COLLEGE OF PHYSICIANS AND SURGEONS OF NOVA SCOTIA

SUMMARY OF DECISION OF INVESTIGATION COMMITTEE D

Dr. Kieron McGibney
Licence Number: 015186

Investigation Committee D of the College of Physicians and Surgeons of Nova Scotia ("College") concluded its investigation into a complaint against Dr. Kieron McGibney by issuing its decision dated July 31, 2019. The Investigation Committee reached agreement with Dr. McGibney with respect to the disposition of the complaint. A summary of the complaint and disposition appears below.

OVERVIEW

This matter was initiated by a letter from the Complainant received on June 20, 2018. A response from Dr. McGibney was received on August 13, 2018.

Investigation Committee D, formed in accordance with the *Medical Act* of Nova Scotia, 2011, was responsible for the investigation of this complaint

In addition to correspondence from the Complainant and Dr. McGibney, the Committee conducted an interview with Dr. McGibney on February 5, 2019.

PARTIES

Dr. Kieron McGibney is a physician in Truro, licensed to practise medicine in Nova Scotia in the specialty of General Surgery.

The Complainant is the sister of the deceased Patient, who died in November 2017.

SUMMARY

Key points as reported by the Complainant

On November 5, 2017 the complainant's sister, the Patient, died after having been diagnosed with cancer. The Complainant questions the capability and competence of doctors when it comes to getting an accurate diagnosis, prognosis, and treatment. She states not one of the Patient's doctors told them that she only had a couple of months to live. The family was especially in the dark regarding ovarian/Krukenberg tumors until this complaint was filed.

The Complainant alleges Dr. McGibney failed to read her sister's CT scan in March 2017. He confessed this on September 3, 2017. The Complainant thinks Dr. McGibney caused the death of her sister.

The Complainant does acknowledge Dr. McGibney is the only physician who was up-front regarding this whole situation. From the start he told the family that the deceased was at high-end of not good. They still did not know about the ovarian tumors. The family carried on as if the bowel cancer was the only issue.

The Complainant alleges Dr. McGibney cannot say with 100% certainty, if this cancer had been discovered and diagnosed in March 2017 when the CT report was given to him, the Patient would not have been given a better, more positive prognosis. If found in March 2017, her ovaries could have been removed, and with chemotherapy, extended her time with family to prepare for the ultimate outcome.

Key points as reported by Dr. McGibney

The Patient was referred to Dr. McGibney for assessment on January 11, 2017 with regards to her incisional hernia. Dr. McGibney was aware her assessment would require an abdominal CT scan so this was immediately ordered.

Dr. McGibney first met the Patient for an initial consultation on February 24, 2017. The Patient had been diagnosed with anemia in 2016 and colonoscopy had shown a cancer which was resected in an open resection in July 2016. She suffered a delayed dehiscence of her wound which had been repaired. About three months after this she developed a large incisional hernia.

At the time of Dr. McGibney's initial assessment, the Patient was undergoing adjuvant systemic chemotherapy. During that visit the hernia was deemed likely to need a fairly extensive and complex repair. Prior to making any final decisions, Dr. McGibney wished to have the results of the CT scan, which had not yet been performed. He also desired further information about a prior ventral hernia repair done in Ontario years earlier.

At a second appointment on April 28, 2017 Dr. McGibney had the information about the Patient's prior hernia repair. Her CT scan had also been performed on March 20, 2017. He spent time going over the details of both the report and looking at the images themselves. His letter from that visit dated the same day contains the assessment of the abdominal wall findings as they would relate to her hernia repair. They went over the details of the planned repair as well as the possible complications related to the surgery. She was in the process of losing some weight and wished to continue this prior to surgery. Dr. McGibney agreed with this plan. Since she had also only just completed her Xeloda he felt more time was prudent to allow her to better recover her strength and a note was made on her booking application not to book her for at least three months. She gave her consent to the operation and although they did not plan to meet again until her surgery, she was invited to make contact if she had any issues.

Dr. McGibney saw the Patient on August 30, 2017. They met before the operation and went over

the surgery, as well as her current clinical status. She stated she was having a lot of problems with abdominal bloating and discomfort which were similar to those previously attributed to the hernia. Although the Day Surgery area does not have a formal examination area he did palpate her abdomen and no particular issues were noted other than the known hernia. He reviewed her medical history, his notes, as well as the CT scan images with regards to the anatomy of the hernia.

The Operative Report dated August 30, 2017 notes at the start of the operation her subcutaneous tissues were noted to be quite edematous and there were ascites in the abdomen immediately on entry. This raised concerns as no ascites should have been present. Palpation through the defect suggested carcinomatosis. A hernia repair could not be done. Only a small extension of the incision was made to allow drainage of the ascites and evaluation of the tumor spread. Tumor nodules were found and one of these was biopsied to determine its exact etiology to guide future therapy. In the mid abdomen there was a large domed structure with a smooth greyish surface and no obvious adhesions to surrounding structures. Palpation showed this to be tapering down into the pelvis. The abdomen was not opened further as this would not help therapy and could lead to wound healing issues.

