Waitemata District Health Board

Dr B, Gynaecologist

Dr C, Gynaecologist

A Report by the

Health and Disability Commissioner

(Case 03HDC15479)

Parties involved

Mrs A	Consumer
Mr A	Complainant/Consumer's husband
Dr B	Provider/Gynaecologist
Dr C	Provider/Gynaecologist
Dr D	Provider/Clinical Director of Surgery
Dr E	Provider/ED House Officer
Dr F	Provider/General Practitioner
Dr G	Provider/Gynaecology Registrar
Dr H	Gynaecology Consultant
Dr I	General Practitioner
Dr J	Head of the Colposcopy Service
Waitemata District Health Board	Provider

Complaint

On 16 October 2003 the Commissioner received a complaint from Mr A about the care his wife received at North Shore Hospital. The following issues were identified for investigation:

- *The appropriateness of Mrs A's diagnosis and treatment during her emergency admission to North Shore Hospital on 22 April 2002.*

- *The appropriateness of treatment and follow-up at outpatient clinics between April and November 2002.*

An investigation was commenced on 8 March 2004.

The investigation was extended on 30 June 2004 to include the following:

- *The appropriateness of Dr C's diagnosis and treatment of Mrs A in June 2002.*

- *The appropriateness of Dr B's diagnosis and treatment during Mrs A's emergency admission to North Shore Hospital on 28 November 2002, and subsequent care in December 2002.*

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Information reviewed

Information was obtained from the following sources:

- Mrs A
- Mr A
- Waitemata District Health Board
- Dr D
- Dr C
- Dr B
- Dr F.

Independent expert advice was obtained from Dr Sue Hayde, gynaecologist.

Information gathered during investigation

Overview

This complaint concerns the care Mrs A, a Maori woman aged 42 years, received at North Shore Hospital between April 2002 and January 2003. It centres on the delay in diagnosing Mrs A's invasive squamous cell carcinoma of the cervix and referring her to appropriate secondary services for treatment.

Chronology

Background
The results of any cervical smears Mrs A had prior to 2002 have not been located during this investigation, and the records of her first presentation at North Shore Hospital in April 2002 are unclear as to when her last smear had been taken. Her general practitioner, Dr F, has no record of a smear being taken between 1995 and 2001; he was aware of her reluctance to have smears and had noted on her file that she had "refused" them.

April 2002
On 22 April 2002, Mrs A attended North Shore Hospital with severe pain in her right side. She was assessed in the Emergency Department by a house officer, Dr E, at 4.00pm. During the assessment Dr E noted that Mrs A had a polyp on her cervix. Dr E referred Mrs A to Dr D's surgical team, querying whether she had appendicitis, or her symptoms had a gynaecological cause.

It is not clear why Mrs A did not receive a gynaecology assessment before she was routed for surgery. She was assessed by a surgical registrar. He ordered Mrs A's admission, pain relief and antibiotics, and arranged for her to proceed to theatre for acute appendicectomy. Mrs A had a CT scan which revealed free fluid in the pelvis, and a mass in the right

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adnexa. She was transferred to theatre for an open appendicectomy, performed by a surgical registrar. During the operation it was noted that the appendix was normal, but there was an abscess on the right fallopian tube with infected material in the peritoneum. The surgical registrar consulted Dr H, a gynaecology consultant, who diagnosed Mrs A with pelvic inflammatory disease and right salpingitis (inflammation of the right fallopian tube caused by bacterial infection spreading from the vagina or uterus or carried in the blood). An appendectomy and a pelvic lavage were undertaken. Mrs A's care was transferred to the gynaecology team for follow-up management of her pelvic inflammatory disease. Dr H recorded in Mrs A's clinical notes that her last cervical smear had been in 1988.

Mrs A said that a member of staff spoke to her and said her condition was most likely caused by unsafe or unfaithful sex, which, after 21 years of marriage to her husband, Mrs A found upsetting. Another staff member apologised for these comments. Mrs A made an uneventful recovery and was discharged from North Shore Hospital on 27 April 2002. She had appointments for a repeat pelvic scan and a postoperative check at the gynaecological clinic. The records state that Mrs A's general practitioner at the time was Dr I, and copies of Mrs A's operation note appear to have been sent to Dr I. However, Mrs A has informed me that she never consulted Dr I, and requested her notes to be forwarded to Dr F at a medical centre. No other discharge correspondence has been provided.

June 2002
Mrs A saw Dr C, consultant gynaecologist, on 6 June 2002 at the gynaecology outpatient clinic for her follow-up appointment. Dr C reviewed the discharge summary, the operation notes and all the laboratory results of the investigations during her April admission. The appendix histology results reported "acute inflammation confined to the surface of the appendix". Dr C stated that "[Mrs A] had recovered from the operation and was well. She no longer had any pains." He explained the operation to Mrs A and discussed salpingitis.

The cervical polyp that had been noted by Dr E on 22 April was not investigated or discussed with Mrs A. Dr C stated: "I did not see the note referring to her cervix. It is only on going through her hospital notes in detail following her complaint that I have found in those notes mentioned by a surgical house officer of a polyp on the cervix. As I say, I did not know of this at the time and as such there were no indications for further investigation."

Mrs A's clinical notes should have been available for Dr C, including Dr H's note that Mrs A had not had a cervical smear since 1988. Yet Dr C did not take a cervical smear as he did not feel it was an appropriate time to do one, because "she was recovering from an acute pelvic infection and [was] without symptoms; I did not feel that a smear was warranted at that visit." Dr C did not arrange any further appointments, but advised Mrs A that as pelvic infections may recur she should return to her general practitioner for immediate treatment if she had any more pains.

Dr F did not receive any information about this consultation. Dr C states that he is certain that a reporting letter would have been dictated. The DHB accepts that it is "very possible"

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that Dr C (who is very conscientious about writing to general practitioners and referring patients) dictated a letter that was not transcribed or sent. In any event, it appears that no letter was typed or sent in this case. In 2002 the system used at North Shore Hospital did not record if a letter had been dictated but not typed. The system used now does record this information.

On 13 June Mrs A had a repeat pelvic ultrasound scan, which was reported as normal.

September 2002

Mrs A's pain returned and was ongoing in her lower back. She attended the outpatient clinic at North Shore Hospital on 12 September 2002 for a scan of her lumbar spine and AP (anterior posterior) pelvis. The report stated there were trivial degenerative osteophytes (projection of bone that occurs at sites of cartilage degeneration or destructions near joints and intervertebral discs) in her spine, but otherwise no abnormality was detected.

November 2002

Mrs A returned to Dr F on 28 November 2002 with severe pain in her right side and lower back, and complained of heavy and irregular periods. Dr F referred her back to North Shore Hospital. She was admitted the same day under Dr B's team by a trainee intern, (under the supervision of a house officer), who observed that the cervix looked ulcerated, and ordered further tests. There is reference in the records to discussion with a registrar. Dr B stated that he "did not see [Mrs A] on the ward that day after her admission as she was either at an ultrasound or out of the ward, smoking".

The trainee intern recorded "Cervical smear —? last one in April 2002 — previously 5 years ago — N [Normal]". However, the next day, a registrar (not named in the records) noted that Mrs A's last smear was five years ago and was "abnormal". No cervical smear was taken.

Mrs A was reviewed by a registrar, Dr G, during a ward round on 29 November. Dr G discussed Mrs A's condition with Dr C, but did not conduct an internal examination. An ultrasound on 29 November identified a possible cervical mass.

Dr G requested an urgent referral to the colposcopy clinic for the next week, although this does not appear to have been followed up by a telephone call. Her notes record "Need to exclude cx cancer. Chase smear from 5 yrs ago — tried Medlab/Cx Screening Register with no result. √ → refer colp clinic (urgent) — D/W [Dr C]." Dr G's referral stated "last smear 5 yrs ago — abnormal according to px but no result from cervical screening register or Medlab. Case d/w [Dr C] → needs colp for next week."

Mrs A was discharged on 1 December 2002. No smear was taken during this admission. No information has been provided about the advice given to Mrs A about her condition at this time.

