Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Deputy Health and Disability Commissioner

(Case 21HDC00619)

Introduction

1. This report is the opinion of Deputy Health and Disability Commissioner Carolyn Cooper and is made in accordance with the power delegated to her by the Commissioner.

2. The report discusses the care provided to Ms A by Dr B at a medical centre.

3. The following issues were identified for investigation:

- *Whether Dr B provided Ms A with an appropriate standard of care from February 2018 to April 2021 (inclusive).*
- *Whether the medical centre provided Ms A with an appropriate standard of care from February 2018 to April 2021 (inclusive).*

Background

4. At the time of events, Ms A was aged in her sixties and her medical history included osteoarthritis and asthma. She was an enrolled patient of the medical centre and Dr B[1] was her general practitioner (GP).

[1] Dr B is a vocationally registered general practitioner and urgent care physician. He is a Fellow of the Royal New Zealand College of Urgent Care, and of the Royal New Zealand College of General Practitioners. He is one of two directors of the medical centre and is the sole doctor operating from the clinic.

Assessment at public hospital

5. On 24 February 2018, Ms A suffered an injury and presented to the Emergency Department (ED) at a public hospital. While in the ED, Ms A underwent an X-ray (which showed no fractures) and a CT scan.[2] Ms A was discharged a few hours later with a primary diagnosis of a soft tissue injury to the right shoulder, and she was advised to see her GP the following Monday. The CT scan was not reported formally before Ms A's discharge.

6. The original discharge summary from this visit was amended late on 24 February to add a clinical note, and then again two days later, on 26 February 2018 at 11.50am with the formal reporting of the CT scan. The second amendment to the discharge summary, written by a hospital clinician, noted that the CT report showed no intracranial abnormality or fractures. However, it had identified an incidental finding of a mass in Ms A's neck. The discharge summary stated:

> 'In the upper left neck, there is a 17mm diameter cystic appearing mass … a necrotic lymph node is possible. ENT [ear, nose and throat] referral and further evaluation with MRI is recommended.
>
> I have discussed this CT result with [Dr B] who will organise ENT followup for [Ms A]. I couldn't get a hold of [Ms A] on her phone.'

Events after assessment

7. All three discharge summaries (the original and the two subsequently amended summaries) from the hospital were copied to Dr B, as Ms A's GP.

8. Dr B confirmed to HDC that he received all three summaries. However, he stated that because the first two did not have any significant changes, he filed the third summary in Ms A's record without looking at it, presuming it to be a duplicate of the others. Dr B said that he has no recollection of a telephone call alerting him to the ENT recommendation as per the note in the third discharge summary, and there is no documentation of this telephone call in the medical centre's clinical records.

9. Dr B stated that because he did not review the third discharge summary, he did not act on the recommendations from the CT scan (an ENT referral and further evaluation with MRI) as he was unaware of them.

10. Ms A presented to Dr B on 26 February 2018 (Monday) as per the advice from the ED. At this appointment, it was noted that Ms A had a tender right hip, was limping, and was in discomfort. An ACC claim was submitted, and Ms A was prescribed medication to help her to sleep, alongside her usual medications.

11. There is no mention of the CT scan finding at this appointment, or at any subsequent appointments.

[2] A computed tomography (CT) scan is a medical imaging technique used to obtain detailed internal images of the body.

Subsequent events

12. Ms A told HDC that on 21 October 2020 (over two years later) she presented to an Accident and Emergency Clinic with pain in her hip. She said that at this appointment, she was informed of her 2018 CT scan result. This was the first time she was made aware of the result.

13. Ms A contacted Dr B to inform him of the information contained in the third discharge summary. Dr B told HDC that this was the first time he had learnt of the CT result and recommendations.

14. In a letter to Ms A written on 27 October 2020, Dr B stated:

> 'I unreservedly apologise for missing an amended report from your discharge summary dated 24 Feb 2018 from the ED department [of the hospital]. The report states that I was called and informed of the scan, and that I would organise an ENT referral. I am incredulous that I would not have done this immediately as this is what I do when I receive something of this nature … In addition, I did not see the amended CT scan report on the discharge summary.'