A cytology sample was taken. The mass itself had characteristics remarkably in keeping with an enlarged uterus. For this reason gynecology was asked to assess. Although the clinical circumstances would favour a recurrence of her known colon cancer, gynecology felt the mass looked like her uterus and might therefore represent a second primary tumor. The abdomen was closed with a plan for further investigations and therapy. An urgent CT scan and bone scan were ordered.

Dr. McGibney met with the Patient and her family to go over the findings. He does not recall his exact words but does remember describing the findings as representing an advanced tumor.

A CT scan performed the next day showed the mass represented Krukenburg tumors, rather than a uterus. The CT also showed increased spread within the abdomen and newer metastases.

During the Patient's post-operative course Dr. McGibney arranged for consultations with social work and palliative care. He also spoke directly with her oncologist for an expedited referral.

After the finding of the Patient's diffuse disease Dr. McGibney went back to review her original imaging to see if there had been any evidence of recurrence at that time. As noted in his operative note, he had been under the impression that workup had cleared her of this, and that it was safe to proceed with repair.

He reviewed the CT again on September 2, 2017. He was shocked to discover the March 2017 CT scan had shown some small nodules suspicious for recurrence. Dr. McGibney had not recognized this. He immediately spoke with the Patient and explained the situation. He offered an apology for the error. This information was also communicated to her family and she also asked him to review this with her husband, which he did. This same information was passed to the oncologist when he spoke with him on September 6, 2017.

Dr. McGibney confesses and acknowledges in the midst of the Patient's care he committed the error of misreading the Patient's CT report and missed an important piece of information regarding the return of her cancer.

Dr. McGibney is unsure of how he failed to note this when he first read the CT report. In his practice he undertakes a number of measures specifically designed to minimize the risk of this type of error. He usually looks at labs on the computer system rather than paper which allows trending to show patterns that could otherwise be overlooked. He reviews needle localization for breast tumors directly with the performing radiologist rather than relying on the drawings provided to the OR. He reviews pathology reports on the computer immediately prior to surgery to ensure there have been no updates or changes. One such preventative practice is related to imaging reports. It is his habit to read the entirety of a report rather than the summary only. This is because there can sometimes be information in the body of the report that will affect care that may not be important enough to be singled out in the final statement.

In the body of the Patient's report there is a detailed description of the abdominal wall. He recalls going over this description in detail and correlating it directly with the images themselves to help plan the operation. The rest of the report notes multiple liver and adnexal findings and other details of lesser importance. He suspects with this abundance of information, and with his focus on the abdominal wall, he may have failed to recognize the pelvic nodules as concerning and missed the single, short, but significant sentence mentioning the possibility of metastatic deposits.

When he noted this oversight after the Patient's surgery he was quite shaken and continues to be disturbed by the error to this day. He thinks of the Patient when reading reports on a regular basis to help ensure this never happens again.

He is unable to exactly identify what he could have done differently to have prevented this from occurring. He recalls reviewing the entire CT report with full attention. He recalls correlating the comments of the radiologist with the images themselves. He must have missed this sentence or read it, but it failed to register. He can only say his practice has been to diligently read all aspects of all reports and has redoubled efforts in this way to ensure something like this does not happen again.

Outside of his practice, it may also be possible to adjust the reporting systems so that this type of finding is less likely to be missed. Abnormal lab values are visually highlighted in reports and critical values are called directly to the ordering physician. It may be this type of approach to imaging reports could be considered and he is considering how to approach Radiology colleagues to advocate for such a change.

Dr. McGibney's error was first discovered by him, and he immediately communicated the error to the Patient, her husband and extended family, and to other treating physicians. No attempt was made to hide any fact. He was shocked and had felt terribly about this. Once this issue was recognized, he did all he could to expedite care for the Patient.

The Patient's tumor was locally advanced when it was found, and subsequently showed highly

aggressive behaviour with progression on chemotherapy and rapid growth in just a few months within her abdomen and spread to the liver. Dr. McGibney is sure a recognition of the March 2017 CT report would have led to an alternate path of therapy for her disease, but likely with no change to the ultimate outcome. Dr. McGibney appreciates this must have been very difficult for the Patient, and must continue to be very difficult for the Complainant. Dr. McGibney offered apologies to the Patient and her family and to the Complainant.

Dr. McGibney notes the Patient's ovarian tumors were not of ovarian origin and she did not have a second cancer. These represented metastatic deposits from her original colon cancer. Metastases in this location are referred to as Krukenberg tumors.