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December 2002
Mrs A complained that Dr B, the gynaecologist to whom the referral for colposcopy was made, told her there was no urgency for her to be seen and she received an appointment for 23 December. Dr B denied that he said this, and explained that he has no control over the triaging of patients to his clinics, which is done by the Clinical Director of Gynaecology. Waitemata DHB has provided a note on the file which indicates that the referral was received by the Colposcopy Clinic Booking Officer on 6 December 2002. The clerk asked Dr B what to do with the referral and he indicated that an appointment should be allocated as soon as possible. The first available date was 23 December 2002.

Mrs A attended the colposcopy clinic on 23 December as scheduled and saw Dr B. He took a smear and representative biopsies. He was unable to perform an accurate colposcopy because of the condition of Mrs A's cervix. The notes for the consultation record:

> "23/12/02 Nursing — Colposcopy S/B [Dr B]
> Smear 1 slide
> Biopsies x 3 2 O'C
> 6 O'C
> 11O'C
> Tolerated well to return 4–6/52 [four to six weeks] for results."

Dr B said:

> "I examined her and noted a tumour replacing her entire cervix. There was bleeding to the touch. Her cervix was clinically malignant. It was impossible to perform an accurate colposcopy at this time. I took a smear and representative biopsies. As it was the Christmas period and the clinic and hospital facilities were closed for the holiday period I [al]luded to that fact."

Mrs A said Dr B told her that "things are not looking good", but that as the labs were closing down for Christmas the results would not be available until "well into the New Year". Dr B stated, "I was extremely concerned about the appearance of her cervix. I felt they needed to be alerted but I could not say definitely until the histological proof was obtained." Mrs A was given an appointment at the next available clinic after the holiday, which was on 20 January 2003.

January 2003
The histology results were available on 3 January. The Waitemata DHB stated: "usually the laboratory would telephone a consultant if a biopsy showed cancer. As Dr B was on leave this was not possible. In Dr B's absence, the colposcopy nurse checked all the hard copy results for his patients and showed the abnormal ones to Dr I, the head of the colposcopy service." It is not clear whether Dr I saw Mrs A's results before her first colposcopy clinic for the New Year, on 8 January. Dr I noted that Mrs A had an appointment to see Dr B on 20 January and felt it was more appropriate for Dr B to give

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her the results at that appointment, which was not too far away. A further scan of Mrs A's pelvis taken on 13 January was reported on 14 January for the attention of Dr C.

Mrs A returned to the colposcopy clinic on 20 January 2003 to receive her test results. She said that Dr B advised her that she had cervical cancer, but that "this would not kill her". The news came as a shock to Mrs A and her family. Mrs A was referred to a city hospital on 21 January 2003.

February 2003
On 5 February Mrs A's condition was reviewed by the gynaecological tumour panel at the city hospital. She had an invasive squamous cell carcinoma of the cervix. The plan was to see her and perform an examination under anaesthetic and provide radical radiotherapy.

Mrs A attended an appointment with a doctor at the city hospital on 20 February 2003. She informed me that the doctor did not have any of her records from North Shore Hospital at this appointment, and she had to give him her history since April 2002. The DHB stated that there is no record of the city hospital requesting Mrs A's notes at that time.

Mrs A continued to have ongoing treatment from the city hospital.

Current situation
In October 2005, Mr A informed me that Mrs A's cancer is still in remission. However, she has a number of ongoing symptoms due to the radiation treatment she underwent for the cancer, including severe back pain for which she is on pain relief medication. Mrs A is due to undergo a colostomy, as well as further tests to investigate severe pain in the left side of her abdomen and hip. She is unlikely to be able to return to work.

Independent advice to Commissioner

Initial advice
The following expert advice was obtained from Dr Sue Hayde, gynaecologist:

> "Ref: 03/15479/WS
>
> I have been asked to provide an opinion to the Commissioner on Case Number 03/15479/WS and have read and agree to follow the Commissioner's Guidelines for Independent Advisors.
>
> My qualifications are M.B. Ch.B., FRANZCOG, FRCOG and I am a practising Gynaecologist with experience in General Gynaecology and Colposcopy both in the public and private sector. I am a Member of the Australian Society for Colposcopy and Cervical Pathology and the New Zealand Society for Colposcopy and Cervical Pathology.

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My referral instructions from the Commissioner are:

To advise the Commissioner whether, in [my] professional opinion, the standard of care [Mrs A] received from [Dr B], [Dr C] and Waitemata District Health Board was of an appropriate standard. In particular:

- Was the care [Mrs A] received at North Shore Hospital in April 2002 appropriate?
- Should [Mrs A] have had a smear taken at North Shore Hospital during her April admission?
- Should [Dr C] have performed a smear at the 6 June 2002 follow-up consultation?
- Should any other follow-up or investigations have been planned other than referral back to [Mrs A's] GP?
- Was the care provided by North Shore Hospital in November 2002 appropriate?
- What information should [Mrs A] have been given during her admission in November 2002?
- Was [Mrs A's] urgent referral to the colposcopy clinic at her November admission followed up appropriately, given that she was not seen until 23 December when she was urgently referred to the colposcopy clinic in November?
- Was the care provided by [Dr B] at the 23 December 2002 appointment appropriate?
- What information should [Dr B] have given [Mrs A] at this consultation?
- If, in answering any questions, you believe that [Dr B], [Dr C] and/or other Waitemata District Health Board Staff did not provide an appropriate standard of care, please indicate the severity of his/their departure from that standard. To assist you in this last point we note that some experts approach this question by considering whether the provider's peers would view the conduct with mild, moderate, or severe disapproval.
- Are there any aspects of the care provided by [Dr B], [Dr C] and/or other Waitemata District Health Board Staff that you consider warrant additional comment?

My sources of information are:

- Letter from [Mr A] to the Commissioner dated 13 October 2003, with enclosures, marked 'A' (numbered 1–10).
- Transcript of interview with [Mrs A] on 8 January 2004, marked 'B' (numbered 11–20).
- Clinical notes received from Waitemata District Health Board on 10 May 2004, marked 'C' (numbered 21–176).
- Investigation letter to [Dr B] dated 29 June 2004, marked 'D' (numbered 177–180).
- Investigation letter to [Dr D] dated 30 June 2004, marked 'E' (numbered 181–184).
- Investigation letter to [Dr C] dated 30 June 2004, marked 'F' (numbered 183–185).

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- Investigation letter to Waitemata District Health Board dated 30 June 2004, marked ‘G’ (numbered 186–187).
- Letter to the Commissioner from ACC received on 2 July 2004, marked ‘H’ (numbered 188).
- Letter date 9 July from [Dr F] to the Commissioner, marked ‘I’ (numbered 189–207).
- Letter from Waitemata District Health Board received on 22 July 2004, marked ‘J’ (numbered 208).
- Letter from [Dr D] to the Commissioner received on 27 July 2004, marked ‘K’ (numbered 209).
- Letter from [Dr B] to the Commissioner received on 3 August 2004, marked ‘L’ (numbered 210–214).
- Letter from Dr C to the Commissioner received on 13 October 2004, marked ‘M’ (numbered 215–226).
- Letter from Waitemata District Health Board to the Commissioner received on 21 October 2004, marked ‘N’ (numbered 227–229).

The background summary is as follows:

[Mrs A] was a 42 year old who attended North Shore Hospital on 22 April with severe pain in her right side. She was assessed, investigations done, and a provisional diagnosis of appendicitis made.

An emergency laparotomy was performed by the surgical team and found a normal appendix, but an infection in her right fallopian tube was discovered. The appendix was removed and a pelvic lavage done.

[Mrs A] was commenced on antibiotics and pain relief. One of the clinicians said that her infection was due to unsafe sex. [Mrs A] was discharged 5 days later and was given appointments for a repeat pelvic scan, and for review at the gynaecological clinic for a postoperative check.

[Mrs A] saw [Dr C], gynaecologist, on 6 June 2002 at the gynaecology clinic. Her tests were reviewed. No smear was taken. She was referred to her GP if she had any further pain.

On 13 June [Mrs A] had a repeat pelvic scan which was normal.

In the following months [Mrs A] experienced ongoing lower back pain and attended outpatient clinics at North Shore Hospital for three scans. There are no records of her presenting to North Shore Hospital until 28 November 2002.

