Gynaecologist, Dr B

Oncologist, Dr C

Cancer Clinic

Ascot Central Women's Clinic Limited

District Health Board

A Report by the

Deputy Health and Disability Commissioner

(Case 15HDC01370)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. On 5 August 2014, after a CT scan showed a large ovarian tumour, Ms A had surgery for removal of her ovaries, fallopian tubes, uterus, and omentum. This was carried out by Dr B. On the same day, histology and cytology results were reported by pathologist Dr E. The report described the ovarian tumour as a "papillary serous carcinoma [an aggressive cancer] of mullerian origin with moderate to high grade features". It also stated: "Sections of the deposits on serosa [on the uterus] and nodule on right ovary show high grade tumour similar to tumour in specimen 2 [the left ovary]."

2. Dr E did not report on a stage for the cancer. He told HDC that staging a cancer is carried out by the surgeons and oncologist at the multidisciplinary meetings (MDMs). On 12 August 2014, Ms A's results were discussed at an MDM at a women's clinic (owned and operated by Ascot Central Women's Clinic Limited). Dr B and a medical oncologist, Dr C, were part of the group present at the MDM.

3. Dr E told HDC that the tumour was not staged at the MDM on 12 August, as further tissue still needed to be examined — in particular because there was a suspicious lesion on the uterus. Dr E said that he reviewed the remainder of the histology slides on 13 August 2014. Evidence was found to confirm that there was some tumour on the serosa of the uterus. Accordingly, Dr E asked for an MDM to be convened to review Ms A's case for the purpose of staging the tumour. He sent a copy of his report with his findings to Dr B.

4. On 14 August 2014, prior to any further MDM, Ms A had a follow-up appointment with Dr B, who told her that her cancer had been graded as Stage 1 C 3 high grade serous carcinoma of the ovary and fallopian tube. Dr B told Ms A that she would require a course of six cycles of chemotherapy, and referred her to Dr C at the cancer clinic. Dr B's referral letter summary refers to Stage 1 C 3 high grade serous carcinoma of the ovary or tube. A copy of all of the histology results and the operation note were provided to Dr C.

5. On 29 August 2014, Ms A had her initial consultation at the cancer clinic with Dr C. Ms A said that Dr C recommended three cycles of chemotherapy.

6. Dr C told HDC that a Stage 1 C 3 tumour can be treated with three to six cycles of chemotherapy, and because of her understanding that Ms A's cancer was predominantly low grade in nature, Dr C said that she recommended that they "stop at 3 cycles". Following this appointment, Dr C wrote to Dr B advising him that three cycles of chemotherapy would be recommended.

7. Ms A told HDC that she had misgivings about having only three cycles of chemotherapy. Dr C told HDC that she was unaware that Ms A had such concerns.

8. The second MDM to finalise the tumour staging took place on 9 September 2014. No formal notification was provided to Dr C advising that Ms A, specifically, was to be discussed at the MDM of 9 September 2014.

9. Dr E told HDC that it was at this MDM that Ms A's tumour was staged. Dr B was present at the MDM, but Dr C was not. No oncologist was present at the meeting. Ms A's cancer was classified as being Stage 2 C 3 serous carcinoma.

10. The management plan documented in the MDM report was stated as "Planned treatment unchanged". Dr B noted at the bottom of the MDM report: "Please ensure [the cancer clinic] is informed of current progress."

11. The MDM report was sent to Dr C at the cancer clinic. The report made no reference to the fact that previously Dr B had told Ms A and Dr C that the cancer was Stage 1 C 3 and that there had now been a change in staging. Dr C did not receive any further communication from Dr B about the MDM and its outcome.

12. Dr C told HDC that she recalls receiving the MDM report for review, but she could see that there was an error, as the report had been scanned in with another patient's details attached. Dr C organised for the administrative support team to remove the non-the cancer clinic patient's details, and expected that the report would come back to her in due course. Dr C also told HDC that she thought that the document related to the original MDM. The report was not returned to Dr C owing to an administrative error.

13. Neither Ms A nor her GP were notified at this time that Ms A's carcinoma had been classified as Stage 2 C 3 serous carcinoma. After these events, Dr B told Ms A that he had assumed that Dr C knew, and he therefore assumed that she had told Ms A. Ms A went on to have three cycles of chemotherapy.

14. On 17 February 2015, Ms A had a monitoring consultation with Dr B. Ms A told HDC that at this appointment she discussed with Dr B that she had had only three cycles of chemotherapy. Dr B has no recollection of this conversation. He said after these events that he had assumed that she was having "full chemo" (six cycles).

15. At the 17 February 2015 appointment, Dr B referred Ms A to the district health board's (DHB) Gynaecology Oncology Services for monitoring. Dr B's referral letter to the DHB's Gynaecology Oncology Services mistakenly stated Ms A's staging as Stage 1 C 3 high grade serous carcinoma.

16. On 28 May 2015, Ms A had her first appointment at the DHB's Gynaecology Oncology Services for follow-up. Her appointment was with Dr B in his capacity as a consultant for the DHB's Gynaecology Oncology team.

17. Dr B provided Ms A with a blood test form to check her serum CA125 (cancer marker) levels. The result showed a level of 43 (which is above the normal range). Ms A was not told the result of this test. Dr B said that he did not inform her of the result as he does not normally contact patients about all blood test results, and expected that it would be repeated before her next visit.

18. In August and September 2015, before her next follow-up appointment with Dr B, Ms A went to her GP with discomfort in her right chest, and further tests were taken in view of this. Ms A was found to have incurable cancer.

Findings

19. It was found that by failing to take steps to ensure that Dr C was advised specifically of the change in the staging of the cancer and, having not done so, failing to notice that she continued to refer to the cancer stage as 1 C 3, and then referring to the incorrect stage himself in his referral letter to the DHB, Dr B failed to co-operate with Dr C and the DHB to ensure the quality and continuity of the services provided to Ms A. Accordingly, he was found to have breached Right 4(5) of the Code. In addition, for failing to advise Ms A of the upgraded cancer stage, or to take appropriate steps to make sure that information would be communicated to her by someone else, and by failing to provide Ms A with the result of her tumour marker test in May 2015 and the significance of that, Dr B was found to have breached Right 6(1) of the Code.

20. By failing to communicate effectively with Dr C, as Ms A's treating clinician, including failing to advise her in advance of the 9 September MDM that specifically Ms A was to be discussed again (and the reasons for this) and, in these circumstances, for failing to advise Dr C specifically of key clinical information arising out of that MDM, Ascot Central Women's Clinic Limited was found to have breached Right 4(5) of the Code.

21. Adverse comment was made in relation to Dr C and the cancer clinic.

Recommendations

22. It was recommended that Ascot Central Women's Clinic Limited review its MDM process significantly. The following are to be considered as part of the review:

- Whether the results of relevance from MDMs should be communicated directly to all doctors involved, including the patient's GP, the oncologist, and the surgeon, as a separate confidential document to the clinician, and sent separately from the general MDM report regarding all patients.
- Whether the relevant part of each MDM report should routinely be sent to the patient concerned.
- Where there is a second or subsequent MDM for a patient, whether the original documentation should be retained on the report, with the update, and the reasons for this, documented beneath the original report, so that all information can be understood in a chronological way.

23. In response to my provisional opinion, Ascot Central Women's Clinic Limited provided Ms A with a written letter of apology.

24. It was recommended that the Medical Council of New Zealand consider whether a review of Dr B's competency is required.

25. It was recommended that Dr B provide Ms A with a written letter of apology.

26. It was recommended that the DHB consider reviewing its protocols and procedures in relation to the treatment and follow-up of cancer patients who are transitioning between the private and public sector.

Complaint and investigation

27. The Commissioner received a complaint from Ms A about the services provided to her by Dr B, the women's clinic, Dr C, the cancer clinic, and the DHB. The following issues were identified for investigation:

- *Whether Dr B provided Ms A with an appropriate standard of care between July 2014 and September 2015.*
- *Whether the DHB provided Ms A with an appropriate standard of care between February 2015 and September 2015.*
- *Whether Ascot Central Women's Clinic Limited provided Ms A with an appropriate standard of care between July 2014 and February 2015.*
- *Whether Dr C provided Ms A with an appropriate standard of care between July 2014 and December 2014.*
- *Whether the cancer clinic provided Ms A with an appropriate standard of care between July 2014 and December 2014.*

28. This report is the opinion of Rose Wall, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

29. The parties directly involved in the investigation were:

Ms A	Consumer/complainant
Dr B	Provider/gynaecologist
Dr C	Provider/oncologist
Cancer clinic	Provider
Women's Clinic	Provider
DHB	Provider

Also mentioned in this report:

Dr D	General practitioner

30. Information from pathologist Dr E and a medical centre was also reviewed.

31. Independent expert advice was obtained from an obstetrician and gynaecologist, Dr Kenneth Clark (**Appendix A**), and a medical oncologist, Dr Richard Isaacs (**Appendix B**).

Information gathered during investigation

Background

32. In 2001, Ms A had a bilateral mastectomy due to a strong family history of breast cancer.

33. Around June 2014, Ms A (50 years old at the time) started to notice that her abdomen was bloated and that it was painful when she rolled over in the night. She also had not had any menstrual cycles since March 2014.

34. Ms A's symptoms persisted and, on 18 July 2014, Ms A saw a general practitioner (GP), Dr D[1].

35. Dr D documented the finding of a distended, large and firm abdominal mass. Dr D's impression was that the mass could be a large fibroid.[2] Dr D referred Ms A to a radiology service for an ultrasound of her pelvis. The referral documented that the ultrasound was indicated for a "[l]arge lower abdominal mass", and noted Ms A's strong family history of breast cancer.

36. The ultrasound was performed on 21 July 2014, and the findings noted a mass that appeared to be an ovarian malignancy involving the left ovary. Gynaecology/oncology opinion was recommended and, on the same day, Dr D referred Ms A to a gynaecologist, Dr B, at the women's clinic.

37. On 24 July 2014, Ms A had her first appointment with Dr B. He examined her and arranged for her to have a CT scan[3] the following day, and tests for tumour markers. He noted in his clinic letter to Dr D that it was likely that the mass was malignant, but that it could be a borderline tumour. He also wrote that it was likely that Ms A would require a laparotomy,[4] hysterectomy,[5] BSO (bilateral salpingo oophorectomy[6]), and an omentectomy.[7]

38. On 25 July 2014, the CT scan of Ms A's chest, abdomen, and pelvis was performed by a radiologist. The report noted a large ovarian tumour. In addition, Ms A's blood test result showed an elevated CA125 level of 586U/mL.[8]

39. On 31 July 2014, Ms A returned to see Dr B. He documented in his clinic letter to Dr D that based on the results of the CT scan and the highly elevated CA125 level, there was "a high chance" that Ms A's mass could be malignant, and therefore she required surgery. He wrote that he planned to carry out a laparotomy, hysterectomy, BSO, omentectomy, and debulking.[9]

[1] Ms A was a new patient of Dr D, and this was Ms A's first appointment with Dr D.
[2] The most frequently seen tumors of the female reproductive system.
[3] A CT (computerised tomography) scan combines a series of X-ray images taken from different angles and uses computer processing to create cross-sectional images, or slices, of the bones, blood vessels, and soft tissues inside the body. CT scan images provide more detailed information than plain X-rays.
[4] An operation to open the abdomen.
[5] Surgical removal of all or part of the womb.
[6] Surgical removal of both ovaries and both fallopian tubes.
[7] Surgical removal of the omentum — a thin fold of abdominal tissue that encases the stomach, large intestine, and other abdominal organs.
[8] CA 125 is a protein found in blood that is used as a tumour marker. The normal value is less than 35U/mL. A CA 125 level that is higher than normal may indicate a benign condition, or may indicate ovarian, endometrial, peritoneal, or fallopian tube cancer.
[9] Reduction of as much of the bulk (volume) of a tumour as possible.