Preliminary Investigation

Pursuant to Section 88 (1) of the *Medical Practitioners Regulations*, an Investigator was appointed to conduct a preliminary investigation of this complaint.

CONCERNS/ALLEGATIONS OF COMPLAINANT

The Complainant alleges Dr. McGibney:

- did not thoroughly review a March 2017 CT scan prior to the Patient's hernia surgery and subsequently failed to arrange appropriate follow-up for the Patient.

CONCERNS OF COMMITTEE

As with all complaints, the Investigation Committee is not limited to investigating only the concerns set out in the complaint. The Committee has the responsibility to look into all aspects of a physician's conduct, capacity or fitness to practise medicine that arise in the course of the investigation.

In this instance, the Committee had no additional areas of concern arising from the investigation of this complaint beyond those expressed by the Complainant.

DISCUSSION

The Committee reviewed the complaint, response and relevant medical records. The Committee interviewed Dr. McGibney.

March 20, 2017 CT Report

The Patient was referred to Dr. McGibney for assessment of a hernia on January 11, 2017. Her assessment required an abdominal CT. Dr. McGibney ordered one. His initial consultation with the Patient was on February 24, 2017.

At a second appointment on April 28, 2017, Dr. McGibney reviewed the March 20, 2017 report and the CT images (the "Report") with the Patient. His letter from that visit speaks to the Patient's abdominal wall findings as they relate to her hernia repair.

Dr. McGibney saw the Patient again on August 30, 2017. He palpated her abdomen and no issues were noted other than the hernia. He reviewed her medical history as well as the CT scan images with regards to the anatomy of the hernia.

The Operative Report of August 30, 2017 notes the Patient's subcutaneous tissues were edematous (full of excessive fluid) and there were ascites (fluid buildup) in her abdomen. This raised concerns. Palpation through the defect suggested carcinomatosis.

In the body of the Patient's Report there is a detailed description of the abdominal wall. Dr. McGibney recalls going over this description in detail and correlating it directly with the images themselves. The rest of the report notes multiple liver and adnexal findings and other details of lesser importance.

Dr. McGibney suspects the abundance of information in the Report, in the context of him being focused on the abdominal wall, may have contributed to his failure to recognize the pelvic nodules as concerning. Dr. McGibney missed a single, short, but significant sentence, which mentioned the possibility of metastatic deposits.

The Committee reviewed the Report. The Findings section contains seven short paragraphs. The seventh paragraph notes a, "new 1.5 cm soft tissue density and multiple new tiny soft tissue densities within the anterior omentum of the inferior pelvis".

Immediately following the Findings is the Summary. The first single-sentence paragraph of the Summary notes a, "Midline ventral abdominal wall hernia as described". Paragraph two states, "New 1.5 cm left pelvic soft tissue density is indeterminant (sic). Multiple new tiny soft tissue densities within the anterior omentum of the inferior pelvis. These are indeterminant (sic). Cannot rule out metastatic deposits in this clinical context".

In his interview before the Committee, Dr. McGibney stated he must have considered the pelvic nodules mentioned later in the Report to represent further postoperative changes. Despite a conscious efforts to avoid that sort of issue, Dr. McGibney thinks he fell into a search scan, a cognitive error, or a satisfaction of search error.

Dr. McGibney acknowledged he made two errors. One error was made in not interpreting the second referral to new soft tissue densities as being a different interpretation from the first discussion (in the Findings). His second error was missing the comment about malignancy in the Summary section.

The Committee noted the soft tissue densities in the omentum, mentioned in the Findings, would not be interpreted typically as being post-surgical abnormalities.

Dr. McGibney stated he did not interpret the soft tissue densities in the omentum correctly because he spends so much time interpreting other soft tissue densities, and the exact same phrase is used. Cognitive priming meant his brain was already set to interpret soft tissue densities in one way, and that was not the correct way.

Dr. McGibney explained the psychology of being cognitively primed to view certain phraseology as postoperative changes. He also noted there is also an element of visual fatigue associated with reading a long report, and probably passed over the line that noted the new 1.5 cm left pelvic soft tissue density, and multiple new tiny soft tissue densities that could be metastatic deposits.

Dr. McGibney told the Committee he thought he had read the entire Report thoroughly, and noted it was possible to make errors. He noted he read the entire Report, but said it is possible to skip over or miss a single line when you reading thousands of lines of information.

The Committee wanted to establish whether Dr. McGibney read the entire Report, or did not read some portions of it. When asked if there was a part of the Report he did not read, he confirmed he thinks he missed a line in the Report, stating although he did read the entire Report, did not read the small portion that noted possible metastatic deposits. The Committee found it difficult to confirm whether or not Dr. McGibney read the entire Report.