[Mrs A] returned to her GP on 28 November 2002 with severe pain in right side and lower back, and heavy and irregular periods. Her GP referred her back to North Shore Hospital. She was admitted for further tests. An ultrasound on 29 November identified a possible cervical mass.

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[Mrs A] said the doctor requested an urgent biopsy, but the specialist (possibly [Dr C]) said there was no urgency and an appointment was made for 23 December. ([Dr B] said he did not see [Mrs A] until 23 December 2002 after referral from gynaecology registrar [Dr G]). [Mrs A] was discharged on 1 December 2002. No smear was taken during this admission.

[Mrs A] attended the colposcopy clinic on 23 December and saw [Dr B]. He took a smear and representative biopsies. [Dr B] told [Mrs A] that 'things are not looking good', but that as the labs were closing down for Christmas, results would not be available until well into the New Year, and that [Mrs A] would receive an appointment when the results were available. This was set for 20 January. At this appointment [Mrs A] was advised that she had cervical cancer, but that this would not kill her.

An ultrasound of [Mrs A's] pelvis was reported on 13 January 2003.

[Mrs A] was referred to [a city hospital] on 20 January 2003.

On 5 February [Mrs A's] condition was reviewed by the gynaecological tumour panel. She had an invasive squamous cell carcinoma of the cervix. The plan was to see her and perform an examination under anaesthetic and radical radiotherapy.

[Mrs A] attended an appointment with [a doctor at the city hospital] on 20 February 2003. [The doctor] did not have any of [Mrs A's] records from North Shore Hospital at this appointment, and she had to give him her history from April 2002. She has continued to have ongoing treatment from [the city hospital].

Expert Advice:

With respect to the specific questions. In my professional opinion the standard of care [Mrs A] received from Waitemata District Health Board was not of an appropriate standard. In particular the delays experienced in her being adequately assessed by appropriate clinicians were disappointing and failed to meet recognised guidelines.

The 'Recommendations for Cervical Screening 1997' state that 'the cervical smear will be part of the investigation of women with signs and/or symptoms of cervical cancer. It is not sufficiently sensitive however, for a negative result to override clinical concerns. Such women should be referred for gynaecological assessment irrespective of the smear result'. A smear should have been taken on [Mrs A's] admission in November 2002 despite the fact that she was bleeding. [Mrs A] should also have been seen within one week of her admission. 'The urgency of colposcopic examination depends on the degree of abnormality indicated by the smear <u>or by clinical examination.</u> For women in whom there is a clinical suspicion of invasive carcinoma, an immediate colposcopy/gynaecological oncology appointment should be sought. For women in whom the smear is suspicious of invasive disease, the opinion of an experienced colposcopist should be sought. These two groups of women should be seen within one week'. (Guidelines for the Management of Women with Abnormal Cervical Smears).

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With respect to the other specific questions:

1. Was the care [Mrs A] received at North Shore Hospital in April 2002 appropriate?
[Mrs A] was admitted under the General Surgeons in April 2002. She was initially examined by a Junior Doctor ([Dr E]) who did question the finding of a possible polyp on the cervix. Swabs were taken but not a smear and this clinical finding was not followed up by more senior colleagues once the diagnosis of pelvic infection was made. The care by the Surgical Team was appropriate and the transfer of care to the Gynaecology Service was appropriate.

2. Should [Mrs A] have had a smear taken at North Shore Hospital during her April admission?
The Junior Doctor examining [Mrs A] would not have [been] expected to take a smear given the presenting history. The appropriate equipment was probably not immediately available. It would not have been appropriate for a smear to have been taken immediately following surgery because of the discomfort that this could have involved immediately postoperatively.

3. Should [Dr C] have performed a smear at the 6 June 2002 follow-up consultation?
The notes related to this consultation are brief. They do report that [Mrs A] had no symptoms and the consultation relates to the original principal diagnosis of pelvic inflammatory disease. [Dr C] did not appear to be aware of the possible abnormality on the cervix although this was recorded in the notes. In retrospect an examination at this stage would have been appropriate and may have resulted in [Mrs A] receiving appropriate care earlier. The notes simply state that [Mrs A] was well and had no pain. Her diagnosis was discussed and she was advised to seek early help if she developed further symptoms. It would not be routine for an examination and smear to be carried out unless there was a further indication.

[Dr C] however does not dictate a letter to the General Practitioner discharging [Mrs A] and advising as to any appropriate follow-up. Her care at this visit would therefore not be considered optimal.

4. Should any other follow-up or investigations have been planned other than referral back to [Mrs A's] GP?
The care given to [Mrs A] was related to her presentation with infection. The limited notes indicate the problem was resolved and in this respect further investigation was not indicated.

5. Was the care provided by North Shore Hospital in November 2002 appropriate?
The Admitting 'Doctor' according to the Nursing Notes is a Trainee Intern. The notes outlining the examination indicate that an appropriate examination has been carried out although a smear is not taken because of the bleeding. The description of the cervix

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however is very suggestive of invasive cancer with the examination note commenting on infiltration extending to the anterior vaginal wall. The findings are reported to the Registrar who the next day reviews her history and notes from the previous admission and the scan results and concludes that cervical cancer needs to be excluded. This is discussed with [Dr C] and the decision is made for an urgent referral to the Colposcopy Clinic. [Mrs A] is given appropriate treatment for her apparent recurrence of pelvic infection. There is no record in the notes provided however of [Mrs A] having her cervix examined by the Registrar or by the Consultant Gynaecologist. The decision to have her seen however within a week at the Colposcopy Clinic as documented is appropriate.

6. What information should [Mrs A] have been given during her admission in November 2002?

[Mrs A] was not apparently told that there was a concern regarding cancer of the cervix at this time. If given this information then she would have been able to raise concerns at the delay in being seen at the Colposcopy Clinic. [Mrs A] tells us that she was told that the delay was because there was no urgency.

7. Was [Mrs A's] urgent referral to the Colposcopy Clinic at her November admission followed up appropriately, given that she was not seen until 23 December?

As previously stated the delay in [Mrs A] being seen at the Colposcopy Clinic in view of the very clear concern that she had invasive cancer of the cervix is inappropriate. She should have been seen within a week of the referral request.

8. Was the care provided by [Dr B] at the 23 December 2002 appointment appropriate?

On the 23 December 2002 [Dr B] carried out an appropriate history, examination and biopsy. The notes state that he considered the cervix to be 'clinically malignant'.

9. What information should [Dr B] have given [Mrs A] at this consultation?

It would be appropriate at that point for [Dr B] to advise [Mrs A] that the biopsies would almost certainly confirm cancer of the cervix. Delaying this information and appropriate referral until 'the next available clinic after the holiday' which resulted in a further delay of a month was totally unsatisfactory. The histology report was in fact available on the 3rd January and the delays in the Colposcopy Clinic appointments added to [Mrs A's] distress and delayed her appropriate referral to the Oncology Services.

[Mrs A's] cervical cancer would almost certainly have been diagnosed at an earlier stage if she had been examined clinically by a Gynaecologist in April 2002. Because her presentation was of appendicitis/pelvic inflammatory disease the treatment given was appropriate although inappropriate communication of information from staff at that time also distressed Mrs A and impacted on her reluctance to return to [North Shore Hospital]. In this respect their standard of care was deficient, but may be related to communication problems with overseas trained Doctors. The delays in further

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investigation and referral of [Mrs A] in November and December of 2002 were inappropriate and were a moderate departure from the expected standard of care. This reflects recent statistics which indicate delays in providing care for Maori women.

Further Comments.

The letter from [Dr …], Waitemata District Health Board to [the] Health and Disability Commissioner dated 16.03.2004 (pages 22 and 23) gives inaccurate admission dates. The letter states that all clinical records are provided and included in these records are results relating to another patient (page 158) and also the scan dated 13.01.2003 which also related to another patient. In the letter from [Dr …] to [the investigator] dated 14.08.2004 (page 227) [Dr …] does not explain why there is a delay in the urgent colonoscopy and she continues to refer to the procedure as a colonoscopy and not colposcopy. It is also noted that Gynaecologists do not have formal Ward rounds which raises concern as to the protocols for communication between junior and senior staff and supervision and responsibility for junior staff at Waitemata District Health Board.