40. On 5 August 2014, Ms A had surgery for removal of her ovaries, fallopian tubes, uterus, and omentum. This was carried out by Dr B. In his operation note, Dr B described a "[s]mall area of nodular tumour anterior surface uterus". Samples were sent for histology and cytology assessment.

41. On the same day, the results were reported by pathologist Dr E. The report described the ovarian tumour as "papillary serous carcinoma[10] of mullerian origin with moderate to high grade features". It also stated: "Sections of the deposits on serosa [on the uterus] and nodule on right ovary show high grade tumour similar to tumour in specimen 2 [the left ovary]."

42. Dr E did not report on a stage[11] for the cancer. He told HDC that staging a cancer using the FIGO[12] classification of tumours is carried out by the surgeons and oncologist at a multidisciplinary meetings (MDM).

43. On 12 August 2014, Ms A's results were discussed at an MDM at the women's clinic.[13] Dr B and a medical oncologist, Dr C, were part of the group present at the MDM. Dr E told HDC that he "presented the histology macroscopic pictures" and "highlighted the cystic nature of the ovarian tumour with a focal papillary component". Following this, he presented the histological slides and said that there was a large cystic tumour on the left ovary.

44. Dr E told HDC that "[a] significant component of the tumour show[ed] a low grade component", but some parts showed high grade features.[14] Dr E further said:

> "The fact that most of the tumour was low grade, but with a component of high grade features, was documented by [Dr B] who wrote in the minutes 'Grade 3[15] tumour (much is low grade)'."

45. No FIGO stage was annotated in the summary. Dr E told HDC that the tumour was not staged (i.e., the tumour was not given a FIGO classification) at the first MDM as further

[10] An aggressive cancer, usually of the uterus/endometrium.
[11] A cancer's "stage" refers to the size and/or extent (reach) of the original (primary) tumour and whether or not cancer cells have spread in the body. The stage is assessed using the International Federation of Gynaecology and Obstetrics (FIGO) gynaecological cancer staging system. The defined stage of disease is important in defining the type of therapy offered.
[12] The stages in the FIGO gynaecological cancer staging system are: Stage 0: carcinoma in situ stage 1 — confined to the organ of origin; Stage 2: invasion of surrounding organs or tissue; Stage 3: spread to distant nodes or tissue; Stage 4: the cancer has spread from where it started to at least one other body organ — also known as "secondary" or "metastatic" cancer. The higher the number (0–4), the larger the cancer tumour and the more it has spread into other tissues.
[13] Further information about how the women's clinic's MDMs were organised at the time of these events is included below under "subsequent information".
[14] Whether a tumour is referred to as "high grade" or "low grade" depends on a number of issues; most notably, a low grade tumour has a better outcome than a high grade tumour.
[15] A tumour's "grade" is a description of the tumour based on how abnormal the tumour cells and the tumour tissue look under a microscope. Ovarian tumours are graded as Grade 1 (low grade, cancer cells that resemble normal cells and are not growing rapidly), Grade 2 (intermediate grade, cancer cells that do not look like normal cells and are growing faster than normal cells), and Grade 3 (high grade, cancer cells that look abnormal and may grow or spread more aggressively).

tissue still needed to be examined — in particular because there was a suspicious lesion on the uterus. He stated:

> "[T]umour staging is a multidisciplinary process requiring histological, radiological and clinical findings … [It] is not uncommon for further information to be obtained before staging a tumour … [Ms A's] case was re-presented [at a second MDM on 9 September 2014] … for the purpose of staging the tumour so the additional information that was not available … would have become available."

46. Dr E said that on 13 August 2014 he reviewed the remainder of the histology slides. Evidence was found to confirm that there was some tumour on the serosa of the uterus. Accordingly, he asked for an MDM to be convened to review Ms A's case for the purpose of staging the tumour. Dr E sent a copy of his report with his findings to Dr B.

47. On 14 August 2014, prior to any further MDM, Ms A had a follow-up appointment with Dr B, who told her that her cancer had been graded as Stage 1 C 3[16] high grade serous carcinoma of the ovary and fallopian tube, and that chemotherapy was recommended. Dr B told HDC that he advised Ms A of a stage based on the information available at the time. He said that he told Ms A that she would require a course of six cycles of chemotherapy,[17] and referred her to Dr C at the cancer clinic. Dr B's referral letter summary refers to the resected tumour being Stage 1 C 3 high grade serous carcinoma of the ovary or tube. It also refers to the tumour containing many areas of low grade tumour, but with some areas that were technically high grade and, therefore, postoperative chemotherapy needed to be considered. A copy of all the histology results and the operation note were provided to Dr C.

48. Also on 14 August 2014, Dr B wrote to Dr D advising her of the events to date and stating: "[H]istology confirms a serous carcinoma of the ovary with much of it being low grade but some small high grade areas as well. This is therefore a Stage 1 C 3 with positive cytology."

49. On 29 August 2014, Ms A had her initial consultation with Dr C at the cancer clinic. Dr C told Ms A that she would require chemotherapy (which consisted of carboplatin and paclitaxel[18]). Ms A said that the option of three versus six cycles of chemotherapy was discussed with her, and she expressed her understanding to Dr C that six cycles would be required. Ms A said that Dr C told her that three cycles was recommended.

50. Dr C told HDC that a Stage 1 C 3 tumour can be treated with three to six cycles of chemotherapy, and because of her understanding that Ms A's cancer was predominantly low grade in nature, Dr C said that she recommended that they "stop at 3 cycles".

51. Following this appointment, Dr C wrote to Dr B advising him:

[16] Stage 1C indicated the presence of the cancer in one or both ovaries or fallopian tubes. Grade 3 indicated that laboratory examination had found cancer cells in fluid or washings from the abdomen.
[17] Use of drugs to treat disease.
[18] Both these drugs are commonly used in chemotherapy treatment of different cancers including ovarian and womb cancer.

> "In terms of number of cycles; a minimum of 3 would be recommended. Depending on her tolerance of the chemotherapy we will consider this after 3 cycles (a maximum of six cycles are given, but frequently three in early stage disease)."

52. A copy of this letter was sent to Ms A via email, and to Dr D.

53. Ms A told HDC that she had misgivings about having only three cycles of chemotherapy. Dr C told HDC that she was unaware that Ms A had such concerns. Dr C said: "At the time I felt we had open channels of communication and I do not recall any difficulty with discussing matters during the consultations."

54. In Dr C's letter to Dr B, she describes the diagnosis of Stage 1 C 3 high grade serous carcinoma. She also makes note of the disease being predominantly low grade but with some high grade tumour present. Her summary also included Dr B's description of the deposit on the uterine serosa[19] and the nodule on the right ovary.

55. The second MDM to finalise the tumour FIGO staging took place on 9 September 2014. Dr C was not provided with any formal notification that Ms A, specifically, was to be discussed at the MDM of 9 September 2014.

56. Dr E told HDC that it was at this MDM that Ms A's tumour was staged. Dr E said: "In this case, clinical and pathological data were integrated at the second MDM meeting on [9 September 2014] and documented as FIGO stage 2C in the MDM minutes."[20] As stated in footnote 12 above, the higher the number (0–4), the larger the cancer tumour and the more it has spread into nearby tissues.

57. Dr B was present at the MDM meeting but Dr C was not. No oncologist was present at the meeting.

58. The management plan documented in the MDM meeting report was stated as "Planned treatment unchanged". Dr B noted at the bottom of the MDM report: "Please ensure [the cancer clinic] is informed of current progress."

59. The MDM report was sent to Dr C at the cancer clinic. The cancer clinic provided a copy to HDC. The report makes no reference to the fact that previously Dr B had told Ms A and Dr C that the cancer was Stage 1 C 3, and that there had now been a change in staging. Dr C did not receive any further communication from Dr B about the MDM and its outcome. In relation to her experience of MDMs, Dr C stated that she receives a general email regarding the upcoming list of patients and results of MDMs. However, she stated:

> "[T]his contains the general information regarding all cases to be discussed … so that clinicians can confirm that a patient's case has been added to the list if they have requested discussion … This email is not intended as a formal notification of change in results or discussion of patients and pertinent results are usually communicated in a physician and patient specific manner."

[19] The outer layer of the uterus.
[20] The "grade 3" noted at the first MDM remained unchanged.

60. Dr C also told HDC:

> "Usually any communication regarding the MDM relating to patients for whom I am caring would be scanned to me for review and approval … Therefore I do not routinely review the MDM reports when not present unless I have asked for a patient to be discussed or been informed that there is a patient who is being referred for opinion."

61. Dr C said that she was not formally notified that Ms A was to be re-discussed at the September 2014 MDM, and she did not expect this as she was undergoing treatment and the surgery results and pathology had been reviewed at the August 2014 MDM.

62. Following these events, the cancer clinic carried out a root cause analysis about the care provided to Ms A. The report noted that the cancer clinic uses an electronic patient management system and that a review of Ms A's documentation showed that the MDM report from 9 September 2014 was scanned into the electronic system on 17 September 2014 and marked as "review required". However, the MDM report was never approved by Dr C.

63. Dr C told HDC that she recalls receiving the MDM report for review, but noticed that the report had been scanned in with another patient's details attached in error. Dr C organised for the administrative support team to remove the non-cancer clinic patient's details, and expected that the report would come back to her in due course.

64. Dr C's expectation was that the rescanned MDM report would be re-delivered to her inbox for her to review and sign off. She said: "Unfortunately the re-scanned MDM report was saved directly into [Ms A's] notes." It was not brought back to Dr C's attention.

65. Dr C also told HDC that she thought that the document related to the original MDM. She said that the system in place at the time meant that often she received multiple copies of the same report from different sources. She stated that when she first looked at the relevant MDM report there was nothing to alert her to the fact that it was a new, revised report. She said:

> "I did not believe [Ms A's] situation had been re-discussed so I did not appreciate that this was new information. I anticipated that this would be rescanned as 'review required' and I was distracted by the confidentiality issue."

66. Dr C said that she attached no urgency to this because she assumed that it was a duplicate of the August MDM report.

67. Dr C stated: "Had the MDM documents specific to [Ms A] come back to me as 'review required' I would have looked at them before marking them as 'approved'." Dr C said that she would have done this despite her expectation that it probably related to the August MDM. She told HDC that she would never sign off a report without reviewing it.

68. The root cause analysis carried out by the cancer clinic found that when the MDM report was re-presented into the system, there was an assumption that the document had been viewed, and so was filed without requiring electronic approval. As it was never returned to

Dr C, she was not aware of the information regarding the upstaging of the disease (from stage 1 C 3 to stage 2 C 3). Ms A and her GP, Dr D, were also not notified of Ms A's carcinoma being classified as Stage 2 C 3 serous carcinoma at this time. After these events, Dr B told Ms A that he did not tell her as he was not aware that she did not know. He said he assumed that Dr C knew, and therefore he assumed that she had told Ms A.

69. Dr B told HDC that MDM minutes are not sent to the GP "as a matter of course, usually, as it is only normally relevant to the treating specialists".

70. On 16 September 2014, Ms A gave her consent for chemotherapy. On 18 September 2014, 9 October 2014, and 30 October 2014, Ms A had a cycle of chemotherapy at the cancer clinic.