Conclusion

The Committee is aware an error in judgment does not necessarily equate with professional misconduct. There must be evidence Dr. McGibney deliberately departed from accepted standards, or failed to meet those standards in such a manner, which although not deliberate, portrays indifference or a lack of concern for the welfare of the patient involved.

Dr. McGibney was aware of the Patient's history of cancer. She was on adjuvant systemic chemotherapy when he initially assessed her. Although Dr. McGibney explained to the Committee how he was cognitively primed to misrepresent the findings in the Report, this does not explain how he failed to read a line in the Report which clearly stated the Patient's images could not rule out metastatic disease. He knew he was treating a cancer patient.

The Committee is concerned Dr. McGibney read the Report and the CT images in the context of a tunnel vision with a view to the hernia repair he was going to complete, and failed to read and correctly interpret other relevant information. The Committee is concerned Dr. McGibney was only reading the Report for the purposes of the hernia repair he was about to perform, and not in the context of the patient's full clinical picture. The changes to the Patient's omentum could not be interpreted as post-operative changes, and this does not meet the standard of care. The Report also clearly states the Patient, a cancer patient, could have metastatic deposits. The Committee is concerned Dr. McGibney's error goes beyond an error in judgment. The Report was only two pages in length. It clearly indicates the Patient is ill. It appears Dr. McGibney failed to read the entire Report, and failed to appreciate the findings in the context of her entire clinical picture

While the Committee was pleased to see Dr. McGibney has made attempts to address any improvements that could be made from a radiology reporting standpoint, it is the Committee's

view Dr. McGibney was responsible for reviewing the report from beginning to end, regardless of the format.

The Committee concluded it is more likely than not a Hearing Committee would come to the conclusion Dr. McGibney's actions constitute professional misconduct.

The Committee turned its mind to the mitigating and aggravating factors in this case.

Dr. McGibney's error was first discovered by him, and he immediately communicated the error to the Patient, her husband and family, and to other treating physicians. Once this issue was recognized, he did all he could to expedite care for the Patient.

Dr. McGibney thinks of the Patient when reading reports on regular basis to help ensure this never happens again. His practice has been to diligently read all aspects of all reports, and he has redoubled efforts to ensure something like this does not happen again.

The Committee notes Dr. McGibney is early in his career. The Committee is hopeful Dr. McGibney has, and will, continue to learn from this error.

Dr. McGibney appreciates this must have been very difficult for the Patient, and must continue to be very difficult for the Complainant. Dr. McGibney offered apologies to the Patient and her family and to the Complainant.

Dr. McGibney indicated he is sure a recognition of information in the Report would have led to an alternate path of therapy for the Patient's disease, but likely with no change to the Patient's ultimate outcome. The Complainant alleges if the metastatic deposits were found in March 2017, the Patient's ovaries could have been removed, and with chemotherapy, this may have extended her time with family so as allow for time to prepare for the ultimate outcome. The Committee is unable to confirm whether earlier recognition would have changed her outcome, but it certainly would have allowed her family more time to prepare for her death. The Patient suffered a catastrophic outcome, and her family had very little time to process her new diagnosis and prepare for her passing. They were robbed of this time.

The Committee noted Dr. McGibney had multiple occasions to review the Report himself, and review the findings with the patient. Dr. McGibney acknowledged he reviewed the report and the images themselves on April 28, 2017. He also reviewed the CT images again on August 30, 2017.

Dr. McGibney provided an April 28, 2017 consult letter to the Patient's family physician. Because Dr. McGibney did not appreciate the report questioned whether the Patient had metastatic deposits, he subsequently communicated incomplete information to a family physician.

Dr. McGibney noted in a February 12, 2019 letter to the Committee he felt his attempts during his interview to explain his methodology came across as an attempt to diminish his errors rather than an explanation of his attempts to understand and prevent them in future.

DECISION

In accordance with clause 99(5)(f) of the *Medical Practitioners Regulations,* the Committee has determined there is sufficient evidence that, if proven, would constitute professional misconduct warranting a licensing sanction.

Pursuant to clause 99(7)(a)(i) of the *Medical Practitioners Regulations,* and with Dr. McGibney's consent, Dr. McGibney is *reprimanded* for:

- departing from accepted standards of care when he read the Patient's CT report only with regards to how he was treating her hernia, as opposed to fully appreciating her entire clinical picture. This resulted in a delay in arranging appropriate further investigations regarding the patient's potential for metastatic disease.

In addition, Dr. McGibney agreed to contribute an amount toward the College's costs.

Dr. McGibney agreed to accept this disposition on August 13, 2019.

For further information related to the Nova Scotia Medical Act & Medical Practitioners Regulations, along with the College Standards and Guidelines, please visit our website at: www.cpsns.ns.ca