I have referred to the booklet produced by the National Cervical Screening Programme (New Zealand 1999 Cervical Screening Guidelines for the Management of Women with Abnormal Cervical Smears)."

Further advice

The following further expert advice was received from Dr Hayde on 22 July 2005:

"With respect to your further inquires: [Dr B] raises the issue of informing patients of the possibility of having cancer prior to histological confirmation of the disease. I would agree that it is preferable to have histological confirmation of cancer. However this was a clinically apparent malignancy.

[Dr B] states in his letter to the General Practitioner dated 23.12.02 'the cervical anatomy was replaced by friable tumour which bled on contact'. In his report to the Health and Disability Commissioner he states 'I examined her and noted a tumour replacing her entire cervix. There was bleeding to the touch. Her cervix was clinically malignant. I took a smear and representative biopsies. As it was the Christmas period and the Clinic and Hospital facilities were closed for the holiday period I [al]luded to that fact.'

Regarding the follow-up arrangements, [Dr B] was shown the original referral to the Colposcopy Clinic, [Mrs A] having been admitted on 28th November and the request being made on 29th November. The original referral indicated that a tumour needed to be excluded. The request was for an appointment in a week's time. [Dr B] labelled the request 'ASAP New Booking'. When he saw [Mrs A] at the Clinic on 23rd December (over three weeks after her admission date) he was clinically aware that this was a malignant tumour. The diagnosis was unlikely to be any other pathology. At that time he puts in a request for a second appointment at the Clinic to discuss her results in 'mid

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January'. By the time that [Mrs A] was seen in the Clinic to confirm her diagnosis she has had a delay of nearly two months not 2–3 weeks.

I agree with [Dr B's] comment that the lack of a smear history is more significant in terms of being able to intervene in the progress of her disease, however the delay in her being given her diagnosis and referred for appropriate treatment is still unsatisfactory.

[The DHB CEO] does provide additional information regarding the Gynaecology Ward Rounds and Procedures at the Hospital. With regard to his comments under Heading 5, the smear test is used as a screening test however it can also be diagnostic. The results when bleeding is present can be unreliable and the smear should be interpreted in light of this. It should not take 'quite sometime' for smear results to become available and these results should be available within a week. You will note that [Dr B] did take a smear at the Colposcopy Clinic as well as biopsies and these results were certainly available by the 3rd January for the biopsy results and the 8th January for the smear result. This is despite it being a Christmas/New Year break. [The DHB CEO] does point out that the logical and appropriate thing to do was to arrange for an urgent colposcopy and certainly the referral was completed but the delay in the Clinic appointment was not consistent with the original request."

Responses to provisional opinion

Dr C

In response to my provisional opinion, Dr C provided the following further information:

"**Breach of the Code for suboptimal postoperative review on 6 June 2002**

I saw [Mrs A] for a post operative review following an appendectomy. All issues of the operation and the histology were discussed in detail. She was totally asymptomatic. I went through the discharge summary, the operator notes and all of the laboratory results. I did not see the note referring to her cervix. It is only on going through her hospital notes in detail following her complaint that I have found in those notes mentioned by a surgical house officer of a polyp of the cervix. As I say, I did not know of this at the time and as such there were no indications for further investigation.

You will appreciate that it is difficult, if not impossible under usual conditions, to go through every line in every patient's notes during follow up visits. Nor is it indicated in may cases, in particular if patients present well and are asymptomatic. One is guided by a patient's symptoms, the discharge summary and investigation findings. Your expert advisor Dr Hayde in her report also mentioned that 'it would not be routine for an examination and smear to be carried out unless there was a further indication.' I concur and hence find it hard to accept your conclusion that I have breached the Code in this regard. In my view there is no objective medical evidence to support that breach

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finding. There was no such indication of the need for a smear in this case. I do not agree that in light of the information I have available that a smear was appropriate/indicated. The benefit of hindsight is very apparent in this matter.

Breach of the Code for not informing [Mrs A's] GP of the follow-up visit

Contrary to Dr Hayde's statement and your finding, it is my practice that after seeing every patient at my clinic a detailed letter is dictated to that patient's general practitioner. That letter will outline the patient's condition, and give advice as to future care. To a large degree this letter reflects or takes the place of my clinical records. I am aware this practice is followed by a significant number of my colleagues. I usually review the typed letters a week later and after reading through them, put my signature to it.

In addition to this reporting letter I also make a brief note in the patient's chart. This is the 'brief note' that Dr Hayde refers to. As stated, it is brief because the more detailed information is contained in the reporting letter. I make both of these records diligently and also dictate letters to practitioners of patients who do not attend their appointments.

In light of my well established practice as outlined, I find it difficult to accept a letter was not dictated in this case, and to the contrary I am certain that one would have been.

As a consequence of [Mrs A's] complaint and the fact that the reporting letter is missing, I have carried out a detailed assessment of the dictation process at North Shore Hospital. On the day in question when I saw [Mrs A], I reviewed 12 patients. It appears that of all of these patients it is only [Mrs A] for whom there is no letter. On the same day in a neighbouring room, a colposcopy clinic was run by another specialist. I have gone through those patients' notes, and it is apparent that letters that had been dictated are also missing. I have gone a step further and looked at all notes of patients seen at different clinics during the week in question, and again, a number of letters have not been found. I believe that all of these letters would have been dictated, but for some reason or other have not been typed and/or have not made their way onto the files. This is of course concerning for myself and the other consultants who are conducting these clinics. I have notified North Shore Hospital about this and I believe they are looking into the situation. I make this point to highlight the position that I am certain a letter was dictated as is my usual practice. In those circumstances, I do not consider the breach finding to be reasonable."

Dr B

In response to my provisional opinion, Dr B submitted:

"Thank you for the opportunity to respond to your provisional opinion in this case. I do not accept it is reasonable to find myself to be in breach of Right 4(4) of the Code and nor do I accept this is reasonable with respect to Right 6(1)(a).

In particular I disagree with Dr Hayde's opinion on the standards [s]he recommends for informing patients of the possibility of having cancer prior to histological confirmation

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of the disease. I have, myself, been in practice for many years now and this does not reflect how I, and I believe most of my colleagues, practise in this regard. Of course I respect Dr Hayde for having a different approach to these matters but I do not believe h[er] approach is the preferable one to follow.

There are significant downside risks to following a practice as recommended by Dr Hayde where [s]he considers I ought to have advised this (and other similar patients) that the biopsies '*would almost certainly confirm cancer of the cervix*'. If this proved not to be the case then the distress and upset caused to patients in the meantime is unacceptable and entirely avoidable.

I do not accept that I breached the provisions of Rule 6(1)(a) of the Code.

The results were in fact signed off by [Dr I] in my absence in January 2003 (see photocopy marked 1). I also requested an urgent follow-up appointment (see photocopy marked 2). I requested a double booking for her. The fact that she only got the appointment on the 20 January was not in any way my doing.

I believe I made adequate arrangements for her follow-up. The results were not sitting in my '*in tray*' but were signed off. I did arrange for appropriate follow-ups and do not accept that I breached Rule 4(4) of the Code.

I did not see [Mrs A] on the ward the day after her admission as she was either at an ultrasound or out of the ward, smoking.

As to her delay in being seen at Colposcopy Clinic, I wrote very clearly on a piece of paper (see photocopy marked 3) that she needed an appointment ASAP and underlined it. I do not triage patients.

As far as delaying her referral to oncology services, I do not believe it is appropriate to expect referral until the clinician has histological confirmation of the disease. As far as the natural history of the disease is concerned, one, two or three weeks' delay is not significant.

Finally, I note that [Mrs A] was told five years prior to being seen as [North Shore Hospital], to have a follow-up smear. For reasons that only she can explain, she chose not to do so. That could have changed her disease for her, not the short 2–3 weeks.

Conclusion

In conclusion, whilst I acknowledge that Dr Hayde has expressed an opinion that is contrary to what I have said (and I note also contrary to the practice followed by my colleagues) I do not consider h[er] approach to this case, with the advantages of hindsight, is a reasonable one. It certainly does not reflect current practice and I consider it unreasonable to find that I have been in breach of the Code as a consequence."