71. On 16 September 2014, 7 October 2014, and 28 October 2014 (which were prior to each chemotherapy cycle) Ms A had an appointment with Dr C. Ms A told HDC:

> "[O]n each occasion I met with [Dr C], I clearly indicated to her that I was willing to undergo 6 cycles and my concern that 3 cycles (given the size and findings of cells in the wash out) was not going to prove adequate however [Dr C] was very reassuring and stated that there was a minimal risk of recurrence."

72. Following each appointment, Dr C wrote to Dr B to provide an update on Ms A's care. On each occasion she referred to "Diagnosis: Stage 1 C 3 high grade serous carcinoma of the ovary" and "three cycles of adjuvant chemotherapy". Copies of all of these letters from Dr C to Dr B were sent to Ms A and to Dr D. Regarding the number of cycles of chemotherapy, Dr C's initial letter states: "[Ms A] is comfortable with 3 cycles as am I."

73. Dr C's letter of 28 October 2014 states: "… We discussed again 3 versus 6 cycles and I have let her know that I am satisfied with 3."

74. On 19 November 2014, Ms A had her final consultation with Dr C. Dr C referred Ms A for a CT scan at the radiology service in three months' time, and referred her back to Dr B for ongoing monitoring.

75. Dr C's letter to Dr B following this consultation refers to Stage 1 C 3 high grade carcinoma, and also states: "For three cycles of adjuvant chemotherapy[21] … [now] completed November 2014."

76. On 2 February 2015, Ms A had the CT scan of her chest, abdomen, and pelvis. The scan indicated no findings of any cancer/tumour being present. The report stated: "No local recurrence or metastatic disease from the prior ovarian tumour."

77. On 17 February 2015, Ms A had a monitoring consultation with Dr B at the women's clinic. Blood samples were taken, and her CA125 (cancer marker) levels were tested. The results indicated that Ms A's CA 125 levels were at 18.

[21] An approach to fighting cancer that combines different forms of healing — in this case, chemotherapy and surgery being used together after all the known and visible cancer had been removed surgically.

78. Ms A told HDC that at this appointment she discussed with Dr B that she had had only three cycles of chemotherapy, and commented on the fact that she had misgivings about having only three cycles.

79. Dr B has no recollection of this conversation. After these events, Dr B wrote to Ms A telling her that he had assumed that she was having "full chemo" (6 cycles).

80. At the 17 February 2015 appointment, Dr B referred Ms A to the DHB's Gynaecology Oncology Services for monitoring.[22] Dr B's referral letter to the DHB's Gynaecology Oncology Services stated Ms A's staging as Stage 1 C 3 high grade serous carcinoma. Dr B told HDC that the reference to the cancer stage as 1 C 3 was a mistake, and said: "I would not have expected that to have changed anything."

81. On 28 May 2015, Ms A had her first appointment at the DHB's Gynaecology Oncology Services for follow-up. Her appointment was with Dr B in his capacity as a consultant for the DHB's Gynaecology Oncology team.

82. Dr B documented in his clinic letter: "[Ms A is] currently very well indeed … examination shows no evidence of recurrence of her high grade serous carcinoma on the ovary." The letter was also sent to Dr D.

83. Dr B provided Ms A with a blood test form to check her serum CA 125 (cancer marker) levels. He stated in the clinic letter: "I will follow her up in three months' time with a further CA125 at that stage as well."

84. The DHB told HDC that Dr B's usual practice was for blood tests (including cancer marker levels) to be performed prior to the clinical appointments so that the results could be discussed at the appointment. However, Ms A told HDC that on this occasion she had not been told this or been provided with a blood test form. The DHB said that the tests were probably not carried out in the usual way on this occasion "due to [Ms A's] movement across the public and private sector for treatment and follow up".[23] Directly following the appointment, Ms A had the blood tests.

85. Dr B told HDC that the result of Ms A's blood test for CA 125 was 43, "which is just above the 'normal' range". He said: "I did not think imaging was warranted on the basis of this alone." He further said that his intention was to repeat the test for her next visit.

86. Ms A told HDC that she was never told the result of this test. Dr B said that he did not inform her of the result as he does not normally contact patients about all blood test results, and expected that it would be repeated before her next visit. After these events, he wrote to Ms A stating that when he saw her she was asymptomatic, and that based on the available scientific literature there is no evidence that acting on a CA 125 at this stage would make any difference to a patient's outcome.

[22] Ms A's health insurance did not fund the follow-up, and therefore Dr B referred her to the DHB's Gynaecology Oncology clinic under the public health system.
[23] The DHB apologised to Ms A that the plan to repeat them at the next appointment (and perform imaging if symptoms developed) was not explained to her adequately.

87. On behalf of the DHB, a consultant gynaecological oncologist told HDC: "In terms of the actions undertaken by [Dr B] at [the DHB] in May 2015 … [t]he patient does have a right to be informed of her results if she wished and this may or may not have led to different action …"

88. On 13 August 2015, Ms A consulted with a GP owing to discomfort in her right chest. Ms A asked if she could be referred for a CT scan.

89. On 18 August 2015, a CT of Ms A's chest, pelvis, and abdomen was performed, and repeat CA 125 blood tests were performed.

90. The CT scan concluded: "Metastatic disease likely peritoneal[24] deposits surrounding and deforming the liver. Possible Peritoneal disease left flank. New right anterior basal sub pleural node."

91. On 20 August 2015, Ms A consulted with the GP regarding the results of her blood tests and CT scan. She was told that her CA 125 levels were elevated to 604 (indicating the presence of cancer activity), and she was also informed of the results of the CT scan. An urgent appointment with Dr B was arranged the same day.

92. At the appointment, Dr B referred Ms A to the DHB's Medical Oncology Centre. The referral to Medical Oncology indicates that it was for "[r]ecurrent high grade serous carcinoma of the ovary". Ms A's cancer stage following surgery (from 5 August 2014) was noted as being Stage 2 C 3 serous carcinoma.

93. On 2 September 2015, Ms A's case was discussed at a gynaecology/oncology MDM at the DHB.

94. On 3 September 2015, Ms A had her first consultation with a consultant oncologist. At this appointment, the oncologist told Ms A of the fact that on 9 September 2014 her staging had been identified as Stage 2 C 3 serous carcinoma. This was the first time Ms A had been told that her cancer had been staged as Stage 2 C 3.

95. The oncologist documented in her clinic letter made on 3 September 2015 that owing to the recurrence of Ms A's disease, although further treatment could be offered to slow the progression of the cancer, it would not be curable. Ms A underwent further chemotherapy treatment.

Subsequent information

Women's Clinic

96. The women's clinic was asked to provide information in relation to how it ran its MDMs at the time of these events, and how it runs MDMs currently.

[24] The peritoneum is a thin layer of tissue that lines the abdomen. It covers most of the intra-abdominal organs. If there is a peritoneal tumour, exfoliated tumour cells can detach from it and be transported throughout the peritoneal space by peritoneal fluid and disseminate within the abdominal cavity. In the management of epithelial ovarian cancer, the identification of peritoneal deposits is the most important prognostic factor.

97. It told HDC that it uses the Australian guidelines "Multidisciplinary meetings for cancer care: A Guide for Health Service Providers" (2005).

98. The guidelines document that the principles of multidisciplinary care include an emphasis on a team approach "involving core disciplines integral to the provision of good care", which it notes includes the patient's general practitioner, with input from other specialties as required, and communication "among team members regarding treatment planning".

99. The MDMs are managed by the women's clinic's Practice Manager. Following a request from an external practitioner or a practitioner at the women's clinic, the Practice Manager organises the scheduling of the MDMs. Pathology and radiology services are informed of the planned discussion.

100. The documentation for each MDM consists of the lists of patients to be reviewed on the day of that meeting plus the patient reports from any previous meetings.

101. Following the meeting, the referring clinician is informed of the result. Dr B told HDC that a patient's GP is now also copied in on the results. At the time of these events, however, that did not occur.

102. The women's clinic did not provide any further details, or policies and procedures (written or otherwise) in relation to its MDM process.

Dr C

103. Dr C acknowledged to HDC that she accepted Dr B's staging of the cancer because it was consistent with her recollection of the discussion about Ms A's cancer at the MDM meeting of 12 August 2014, which "particularly related to the large amount of low grade cancer in the specimen". She said that this was also reflected in Dr B's letter to her of 14 August 2014, which increased her confidence in her recollection of the MDM discussion. She said that she cut and pasted a section of the histology report she was provided with on referral into a new patient letter, "without noticing the detail within this did not align with the surgeon's letter and the MDM".

104. Dr C also stated: "The surgical findings are important in the clinical staging of gynaecologic cancer and I have failed to notice the discrepancy between the surgeon's stage and the histology report." She said that the assumption that the staging was still 1 C 3 was perpetuated by being repeated in subsequent letters, "as it is not routine to review the original stage as treatment progresses".

105. Dr C told HDC that had she known that Ms A's disease was Stage 2, she would have advised six cycles of chemotherapy. Dr C also said that "the usual safety-net for resolving staging is through consideration at a [MDM]", and that this occurred "but unfortunately [she] did not become aware of this at the time".

106. Dr C said that she now double checks and cross checks the accuracy of the clinical information provided to her by MDM meetings and clinical letters, to try to pick up discrepancies.

107. In relation to the number of cycles of chemotherapy Ms A received, Dr C told HDC:

> "I will now be even more careful to check at the end of each consultation for the patient's satisfaction with the plan to help ensure that I am not missing vital communication like this from a patient. I am very sorry and must express deep regret to [Ms A] that I did not hear her concerns at the time."

Dr B

108. Dr B told HDC:

> "There was no need to communicate in any special way … I would not have expected the change in staging to change her treatment in any way. Chemotherapy for both stage 1 C 3 and stage 2 C 3 is usually the same. I was not aware that [Dr C] was considering 3 cycles of chemotherapy, in my experience that is not generally the course of action taken."

109. Dr B also said: "I did not think it was appropriate or necessary to inform [Ms A] of the change as I had passed her management on to [Dr C] and expected she would inform her." In response to the provisional opinion, he said that this was normal practice once a referral was made.

110. Dr B told HDC that he is now considering sending copies of the MDMs to patients' GPs. He further said that he is being particularly vigilant to check details in his referral letters.

111. The DHB told HDC that it uses the Medical Council of New Zealand guidelines *Good Medical Practice* regarding the reporting of results, and it does not have its own policy regarding this. It further stated that it has discussed with Dr B that "it is good practice to send results to patients".

112. In response to my provisional report, Dr B said with regard to the CA 125 elevation: "[I]n hindsight, I should have informed [Ms A] of the slightly elevated result and discussed with her whether to arrange for a more timely repeat of the test." He further stated: "I fully intended to discuss this result with her at her follow up appointment following further testing."

Changes made following these events

Cancer clinic

113. All documents pertaining to patient care are now scanned as "review required" and remain pending until electronically approved by the physician. Timeframes are now set for documentation approval, and all documents should be approved within seven days of receipt by the physician. In addition, weekly reports were undertaken for a month to follow up on any outstanding documents waiting for review. These checks are now conducted at random at least once a month. The documentation policy was updated to reflect these and other changes made subsequently, and a notice was sent out to all staff advising of the changes to process.

114. At the time of these events, document scanning was the responsibility of part-time members of staff. This has now been made the responsibility of one full-time staff member.

115. The cancer clinic no longer participates in the women's clinic's private gynaecology MDMs. All gynaecology oncology patients being treated by the cancer clinic are discussed at the Regional Gynaecology MDM.