15. Subsequently, Ms A underwent surgery to remove the mass in her neck, which was found to be metastatic squamous cell carcinoma.[3]

Responses to provisional opinion

16. Ms A was provided with the opportunity to comment on the 'background' section of the provisional opinion and had no comments to make. She told HDC that since these events, she has struggled alone with nobody to assist her.

17. The medical centre was provided with the opportunity to comment on the provisional opinion and had no comments to make.

18. Dr B was provided with the opportunity to comment on the sections of the provisional opinion that were relevant to him and, with the exception of one issue outlined further below, stated:

> 'I agree with the findings and recommendations from the Commissioner. I remain humbled by the unfortunate events that have changed my practice, I trust, for the betterment of my patient whom I serve.'

19. In addition, Dr B reiterated his unreserved apology for his omission and the fact that he assumed that he had received a duplicate discharge summary, resulting in him overlooking such an important report.

[3] A common form of skin cancer that develops in the squamous cells that make up the middle and outer layers of the skin.

Opinion: Dr B — breach

20. As noted above, Dr B was Ms A's registered GP, and after Ms A's presentation to the public hospital in February 2018, Dr B was sent three discharge summaries about the presentation. The third discharge summary, amended on 26 February 2018, noted an incidental finding of a mass in Ms A's neck, and recommended ENT follow-up and an MRI to investigate the mass further. It also noted a conversation had between the hospital clinician and Dr B about the finding and recommendations. However, these recommendations were not actioned by Dr B.

21. To assist my assessment of the care provided by Dr B, I sought in-house clinical advice from GP Dr David Maplesden.

22. Dr Maplesden considers that the actions taken by Dr B on receipt of the amended ED discharge summary, which included the CT scan report identifying an abnormal neck mass and specifically requesting the GP to make an ENT referral, were inadequate. Dr Maplesden advised that if there was no accompanying telephone call from the clinician at the public hospital, he would be moderately critical of Dr B's failure to review the amended discharge summary adequately and act on the recommendations made in the summary. Dr Maplesden stated:

> 'Mitigating factors considered are this was apparently the second amendment made to the discharge summary which means the third copy of the summary provided to [Dr B], and receipt of duplicate (non-amended) discharge summaries is not an uncommon occurrence.'

23. However, Dr Maplesden advised that if Dr B did receive a telephone call from the hospital in addition to the written request to refer Ms A for an ENT review, he would be 'moderately to severely critical this contact was not documented or acted on by [Dr B] in a timely manner'.

24. I acknowledge Dr B's submission that he cannot recall such a telephone call, and I note that there is no record of the call in the medical centre's clinical records. However, the amended discharge summary is clear that the CT result and the recommendation was discussed with Dr B, and it was planned that Dr B would organise the ENT referral. In addition, I acknowledge that at the time the error was brought to Dr B's attention, it had been over two and a half years. It would be expected that any telephone call would be difficult to recall.

25. In response to the provisional opinion, Dr B stated that he takes exception to a conclusion that he did receive a telephone call from the clinicians at the hospital. He told HDC that he never receives phone calls in the weekend, so the call must have occurred on Monday 26 February 2018 before 11.50am (which is when the third discharge summary was timestamped). He stated that he started work at 9am that morning and was consulting patients continuously all morning. In addition, he noted that he saw Ms A that morning for a consultation and would therefore not have forgotten a phone call regarding her care the same day he had seen her. He stated: '[M]y conclusion is that it is not possible that I was informed of the CT result by phone.'

26. I have carefully considered Dr B's submission above. Although I am mindful of the contemporaneous record that a discussion occurred, I also acknowledge that the record is not specific as to how and when this discussion occurred. Acknowledging Dr B's strongly held view that he did not receive a telephone call, I allow the possibility that he may not have been informed of the CT result by phone. However, Dr Maplesden notes that even if there was no accompanying telephone call from the hospital, he would still be moderately critical of Dr B's failure to review the amended discharge summary adequately and act on the recommendations made in the summary. On that basis, Dr B's care fell below the appropriate standard in either case.