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Waitemata District Health Board
In response to my provisional opinion the Chief Executive made the following submission on behalf of Waitemata District Health Board:

> **"June 2002 Outpatient Consultation**
>
> 1. [Mrs A] was seen in [Dr C's] outpatient clinic in June 2002 because [Dr H] does not hold a gynaecology outpatient clinic at [North Shore Hospital]. In-patients admitted under [Dr H] are seen as outpatients by [Dr C] in a general 'gynaecology follow-up' clinic. This process has been in place for a long period of time and has worked well. [Dr C] and [Dr H] work collegially and [Dr C] is fully aware that he is assessing patients previously under the care of [Dr H].
>
> 2. [Dr C] is widely recognised within the gynaecology department as a thorough practitioner who generally dictates comprehensive letters for patients attending his outpatient clinics. It is not clear why there is no clinic letter for [Mrs A] in this case. Unfortunately the systems that were in place in 2002 cannot tell us whether a letter was dictated but not typed. I believe it is very possible that [Dr C] dictated a letter but that for some reason this was not transcribed and sent. I say this because it would be inconsistent with [Dr C's] usual practice for him not to do so. The current transcription system can confirm whether a letter was dictated as well as whether it was typed.
>
> **November 2002 Admission**
>
> 3. During this admission [Mrs A] was admitted under [Dr B] because Thursday, the day of her admission, was [Dr B's] 'on call' day. All new patients are admitted under the on-call doctor. The following day [Dr C] was on call. [Dr C] and [Dr G] did the ward rounds on Friday. [Dr G], a senior and competent registrar, spoke to [Dr C] (the on-call doctor that day) about her concerns about [Mrs A's] cervix. [Dr G] attempted to get [Mrs A] seen urgently at the colposcopy clinic for further investigations by a recognised colposcopist. Given the involvement of both [Dr G] and [Dr C] with the clinical decisions during [Mrs A's] November 2002 admission, I do not agree that her care was left to junior staff.
>
> 4. There is a clear practice in the gynaecology service that the 'on-call' consultant of the day deals with any problems as yet unresolved for patients admitted acutely the previous day. This is because many consultants are no longer in the hospital the day after they have been on-call. Therefore they are not available to perform surgery, review scan results and undertake other follow up activities the next day. It is far more effective and safer to have problems dealt with by the on-site on-call consultant than to have the responsibility for care allocated to the 'admitting consultant' when that consultant is not on-site on subsequent days. This is why [Dr C], and not [Dr B], was consulted regarding [Mrs A's] care.
>
> 5. There has been criticism of the failure to take a smear during this admission. My understanding is that this would not have been warranted or useful for the following reasons.

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a. A smear test is only a screening test.
b. When bleeding is present, the results can be unreliable.
c. It can take quite some time for smear results to become available.
d. In [Mrs A's] situation the logical and appropriate thing to do was to arrange for an urgent colposcopy, and a referral to this effect was completed.

6. The information previously provided to you by […] indicated that there were no consultant ward rounds carried out within the gynaecology service. Unfortunately that advice was not correct. The system operates (in 2002 and now) as set out below.

7. A house officer or senior house officer and 2nd on-call registrar are allocated to perform the Gynaecology Service ward round and to liaise with the relevant consultant if there are any problems. Usually the on-call consultant will physically go to the gynaecology ward to identify which patients need consultant review. This process is intended to provide the most appropriate coverage for all patients within the gynaecology and obstetric services within the staff constraints that exist. In addition, at handover at 8am each day, all acute gynaecology patients requiring on-going management are discussed with the consultant of the day and the registrar on-call. The consultant and registrar then go to the delivery suite and the maternity suite to deal with any problems there, and then to the emergency care department if there are any gynaecology patients there requiring consultant review before going to the gynaecology ward. This process can take a considerable amount of time if the obstetric service is busy which is why the house officer or senior house officer and the second on-call registrar are allocated to assist with the gynaecology service ward round.

8. Waitemata DHB has continued to look at improvements to the management of patients, including those under the care of the gynaecology medical team. In February 2004, a twenty four hour roster for house officers was implemented to ensure greater continuity of care for patients under the care of the gynaecology medical team.

9. Waitemata DHB accepts that the probable diagnosis of cervical cancer should have been discussed with [Mrs A] during her stay in North Shore Hospital between 28 November and 1 December 2002. Waitemata DHB will remind staff that the better course is to foreshadow a probable diagnosis (even one as serious as cancer) while advising the patient the preliminary diagnosis is subject to tests confirming the diagnosis.

Colposcopy Referral

10. There is a small note attached to the colposcopy referral form on the original clinical file. This does not seem to be replicated on our photocopy of the clinical notes and we are not sure whether this note was included in the copy of the clinical file that was sent to your office. This note seems to document a communication between [Dr B] and the clinic booking officer. A copy of this note is attached. The colposcopy referral seems to have been received by the Colposcopy Clinic Booking Officer on 6 December 2002. The clerk asked [Dr B] what should be done with the referral and he indicated

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that an appointment should be allocated 'ASAP'. It seems the clerk then allocated the next available clinic appointment for [Mrs A]. This was on 23 December 200[2]. Given the pressures on the colposcopy service during this period of time it would not have been unexpected for there to be a several week delay before even an urgent appointment could be allocated. Waitemata DHB is aware that the Guidelines indicate that best practice is that patients with suspected invasive cervical cancer be seen by an experienced colposcopist within a week. However, the pressure on the colposcopy service was such that, unfortunately, even the most urgent cases could not always be seen in that short timeframe. Waitemata DHB continues to work on improving access times. New clinics have been established recently and current clinics have gaps available for urgent referrals.

Results and Follow-Up Appointment

11. It seems that the laboratory results from the colposcopy on 23 December 2002 were printed by the laboratory on 3 January 2003. [Dr B] was on leave during January. Usually the laboratory would telephone a consultant if a biopsy showed cancer. As [Dr B] was on leave this was not possible. In [Dr B's] absence the colposcopy nurse checked all the hard copy results for his patients and showed the abnormal ones to [Dr I], the head of the colposcopy service. [Dr I's] first clinic for the New Year was on 8 January 2003, but it is not clear exactly when [s]he saw the result for [Mrs A]. This may have been later than the 8th given the post Christmas/New Year backlog of results. [Dr I] noted that the patient had an appointment already booked for 21 January, [Dr B's] first clinic of the New Year and it seems that given [Dr B's] previous contact with [Mrs A] it was felt more appropriate for him to meet with her and discuss the outcome, given that the appointment already booked was not far away.

12. Both [Mr A] and Dr Hayde make mention of the WDHB clinical records not being available for [the doctor] at the appointment at [the city hospital] on 21 February 2003. The clinical records were 'tracked out' by the clinical records department at North Shore Hospital to the Gynaecology service at [the city hospital] on 3 February 20[03]. They were tracked back (i.e. returned) to North Shore Hospital Clinical records department on 7 February 2003, presumably after the Gynaecology Tumour Panel met on 5 February 2003. The records were tracked out to the [city hospital] Oncology Department on 1 March 2003. It is the usual responsibility of the service requiring the records to request them (i.e. Waitemata DHB does not unilaterally anticipate who may need the records and send them). If a request was received from [the city hospital] but the notes were not made available then we apologise for this, but it is not clear from our records whether any request was received prior to the 20 February appointment. In addition we note that [Dr B] advised you in his letter of 19 July 2004 that by letter dated 21 January 2003 he referred [Mrs A] to [the city hospital] and that he sent the referral letter and relevant results by fax to that Hospital. Waitemata DHB has no knowledge as to why the referral letter and results would not have been available to [the doctor at the city hospital] on 20 February 2003.

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13. There is also a reference made by Dr Hayde to the scan results in the records being for another person and information about another patient being included in the documents provided to her. In a letter dated 20 February to [Dr B], [the doctor at the city hospital] also mentions a scan for 13 January 2003 showing results for another individual. All requests, images and reports on our system have been rechecked and all are correctly labelled with [Mrs A's] name and are clearly her results. If there was incorrect documentation provided to you, or information about the wrong patients, we have not been able to identify this from the information we hold on file or on our electronic systems. However, I do apologise if incorrectly labelled results or information about the wrong person were provided to you.

14. I am also sorry for the inadvertent reference to 'colonoscopy' rather that 'colposcopy' in the material provided by [Dr …].