Responses to provisional opinion

116. The parties were all given the opportunity to respond to relevant sections of my provisional opinion.

117. Dr C had no further comments to make in relation to the provisional opinion. Although not required to do so, Dr C provided a written letter of apology to Ms A, which this Office has forwarded to Ms A.

118. In line with my recommendations, Ascot Central Women's Clinic Limited provided a letter of apology for Ms A. In that letter, Ascot Central Women's Clinic Limited stated that it recognised the recommendations made in my report, and that it would implement them immediately.

119. Ms A was provided with an opportunity to comment on the "information gathered" section of the provisional opinion, and her response has been incorporated where relevant.

120. Dr B provided a response. He stated: "I was not aware that the classification of the cancer staging at my consultation with [Ms A] on 14 August 2014 was provisional." He said: "I had not been informed that this was the case or that further tissue was being analysed. It therefore came as a surprise to me at the MDM in September, that this was discussed and the staging changed from 1C3 to 2C3." He said that had he known that the stage was provisional, he would have informed Ms A of this when he saw her in August 2014.

121. In terms of not directly communicating the change in staging to Dr C, Dr B said that Dr C is an experienced medical colleague who would be able to understand both the MDM meeting notes as well as the histology and pathology results. He said that at the time of these events he thought that annotating the MDM report with the comment "staging has been amended", and requesting that the notes be provided to Dr C would be sufficient communication for her.

122. Dr B said: "I now do contact the medical oncologist directly … to ensure that the medical oncologist is aware of the agreed staging and also to ensure that this is communicated by the medical oncologist to the patient."

123. Other aspects of Dr B's response have been incorporated into this report where relevant.

124. The cancer clinic and the DHB advised that they had no additional comments to make.

Opinion: Introduction

125. On 14 August 2014, Dr B told Ms A that her cancer had been graded as Stage 1 C 3. He also repeated this in correspondence with Dr C and Dr D.

126. Dr B's staging of Ms A's cancer followed an MDM on 12 August 2014, at which Ms A's results were discussed. Dr B recorded in the minutes: "Grade 3 (much is low grade)." However, no FIGO stage was annotated in the minutes.

127. Dr E told HDC that the tumour was not staged at the August MDM because there was a suspicious lesion on the uterus and further tissue still needed to be examined. He also stated that "tumour staging is a multidisciplinary process requiring histological, radiological and clinical findings … It is not uncommon for further information to be obtained before staging a tumour." He said that after he had reviewed the remainder of the histology slides on 13 August 2014, he sent a copy of his report with his findings to Dr B and asked for an MDM to be convened to review Ms A's case for the purpose of staging the tumour now that the additional information had become available. Dr E said that the clinical and pathological data were integrated at the 9 September 2014 MDM, and the FIGO stage documented in the minutes was 2C.

128. My expert specialist obstetrician and gynaecologist advisor, Dr Kenneth Clark, advised me that it would be appropriate for a doctor to give a patient an idea of the stage of the cancer, even before receiving all the information needed to determine the absolute stage, and he considered that Dr B possessed the experience and skills necessary to give such an opinion. However, Dr Clark advised that this was on the proviso that the doctor should indicate that it was provisional or could be confirmed only on receiving all of the information.

129. I note that Dr Clark advised that it was acceptable to have communicated the stage to Dr C without advising that it was provisional, however, because "it is a reasonable assumption that both practitioners fully understand that these things are provisional pending final/all results".

130. In response to my provisional opinion, Dr B stated that he was not aware that his classification of the cancer staging was provisional. He said that he "had not been informed that this was the case" or that further tissue was being analysed. He also said: "It therefore came as a surprise to me at the MDM in September, that this was discussed and the staging changed from 1C3 to 2C3."

131. I note that based on the information provided there appear to be differences in understanding and/or expectation between the clinicians involved about when, how, and by whom cancer staging is undertaken, and when and how it is confirmed. This includes whether it is done through the MDM process or by individual clinicians. I consider that it would be prudent for the women's clinic and the clinicians involved in this case to reflect on this and to discuss the matter as appropriate.

Opinion: Dr B — breach

Reporting of Ms A's final cancer stage following MDM — breach

132. Ms A's cancer was discussed again at the second MDM meeting on 9 September 2014, when additional pathology information had become available. The minutes/report record that it was staged as 2 C (the grade was not recorded but remained as 3). This represented a change in the stage that Dr B had previously given to Ms A and Dr C.

133. Dr C was not present at the MDM meeting. She told HDC: "Usually any communication regarding the MDM relating to patients for whom I am caring would be scanned to me for review and approval …" She stated that usually pertinent results are communicated in a physician and patient specific manner. She also said that she was not expecting Ms A's case to be discussed again, as the surgery and pathology results had been discussed at the August MDM.

134. Although Dr B did note on the MDM "Please ensure [the cancer clinic] is informed of current progress", and a copy of the MDM report was sent to the cancer clinic, Dr C did not receive any other communication that Ms A had been discussed at the MDM, and that the cancer had been given an updated (and upgraded) stage from Dr B or anyone else. Further, as set out above, Dr C was not aware of the change in stage during Ms A's treatment.

135. Dr Clark advised that given the potential impact on Ms A's management and prognosis, "it is [his] considered opinion that [Dr B] should have taken formal steps to notify [Dr C]". Dr Clark said that this could have taken the form of a direct telephone call, a letter containing specific information, or arranging for another attendee at the MDM to contact Dr C. Dr Clark advised that not doing so was a moderate departure. I am guided by this advice.

136. Even though Dr B noted that he passed management of Ms A to Dr C, he had performed Ms A's surgery and made the referral to Dr C, which included reference to a stage of 1 C 3. In addition, Dr B was still involved in Ms A's care, and attended the MDM where the staging was discussed expressly. Given his presence at the MDM, Dr B would also have been aware that Dr C was not in attendance, and therefore not immediately aware of the change in stage. While I note Dr B's comment that Dr C is an experienced medical colleague who he expected would be able to understand the MDM meeting notes as well as the histology and pathology results, I note that he also said that he was not aware that the original cancer stage he gave was provisional, and was surprised when this was discussed again at the September MDM and the stage changed from Stage 1 C 3 to 2 C 3.

137. Further, even if Dr B felt that Dr C would ascertain the change in stage from the MDM report provided, and did not expect the change in staging to change Ms A's treatment in any way, he was not the clinician providing the treatment to Ms A. The change in stage was pertinent clinical information that could have affected the management of Ms A's care and her prognosis. I note that Dr C told HDC that if she had known that Ms A's cancer was Stage 2, she would have recommended six rather than three cycles of chemotherapy. In all of these circumstances, I consider that Dr B had an ongoing responsibility to Ms A in terms of ensuring quality and continuity of services.

138. In response to the provisional opinion, Dr B told HDC that he thought that by annotating the MDM report with a comment "staging has been amended" and requesting that these notes be provided to Dr C, this would be sufficient for communication. However, as above, I note that this annotation was not on the report that was sent to Dr C at the cancer clinic and provided to HDC by the cancer clinic. In any event, for the reasons discussed, I do not consider that such action was sufficient in these circumstances.

139. In my view, in these circumstances Dr B should have taken further steps to make sure that Dr C was specifically advised of the change in the stage of cancer from that he had advised previously. As advised by Dr Clark, this could have been done by way of a revised referral or some other form of communication, such as a letter containing specific information, a direct telephone call, or arranging for another attendee at the MDM to contact Dr C.

140. In addition to the above, following each chemotherapy visit, Dr C wrote to Dr B to provide an update on Ms A's care. Each time, Dr C referred to the diagnosis of Stage 1 C 3 high grade serous carcinoma of the ovary. In addition, at the end of the treatment, Dr C wrote a letter to Dr B again referring to Stage 1 C 3 high grade carcinoma, and stating: "For three cycles of adjuvant chemotherapy … now completed November 2014."

141. There was no reference to the updated and upgraded stage in any return communication from Dr B or in regard to the reference to three cycles of chemotherapy (even though Dr B told HDC that he thought that Ms A should have been getting six cycles of chemotherapy).

142. I am critical that Dr B does not appear to have noticed that Dr C was still referring to Stage 1 C 3 cancer in her written communication to him, especially in light of the fact that Dr B had not taken further steps to make sure that Dr C was specifically advised of the change in stage following the September MDM, and made assumptions about the treatment that Ms A was being provided.

143. I further note that Dr B's referral letter to the DHB's Gynaecology Oncology Services on 17 February 2015 referred to Ms A's staging as Stage 1 C 3 high grade serous carcinoma. I note Dr B's explanation to HDC that this was a mistake and he does not expect that it would have changed anything.

144. Dr Clark described this as a significant mistake, and referred to it as being a "perpetuation of the initial errors during 2014". I agree. As stated above, the cancer stage was information that could have affected the management of Ms A's treatment and prognosis, and I am concerned that greater attention to detail was not applied in the communication of this important information as Ms A transitioned into publicly funded follow-up care.

145. When a patient is being treated by several different clinicians for the same issues, clear communication and an eye for detail when communicating with those other clinicians is paramount. I am critical of Dr B in this regard. There was a failing on Dr B's part in terms of poor communication.

146. Furthermore, by failing to take steps to make sure that Dr C was specifically advised of the change in the stage of cancer and, having not done so, failing to notice that she continued to refer to the cancer stage as 1 C 3, and then referring to the incorrect stage himself in his

referral letter to the DHB, I consider that Dr B failed to co-operate with Dr C and the DHB to ensure the quality and continuity of the services provided to Ms A. Accordingly, I consider that Dr B breached Right 4(5) of the Code of Health and Disability Services Consumers' Rights (the Code).[25]

Communication with Ms A — breach

Change in cancer stage

147. After the September MDM, Ms A was not notified by Dr B of the formal cancer stage, which had been upgraded from the initial stage he had advised her. After these events, Dr B told Ms A that he had not told her of the change in staging because he was not aware that she did not know. He said that he had assumed that Dr C knew, and therefore had told Ms A. In response to the provisional opinion, Dr B also said that he had expected Dr C to inform Ms A because he had made a referral to Dr C, and this is normal practice once a referral has been made.

148. As stated above, the changed cancer stage was important clinical information that could have affected the treatment Ms A received. I consider that a reasonable consumer in Ms A's circumstances would expect to receive information about the changed stage of the cancer, especially when it represented an upgrade from what had been advised previously and could affect treatment.

149. Dr Clark advised: "I do believe that it was [Dr B's] responsibility to ensure that [Ms A] was aware of the change in staging that was decided upon at the MDM …" Dr Clark further advised that he does "not believe it was reasonable for [Dr B] to have assumed that [Ms A] had been notified of the change in staging" by Dr C if Dr B was not completely certain that Dr C had noted the change in staging and informed Ms A of the same. Dr Clark advised that Dr B needed to take the appropriate action to satisfy himself that Dr C would do so. Dr Clark said that Dr B could have told Ms A of the change by contacting her directly himself, asking Dr C to do so, or formally assigning the task to another attendee at the MDM. Dr Clark advised that not ensuring that Ms A was aware of the change in staging was a moderate departure from the accepted standard of care.

150. I am guided by this advice. I note that Dr B told HDC that by that point he had handed over management to Dr C. However, as discussed above, he was still involved in Ms A's care, and would have been aware that Dr C was not present at the meeting at which the stage of the cancer was changed, and therefore would not have been aware of the change immediately. In my view, either Dr B himself should have advised Ms A of the change in her cancer stage, or he should have specifically asked Dr C or another colleague at the MDM to do so. Instead, he assumed that Dr C was aware of the information and would pass it on, without having taken steps to satisfy himself that Dr C would do this. I am critical of this. Dr B's failure to make sure that Ms A would be advised was a factor that contributed to her lack of awareness of the changed stage of her cancer which, in turn, affected her ability to be an active partner in her care and treatment.