27. While I acknowledge that the receipt of three discharge summaries from the hospital may have led Dr B to believe that the third was only a duplicate, I consider that the onus was on Dr B to check each summary before filing it away to satisfy himself that this was the case. As a result, the findings were not actioned, and Ms A's formal cancer diagnosis was delayed by over two and half years.

28. I consider that in failing to act on the CT findings and recommendations from Ms A's discharge summary, Dr B did not provide Ms A with an appropriate standard of care, in breach of Right 4(1)[4] of the Code of Health and Disability Services Consumers' Rights (the Code).

Opinion: Medical centre — other comment

29. Dr B is the sole doctor contracting from the medical centre and is one of its two directors. In my view, the failure to act on Ms A's CT scan results and the recommendations of the hospital was a human error and was the responsibility of Dr B alone, and I am satisfied that this failure does not indicate a systems issue at the medical centre. Accordingly, I find that the medical centre did not breach the Code.

30. However, when reviewing the file for this matter, Dr Maplesden noted that the current policy at the medical centre for the management of clinical correspondence and results lacked detail compared with policies he has reviewed from other practices.

31. The policy titled 'Continuity of Care' states (among other things) that it is the responsibility of Dr B to 'create a seamless and safety netted system to ensure referrals are created, lab/investigations/results are read, recorded, tracked and followed up here at [the medical centre]'. Dr Maplesden considers that the document lacks detail regarding the specifics of how correspondence is managed, including differentiating electronic from hard copy correspondence; details of inbox management, including management in the event of unforeseen absence of a clinician or use of a locum; handling of urgent results; handling of normal versus abnormal results; and which results specifically require tracking.

[4] Right 4(1) states: 'Every consumer has the right to have services provided with reasonable care and skill.'

32. Dr Maplesden advised:

> 'I believe the policy requires review and improvement to reach the standard I have seen from most other practices I have reviewed, but I acknowledge if the practice has received accreditation from RNZCGP for Foundation Standard, this policy has presumably been regarded as acceptable by the Foundation Standard assessors.'

33. I accept this advice. While I consider that the policy did not contribute to the error in this case, I consider that there is room for improvement in the medical centre's policy, and I will make a recommendation to this effect.

Changes made since events

34. Since these events, Dr B has made the following changes to his practice:

a) He has apologised personally to Ms A;

b) He has informed his colleagues of the mistake to reduce the risk of a similar event occurring;

c) He is now meticulous in reading all duplicate documents; and

d) He has closed his practice to new patients to allow himself more face-to-face patient time, and no longer sees patients afterhours to ensure a better work–life balance.

Recommendations

35. I acknowledge that Dr B has reflected on his error thoroughly, has changed his practice accordingly, and has apologised to Ms A. In addition, I recommend that Dr B:

a) Undertake an audit of a random sample of 30 patient discharge summaries received by the medical centre, to confirm whether or not any recommendations and/or follow-up requests have been actioned. The results of the audit are to be sent to HDC within six months of the date of this report.

b) Complete a self-audit of his clinical records, using the Royal New Zealand College of General Practitioners clinical record review,[5] in light of Dr Maplesden's comments that his clinical documentation could be improved by consistent use of a more structured approach. A copy of the audit results is to be sent to HDC once completed, and within six months of the date of this report.

36. I recommend that the medical centre review and amend its policy on the management of clinical correspondence and results, in light of Dr Maplesden's comments. A copy of the amended policy is to be sent to HDC within six months of the date of this report.

[5] https://www.rnzcgp.org.nz/Quality/Foundation/Clinical_record_review/Quality/Foundation_pages/Clinical%20-record-review.aspx?hkey=9f319a37-9471-484f-8fb6-cdf9e7ed74f4 accessed 29 March 2023.

Follow-up actions

37. A copy of this report with details identifying the parties removed, except the advisor on this case, will be sent to the Medical Council of New Zealand and the Royal New Zealand College of General Practitioners, and they will be advised of Dr B's name.