15. It appears that the discharge summary for the April 2002 admission was sent to [Dr I] of [a medical centre]. [Dr I] is noted as [Mrs A's] GP on the in-patient information sheet in the clinical file and her practice is close to [Mrs A's] home address. It is difficult to see why [Dr I] would have been recorded as the relevant GP in the absence of an indication from someone that this was the case, and the admission form is ticked to indicate the form was completed by [Mrs A] (copy attached).

16. I cannot really respond to the comments that seem to have been made to [Mrs A] during her initial admission about sexual practices. There is no mention of these events in the clinical record and it is unlikely that we would be successful in identifying the staff member concerned or confirming the contents of any discussion that took place with [Mrs A] about these matters after this length of time. I can only apologise to [Mrs A] for any hurt she experienced and advise that comments of this nature would not be accepted or expected at Waitemata DHB.

17. WDHB believes that the systems currently in place for supervision of trainee interns, house officers and registrars are consistent with other major health providers. It is recognised within the health sector that a significant degree of day-to-day medical care is provided by skilled junior staff and it is not possible or practicable for consultants to be directly involved in the care of all patients. Consultant supervision of acute patients is provided by the on-call consultant.

Further Response

18. The timing of [Mrs A's] diagnosis and treatment for cervical cancer appears to have been delayed because of an unfortunate combination of events. At the first admission the medical staff believed they had appropriately diagnosed and treated an identifiable clinical condition — pelvic inflammatory disease. The reasonableness of the actions at this point seem supported by your independent advisor and her comments about [Dr C] appear to relate mainly to the lack of a letter to the GP following the clinic appointment (which letter I suspect was dictated but not sent). Although the advisor notes that *in retrospect* an examination at this stage would have been appropriate, she also states that

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it would not be routine for an examination and smear to be carried out without further indication.

19. At the second admission there was concern about the condition of [Mrs A's] cervix and an urgent referral was made for follow up investigations with the colposcopy service. There were some delays and scheduling difficulties compounded by staff absences over the Christmas Holiday period over this time. This meant that following [Mrs A's] discharge on 1 December 2002 there was a delay of approximately 3 ½ weeks before the colposcopy was undertaken and a further delay of approximately 4 weeks before she was informed of the results.

20. Following this 7 week period there was a further gap, outside the control of WDHB, of about a month before she was seen at [the city hospital] ([the city hospital's] tumour panel having assessed her condition in the interim period). The significance of this 7 week delay by Waitemata DHB in the context of the overall management and treatment of [Mrs A's] condition is not clear. Your advisor notes that the events during November/December constituted a 'moderate' departure from the expected standards.

21. Without wishing to detract from the tragic outcome for [Mrs A], the direct liability findings against Waitemata DHB do not seem to take full account of the following factors:

a. The steps that WDHB takes to ensure adequate consultant oversight and input within the staff and resource constraints present.

b. The relatively moderate departure from expected standards (although admittedly in the context of a serious outcome for the individual concerned).

c. The practical difficulties in abiding by 'guidelines' which may express the desirable timeframes and treatment options but which cannot always be easily applied in practice or when there are significant competing demands on available resources. Additional difficulties can arise when clinics are closed over holiday periods.

d. The clinical decisions made by individual staff at various points in the process in light of the information available to them at the relevant times. Although it is easy to be critical of decisions taken when looking at events retrospectively, it is much more difficult to identify these issues in 'real time' and to recognise the significance of events, or their cumulative impact, as they unfold.

22. I would like to state very clearly that despite the above, Waitemata DHB recognises the tragic consequences of this condition for [Mrs A] and her family. I apologise for any deficiencies in the care she received and am very sorry that the likely diagnosis was not communicated to her until her appointment in January 2003.

23. In addition, I am concerned that the DHB was not more proactive in addressing these issues directly with [Mrs A] and her family once we became aware of their

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concerns, via the complaint received from your office on March 2004. I have not met with [Mrs A] and her family members but would welcome the opportunity to talk further with them if they are agreeable … I would be grateful if you could extend an invitation to [Mrs A] and her husband to contact me if they do wish to meet. I would be happy for someone from your office to attend if [Mr and Mrs A] so wished.

24. Finally, I realise that your task may have been made more difficult by the fact that all relevant information was not made available to you earlier. I apologise for any inconvenience this has caused and will endeavour to see that the exchange of information with your office is handled more efficiently in the future."

Further information
In response to a request for clarification of some points, Waitemata District Health Board responded:

"• In the November 2002 admission, [Dr B] would have had primary responsibility for [Mrs A]. Saying that however, the registrar would have been expected to brief the consultant on any issues requiring senior oversight and to ensure that matters were followed up. This is because the consultants work part-time and the registrars work full-time.

- There is no policy as such for handover from the on-call consultant to the admitting consultant, but I am advised that there is an agreed process. This is one of the processes that are being followed up by the new Clinical Director for Gynaecology and the new manager.

- There are 5 consultants that provide an 'on-call' service.

I advise that the Gynaecology Service has recently been taken over by a new management team and a number of system and process issues are under review."

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.

(2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

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…

(4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.

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; and
c) Advice of the estimated time within which the services will be provided; ….

Relevant Standards

The 'Recommendations for Cervical Screening 1997' (Ministry of Health Working Party, *NZMJ* 1998; 111: 94–8) state:

> "The cervical smear will be part of the investigation of women with signs and/or symptoms of cervical cancer. It is not sufficiently sensitive however, for a negative result to override clinical concerns. Such women should be referred for gynaecological assessment irrespective of the smear result."

The National Cervical Screening Programme (NZ) 'Guidelines for the Management of Women with Abnormal Cervical Smears' (1999) state:

> "The urgency of colposcopic examination depends on the degree of abnormality indicated by the smear or by clinical examination. For women in whom there is a clinical suspicion of invasive carcinoma, an immediate colposcopy/gynaecological oncology appointment should be sought. For women in whom the smear is suspicious of invasive disease, the opinion of an experienced colposcopist should be sought. These two groups of women should be seen within one week."

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Opinion: Breach — Dr C

June 2002 consultation
During Mrs A's admission in April 2002 she was transferred to the care of gynaecologist Dr H. On discharge she was given a follow-up appointment at the gynaecology outpatient clinic. Mrs A was reviewed by Dr C at the clinic on 6 June 2002. Dr C reviews Dr H's patients at a general gynaecology outpatients clinic, because Dr H does not hold such clinics at North Shore Hospital.

Although Dr C reviewed Mrs A's histology test results from her April 2002 appendectomy, no gynaecological examination or cervical smear was undertaken. My advisor, Dr Hayde, noted that it would not be routine for these to be done at such a consultation, in the absence of further indications to do so, such as the patient's complaint of ongoing pain or being overdue for a smear.

Dr C reviewed Mrs A in relation to her April surgery and management of her pelvic inflammatory disease, but does not appear to have looked any further. He was satisfied that Mrs A did not report any ongoing symptoms and seems not to have seen the need for an examination. Had Dr C read Mrs A's ED notes thoroughly, he would have noted the polyp identified by Dr E. Dr C should certainly have seen Dr H's note that Mrs A was well overdue for a cervical smear. Dr C submits that it is difficult to read every line in every patient's records, and that he relied on Mrs A's operation note, histology results and discharge record, none of which mentioned the cervical polyp. I find this rather unconvincing. The possible need for a cervical smear is a basic issue that any competent gynaecologist should discuss with a woman referred for a review, even without a prompt from the notes. It is also unconvincing to suggest that a smear would have been inappropriate because of Mrs A's surgery more than six weeks previously.

Had Dr C conducted an examination or performed a smear, Mrs A may have received appropriate care much earlier than she ultimately did.

Dr C did not meet the standard of care expected of a responsible gynaecologist, and breached Right 4(1) of the Code.

Follow-up
Dr C advised Mrs A that pelvic infections may recur and, if she experienced any further pain, she should promptly consult her general practitioner. However, Mrs A's general practitioner, Dr F, did not receive a letter from Dr C advising of the outcome of the visit, or recommending any further follow-up.