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

151. I further note that Ms A's GP, Dr D, was likewise not informed of the change in stage of the cancer. Dr B told HDC that MDM minutes are not sent to the GP as a matter of course, as usually they are relevant only to the treating specialists. I acknowledge this, but see it as an area for improvement in continuity of care and safety-netting. I note that Dr B is now considering sending copies of the MDM minutes to patients' GPs.

Elevated tumour markers

152. Following an appointment with Dr B on 28 May 2015, Ms A was found to have a serum CA125 cancer marker level of 43 (normal being less than 35, and a CA125 level higher than normal indicating that the patient could have cancer). This was significantly higher than her previous result of 18 February. Dr B did not inform Ms A of the result or offer further investigations.

153. Dr B said that the result was "just above the 'normal' range". His intention was to repeat the test before Ms A's next visit. Dr B also said that he did not inform Ms A of the result as he does not normally contact patients about all blood test results. In response to the provisional opinion, he said that he fully intended to discuss the result with Ms A at her follow-up appointment following further testing.

154. The DHB told HDC: "In terms of the actions undertaken by [Dr B] at [the DHB] in May 2015 … [t]he patient does have a right to be informed of her results if she wished and this may or may not have led to different action …"

155. Dr Clark advised:

> "[I]t would have been a reasonable expectation for [Dr B] to have arranged for [Ms A] to be made aware of the elevated CA-125 level and to have engaged with her as to whether any earlier or different investigation was warranted. Having said this, I accept that this is very much a matter of clinical judgment and I believe any departure from an accepted standard of care and practice to be mild. Equally, it is my opinion that my peers would be somewhat divided as to their views on the actions he took in this respect."

156. I am critical that Dr B considered that Ms A did not need to know the results at this stage. As acknowledged by the DHB, the fundamental principle here is that patients have the right to be informed of their results. As someone who had recently undergone surgery and then chemotherapy for cancer, in my view a reasonable consumer in Ms A's circumstances would expect to receive the results of tests that could indicate a return of the cancer. In addition, a reasonable consumer in those circumstances would expect to have the implications and ongoing management options discussed with her.

Conclusion

157. For the reasons discussed above, for failing to advise Ms A of the upgraded cancer stage, or to take appropriate steps to make sure that information would be communicated to her by

someone else, and by failing to provide Ms A with the results of her tumour maker test in May 2015 and the significance of that, I find that Dr B breached Right 6(1) of the Code.[26]

Opinion: Ascot Central Women's Clinic Limited — breach

158. Following the initial MDM on 12 August 2014, which had discussed Ms A's cancer, further histology slides were reviewed by pathologist Dr E. Evidence confirmed some tumour on the serosa of the uterus. Accordingly, Ms A's case was re-presented at a second MDM in September for the purpose of staging the cancer with the additional information available. The minutes record that the cancer was staged as 2 C (the grade was not recorded but remained as 3). This represented a change in the stage that Dr B had given to Ms A and Dr C previously.

159. The women's clinic told HDC that at the time of events it used the Australian guidelines "Multidisciplinary meetings for cancer care: A Guide for Health Service Providers" (2005) for its MDMs. The guidelines document that the principles of multidisciplinary care include an emphasis on a team approach "involving core disciplines integral to the provision of good care". The guidelines note that this includes the patient's general practitioner, with input from other specialties as required, and communication "among team members regarding treatment planning".

160. The women's clinic also said that the MDMs are managed by the women's clinic Practice Manager who, following a request from an external practitioner or a practitioner at the women's clinic, organises the scheduling of the MDMs. Pathology and radiology services are informed of the planned discussion. The women's clinic did not provide HDC with any further information or policies and procedures regarding its MDMs.

161. Dr C told HDC that she receives an email regarding the upcoming list of patients and MDM results, but this contains general information regarding all cases being discussed. She said that the email is not intended as a formal notification of a change in results or a discussion of particular patients, and that usually pertinent results are communicated in a physician and patient specific manner. She told HDC that in this case she was not formally notified that Ms A's case was to be re-discussed, and she did not expect this given that Ms A was undergoing treatment and surgery, and the pathology results had been discussed at the first MDM.

162. While I accept that Dr C may have received the general email, I note that she was not given any specific notification that her patient, Ms A, was to be discussed at the MDM of 9 September 2014, and so she was not aware that this was to occur. Therefore, Dr C was also unaware of the reason for the further MDM. While the MDM report was sent to Dr C later, and it did document the stage, it did not note that there had been a change in the stage. No confirmation was sought and obtained by the women's clinic that Dr C had received the

[26] Right 6(1) of the Code states: "Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive — including … the results of tests …"

MDM report and, as outlined above, Dr C was not aware of the change in stage during Ms A's treatment.

163. My expert medical oncologist advisor, Dr Richard Isaacs, advised that the failure to advise Dr C of the reason why Ms A's case was to be re-discussed was a mild departure from the accepted standard. He said that if Dr C had been advised of this, it would have alerted her to pursue the results of the MDM. He further commented that "[w]ithout effective communication of MDM findings, including a change in stated disease stage, there is the potential for clinical risk".

164. Dr Clark advised that given the potential impact on Ms A's management, Dr B should have taken formal steps to notify Dr C of the change in cancer stage after the 9 September MDM. Dr Clark said that Dr B could have done this by a direct telephone call, a letter with specific information, or arranging for another attendee at the MDM to contact Dr C. Dr Clark considered that the failure to do so was a moderate departure from accepted standards. In terms of MDM processes generally, Dr Clark advised that robust and reliable processes should underpin all MDMs, "with facilitation and leadership by skilled clinicians and support by experienced clerical and administrative staff being key to the quality of decision-making, documentation and distribution of information from any MDM". He further advised that "a major feature of MDM procedure is ensuring that key decisions affecting the management of a patient are assigned to specific individuals present at the MDM, with this being done in a very deliberate and clear fashion".

165. While I support a multidisciplinary approach to patient management, I agree with the opinions expressed by my expert advisors that the processes and procedures around MDMs need to be robust and reliable to ensure that clinical risk is minimised. In my view, it is particularly important to have clear practices and lines of responsibility regarding communication and distribution of information. If this is not the case, the benefits of a multidisciplinary approach can be lost, and clinical risk can ensue. While I have been critical of Dr B for not taking formal steps to ensure that Dr C was specifically advised of the MDM's result, I consider that the women's clinic had overarching responsibility regarding the administration and operation of its MDM processes, including ensuring that communication, especially of pertinent clinical information, is effective.

166. The women's clinic told HDC that it follows a guideline that emphasises the importance of a team approach (involving core disciplines) and communication (regarding treatment planning). However, Ms A's treating clinician (Dr C) was not present at the second MDM and was not specifically advised in advance that Ms A was to be discussed further (and the reasons for this). I note Dr Isaacs' advice that "it would not be [the] standard practice [at his cancer treatment service] for an MDM to proceed without any medical oncologist present". Dr C's lack of knowledge of this second MDM meant that she was not on notice to follow up on its outcome. In my view, given the clinical significance of the change in stage, in these circumstances it was inappropriate that no further steps were taken specifically to advise Dr C of this outcome. I note Dr C's expectation that usually pertinent results relating to her patients are communicated specifically to her as their physician.

167. Dr Isaacs advised that the primary concern in this case "was a failure of MDM communication on a number of levels which would need to be corrected if that particular

MDM was to continue". This is a strong statement. I share Dr Isaacs' view that in this case there was a failure of communication within the MDM process in the ways discussed above. Regarding the content of the report sent to Dr C, I also note that it did not document that the stage represented a change from what Dr B had advised previously. I consider that the absence of more specific policies and procedures around the MDM process is likely to have contributed to these failures in communication. In my view, as the organisation running the MDMs, the women's clinic is responsible for these failures at a service level.

168. By failing to communicate effectively with Dr C, as Ms A's treating clinician, including failing to advise her in advance of the 9 September MDM specifically that Ms A was to be discussed again (and the reasons for this), and in these circumstances for failing to advise her specifically of key clinical information arising out of that MDM, the women's clinic failed to ensure co-ordination among the providers involved in Ms A's care to ensure quality and continuity of services. Accordingly I find that Ascot Central Women's Clinic Limited breached Right 4(5) of the Code.

169. In addition, as noted above, based on the information provided there appear to be differences in understanding and/or expectation between the clinicians involved about when, how, and by whom cancer staging is undertaken, and when and how it is confirmed. This includes whether it is done through the MDM process or by individual clinicians. I consider that it would be prudent for the women's clinic and the clinicians involved in this case to reflect on this and to discuss the matter as appropriate.

Opinion: Dr C — adverse comment

Cancer stage — adverse comment

170. Dr B referred Ms A to Dr C. His referral letter summary refers to the resected tumour being Stage 1 C 3 high grade serous carcinoma of the ovary or tube. It also refers to the tumour containing many areas of low grade cancer. A copy of the histology results and the operation note were provided to Dr C. Dr C told HDC that a Stage 1 C 3 tumour can be treated with three to six cycles of chemotherapy and, based on her understanding that Ms A's cancer was low grade disease, she recommended three cycles.

171. In Dr C's clinic letters to Dr B, she describes Ms A's diagnosis of Stage 1 C 3 high grade serous carcinoma. Dr C's summary of Ms A's condition, however, included the description of the deposit on the uterine serosa and the nodule on the right ovary. My expert medical oncologist advisor, Dr Richard Isaacs, advised that Dr C "appears to have accepted the stage in the referral letter [from Dr B], despite her own new patient letter clearly describing features of Stage IIC disease". Dr Isaacs said that the malignant nodule on the uterus described in the pathology report and operation note were features of Stage 2 disease.

172. Dr Isaacs advised:

> "[Dr C] was only individually responsible for inaccurately defining the stage of her patient as Stage IC, with the pathology information provided, which indicated Stage IIC. She acknowledges this in her letter and has taken steps to avoid this in future."

173. Dr Isaacs further advised that normally this would be corrected by the MDM process but, due to a succession of communication and clerical errors, this did not occur. Dr Isaacs refers to Dr C's error as being "[a] minor deviation" from accepted standards.

174. I am guided by this advice. I am critical that Dr C did not herself identify the discrepancy between the stage she was advised of and the information in the pathology report. However, I acknowledge that she had been told by Dr B that the cancer was Stage 1 C 3, and that this, as well as his description of the cancer in his letter, aligned with her recollection of the focus on the cancer being low grade at the first MDM. I also acknowledge that the subsequent September MDM meeting process should have corrected her understanding of the cancer stage but did not do so because she was not at the MDM and, for the reasons set out above, ultimately she did not review the MDM report. I consider it appropriate that Dr C has taken steps to avoid this in the future.

Second MDM report — adverse comment

175. As stated above, Dr C was unaware that Ms A's cancer stage had changed as a result of the MDM in September 2014. Dr C did not attend the September MDM, as she had not been notified specifically that Ms A was to be discussed. Dr C told HDC that routinely she does not review the MDM reports from meetings at which she has not been present unless she herself has asked for a patient to be discussed, or if she has been informed that one of her patients has been referred for an opinion. She also said that usually any communication from the MDM that relates to her patients would be scanned for her review and approval.

