. However, he does also go on to say, in discussion regarding the cortex of the anterior margin of C2, that the cortical line was faintly visible on the previous film, suggesting that he has also reviewed the films as well as the previous report. He does <u>not</u> go on to say that this is an abnormality but suggests that what was perceived by the previous radiologist and himself to be within the normal range has now progressed to be outside the normal range in the interval of two weeks, and therefore further evaluation with CT is recommended.
>
> Therefore, I do not think the second report has contradicted the first report. There is always a normal range of appearances of radiographs as in any other branch of medicine or life in general and I think, although succinct, [the] first report, suggesting the appearances are normal, is just as valid as [the second] more full report, suggesting on review of the previous films (even with the hindsight of the second set of films) the cortex was present previously but relatively thin. Again we can deduce from the way this was written that he considers to be within the normal range although one extreme of it. The main thrust of the second report is that there has been change between the first and second set of films. Change is very important in radiological interpretation.
>
> Of course, as discussed on the telephone, I do not have the previous films available for review. If you wish to know whether the appearances were in my opinion within

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

normal range on the first set of films, please do not hesitate to supply those films to me."

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.