Dr C is certain that he would have dictated a letter to Mrs A's general practitioner, as it is his practice to do so, but it does not appear to have been typed or sent in this case. The DHB CEO accepted that it is "very possible" that Dr C dictated a letter that was not typed or sent. I accept that it is probable he did so.

In the event, Dr C's brief clinical notes are the only record of the consultation, and are insufficient to show exactly what was discussed, and what advice was given to Mrs A. Dr

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C states that his reporting letter would have contained more detailed information. Yet if he does not write detailed clinical notes, and does not check that his dictated letters have been typed, there is clearly a gap in the system he relies on.

Dr C has discovered that other letters from clinics in June 2002 also appear to be missing, which is of concern. Information received from the DHB indicates that the system in place in 2002 could not record whether a letter was dictated but not typed. The current transcription system can confirm if a letter was dictated, in addition to whether it was typed.

Appropriate follow-up care and review are essential following hospital admissions and outpatient clinics. It is critical that general practitioners receive all the necessary information about their patients, so that they can appropriately follow up matters identified at hospital. The reviewing doctor is responsible for ensuring that this information is communicated. I accept that Dr C was let down by the Waitemata DHB system, but he must accept some personal responsibility for his failure to ensure that his letter was typed and sent.

Opinion: Breach — Dr B

November 2002 admission

On 28 November 2002 Dr B was the on-call gynaecologist. Mrs A was admitted under his care. However, Dr B did not personally see Mrs A on the day she was admitted, or afterwards, as she was not in the ward at the time Dr B saw his patients. However, Mrs A was seen by other members of Dr B's team — a trainee intern and a house officer, who examined her on admission, and a senior registrar, Dr G. Dr G reviewed Mrs A on a ward round on 29 November and read her notes, including the examination findings and ultrasound. Dr G also discussed Mrs A's condition with on-call consultant Dr C on 29 November.

I was originally advised that gynaecology consultants at North Shore Hospital do not conduct formal ward rounds, but have since been informed that the practice is that a house officer, or a senior house officer, and a second on-call registrar conduct gynaecology ward rounds. Any problems are then discussed with the relevant consultant. The DHB informed me that "[t]here is a clear practice in the gynaecology service that the 'on call' consultant of the day deals with any problems as yet unresolved for patients admitted acutely the previous day". This explains why Dr G consulted Dr C, rather than Dr B, on 29 November. Dr C appears to have been the only consultant actually involved in Mrs A's ongoing care during this admission. However, Waitemata DHB also advised that the admitting consultant, Dr B, was responsible for the overall care — although Dr B obviously did not think he was.

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A cervical smear was not taken during Mrs A's November admission. I note the DHB's response regarding the reasons for not taking a cervical smear during this admission. However, a cervical smear should have been taken at this time, even if Mrs A was bleeding — the results could have been interpreted in light of this.

It is also of concern that Mrs A was not told that she might have cancer of the cervix during this admission. I note that the DHB has acknowledged that Mrs A should have been advised of the probable diagnosis of cancer during this admission and will "remind staff that the better course is to foreshadow a probable diagnosis (even one as serious as cancer) while advising the patient the preliminary diagnosis is subject to tests confirming the diagnosis".

Waitemata DHB also stated that the admitting consultant is responsible for the overall care that a patient receives. However, I do not believe it is appropriate to hold Dr B responsible for Mrs A's care in November when he did not even see her, and when Dr C was the doctor consulted about her care the day following admission.

December 2002 colposcopy clinic
Mrs A saw Dr B for the first time at North Shore Hospital colposcopy clinic on 23 December 2002, as a result of the referral made in November. He examined her and noted a tumour replacing her entire cervix, which was bleeding to the touch. Dr B was unable to perform an accurate colposcopy because of the condition of Mrs A's cervix. Dr B recorded that her cervix was "clinically malignant", and took a smear and representative biopsies. He did not tell Mrs A that she might have cancer, only that "it did not look good", and that she would have to wait until the New Year for the results. The record for this consultation was written by the nurse, and does not state what information was provided to Mrs A about her condition.

My expert, Dr Hayde, advised that Dr B performed "an appropriate history, examination and biopsy" at this consultation. Dr Hayde also stated:

> "It would be appropriate at that point for [Dr B] to advise [Mrs A] that the biopsies would almost certainly confirm cancer of the cervix. Delaying this information and appropriate referral until 'the next available clinic after the holiday' which resulted in a further delay of a month was totally unsatisfactory. The histology report was in fact available on the 3rd January and the delays in the Colposcopy Clinic appointments added to [Mrs A's] distress and delayed her appropriate referral to the Oncology Services."

Dr B submitted that patients should not be informed of the possibility of cancer prior to histological confirmation. He advised that this is not how he and many of his colleagues practice owing to the risk of distress and upset caused if it proves not to be cancer.

Dr Hayde responded that although it is preferable to receive histological confirmation of cancer, in this case it was a clinically apparent malignancy, which Dr B described in some

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detail as covering the whole of Mrs A's cervix. Dr Hayde noted that "the diagnosis was unlikely to be any other pathology".

Mrs A did not receive her test results until 20 January 2003. This is unacceptable. Waitemata DHB explained that usually the laboratory would telephone the consultant if a biopsy result showed cancer. However, Dr B was on leave during January and, in his absence, the colposcopy nurse checked all the results. Abnormal results were shown to Dr I, head of the colposcopy service. Dr I held a clinic on 8 January 2003, but it is unclear whether Dr I had seen Mrs A's results by then. It appears that because Mrs A had an appointment booked with Dr B for 20 January, the communication of her results was left until then.

Under Right 6(1)(a) of the Code, patients are entitled to an explanation of their condition. In the case of a probable diagnosis of cancer, this information should be shared with the patient in a frank and sensitive manner. It is not acceptable to withhold such information out of a misguided (and paternalistic) fear of alarming the patient. (See also my opinion in case 03HDC08493, dated 31 August 2004, on www.hdc.org.nz.) Mrs A should have been told of the probable diagnosis of cervical cancer, and the need for urgent treatment (if the biopsy results confirmed the cancer) should have been explained to her.

Mrs A was only aware that "things did not look good", and she was left to wait and worry for four weeks. This delay added to Mrs A's distress, and meant that she was not referred to oncology services until 21 January 2003.

Dr Hayde noted that the urgent referral to the colposcopy clinic from the November admission was made to exclude cancer, and on 23 December Dr B was aware that the tumour was clinically malignant. Dr Hayde stated that "[b]y the time that Mrs A was seen in the Clinic to confirm her diagnosis she has had a delay of nearly two months not 2–3 weeks". I agree with my advisor that such a delay is "totally unsatisfactory".

In my opinion Dr B's failure to inform Mrs A of her probable diagnosis of cancer is a breach of Right 6(1) of the Code. In addition, Dr B's failure to arrange prompt follow-up of the cervical smear results is unacceptable. Mrs A needed an urgent colposcopy and/or an early referral to oncology services. No patient in Mrs A's situation should be left to wait for four weeks. Mrs A should have been called back to the hospital in early January. Dr B's failure to arrange appropriate follow-up is, in my opinion, a breach of Right 4(4) of the Code (which gives patients the right to have services provided in a manner that minimises potential harm).

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Opinion: Breach — Waitemata District Health Board

Cervical smear and colposcopy referral

The 'Guidelines for the Management of Women with Abnormal Cervical Smears' (1999) state:

> "The urgency of colposcopic examination depends on the degree of abnormality indicated by the smear or by clinical examination. For women in whom there is a clinical suspicion of invasive carcinoma, an immediate colposcopy/gynaecological oncology appointments should be sought. For women in whom the smear is suspicious of invasive disease, the opinion of an experienced colposcopist should be sought. These two groups of women should be seen within one week."

The 'Recommendations for Cervical Screening 1997' state that "a cervical smear will be part of the investigation of women with signs and/or symptoms of cervical cancer".

These guidelines were not followed by North Shore Hospital when caring for Mrs A. I note Waitemata DHB's comments regarding the lack of resources and other factors which contributed to the delays in Mrs A's care. However, there were repeated missed opportunities to take a cervical smear, and a notable failure to "fast-track" appropriate treatment once the ulcerated cervix was identified in November 2002. These were significant factors that contributed to the delay in Mrs A's diagnosis and treatment.