38. A copy of this report with details identifying the parties removed, except the advisor on this case, will be sent to Te Tāhū Hauora | Health Quality & Safety Commission, the New Zealand Medical Association, and Te Aho o Te Kahu | Cancer Control Agency and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: In-house clinical advice to Commissioner

The following in-house advice was obtained from GP Dr David Maplesden:

'1. My name is David Maplesden. I am a graduate of Auckland University Medical School and I am a vocationally registered general practitioner with a current annual practising certificate. My qualifications are: MB ChB 1983, Dip Obs 1984, Certif Hyperbaric Med 1995, FRNZCGP 2003. Thank you for the request that I provide clinical advice in relation to the complaint from [Ms A] about the care provided to her by [Dr B] of [the medical centre]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have reviewed the following information:

- Complaint from [Ms A]
- Response from [Dr B]
- GP notes [medical centre]
- Selected policies [medical centre]

3. [Ms A] was assessed in [the] ED on 24 February 2018 (Saturday) in relation to injuries received … [Ms A] was diagnosed with multiple soft tissue injuries and was discharged the same day. The ED discharge summary includes the patient advice: *Please return to the Emergency department if you develop the following symptom: headache, worsening pain, any new concerns. See your GP on Monday for review to ensure you are improving as expected, and to review your shoulder injury for possible rotator cuff injury. There are no fractures seen on your x-rays. However you can use the wrist splint for comfort over the next 2–3 days as needed*. There is reference to the discharge summary being amended at 2210hrs on 24 February 2018 by Dr … (changes refer to clinical note). There was a further amendment to the discharge summary at 1150hrs on 26 February 2018 by Dr … documented as the leading part of the summary*: ct report: There is no intracranial haemorrhage or other intracranial abnormality. No fractures are identified. In the upper left neck, there is a 17mm diameter cystic appearing mass lying posteromedial to the angle of the mandible and just deep to the anterior aspect of sternocleidomastoid. This may be within the carotid space or from the deep lobe of parotid gland. A necrotic lymph node is possible. ENT referral and further evaluation with MRI is recommended. I have discussed this CT result with [Dr B] who will organise ENT follow-up for [Ms A] I couldn't get hold of [Ms A] on her phone.* It is not entirely clear to me from the amended discharge summary whether it was Dr … or Dr … who stated they contacted [Dr B] (and on what date) and this may require clarification from [the hospital].

4. [Ms A] attended [Dr B] on 26 February 2018 but it is unclear if this was before or after receipt of the amended discharge summary or contact from the [hospital] clinician. It is also unclear if this was a telephone consultation or face to face but the accident is recounted together with current symptoms and, in relation to a physical assessment, the comment: *will come back to see me*. On 28 February there is a note which reads

only: *is pt there*. The next note is dated 16 March 2018 and reads only: *bp*. There is a more complete consultation note dated 16 March 2018 which outlines further detail regarding the accident and current assessment findings with referral made for hip ultrasound. Thereafter there were multiple consultations for various musculoskeletal issues related both to the sequelae of the accident and to [Ms A's] pre-existing joint issues (mainly hands). I can find no record in the consultation notes of February and March 2018 to [Dr B] receiving a phone call from a [hospital] clinician per the amended discharge summary discussed above. I can find no record in these same clinical notes to [Dr B] discussing with [Ms A] the content of the amended discharge summary including the CT result and recommendation for ENT referral. It does not appear [Ms A] received a copy of the amended discharge summary.

5. Around 25 October 2020 [Ms A] attended [the] ED in relation to ongoing hip issues since her accident in February 2018. ED staff provided her with a copy of the amended discharge summary related to her first presentation following the accident and [Ms A] became aware, apparently for the first time, of the fact the CT scan in February 2018 had incidentally identified a possible suspicious mass in her neck and that [Dr B] had been advised to make an ENT referral for further investigation of the mass. [Ms A] informed [Dr B] of the situation and on 27 October 2021 [Dr B] made an urgent referral to an ENT surgeon and also provided a letter of apology to [Ms A]. The mass was found to be metastatic squamous cell carcinoma of unknown primary and [Ms A] has required extensive surgery and radiotherapy.