176. Dr C said that in this case she did receive the MDM report, but she noted that it had been scanned with another patient's details attached. Therefore she returned it to staff at the cancer clinic to rectify the issue. Dr C's expectation was that the re-scanned MDM report would be re-delivered to her inbox for her to review and sign off. She said: "Unfortunately the re-scanned MDM report was saved directly into [Ms A's] notes." The report was not brought back to her attention. Dr C stated: "Had the MDM documents specific to [Ms A] come back to me as 'review required' I would have looked at them before marking them as 'approved'." Dr C said that she would have done this despite her expectation that the report probably related to the August MDM. She stated that she would never sign off a report without reviewing it.

177. A root cause analysis carried out by the cancer clinic after these events found that when the document was re-presented into the system after the non- cancer clinic patient's details had been removed, there was an assumption that the document had been viewed, and so it was filed without requiring electronic approval. The document was never returned to Dr C. I am mindful that Dr C has said that the system in place at the time meant that often she received multiple copies of the same report. She also said that when she first looked at the relevant MDM report, nothing notified her of the fact that it was a new, revised report, and she was not alerted to the fact that Ms A's situation had been re-discussed, and so did not appreciate that this was new information. As a result, Dr C assumed that it was a duplicate of the August MDM report, and attached no urgency to the matter.

178. I accept that there were administrative issues at play here, and that Dr C did not expect to receive any new information in relation to a patient she was already treating. However, I am critical that Dr C did not pursue the MDM report further, as she did receive it and had noted the incorrect annotation on it.

Decision to treat Ms A with three cycles of chemotherapy — other comment

179. As outlined above, Dr C recommended that Ms A undergo three cycles of chemotherapy for her cancer. Dr Isaacs advised:

> "The decision to treat [Ms A] with 3 cycles of chemotherapy for assumed Stage IC disease must be considered a reasonable and acceptable standard of care, on the basis that this approach is supported by published clinical trial data from a large study group and is supported by a major international guideline."

180. I accept this advice.

181. Ms A told HDC that she had misgivings about having only three cycles of chemotherapy. Dr C told HDC that she was unaware that Ms A had these concerns. Dr C said: "At the time I felt we had open channels of communication and I do not recall any difficulty with discussing matters during the consultations." I further note that in all of Dr C's written correspondence to Dr B, she documented that Ms A was happy with the treatment.

182. Given the different recollections of what occurred, I am unable to make a finding about the nature of the discussions between Ms A and Dr C regarding treatment. However, Dr C has acknowledged what Ms A has said about the way she felt about this at the time, and has taken steps to ensure good communication moving forward. This issue highlights the importance of clear and open communication with consumers.

Opinion: Cancer clinic — adverse comment

183. Dr C received the second MDM report of September 2014 containing confirmation that Ms A's cancer was Stage 2 3 C, but noted that it had been scanned with another patient's details attached. She organised for the administrative support team at the cancer clinic to remove the non cancer clinic patient's details, and expected that the report would come back to her in due course for review and sign-off. She said: "I anticipated that this would be rescanned as 'review required' and I was distracted by the confidentiality issue." In addition, as discussed above, Dr C told HDC that she assumed that the MDM report probably related to the MDM from August.

184. The root cause analysis carried out by the cancer clinic after these events found that when the MDM report was re-presented into the system there was an assumption that it had been viewed by Dr C, and so it was filed into Ms A's medical notes without requiring electronic approval. It was never returned to Dr C, and there was no confirmation that it had been seen by her.

185. I am critical of the cancer clinic's error. However, I note Dr Isaacs' advice that the cancer clinic has "appropriately reviewed their processes in their root cause analysis and appear to have made appropriate changes to minimise the risks of further such events occurring, in relation to the transmission of communication from multidisciplinary meetings." I agree that the changes made are appropriate.

Opinion: DHB — no breach

186. In May 2015 Ms A saw Dr B for follow-up in his capacity as a consultant for the DHB's Gynaecology Oncology team.

187. Dr B provided Ms A with a blood test form to check her serum CA 125 (cancer marker) levels.

188. The DHB told HDC that Dr B's usual practice was for blood tests (including cancer marker levels) to be performed prior to the clinical appointments so that the results could be discussed at the appointment. On this occasion, Ms A had not been told this and had not been provided with a blood test form prior to her appointment. The DHB said that this was probably "due to [Ms A's] movement across the public and private sector for treatment and follow up".

189. Directly following the appointment, Ms A had the blood tests carried out, and the result of the CA 125 was 43 (normal being less than 35). Dr B told HDC that he did not think that further imaging was warranted on the basis of this alone, and his intention was to repeat the test at Ms A's next visit. Dr B further told HDC that he did not inform Ms A of the result as he does not normally contact patients about all blood test results and he expected that it would be repeated on her next visit.

190. I note that the DHB told HDC: "In terms of the actions undertaken by [Dr B] at [the DHB] in May 2015 … The patient does have a right to be informed of her results if she wished and this may or may not have led to different action …"

191. I consider that Dr B's omission in this case does not indicate broader systems or organisational issues at the DHB. Therefore, I find that the DHB did not breach the Code directly.

192. In addition to any direct liability for a breach of the Code, under section 72(2) of the Health and Disability Commissioner Act 1994 (the Act), an employing authority is vicariously liable for any actions or omissions of its employees. A defence is available to the employing authority under section 72(5) if it can prove that it took such steps as were reasonably practicable to prevent the acts or omissions.

193. As set out above, I have found that Dr B breached Right 6(1) of the Code for failing to advise Ms A of her elevated tumour marker results in May 2015 and the implications of

that. At the time of this failure, Dr B was an employee of the DHB. Accordingly, the DHB is an employing authority for the purposes of the Act.

194. The DHB told HDC that it uses the Medical Council of New Zealand guidelines *Good Medical Practice* regarding the reporting of results, and so does not have its own policy regarding this. Given that the expectations on doctors regarding the provision of information to patients is set out clearly in *Good Medical Practice*, and the right of consumers to receive information is set out clearly in the Code, in my view it is reasonable that the DHB does not have a policy specifically addressing the disclosure of test results. Accordingly, I do not find the DHB vicariously liable for Dr B's breach of the Code.

Recommendations

195. I recommend that Ascot Central Women's Clinic Limited review its MDM process significantly. A report in relation to this review is to be sent to HDC within six months of the date of this opinion report. The following is to be considered as part of the review:

a) Whether the results of relevance from the MDM should be communicated directly to all doctors involved, including the patient's GP, the oncologist, and the surgeon, as a separate confidential document to the clinician, and sent separately from the general MDM report regarding all patients.
b) Whether the relevant part of each MDM report should routinely be sent to the patient concerned.
c) Where there is a second or subsequent MDM for a patient, whether the original documentation should be retained on the report with the update, and the reasons for this, documented beneath the original report so that all information can be understood in a chronological way.

196. In response to my provisional opinion, Ascot Central Women's Clinic Limited provided Ms A with a written letter of apology for the breaches of the Code identified in this report. The apology letter has been forwarded to Ms A.

197. I recommend that the Medical Council of New Zealand consider whether a review of Dr B's competency is required.

198. I recommend that Dr B provide Ms A with a written letter of apology for the breaches of the Code identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding.

199. I recommend that the DHB consider reviewing its protocols and procedures in relation to the treatment and follow-up of cancer patients who are transitioning between the private and public sectors.

Follow-up actions

200. A copy of this report with details identifying the parties removed, except Ascot Central Women's Clinic Limited and the experts who advised on this case, will be sent to the Medical Council of New Zealand, and it will be advised of the names of Dr B and Dr C.

201. A copy of this report with details identifying the parties removed, except Ascot Central Women's Clinic Limited and the experts who advised on this case, will be sent to the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, and it will be advised of Dr B's name.

202. A copy of this report with details identifying the parties removed, except Ascot Central Women's Clinic Limited and the experts who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent obstetrics and gynaecology advice to the Commissioner

The following expert advice was obtained from Dr Kenneth Clark, a specialist obstetrician and gynaecologist:

> "I have been asked to provide an opinion to the Commissioner on Case number C15HDC01370. I have read and agree to follow the Commissioner's guidelines for Independent Advisors.
>
> I am a Specialist Obstetrician and Gynaecologist, vocationally registered with the Medical Council of New Zealand. I hold fellowships of both the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, and the Royal College of Obstetricians and Gynaecologists. I am also a vocationally registered specialist in Medical Administration and am a fellow of the Royal Australasian College of Medical Administrators. I work clinically as a general gynaecologist and have 25 years' experience as a specialist in gynaecology. Please note that I am not a College certified subspecialist in Gynaecological Oncology. There are a very small number of such subspecialists in New Zealand, with these doctors managing a significant proportion of the women diagnosed with gynaecological malignancy in any one year. In practice, a number of women are also managed by General Gynaecologists, after taking advice from subspecialists and from appropriate multidisciplinary meetings (MDMs). I have significant experience in the followup of women who have had ovarian cancer and considerable experience in coordinating care between multiple specialists, for instance, other gynaecologists, subspecialists in Gynaecological Oncology, Medical Oncologists and, where appropriate, Radiation Oncologists.
>
> I work in the city of Palmerston North in the lower North Island and in addition to my clinical duties I hold the position of Chief Medical Officer, MidCentral DHB.
>
> My referral instructions from the Commissioner are as follows:
>
> *I have been asked to provide my opinion on the following issues —*
>
> 1. *Following the MDM meeting of 19 September 2014, and noting [Dr C] was not present at this meeting, would you expect [Dr B] to have sent a revised referral/or further communication to [Dr C] advising her of the change in staging of [Ms A's] cancer?*
> 2. *Taking into account the progress letters from [Dr C] to [Dr B] dated 29 August 2014 and 19 November 2014, both of which refer to Stage 1C3 cancer and planning for (and completion of) three cycles of chemotherapy, do you think it reasonable for [Dr B] to have assumed (as stated in his response to this office dated 15 September 2015) that she had been notified of the change in staging and that she had received six cycles of chemotherapy?*
> 3. *Did [Dr B] have a responsibility to ensure [Ms A] was aware of the change in staging following the MDM meeting of 19 September 2014? If not, who do you believe held the responsibility to inform [Ms A] of the updated results?*

4. *Please comment on the adequacy of [Dr B's] referral letter to [the DHB] Gynaecology Oncology dated 17 February 2015, which lists [Ms A's] cancer as stage 1C3 rather than the revised 2C.*
5. *Please comment on [Dr B's] management of [Ms A's] elevated CA125 level requested by him in May 2015, including:*
   a. *The decision not to notify her of the result, and*
   b. *Any change in the clinical management due to the result.*
6. *If you feel able, please comment on the quality of the MDM process and reporting, taking into account the comments in this regard in [Dr C's] response.*
7. *On file is correspondence from the [the DHB] oncology service dated 3 September 2015, and a revised histology report dated 16 September 2015, in relation to [Ms A's] original surgical specimens. Do you feel there is any information in these reports to suggest significant errors were made in [Ms A's] original histology reporting and/or staging?*
8. *Any other comment you wish to make about [Dr B's] management of [Ms A]?*

For each question, it would be helpful if you would advise:

a) What is the standard of care/accepted practice?
b) If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider it is?
c) How would it be viewed by your peers?

In reaching my opinions, I have accessed the following sources of information:

- Letter of complaint.
- [Dr B's] response.
- [Dr C's] response.
- [The cancer clinic's] RCA and additional response.
- [The DHB's] response.
- Clinical notes from [Dr B].
- Clinical notes from [the cancer clinic], including MDM and pathology.
- Clinical notes from [the DHB].