During Mrs A's April admission Dr E noted a possible polyp on her cervix. Although swabs were taken, no smear was performed. Dr Hayde informed me that "the junior doctor examining Mrs A would not have [been] expected to have taken a smear given the presenting history" and that "it would not have been appropriate for a smear to have been taken immediately following surgery because of the discomfort that this could have involved immediately postoperatively".

However, Dr Hayde also indicated that the clinical finding of the possibility of a polyp on the cervix should have been followed up by more senior colleagues, and Mrs A should have been informed of this finding. Dr Hayde stated that, had Mrs A been examined by a gynaecologist in April 2002, her cervical cancer would "almost certainly have been diagnosed".

A further opportunity to make a diagnosis and initiate treatment was lost in June 2002 when Mrs A was seen by Dr C at her follow-up appointment at the gynaecology outpatient clinic. As previously discussed, Dr C was not aware of the polyp discovered in April, and did not see the need to perform a cervical smear, even though it was long overdue.

Mrs A also did not have an immediate colposcopic examination or smear during her November admission to North Shore Hospital, even though clinical examination by junior staff indicated that cancer needed to be excluded. An urgent referral was made for Mrs A to attend the colposcopy clinic to exclude cervical cancer, but she was not seen for over three weeks. There is no indication that more senior staff such as Dr C or Dr G performed

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a gynaecological examination of Mrs A, and she was not informed about the possible diagnosis, or the need for an urgent referral for a colposcopy and/or to oncology services.

Although it would not have been appropriate for the trainee intern to convey this information, a registrar or consultant should have seen Mrs A, and explained the possible diagnosis and the need for an urgent follow-up. Had she been informed of this, she would have been in a position to question the subsequent delay in being seen by Dr B at the colposcopy clinic. Waitemata DHB has acknowledged that Mrs A should have been informed of the possible diagnosis of cancer during this admission, and intends to remind staff that they should alert patients to a probable diagnosis.

Waitemata DHB has provided information about why a cervical smear would not have been warranted during the November admission. However, the guidelines for cervical screening are unequivocal. In addition, Dr Hayde advised that the smear test is not only a screening test — it can also be diagnostic. She acknowledged that the results of the test can be unreliable where there is bleeding and should be interpreted in light of that. The results should also be available within a week, and should not take "quite sometime". Dr Hayde noted that Dr B took a cervical smear and biopsies on 23 December and the biopsy results were available on 3 January, and the smear results available on 8 January, despite the Christmas and New Year break.

Information has also been received from Waitemata DHB about the urgent referral made in November 2002, which indicates that the referral was received by the booking clerk on 6 December 2002, five days after Mrs A's discharge. It remains unclear why it took so long for an urgent referral to be transferred. A note has been provided to show that the booking clerk then contacted Dr B and asked what to do about the referral, and Dr B has written that an appointment should be allocated as soon as possible. Dr B advised that he had no control over triaging patients for his clinics. Waitemata DHB explained that in late 2002, the colposcopy clinic was under pressure and there were significant delays in allocating even urgent appointments. At that time it was not always possible for patients to be seen within the timeframes in the guidelines.

Dr Hayde advised that "the delays experienced in [Mrs A] being adequately assessed by appropriate clinicians were disappointing and failed to meet recognised guidelines". I share her view that the delays experienced by Mrs A were "totally unsatisfactory".

Ward rounds
Dr Hayde commented:

> "It is also noted that gynaecologists do not have formal ward rounds which raises concerns as to the protocols for communication between junior and senior staff and supervision and responsibility for junior staff at the [the DHB]."

More recent information from Waitemata DHB confirms that ward rounds are undertaken as follows:

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"A house office or senior house officer and 2nd on-call registrar are allocated to perform the Gynaecology Service ward round and to liaise with the relevant consultant if there are any problems. Usually the on-call consultant will physically go to the gynaecology ward to identify which patients need consultant review. This process is intended to provide the most appropriate coverage for all patients within the gynaecology and obstetric services within the staff constraints that exist. In addition, at handover at 8am each day, all acute gynaecology patients requiring on-going management are discussed with the consultant of the day and the registrar on-call. The consultant and registrar then go to the delivery suite and the maternity suite to deal with any problems there, and then to the emergency care department if there are any gynaecology patients there requiring consultant review before going to the gynaecology ward. This process can take a considerable amount of time if the obstetric service is busy which is why the House Officer or Senior House Officer and the second on-call Registrar are allocated to assist with the gynaecology service ward round."

Waitemata DHB has provided information that Dr B would have had primary responsibility for Mrs A's admission in November. However, Dr B never in fact saw Mrs A during that admission, and the registrar consulted the on-call consultant, Dr C, the day following Mrs A's admission. Waitemata DHB also advised that "there is no policy as such for handover from the on-call consultant to the admitting consultant", but there is an agreed process that is being followed up by the new Clinical Director for Gynaecology and the new manager. In February 2004 a new 24-hour roster for house officers was implemented to ensure greater continuity of care for patients in the gynaecology service at North Shore Hospital.

Public hospitals must have reliable systems in place to make the best use of the resources and staff available. Within those systems, clinicians must ensure that clear communication occurs at every point, and that patients in need of urgent treatment are followed up urgently. Written referrals should be followed up by telephone calls when a patient needs to be "fast-tracked".

I am not satisfied that the way the system operated in the gynaecology department at North Shore Hospital was adequate to ensure appropriate quality and continuity of patient care. A succession of missed opportunities resulted in avoidable delays in the diagnosis and treatment for Mrs A. The totality of these failures has, in my opinion, hampered the management of Mrs A's disease. The awareness of and response to cervical cancer on the part of medical staff appears to have been poor. It is unacceptable that a disease that is so well known, well described and for which there are clear established guidelines for diagnosis and treatment has gone undetected and untreated for so long in a public hospital setting in 2002/03. Although the delay from November 2002 may not have altered Mrs A's outcome, earlier detection of her cancer (in April or June 2002) could well have improved her chances. Women in New Zealand are entitled to a far better standard of care and communication from the publicly funded health system. In my opinion, Waitemata District Health Board breached Right 4(1) of the Code.

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Other comment — Waitemata District Health Board

Inappropriate communication — April 2002 admission
My advisor noted:

> "[I]nappropriate communication of information from staff at that time [April 2002] also distressed Mrs A and impacted on her reluctance to return to [North Shore Hospital]. In this respect their standard of care was deficient, but may be related to communication problems with overseas trained Doctors."

Mrs A has received an apology for the comments made to her about unsafe sex. The comments were totally inappropriate and would understandably have reduced her willingness to return to North Shore Hospital, even though her pain and bleeding had continued.

Actions taken

Dr C has provided a letter of apology to Mrs A and her family in which he states:

> "The Health and Disability Commissioner has done a detailed review of your admissions to North Shore Hospital in 2002. I am the doctor that saw you in the Gynaecology clinic 6 weeks after your operation for suspected appendicitis. The opinion is that a cervical smear should have been done at that visit.
>
> I write to offer my sincere apologies for any distress that I may have caused you. I very much regret that an opportunity may have been missed to pick up your cervical cancer at an earlier stage. As you know, it was my view when I saw you on 6 June 2002 that there was no indication for a smear to be taken at that time. Of course with the benefit of hindsight I wish that one had been taken …"

The Chief Executive of the Waitemata District Health Board has apologised "for any deficiencies in the care" Mrs A received, and has stated that he is "very sorry that the likely diagnosis was not communicated to her until the clinic appointment in January 2003".

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Recommendations

I recommend that Dr B take the following actions:

- Review his practice in light of this report.

I recommend that Waitemata District Health Board take the following actions:

- Review the systems currently in place in its gynaecology service and advise the Commissioner by 1 February 2006 of the steps taken as a result of the review.

Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.
- A copy of this report, with details identifying the parties removed (except Waitemata District Health Board and North Shore Hospital), will be sent to the National Cervical Screening Unit, Women's Health Action, the Federation of Women's Health Councils of Aotearoa, and all District Health Boards, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

Following receipt of this report, Waitemata District Health Board undertook a comprehensive review of its gynaecology services and instituted a range of improvements. The review identified a number of issues that will become key performance indicators for the Board's gynaecology services, to be reported on annually.

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