6. In his response to HDC, [Dr B] accepts he overlooked the findings and recommendations made in the amended ED discharge summary but he has no recollection of a phone call alerting him to the recommendation and, in particular, no phone call to his private number on 26 or 27 February 2018 (weekend) when the surgery was closed. He states it is likely he reviewed and filed the original discharge summary and the second amended summary, but filed the final amended summary (which contained the recommendations in question) without review as he likely believed it was a duplicate (receipt of duplicate ED summaries being a not uncommon occurrence). He states his usual practice is to enter such contact and recommendation into the patient note contemporaneously, and to communicate with the patient a need to come in for discussion and review. [Dr B] notes GPs are unable to order MRIs directly in the situation described in the discharge summary.

7. The current RNZCGP Foundation Standard (standard 5.1) requires the practice to have:

A documented clinical correspondence and investigations policy and procedure; covering how to manage and track:

- *laboratory results*
- *imaging reports*
- *significant investigations*
- *clinical correspondence*
- *urgent referrals*

I have reviewed the policy document provided by [the medical centre] in relation to this indicator. The policy describes in general terms the goal to ensure continuity of care and how it is the responsibility of [Dr B]: to create a seamless and safety netted system to ensure referrals are created, lab/investigations/results are read, recorded, tracked and followed up here at [the medical centre]. Tracking methods may include:

- *Automated electronic 'flag' to alert the requester at an identified period*
- *Automated electronic 'task' to direct the requester to investigate receipt of results at an identified period.*

Compared with policies I have reviewed from other practices regarding management of clinical correspondence and results, the document is lacking in detail regarding the specifics of how correspondence is managed including: differentiating electronic from hard copy correspondence; details of inbox management including management in the event of unforeseen absence of a clinician or use of a locum; handling of urgent results; handling of normal versus abnormal results; which results specifically require tracking. I believe the policy requires review and improvement to reach the standard I have seen from most other practices I have reviewed, but I acknowledge if the practice has received accreditation from RNZCGP for Foundation Standard, this policy has presumably been regarded as acceptable by the Foundation Standard assessors.

8. You have asked the following questions:

(i) *Whether the actions taken by [Dr B] with respect to the incidental finding found on the CT scan in February 2018 were adequate/appropriate.*

I do not believe the actions taken by [Dr B] on receipt of the amended ED discharge summary, which included the CT scan report identifying an abnormal neck mass and specifically requested the GP to make an ENT referral, was adequate. If there was no accompanying phone call from the clinician at [the hospital] discussing the abnormality and formally handing over management of the referral to [Dr B], I would be moderately critical of his failure to adequately review the amended discharge summary and act on the recommendations made in the summary. Mitigating factors considered are this was apparently the second amendment made to the discharge summary which means the third copy of the summary provided to [Dr B], and receipt of duplicate (non-amended) discharge summaries is not an uncommon occurrence. Given the potential significance of the information contained in the amended summary, and the risk of the written information not being received or reviewed by the target clinician, I believe it was important the amended summary was accompanied by telephone contact from the clinician who had referred [Ms A] for her scan (or a clinician acting on the referrer's behalf) to confirm the relevant information was received by [Dr B] and the request that he take over management of the abnormal result (by referral to an ENT surgeon) was accepted by him. If [Dr B] did receive such a phone call in addition to the written request to refer [Ms A] for an ENT review, I would be moderately to severely critical this contact was not documented or acted on by [Dr B] in a timely manner.

2. *Whether the policies and procedures in place at the time of events at [the medical centre] were adequate/appropriate.*

The 'usual' procedure [Dr B] states he would undertake on receipt of a phone call from a clinician regarding his patient is consistent with accepted practice and best practice would be to track any action planned as a consequence of the contact (eg schedule and complete a patient review, send a referral etc). I believe there are some deficiencies in the relevant practice policy as discussed in section 7.

3. *Any other matter that you consider amounts to a departure from the accepted standard of care.*

I do not believe there are any other matters, in relation to the incident in question, that amount to a departure from the accepted standard of care. I believe the standard of [Dr B's] clinical documentation might be improved by consistent use of a more structured approach to this documentation (eg the SOAP model) as it was difficult on occasions to identify a management plan or rationale for that plan. The issue identified of provision of information to a third party without specific consent (in relation to contact with … on 16 December 2020) I presume will be addressed by the Privacy Commissioner.'