1. *Following the MDM meeting of 19 September 2014, and noting [Dr C] was not present at this meeting, would you expect [Dr B] to have sent a revised referral/or further communication to [Dr C] advising her of the change in staging of [Ms A's] cancer?*

Yes, it would be my expectation that [Dr B] would have sent a revised referral or some other form of communication to [Dr C] to ensure that she was aware of the change in staging of [Ms A's] cancer. This could have taken the form of a direct telephone call or a letter with specific information within it, or alternatively he may have arranged for another attendee at the MDM to have contacted [Dr C] with this information. As will be touched on later, a major feature of MDM procedure is ensuring that key decisions affecting the management of a patient are assigned to specific individuals present at the MDM, with this being done in a very deliberate and clear fashion. It is my considered

opinion that this is the standard of care and accepted practice and I believe the departure from this standard of care in this case to be of a moderate degree. I would expect a majority of my peers to view this lack of communication as a true departure from an expected standard of care.

2. *Taking into account the progress letters from [Dr C] to [Dr B] dated 29 August 2014 and 19 November 2014, both of which refer to Stage 1C3 cancer and planning for (and completion of) three cycles of chemotherapy, do you think it reasonable for [Dr B] to have assumed (as stated in his response to this office dated 15 September 2015) that she had been notified of the change in staging and that she had received six cycles of chemotherapy?*

No, I do not believe that it was reasonable for [Dr B] to have assumed that [Ms A] had been notified of the change in staging. To make such an assumption [Dr B] would need to have had full satisfaction that not only would the electronic record of the MDM reach [Dr C] but also that she would have definitely noted the change in staging of the tumour within the MDM record and informed [Ms A] of the same. Given the potential impact on a patient's management and prognosis, as stated in my response to question one above, it is my considered opinion that [Dr B] should have taken formal steps to notify [Dr C]. Where the matter of assuming that [Ms A] had received six cycles of chemotherapy is concerned, [Dr B] could *only* have made an assumption that [Dr C] would counsel [Ms A] appropriately as to the most suitable treatment regimen for the stage assigned.

I see [Dr B's] practice in assuming [Ms A] had been notified of the change in staging as being a departure from the standard of accepted care and practice. I would consider it to be mild-to-moderate in degree and would be viewed as such by the majority of my peers.

3. *Did [Dr B] have a responsibility to ensure [Ms A] was aware of the change in staging following the MDM meeting of 19 September 2014? If not, who do you believe held the responsibility to inform [Ms A] of the updated results?*

Yes, I do believe that it was [Dr B's] responsibility to ensure that [Ms A] was aware of the change in staging that was decided upon at the MDM on the 19th of September 2014. This may have taken the form of [Dr B] himself contacting [Ms A] or it would have been entirely acceptable for him to have asked [Dr C] to communicate this to [Ms A], given that she was actively caring for [Ms A] at that time and coordinating her cycles of chemotherapy. The only variation on the above would have been if at the MDM another attendee was formally assigned the task of communicating this information to [Ms A]. Again, I believe there has been a departure from the standard of care and accepted practice that one would expect in these circumstances. I would see it as being of a moderate degree and to be seen as such by the majority of my peers.

4. *Please comment on the adequacy of [Dr B's] referral letter to [the DHB] Gynaecology Oncology dated 17 February 2015, which lists [Ms A's] cancer as stage 1C3 rather than the revised 2C.*

Clearly, a significant mistake is made in this letter, with the diagnosis in terms of the staging of [Ms A's] tumour being incorrect. Whilst I accept that once an inaccurate record becomes part of the medical notes it is all too likely that this will be perpetuated as being the real state of affairs, it must be noted that [Dr B] was a party to the second MDM where [Ms A's] staging was changed, and had received documentation of such. I see this error as being a perpetuation of the initial errors during 2014, with the same ramifications as noted in the answers to the questions above.

5. *Please comment on [Dr B's] management of [Ms A's] elevated CA125 level requested by him in May 2015, including:*
   a. *The decision not to notify her of the result, and*
   b. *Any change in the clinical management due to the result?*

Firstly, in respect to the decision made by [Dr B] not to notify [Ms A] of the CA-125 result in May 2015; in assessing this I think it pertinent to consider what is the expected standard of care and, within this assessment, what would be considered a reasonable standard of practice in terms of the rights of patients in this country.

I would see the expected standard of practice being *notification of the patient when the result of the particular investigation may be of real consequence in terms of the patient's management and ongoing health and/or the patient has specifically requested to be notified of the result of the investigation*. Whilst I accept [Dr B's] comment in his letter of the 15th of September 2015 that based on the available scientific literature, acting on a CA-125 result at this stage may not make any difference to a patient's outcome, the CA-125 result still represented a departure from normal in a standard investigation being undertaken for monitoring of a patient with cancer of the ovary. Discussion of the slight elevation in the CA-125 level with [Ms A] may have initiated a further repeat investigation within a shorter time frame than the planned follow-up. It is, though, a matter of conjecture as to whether a second test at an earlier stage would have shown a more marked departure from a normal result.

It is therefore my opinion that it would have been a reasonable expectation for [Dr B] to have arranged for [Ms A] to be made aware of the elevated CA-125 level and to have engaged with her as to whether any earlier or different investigation was warranted. Having said this, I accept that this is very much a matter of clinical judgement and I believe any departure from an accepted standard of care and practice to be mild. Equally, it is my opinion that my peers would be somewhat divided as to their views on the actions he took in this respect.

6. *If you feel able, please comment on the quality of the MDM process and reporting, taking into account the comments in this regard in [Dr C's] response.*

On the information provided to me it is not possible for me to have an intimate knowledge as to the processes and workings of the MDMs that were operational in these clinical settings at the time of [Ms A's] care. My only real comment would be that robust, reliable, repeatable processes should underpin all MDMs, with facilitation and leadership by skilled clinicians and support by experienced clerical and administrative staff being key to the quality of decision-making, documentation and distribution of information from any MDM.

7. On file is correspondence from the [DHB] oncology service dated 3 September 2015, and a revised histology report dated 16 September 2015, in relation to [Ms A's] original surgical specimens. Do you feel there is any information in these reports to suggest significant errors were made in [Ms A's] original histology reporting and/or staging?

If necessary the Commissioner may wish to seek an opinion from a pathologist in respect to this question. From a clinical gynaecological viewpoint, the reports do not so much indicate that significant errors were made in terms of the original histology reporting and/or staging, but rather there was an *omission* from the first report in terms of any reference to staging of the tumour. This may have contributed to the early lack of clarity in assigning the correct stage to [Ms A's] tumour however the clinicians that were present at the MDMs undoubtedly possessed the knowledge and skills to reach an accurate determination on this even without full pathology assignment.

8. Any other comment you wish to make about [Dr B's] management of [Ms A]?

At this point I have no other comments to proffer to the Commissioner however I am available to the Commissioner for further comment or clarification of the above points, should this be required.

Yours sincerely,

K F CLARK
FRANZCOG FRCOG FRACMA"

On 18 February 2017, Dr Clark provided further comment:

"Thank you for the opportunity to review further information relating to this case and to consider whether any changes to my original advice are warranted or whether any new issues are raised.

Two further documents have been provided

- [The DHB's] response (dated 1 September 2016) to my opinions.
- [Dr B's] response (dated 5 September 2016) to my opinions.

I have examined these responses very carefully and I have assessed them against my advice of 09 February 2016. I am comfortable that at all points I have restricted my opinions to matters where I possess the necessary clinical expertise and experience. [Dr B] feels I may not have understood certain clinical considerations but I have no such reservations. I do clearly appreciate the difference between 'staging' and 'grading'.

I do not wish to alter my original advice to the Commissioner and I do not believe that any new issues have been raised. Thank you for the opportunity to provide further comment.

Yours sincerely,

Dr Kenneth Clark
FRANZCOG FRCOG FRACMA."

On 9 January 2018, Dr Clark was asked whether it was appropriate for Dr B to discuss with Ms A a stage of cancer prior to the MDM process. Dr Clark advised:

> "I would generally see it as very appropriate for a doctor to give a patient an idea of the stage of the cancer, even before receiving all the information needed to determine the absolute stage. The proviso being that the doctor indicated that this was provisional or could only be confirmed on receiving all of the information. It would also not be appropriate if the doctor didn't have the experience and skills to give such an opinion but I think in this case [Dr B] definitely possessed those.
>
> …
>
> I think it is okay that he also communicated this to the oncologist and I think it is a reasonable assumption that both practitioners fully understand that these things are provisional pending final/all results.
>
> It is unfortunate though that there is no evidence that he indicated to the patient that the staging was provisional."

Appendix B: Independent medical oncology advice to Commissioner

The following expert advice was obtained from Dr Richard Isaacs, a consultant medical oncologist:

> "Thank you for asking me to provide advice to the Health and Disability Commissioner on the above complaint.
>
> This case relates to the care provided to [Ms A] by [Dr C] at [the cancer clinic] and communication processes from the related Multidisciplinary Meetings (MDMs).
>
> Thank you also for not only providing correspondence from [Ms A] and [Dr C], but also relevant pathology results, MDM summaries and the Root Cause Analysis from [the cancer clinic].
>
> You have asked me to provide an opinion on three specific areas, namely:
>
> 1. the reasonableness of the care provided by [Dr C];
> 2. the reasonableness of how [the cancer clinic] and [Dr C] handled the incoming documents from the MDMs; and
> 3. the reasonableness of the pathology documentations sent to [Dr C].
>
> I will comment specifically on those issues, but firstly I would like to annotate a summary of the events of the case as I understand them.
>
> Clinical Summary
>
> [Ms A] was diagnosed with early stage ovarian cancer in July 2014. She had initial surgery with [Dr B] on 5 August 2014 at [a private hospital]. Laparoscopy, total abdominal hysterectomy, bilateral salpingo oophorectomy, and omentectomy were performed. In his operation note, [Dr B] describes a 'small area of nodular tumour anterior surface uterus'. The histology report on 5.8.14 describes the ovarian tumour as 'papillary serous carcinoma of mullerian origin with moderate to high grade features'. Both a serosal deposit on the uterus and a nodule on the outer surface of the right ovary show 'high grade tumour' similar to the tumour in the left ovary. A final stage is not stated on the pathology report.
>
> [Ms A's] case was discussed at an MDM on 13.8.14. The MDM summary is brief, but states the tumour was 'Grade 3 (much is low grade)'. Importantly, no FIGO stage was annotated in the summary. The defined stage of disease is important in defining the type of systemic therapy offered.
>
> [Ms A] was then referred to [Dr C], Consultant Medical Oncologist at [the cancer clinic] on 14 August 2014 by [Dr B]. [Dr B's] referral letter summary refers to the resected tumour being Stage IC3 high grade serous carcinoma of the ovary or tube, although he again refers to the tumour containing many areas of low grade. A copy of the histology and the operation note was provided to [Dr C].

[Dr C] first saw [Ms A] on 29 August 2014 and her comprehensive summary and assessment describes [Ms A] as having Stage IC3 high grade serous carcinoma (as described in the referral letter). [Dr C] does make note of the predominant low grade of the disease, but with some high grade tumour present. Her summary did include the description of the deposit on the uterine serosa and the nodule on the right ovary, but did not lead to her changing the stage of disease.

[Dr C] discussed options for chemotherapy including six cycles of single agent Carboplatin, or combination Carboplatin with Paclitaxel with a minimum of three cycles required. [Dr C] states in her replies to this enquiry that she felt the prominent low grade nature of the disease favoured her offering three cycles of treatment.

[Ms A] went on to receive three cycles of Carboplatin/Paclitaxel from 18.9.14 until 30.10.14.

A second MDM, when [Ms A's] histology was discussed was held on 9.9.14, which was prior to her starting chemotherapy. [Dr B] has stated that the reason for the second discussion was: 'The Histology slides were reviewed by the Pathologist and Staging was amended from Stage 1C to Stage 2C. The 2nd MDM on 09 September 2014 was for discussion of this amendment.' [Dr C] acknowledges that she would have received a list of all cases to be discussed at that MDM and that she would have received an electronic document containing the MDM reports. She states, however, that she was not specifically informed that there had been a change in [Ms A's] disease stage. She did receive an electronic request to review the MDM document, but there was apparently an error in the patient identification details. [Dr C] states she requested the results from the MDM be rescanned with correct patient identification and marked as 'review required'. It is not clear to me that this process was completed.

[Dr C] repeatedly states that she understood the MDM document related to the original MDM in August. I find this difficult to reconcile as I assume she would have signed off that original MDM summary.

Without awareness of the change of stage to IIC, [Ms A] and [Dr C] proceeded with the plan for 3 cycles of chemotherapy.

After her 3rd cycle of chemotherapy, [Ms A] remained well until 13 August 2015, when she saw her GP with discomfort in her right chest and requested a CT scan. Bloods done at the time showed a markedly elevated CA125 (the tumour marker for ovarian cancer) and the CT scan confirmed recurrent disease with peritoneal and pleural disease. She was subsequently seen by […] at [the DHB] and has received second line chemotherapy.

When this recurrence was confirmed, the initial assessment of the stage was reviewed and confirmed as Stage IIC.

[Dr C] stated that had she appreciated [Ms A's] disease was Stage II then she would have advised six cycles of chemotherapy.

Discussion:
[Dr C] and [Ms A] are both concerned that the incorrect initial staging of the disease, and subsequent modified chemotherapy, significantly affected [Ms A's] outcome.

[Dr C] has expressed not only her extreme regret over the circumstances, but also her frustration over her perceived lack of communication relating to a second MDM discussion.

Specific questions to address:

1. **The reasonableness of the care provided by [Dr C];**
   a) The reasonableness of [Dr C's] decision to provide [Ms A] with three cycles of chemotherapy for stage IC3 high grade serous carcinoma of the ovary and tube

[Dr C] based her initial treatment advice on [Ms A] having Stage IC disease, with a predominant low grade component, but with elements of high grade. This disease stage is considered high risk, early stage disease (Stage 1B/C, grade 2/3, any grade 3 or clear cell histology (European Society of Medical Oncology (ESMO) Guideline 2014). Standard treatment has been with 6 cycles of platinum-based chemotherapy, providing a modest benefit and this duration is still advocated by the ESMO and National Institute for Health & Care Excellence (NICE) guidelines.

[Dr C's] advice for 3 cycles is based on the results of clinical trial GOG 157, authored by Bell et al (2006), which randomised 427 patients with high grade Stage 1 (as per the above criteria) or resected Stage II disease (134 patients), between 3 and 6 cycles of carboplatin/paclitaxel. This study showed no clear improvement in the rate of recurrence, but greater toxicity with the longer treatment regimen. Results from this trial have resulted in the National Comprehensive Cancer Network (NCCN), the major US guideline group, accepting the shorter treatment as a valid treatment strategy in high risk stage I disease only, but all groups still advocate $\geq$ 6 cycles for Stage II disease and higher. The GOG 157 study actually suggests, although in a limited data set, that stage II patients similarly may not get greater clinical benefit from a further 3 cycles of chemotherapy.

The decision to treat with 3 cycles of chemotherapy for assumed Stage IC disease must be considered a reasonable and acceptable standard of care, on the basis that this approach is supported by published clinical trial data from a large study group and is supported by a major international guideline.

b) The reasonableness of [Dr C] not knowing about [Ms A's] change in staging

[Ms A's] staging was incorrectly defined from the time of referral, for the following reasons:

- The referral letter from [Dr B] described the disease as Stage IC3, despite the pathology report and operation note clearly describing a malignant nodule on the uterus, which upstaged the disease.
- The treating clinician ([Dr C]) appears to have accepted the stage in the referral letter, despite her own new patient letter clearly describing features of Stage IIC disease as above.

- The initial MDM did not include a FIGO stage in the summary of that meeting.

This sequence of errors resulted in an incorrect treatment choice. Once the label of disease stage has been applied, it is often 'copy and pasted' in subsequent letters and the clinician will not review the original stage as a routine. The second MDM review should have corrected this error, but due to a number of process errors this did not occur.

The process errors related to that MDM were:

- [Dr C] was not informed of the significance of the MDM review for [Ms A], prior to or following that meeting
- When the MDM summary came for review, a clerical error resulted in another patient's details being annotated on [Ms A's] report
- A fresh summary was requested by [Dr C], without viewing the MDM summary, but this appears to have gone directly to the patient's clinical record, rather than back to [Dr C] for review.

In my opinion, [Dr C] should have been directly informed of the reason why [Ms A's] case was to be rediscussed. This would have alerted her to pursuing the MDM outcome. **Not to do so was a mild departure from an acceptable standard of care, as the treating clinician still received a list of cases to be discussed at the MDM.**

[Dr C] should still have pursued the results of the MDM, as she did receive the MDM document from 9.9.14 and noted there was an incorrect annotation. This document indicated a second discussion had occurred, which was unusual. She made an attempt to obtain an accurate summary, but this process does not appear to have been completed and the MDM report was not fully appreciated. **On its own this is again a mild departure from the accepted practice.**

The provision of an accurate MDM report to [Dr C] and *confirmation that it had been seen* was not completed. **On its own again this is a mild departure from accepted practice.**

The sequence of these failures combined to produce a moderate departure from acceptable practice in terms of communication over MDM discussions, as the process should have ensured [Dr C] was aware of the accurate stage of [Ms A's] disease and she would likely have been offered standard treatment.

2. The reasonableness of how [the cancer clinic] and [Dr C] handled incoming documents from MDMs;

It is standard practice in my DHB, and others, to receive a list of patients to be discussed at an MDM, with no individual contact that a specific issue is to be addressed. On occasion, a patient will be re-discussed because the pathology or radiology had not been discussed previously. In this situation, the involved clinician may not attend, but will expect to be informed if there are significant changes identified.

[Dr C] was not directly informed of a specific change to the assumed stage for [Ms A], which was an error as stated above. It would not be our standard practice for an MDM to proceed without any medical oncologist present, particularly when the findings addressed would potentially modify systemic treatment for a patient. If the meeting did proceed in that setting, then it would be important, in my opinion, that the treating clinician was directly informed of a change.

There was a sequence of errors, as described in the section above in the MDM summary communication. Each one, on its own, should have been manageable and corrected by other processes. The unfortunate chain of events meant that [Dr C] neither received, nor acknowledged the MDM report summary and thus did not change her treatment.

As stated above, this chain of events combined to produce a moderate departure from acceptable practice. In October 2015, [the cancer clinic] stated a review of their MDM processes was occurring. I believe the Commissioner should obtain details of that review and assurance that processes now exist to prevent a similar chain of events occurring in future.[27]

3. The reasonableness of the pathology documentation sent to [Dr C].

The pathology report provided to me is detailed and appropriate.

In my opinion the MDMs reports in this case are extremely brief and provide very limited clinical guidance. The first report contained no FIGO stage, while the second gave the stage as IIC, but gave no indication that this was a change. I am informed by my pathology colleagues that a FIGO stage is not usually provided by pathologists alone, rather clinicians apply that information with surgical and radiology findings to produce the final stage.

In my opinion, there was no departure from the standard of care in the pathology report. It contained adequate information to accurately define stage from the time it was issued.

Thank you for the opportunity to review this case. Please contact me if you wish to clarify any points.

Yours sincerely,

Document checked and signed electronically.

Dr Richard Isaacs MNZM MBChB D.Phil (Oxon) FRACP
CONSULTANT IN MEDICAL ONCOLOGY
MEDICAL HEAD, MIDCENTRAL REGIONAL CANCER TREATMENT SERVICE"

[27] Please refer to Dr Isaacs' further comment provided 15 February 2017, in that Dr Isaacs identifies his mistake here in that the cancer clinic was not reviewing its MDM processes as it did not conduct the MDMs.

On 15 February 2017 Dr Isaacs provided further comment:

> "Thank you for asking me to provide further advice to the Health and Disability Commissioner on the above complaint.
>
> Thank you also for providing the responses from [Dr C], [a law firm] and [the cancer clinic] in response to my initial advice of 15 May 2016.
>
> **Response to [the cancer clinic]**
>
> [The cancer clinic] [has] appropriately reviewed their processes in their root cause analysis and appear to have made appropriate changes to minimize the risks of further such events occurring, in relation to the transmission of communication from multidisciplinary meetings.
>
> I had misunderstood that the relevant MDM in [Ms A's] case was coordinated by [the cancer clinic], but on further review of the root cause analysis, it is stated on page 51 that the relevant MDM was under the supervision of the [Women's Clinic]. I apologize for that misunderstanding.
>
> Clinicians from [the cancer clinic] have since moved their involvement in the MDM from the [Women's Clinic] to the Regional Gynae-Oncology MDM at [the DHB]. I believe this change is appropriate, on the assumption that the [DHB] MDM functions in a manner consistent with Ministry of Health guidelines, as occurs nationally with support from the cancer networks.
>
> It is my recommendation that the [Women's Clinic] should be asked whether they still run a Gynae-Oncology MDM, which would seem unlikely without Medical Oncology support. If the MDM does still function, the results of the review requested by [the cancer clinic] should be available to the Commissioner.[28]
>
> **[Dr C] Response**
>
> [Dr C] has clearly taken extreme steps to minimise any clinical errors she might make in the future and should be congratulated for doing so.
>
> In response to [the law firm's] letter, my areas of concern relating to this case were a sequence of events which on their own were all mild departures from an acceptable standard of care, but which summated to a moderate departure. I agree with all statements in section 6 of [the law firm's] letter, but note that I am only asked to comment on variance from an acceptable standard of care, not on whether any breach of the code has occurred.
>
> [Dr C] was only individually responsible for inaccurately defining the stage of her patient as Stage IC, with the pathology information provided, which indicated Stage IIC. She acknowledges this in her letter and has taken steps to avoid this in future. This

[28] Please note that the cancer clinic did not request a review of the women's clinic's MDMs. The cancer clinic undertook an internal review of its processes for managing incoming documents including those received from MDMs. A copy of this information was provided to HDC.

misallocation of stage resulted in a shorter course of treatment than she would have planned for Stage IIC disease, which has been assumed to potentially affect prognosis, although this difference in stage is based on a very small difference in disease distribution. This error, which I consider in isolation as a minor deviation, would normally be corrected by the MDM process, but this did not occur due to a succession of communication and clerical errors as described previously. Without effective communication of MDM findings, including a change in stated disease stage, there is the potential for clinical risk.

The use of multidisciplinary meetings has generally enhanced cancer patient care in New Zealand, but the processes involved must be robust. In my opinion the primary concern in this case was a failure of MDM communication on a number of levels, which would need to be corrected if that particular MDM was to continue.

Yours sincerely,

Document checked and signed electronically.

Dr Richard Isaacs MNZM MBChB D.Phil (Oxon) FRACP
CONSULTANT IN MEDICAL ONCOLOGY
MEDICAL HEAD
MIDCENTRAL REGIONAL CANCER TREATMENT SERVICE"